



DICKINSON
COUNTY
HEALTHCARE
SYSTEM

July 19, 2019

Ms. Crystal A. O'Neal, Loan Specialist | Gladstone Area Office
Rural Development, U.S. Department of Agriculture
2003 Minneapolis Avenue
Gladstone, MI 49837

Dear Crystal:

Attached is a draft preapplication by Dickinson County Healthcare System (DCHS) for a Community Facilities direct loan per Federal Catalog Number 10.766 (the CF Loan). DCHS is a Municipal Health Facilities Corporation (MHFC) established under Act No. 230 of the Public Acts of Michigan, 1987 (Act 230). DCHS, as the applicant in connection with this preapplication, should be considered a unit of local government and a public body.

This draft pre-application contains the documents enumerated below. We have adapted this list from the Michigan Guide 2 (MI Instruction 1942-A) – Preapplication / Application Guide for Community Facility Loans and Grants, supplemented by other document forms that you had provided. As a governmental entity, DCHS is exempt from providing preapplication elements applicable only to non-profit organizations. Except for Availability of Other Commercial Credit Certification, all other documents are in draft form. Documents requiring authorization by the DCHS governing board (the Board) remain unsigned until the Board can adopt an appropriate resolution at its July 25 meeting.

1. Financing Plan
2. Introduction to Dickinson County Healthcare System
3. DCHS' CAGE number and evidence of registration with SAM
4. SF-424, together with project cost supporting schedules
5. Clearinghouse letter
6. Executed Availability of Other Commercial Credit Certification, together with denial letters from two lenders (with a third coming next week)
7. Denial letters from two lenders with respect to guaranteed CF Loans, with a third coming next week
8. Past eight years of DCHS' audited financial statements
9. Examined financial forecast prepared by Eide Bailly
10. Operating budget
11. Appraisal

1721 S. Stephenson
Iron Mountain
Michigan
49801

Phone
906/774-1313
www.dchs.org

We Are Here For You!

Ms. Crystal A. O'Neal
July 19, 2019
Re Dickinson County Healthcare System
Page 2

12. Legal Services Agreement
13. The Public Meeting and Public Notice of Intent relating to the July 25 Board meeting
14. Equal Opportunity Agreement
15. Assurance Agreement acknowledging compliance with anti-discrimination laws and regulations
16. acknowledgment of Federal Collection Policies
17. certification regarding Lobbying
18. certification regarding Debarment
19. certification regarding Drug-Free Workplace requirements
20. letters of support from local governments

Executed copies of documents requiring Board authorization will be submitted after the July 25 Board meeting.

Among other uses, the CF Loan will finance certain minor renovation projects which will involve either roofs or building interiors. None of these renovation projects will be ground-disturbing or affect the visible exteriors of buildings, none of which are greater than 50 years old. We understand that processes relating to Section 106 Review by the State Historic Preservation Office (SHPO) and those relating to environmental matters are substantially complete.

While we believe that DCHS' credit characteristics are sufficient to support forecasted debt service coverage ratios that meet Rural Development's underwriting criteria, we do not believe that those credit characteristics are strong enough to attract private-sector lenders. DCHS' certification regarding the lack of availability of commercial credit on reasonable terms, supported by lenders' denial letters, addresses the availability of credit without any federal guarantee. A federally-guaranteed CF Loan is, likewise, unavailable for the following reasons:

- DCHS has begun to post monthly operating surpluses only recently, not the more lengthy track record that private-sector lenders prefer;
- DCHS's liquidity levels remain very low;
- DCHS is highly leveraged;
- DCHS is in technical default of its largest debt instrument;

Ms. Crystal A. O'Neal
July 19, 2019
Re Dickinson County Healthcare System
Page 3

- DCHS' senior management team is not expected to have tenure beyond one year, so the quality and effectiveness of leadership over the longer run is unknown.

Denial letters from three lenders with respect to guaranteed CF Loans are included in this preapplication. We respectfully request that this preapplication be considered for an entirely direct CF Loan.

Please contact me if you have any questions or require additional information.
Cordially,



Jerry L. Worden, Interim Chief Financial Officer

1. FINANCING PLAN

This preapplication reflects a direct CF Loan in the principal amount of \$24,650,000. Proceeds of the CF Loan are expected to be applied in the following manner:

Refinancing of a Term Loan	\$ 9,875,000
Financing of Capital Assets:	
Facilities Improvement Projects	786,700
Major Clinical Equipment:	
Linear Accelerator.	3,242,323
CT Unit	640,673
SPECT CT Unit	690,588
MRI Unit.	1,623,668
Information Technology	3,353,290
Other Equipment.	4,035,690
Payment of Financing Fees	<u>402,068</u>
TOTAL	\$24,650,000

The Term Loan was issued in 2015 and refunded DCHS' Series 1999 Bonds. The Series 1999 Bonds advance refunded DCHS's Series 1994 Bonds which financed the construction of DCHS' main hospital facility (the Hospital Facility).

All of the Major Clinical Equipment requires Certificates of Need (CONs). Letters of Intent to file CONs have been submitted to the Michigan State Department of Health & Human Services (MDHHS). DCHS expects to file the CON applications by the end of July 2019. Because all of the Major Clinical Equipment represents replacements of existing equipment, DCHS expects favorable action. CONs are expected to be issued by the end of September 2019.

CF LOAN STRUCTURE

The CF Loan has a final maturity in 25 years from an assumed December 31, 2019 date of issuance. If the CF Loan were to be amortized monthly according to a level debt service schedule at an assumed rate of 3.50 percent (the rate currently in effect), the weighted average maturity (WAM) of the CF Loan would be approximately 14.3 years. The WAM compares to the composite useful life of the Capital Assets financed and refinanced of 11.3 years. Based on these CF Loan parameters, annual debt service on the CF Loan would be approximately \$1,482,000.

SECURITY FOR THE CF LOAN

Since the 1990s, title to the Hospital Facility and the land on which it is situated (the Real Property) has been held by Dickinson County (the County) and leased to DCHS. In connection with the CF Loan, the County will convey to DCHS title to the Real Property. DCHS expects to secure repayment of the CF Loan by granting to the United States of America acting through the United States Department of Agriculture (USDA) a first mortgage lien on the Real Property and security interests in some, but not all, fixtures and equipment located there (collectively, the Collateral). Repayment of the Term Loan will enable the release of liens and encumbrances currently outstanding in favor of the Term Loan lender.

DISPOSITION OF OTHER DEBT INSTRUMENTS

Prepayment of the Term Loan is imperative because it matures in March 2020, whereupon approximately \$9,395,000 would become due and payable. This amount far exceeds DCHS' financial assets. Closing the CF Loan before then would avert a payment default which could, clearly, have dire consequences.

DCHS plans to apply available financial assets toward the repayment of two other debt instruments. Thereafter, and in addition to the CF Loan, DCHS would still have two significant debt instruments remaining outstanding:

- Series 2004 Bonds, expected to be outstanding in the approximate principal amount of \$2,778,000 at the end of 2019; and
- Series 2016 Bonds, expected to be outstanding in the approximate principal amount of \$1,199,000 at the end of 2019.

Leaving the Series 2004 Bonds and Series 2016 Bonds outstanding would not affect the security for the CF Loan because both are secured by liens on assets other than the Collateral, and neither feature any cross-default provisions with respect to other debt instruments. In addition, leaving them outstanding poses no financial risk to DCHS because they feature long-term, fixed-rate, fully-amortizing structures, with no interest rate resets or possible balloon payments. The interest rate on the Series 2016 Bonds is a favorable 2.63 percent. The interest rate on the Series 2004 Bonds is a less favorable 5.66 percent, but a stiff prepayment penalty precludes their refinancing. Three other debt instruments would also remain outstanding, but their aggregate principal amount at the end of 2019 would be approximately \$188,000. They are either unsecured or secured by assets other than the Collateral.

2. INTRODUCTION TO DICKINSON COUNTY HEALTHCARE SYSTEM

DCHS owns and operates the 49-bed Dickinson County Memorial Hospital (the Hospital), of which 33 beds are currently available for service. All inpatient care and certain outpatient services are delivered in the Hospital Facility located in a commercial area on U.S. Highway 2 in Iron Mountain, Michigan (the City). Iron Mountain is the seat of Dickinson County (the County), and is situated in the central Upper Peninsula (the UP) of Michigan along the border with Wisconsin. The City is located approximately 225 miles north of Milwaukee, Wisconsin, and approximately 300 miles east of Minneapolis, Minnesota. In addition to the Hospital Facility, DCHS owns or leases several properties used for various outpatient and ancillary services which are located in the City and in nearby communities. The Hospital draws most of its patients from the County and from adjacent counties in the UP and in Wisconsin (the Market Area).

The Hospital is a fixture in its community. The Hospital provides essential services to Market Area residents, as evidenced by its designation by Medicare as a Sole Community Hospital. The next closest hospitals to the Market Area, located 44 and 50 miles away from the Hospital Facility, are both designated as Critical Access Hospitals (CAHs) with more limited scopes of services than the Hospital. The Hospital provides a more extensive array of services and in a high-quality manner, as demonstrated by the quality metrics set forth in the Quality section.

The Market Area exhibits a weak demographic profile. Like many rural areas, population is declining and aging. In 2017, the median age of County residents was 46.4, compared to 39.6 for State residents and 37.8 for U.S. residents. Median household income among County residents in 2017 was only 87 percent of that among State residents, and 79 percent of that among all U.S. residents. The County's poverty rates in 2017 exceeded national rates.

DCHS is among the largest employers in the County, paying employees nearly \$47 million in salaries and wages during 2017. The Dickinson Area Economic Development Alliance relies heavily on the availability of health care in the community, anchored by the Hospital, as a selling point for business recruitment and retention. In 2017, DCHS provided nearly \$15 million in community benefits, measured in accordance with Internal Revenue Service guidelines.

Closure of the Hospital Facility as the cornerstone of the local health care system would have a highly adverse impact on Market Area residents. The CF Loan would represent a critical ingredient for the preservation of accessible and quality health care services in the Market Area.

HISTORY

DCHS was formed in 1947 as a county public hospital under the provisions of Act No. 350 of the Public Acts of Michigan, 1913, as amended. In 1990, DCHS was reorganized as a MHFC under Act 230 and assumed all rights, privileges, immunities and franchises of the predecessor county hospital at the time.

In 1992, DCHS received a single license to operate both the Hospital and the former Anderson Memorial Hospital (Anderson) in Norway, Michigan, another acute care general hospital. Effective January 1994, DCHS was accorded Sole Community Hospital status under Medicare regulations. In June 1996, DCHS ceased operation of inpatient services at Anderson, and ceased

operation of outpatient services in October 1997 whereupon the Anderson facility was sold to the City of Norway.

In 1994, DCHS obtained a CON for the construction and equipping of the Hospital Facility. Its original construction was financed by DCHS's Series 1994 Bonds and was placed in service in 1996.

Over the years since the opening of the Hospital Facility, DCHS has added or expanded numerous outpatient and ancillary services. Highlights include:

- Direct Access Endoscopy Program
- UP Sleep Disorders Center
- Occupational Medicine
- Radiation Seed Implant Therapy
- Comprehensive Breast Imaging Program
- Lymphedema Therapy Program
- Bone Density Measurement Technology
- Fast Infusion Therapy
- Ambulatory Care Unit Technology Upgrades
- Digital Mammography
- Hospitalist Program
- Image Guidance Navigation System to Improve Surgical Accuracy
- Relocated Occupational Clinic
- Center for Wound Healing & Hyperbaric Medicine
- Dedicated OB / Gyn Clinic

Few of these services are offered by the CAHs which are the next closest to the Market Area.

2017

DCHS had recorded positive Operating Income for four consecutive years prior to 2016:

<i>Operating Income (\$000s omitted)</i>	
2015	4,479
2014	4,929
2013	41
2012	865

However, DCHS began to incur significant monthly operating losses in late 2016 and into 2017. Some causes were those typically encountered by rural hospitals, including:

- declining population;
- difficulties recruiting and retaining physicians;
- payment rates that do not maintain pace with increasing expenses;
- the inefficiencies of operating a small hospital; and
- decreasing utilization of DCHS services, partly due to increased competition from outpatient facilities and physician practices operated by Bellin Health (Bellin) which are located nearby.

DCHS was also affected by certain more unique challenges:

- loss of eligibility to participate in the 340B drug reimbursement between July 2016 and June 2017 because DCHS' DSH payment percentage was slightly below the threshold for Sole Community Hospitals;
- discontinuation of Blue Cross Blue Shield of Michigan (BCBSM) additional payments (BCBSM is DCHS' most significant non-governmental payor);
- increases in the out-of-pocket cost differential for BCBSM subscribers between health care services delivered by DCHS and other Michigan-based providers compared with the same services delivered by Wisconsin-based providers (an effect of being located on a state border);
- a sudden and sharp increase in premiums for employees' health insurance; and

- significant impact of Medicare's "two-midnight" rule which converted reimbursement for inpatient stays to lesser reimbursement for observation cases.

In response, DCHS began take aggressive action, including the following:

- reducing in staffing levels, as measured by full-time equivalents (FTEs);
- decreasing operating expenses especially among non-clinical functions such as marketing;
- eliminating certain services provided by employed physicians and mid-level providers such as physician assistants and nurse practitioners;
- curtailing capital expenditures, one reason for significant capital expenditures to be funded by the CF Loan.

BELLIN

In September 2016, DCHS announced that it had entered into a collaborative clinical relationship with Bellin Health Partners (BHP), an accountable care organization (ACO) affiliated with Bellin. Bellin is an independent, non-profit, integrated healthcare delivery system headquartered in Green Bay, Wisconsin. This initiative represented an expansion and formalization of long-standing collaborations between DCHS and Bellin.

During 2017, this clinical affiliation evolved into a proposed acquisition of DCHS by Bellin. Bellin increasingly recognized DCHS and its Market Area as the strategic gateway to expanding its presence in the UP. A market opportunity for Bellin emerged after the closure of a UPHS clinic in Iron Mountain. Before increasing its investments, however, Bellin believed that having governance control would be in its best interests. Contemporaneously, DCHS increasingly sensed the need for a stronger partner as its financial issues mounted.

In December 2017, DCHS announced the execution of a Letter of Intent (the Bellin LOI) with Bellin to explore the possibility of being acquired by Bellin. At the time, Bellin envisioned the acquisition as a strategic expansion of its footprint, complementing its family practice and diagnostic services clinic in Iron Mountain. Due diligence proceedings commenced and an Asset Purchase Agreement (the Bellin APA) began to be negotiated.

During due diligence proceedings in early 2018, DCHS' financial condition continued to deteriorate. In March 2018, Bellin, reinforcing its commitment to the preservation of health care services delivered by DCHS, extended a \$1.75 million loan (the Bellin Loan) to assist DCHS meet its short-term cash requirements. The Bellin Loan is one of the debt instruments to be repaid by DCHS from available financial assets contemporaneously with the closing of the CF Loan. Certain liens and encumbrances granted to Bellin will thereby be released.

Later in March 2018, DCHS and the County Board of Commissioners (the County Board) adopted resolutions approving the Bellin APA, despite the continued deterioration of DCHS' financial condition. To preserve the acquisition, DCHS and Bellin requested financial and other assistance from the State of Michigan (the State). However, the State, while agreeing to advance regulatory and licensing approval processes, declined to provide any financial assistance to DCHS. That led us to where we are today. While Bellin is a financially healthy organization, an increasing financial commitment, combined with DCHS's continuing financial issues, are cause for concern. Concerned with DCHS' financial condition, Bellin terminated the Bellin APA in May 2018.

Despite the termination of the Bellin APA, DCHS continues to participate in the BHP ACO. As an active partner in the BHP ACO, DCHS is able to share and measure patient care data, work and lead quality initiatives, participate in the shared savings and learn what it will take to implement high coordination for the entire population and take on full risk as the fee-for-service evolves to fee-for-outcomes. Because the BHP ACO is perennially among the national leaders in cost and quality, DCHS' participation is especially meaningful to Market Area residents.

UPHS

Immediately following the termination of the Bellin APA, DCHS initiated merger discussions with the Upper Peninsula Health System (UPHS). UPHS was originally formed in 2012 upon the acquisition of Marquette General Hospital by Duke LifePoint, a joint venture of Duke University Health System Inc. and LifePoint Health, a privately-held health care company. DCHS and UPHS executed a non-binding letter of intent (the UPHS LOI) in July 2018 to explore a possible sale of DCHS to UPHS, whereupon due diligence proceedings commenced to ensure that the acquisition is in the best interests of both parties. However, the contemporaneous acquisition of LifePoint Health by a private equity firm diverted the attention of UPHS management, causing DCHS and UPHS to terminate the UPHS LOI in September 2018.

LATE 2018

In addition to these operational issues, DCHS's cash position weakened after the Term Loan Lender exercised its right of set off with respect to approximately \$2.3 million of proceeds from DCHS's sale of its ownership interest in the Upper Peninsula Health Plan (UPHP), a State-sanctioned managed care organization for Medicaid beneficiaries. DCHS considered, but ultimately rejected a bankruptcy filing.

In October 2018, DCHS' long-standing Chief Executive Officer (CEO) retired effective at the end of 2018, and its Chief Financial Officer (CFO) resigned to take a CFO position with another local organization. DCHS engaged the law firm Venable LLP, led by Hon. Bart T. Stupak who had formerly represented the UP as its Congressman, to oversee a restructuring and formulation of a turnaround plan. Shortly thereafter, DCHS named Jeanne M. Goche as the Interim CEO and Dennis H. Smith as the Chief Restructuring Officer (CRO). Ms. Goche had previously served in similar capacities, leading financial turnarounds among several rural health care systems. Mr. Smith, a

long-time resident of the UP, had formerly been the CEO of UPHP so is highly familiar with the reimbursement environment in which DCHS operates.

These executives took immediate control over antiquated, duplicative and ineffective billing, revenue collection, expense payment and other revenue cycle systems to stabilize DCHS' financial condition and gain a better understanding of financial challenges facing DCHS. Venable was able to negotiate a 36-month schedule over which to repay excess Medicare periodic interim payments (PIP Overpayments) that were caused by declining patient care volumes. The repayment of the remainder of the PIP Overpayments represents the other debt instrument to be repaid by DCHS from available financial assets contemporaneously with the closing of the CF Loan.

The Michigan Nurses Association (MNA) represents registered nurses at the Hospital under a Collective Bargaining Agreement (CBA) that, at the time, was due to expire in February 2019. DCHS and MNA representatives agreed in December 2018 to extend the CBA until August 2019.

The late 2018 action plan featured the following initiatives:

- adjustments to the defined contribution pension plan;
- reductions in FTEs;
- sale of cardiology practice to Bellin;
- elimination of call pay for orthopaedic surgeons;
- reductions in purchased services;
- curtailment of advertising;
- adjustments to leases and rents;
- reduction of *locums tenens* fees;
- closures of certain physician practices;
- cuts to software maintenance arrangements; and
- change of food vendor.

In addition, management continued its efforts to improve various revenue cycle functions.

EARLY 2019

To round out the senior management team, DCHS engaged Jerry L. Worden as its Interim Chief Financial Officer (CFO) in April 2019. Mr. Worden is a resident of the UP and an experienced hospital CFO, having held that position with Marquette General Hospital from 2008 until its sale in 2012. Mr. Worden's current plan is to remain as Interim CFO until at least October 2019.

As a result of improvement measures commenced in 2018 taking hold, DCHS' financial performance has improved. Tabulated below is a summary of DCHS' six-month internal financial statements. As a governmental entity, DCHS presents its financial statements according to accounting principles prescribed by the Governmental Accounting Standards Board (GASB). This summary converts DCHS' Statements of Revenues, Expenses and Changes in Net Position under GAAP to the more familiar Statement of Operations format that would be applicable to non-profit hospitals which are subject to accounting principles prescribed by the Financial Accounting Standards Board (FASB).

D R A F T

Statements of Operations FASB Format (\$000s omitted)							
	Six Months Ended June 30						
	2019	2019	Favorable (Unfavorable)		2018	Favorable (Unfavorable)	
	Actual	Budget	Dollar Variance	Pct'age Variance	Actual	Dollar Variance	Pct'age Variance
Net Patient Service Revenue	46,594	48,027	(1,433)	(3.0)%	49,171	(2,577)	(5.2)%
Other Operating Revenue	<u>2,826</u>	<u>2,493</u>	<u>333</u>	<u>13.4%</u>	<u>2,407</u>	<u>419</u>	<u>17.4%</u>
Total Operating Revenue	49,420	50,520	(1,100)	(2.2)%	51,578	(2,158)	(4.2)%
Salaries and Wages	19,746	18,048	(1,699)	(9.4)%	22,995	3,249	14.1%
Employee Benefits	7,327	7,429	102	1.4%	7,963	636	8.0%
Supplies and Pharmaceuticals	9,433	10,813	1,381	12.8%	10,401	968	9.3%
Medical & Other Professional Fees	5,055	6,052	997	16.5%	5,967	911	15.3%
Purchased Services and Other	5,012	5,886	874	14.8%	6,122	1,109	18.1%
Depreciation & Amort. Expense	1,467	1,537	70	4.5%	1,730	263	15.2%
Interest Expense	<u>593</u>	<u>598</u>	<u>5</u>	<u>0.8%</u>	<u>464</u>	<u>(129)</u>	<u>(27.8)%</u>
Total Operating Expenses	48,634	50,363	1,729	3.4%	55,643	7,009	12.6%
Income from Operations	786	157	629	401.2%	(4,065)	4,851	
Unrestricted Investment Income	8	7	1	19.6%	9	(1)	(6.5)%
Unrestricted Contributions	<u>53</u>	<u>35</u>	<u>18</u>	<u>50.4%</u>	<u>38</u>	<u>15</u>	<u>39.4%</u>
Revenue over Expenses	847	199	648	326.1%	(4,018)	4,865	

Patient service volumes continue to decrease, as evidenced by decreases in Net patient service revenue since 2018. However, management has offset the impact with expense reduction and other operational improvements. Total operating expenses in 2019 were favorable to budget by 3.4 percent, and represent a 12.6 percent reduction over 2018.

GOVERNANCE

The County Board is elected by popular vote, and oversees the management of all County departments and agencies, including DCHS. One of the County Commissioners serves as liaison to the DCHS Board of Trustees, but the County Board takes a “hands-off” approach with respect to DCHS, and delegates governance of DCHS to its Board of Trustees (the DCHS Board).

The DCHS Board is comprised of nine voting Trustees who are appointed by the County Board. No more than three Trustees may be direct providers of health care. Trustees are appointed

on an at-large basis for four-year terms coinciding with DCHS's fiscal years ending on December 31. The Board of Trustees sets policy but delegates day-to-day management of DCHS to the CEO and other members of senior management.

DCHS Board of Trustees			
Name	Year First Appointed	Term Expires Dec. 31	Occupation / Affiliation
Margaret Minerick, ^{1,3} Chairperson	2018	2021	Secretary/Treasurer, Minerick Logging, Inc. (forest products)
David J.Brisson, ^{1,2,3} Vice-Chairperson	2018	2020	President, Great American Environmental Services, Inc. (refuse systems)
Sally L. Blom, Secretary	2017	2021	Realtor, Stephens Real Estate
Jeffery Campbell	2016	2020	Senior Vice President and Chief Financial Officer, M.J. Electric (electrical contractors)
William Edberg ²	2015	2019	Community Bank President (retired), Range Bank
David Holmes	2018	2022	Principal, Kingsford Middle School
Kim Van Osdol	2018	2022	Market President, Great North Bank
John S. To, M.D. ³	2019	2019	Radiologist in private practice
Daniel Wender	2018	2022	Business Owner, DJW Services (property management)
Donald G. Kube, Jr., D.O.	Ex-officio, non-voting		Anesthesiologist in private practice; Chief of the Medical Staff
¹ Had been a Trustee prior to his/her current term ² Prior Chairperson ³ Appointed to fill unexpired term due to prior Trustee’s resignation			

There has been significant turnover among the Trustees recently. Five of the nine Trustees at the beginning of 2018, a majority, were no longer members of the Board at the beginning of 2019. Two of the new Trustees assumed their positions in November 2018. A new Chairperson and Vice-Chairperson were elected at the beginning of 2019.

FACILITIES AND SERVICES

The Hospital provides access to health care and extensive specialty services to the residents of the Market Area, consisting of small communities and rural areas. Without the Hospital, Market Area residents would be required to travel approximately 90 miles over two-lane roads to obtain comparable health care and specialty services. Brutal winter weather conditions compound the accessibility issue.

The Hospital's current bed capacity is as follows:

<i>Licensed Bed Capacity</i>	
Medical/Surgical, ICU	36
Obstetrics	9
Pediatrics	4
Total	49

The Hospital generally staffs 33 beds which can vary among the three categories.

The Hospital offers most inpatient, outpatient and ancillary services commonly found in community hospitals. Many of these were introduced or expanded since the opening of the Hospital Facility in 1996. Among the more unique services offered are:

- radiation therapy, for which the new linear accelerator included among the Major Clinical Equipment represents the cornerstone of the service;
- hospitalists, which enable the Hospital to treat higher-acuity inpatients;
- UP Sleep Disorders Center; and
- Home Health Care and Home Medical Equipment.

Outpatient and ancillary services are delivered away from the Hospital Facility at multiple locations around the County and in Iron County to the west, Delta County to the east and in northern Wisconsin.

LICENSES, ACCREDITATIONS AND CERTIFICATIONS

LICENSURE

DCHS' Hospital is licensed by the Michigan Department of Licensing and Regulatory Affairs ("LARA"), Bureau of Community and Health Systems. The current license to operate the Hospital and its 49 inpatient beds expires on July 31, 2019, but is expected to be renewed.

Certain other facilities and services are licensed by various federal and state authorities.

<i>Licensure of Clinical and Support Functions</i>			
<i>Hospital Department</i>	<i>Licensing Agency</i>	<i>Function</i>	<i>License Expiration</i>
Durable Medical Equipment	LARA	Durable Medical Equipment	08/30/2021
Pharmacy	LARA	Pharmacy	06/30/2020
Pharmacy	LARA	Controlled Substances	06/30/2020
Laboratory	CMS	Clinical Laboratory	01/02/2021
Radiology	U.S. Nuclear Regulatory Commission	Nuclear Medicine	01/31/2026
Women's Diagnostic Center	LARA Radiation Safety Section	Mammography Unit	12/01/2019
Radiology	LARA Radiation Safety Section	CT Scanner, Radiographs and Fluoroscopes	12/01/2019
Emergency	Federal Communications Commission	Radio Station	10/20/2022
Dietary	Michigan Department of Agriculture & Rural Development	Food Service	08/30/2021
DME (Bark River office)	LARA Board of Pharmacy	Manufacturer	08/10/2021
DME (Iron Mountain office)	LARA Board of Pharmacy	Wholesale Distributor	08/30/2021
DME (Iron Mountain office)	U.S. FDA	Drug Establishment	12/31/2019
DME (Iron Mountain office)	State of Wisconsin Pharmacy Examining Board	Home Medical Oxygen	06/01/2020
Durable Medical Equipment	State of Wisconsin	Medical Equipment	06/01/2020

ACCREDITATIONS AND CERTIFICATIONS

The Hospital is accredited by The Joint Commission. The Hospital's current accreditation was renewed by The Joint Commission for another three-year period, the maximum awarded, on

December 19, 2018. The Joint Commission accredits DCHS' Home Care division for a three-year period that became effective on October 13, 2018. The Joint Commission also accredits DCHS' Clinical Laboratory and Pharmacy Medication Compounding function for two-year periods. Their most recent accreditation surveys were conducted during the spring of 2019. DCHS has not been formally notified of the outcome, but is expecting accreditation to be granted.

Certain clinical functions maintain separate accreditations or certifications:

- American College of Radiology – MRI, CT Scanning, Mammography, Ultrasound
- American Academy of Sleep Medicine – U.P. Sleep Disorders Center
- American Association of Cardiovascular and Pulmonary Rehabilitation – Cardiopulmonary Rehabilitation Center
- American Association of Respiratory Care – Respiratory Care
- Intersocietal Accreditation Commission – Echocardiography Lab
- American Physical Therapy Association – Physical Therapy
- American Occupational Therapy Association – Occupational Therapy
- American Speech-Language-Hearing Association – Speech Pathology
- American Association for Accreditation of Ambulatory Surgery Facilities – OB/GYN Clinic

COMPLIANCE

The DCHS Compliance Program provides a framework from which management, staff and the Board of Trustees can conduct business in such a manner as to ensure compliance with laws and regulations that govern DCHS' activities as a healthcare system and can operate and conduct all of its activities consistent with these standards. The DCHS Compliance Program establishes procedures to ensure that DCHS does not inadvertently become enmeshed in a fraud investigation or improper conduct through the actions of business associates.

QUALITY

DCHS has made an organization-wide commitment to quality improvement, risk management and patient safety. Quality improvement, risk management and patient safety are a collaborative effort among all Hospital departments and affiliated practitioners who have a direct or indirect effect on patient care. DCHS's strategic planning framework encompasses the

interrelated functions, processes, and objectives of quality improvement including governance, business, support and clinical services. Continual improvement is a process by which care delivery, patient outcomes and customer satisfaction are continually measured and opportunities to improve care, safety, processes and applicable requirements are identified. This effort is closely aligned with DCHS' core values, including the concept of "caring for our neighbors" and its vision of striving for perfect care every time.

ORGANIZATION AND LEADERSHIP

The Quality Improvement Committee (QIC) is an interdisciplinary committee comprised of physicians, DCHS Board members, management, staff and community members, together with other individuals having organizational responsibility for quality, safety and risk management. The primary responsibility of the QIC is to establish and maintain a culture of quality improvement, risk management and patient safety throughout the organization. DCHS' Vice President of Clinical Services and Population Health and its Corporate Compliance and Risk Officer are responsible for overseeing quality improvement, risk management and patient safety, and, together, serve as principal staff to the QIC. Each Department Director/Manager is responsible for ensuring that monitoring and evaluation activities occur to identify improvement opportunities, as well as for periodic assessment of individual caregiver performance.

QUALITY IMPROVEMENT PROGRAMS

DCHS participates in KEPRO, the Beneficiary and Family Care Centered Quality Improvement Organization (BFCC-QIO) for more than 30 states under contract with the United States Center for Medicare and Medicaid Services (CMS). The BFCC-QIO Program is an integral part of Medicare's efforts to improve the quality of care and health outcomes for beneficiaries.

PDCA

DCHS utilizes a collaborative interdisciplinary approach to performance improvement that is planned, systematic and organization-wide. Performance improvement activities include how the organization designs, measures, assesses, and improves important processes or outcomes related to patient care, patient safety and/or organizational functions. The processes or outcomes selected are studied utilizing the Plan/Do/Check/Act (PDCA) model.

A cornerstone of the PDCA model is the Daily Patient Safety Huddle process. DCHS utilizes the Daily Patient Safety Huddle to identify immediate past and present quality, risk and safety concerns. Key clinicians, operations leadership and administrators convene each morning to address pressing issues on-the-spot and to conduct other PDCA activities.

DCHS employs several frames of reference to assess ongoing performance, which includes internal comparisons, comparisons to current sources of information, such as accreditation standards, practice guidelines and parameters, and/or benchmarking comparisons with similar processes and outcomes from external sources using reference databases, along with consideration of legal and

regulatory requirements. Process and outcome measurement may include time studies, chart reviews, internal audits, patient/customer surveys and visual reviews. A scientific approach and basic statistical tools are parts of the measurement process. Tools may include flow mapping, *Pareto* charts, cause and effect diagrams, run charts, control charts, check sheets, brainstorming, nominal group technique and multi-voting, among others. While the Daily Patient Safety Huddle is a routine process, sometimes more intensive assessment would be in order, using tools within the PDCA framework such as:

- Lean, a process redesign approach;
- Failure Mode Effect Analysis, a proactive assessment and redesign of a high risk process conducted before an adverse event can occur; and
- Root Cause Analysis, a retrospective analysis of adverse events.

In recent years, DCHS has implemented several leading-edge programs and has earned recognition for its achievements. For instance, DCHS commenced using practice guidelines long before their use was mandated by third-party payors.

DCHS management believes that its staff welcomes external oversight and audits. Management reports that staff routinely engage with surveyors and evaluators to obtain feedback as to how quality practices can be improved even further.

QUALITY AWARDS

DCHS is frequently recognized for superior quality. Recognition from two of the leading quality assessment organizations is summarized in the following table.

Certain Quality Awards							
			2018	2017	2016	2015	2014
Leapfrog Patient Safety Grade			A	A	A	A	A
Healthgrades Awards for Clinical Excellence							
	Critical Care						
		Excellence Award™	✓				
		Top 10% in Nation	✓				
		Sepsis treatment	★★★★★	★★★★★	★★★★★	★★★★★	
		Respiratory failure treatment	★★★★★		★★★★★		
	Cardiac						
		Heart Attack treatment	★★★★★	★★★★★	★★★★★	★★★★★	
		Heart Failure treatment	★★★★★	★★★★★	★★★★★		
	Pulmonary						
		Excellence Award™	✓	✓	✓		
		Top 10% in Nation	✓	✓	✓		
		Pneumonia treatment	★★★★★	★★★★★	★★★★★		
		COPD treatment		★★★★★	★★★★★		
	Patient Safety						
		Excellence Award™	✓	✓	✓	✓	
		Top 10% in Nation	✓	✓		✓	
		Top 5% in Nation	✓	✓			
	Gastrointestinal						
		Excellence Award™		✓	✓		
		Top 10% in Nation		✓	✓		
		GI bleed treatment		★★★★★	★★★★★		
		Bowel obstruction treatment		★★★★★	★★★★★		

The Leapfrog Group, an independent national nonprofit organization, calculates a single safety score, based upon 26 measures of publicly-available hospital safety data, which represents a hospital's overall capacity to keep patients safe from infections, injuries, and medical and medication errors. *The Leapfrog Group* assigns ratings every six months. DCHS earned "A" ratings

for the twelfth consecutive reporting period in 2018, which translates into six consecutive years of this highest rating.

Healthgrades is a US company that provides information about physicians, hospitals and health care providers. *Healthgrades* evaluates hospitals solely on risk adjusted mortality and in-hospital complications based on Medicare discharge data. DCHS earned 5-star ratings for treatment of sepsis and pneumonia again in 2019.

Other awards and citations earned recently by DCHS include:

- ranked by Consumer Reports in 2014 as the 5th best out of 142 Michigan hospitals (not repeated since then);
- designation by BCBSM of DCHS's Family Birth Center as a *Blue Distinction Center+* for Maternity Care, and *Gold Star Designation* by the Michigan Alliance for Innovation on Maternal Health;
- receipt of the Gold Star Award from the Michigan Alliance for Innovation in Maternal Health (MI AIM) from having improved the health outcomes for patients by fully equipping clinical staff in labor and delivery units with the education, equipment, protocols and hands-on training necessary to prevent maternal death and diagnose and treat severe, life-threatening complications that can occur during labor and delivery;
- the Economic Alliance of Michigan's *Excellence in Patient Safety Award* and *Excellence in Maternity Care Award*;
- Governor's Awards of Excellence; and
- recognition by Becker's Hospital Review as one of the *Top 100 Community Hospitals*.

HOSPITAL QUALITY METRICS

COMPARATIVE QUALITY MEASURES

<i>CMS Hospital Compare Overall Rating February 2019</i>		
	<i>Miles from DCHS</i>	<i>Overall Rating</i>
DCHS		★★★★
Aspirus Iron River Hospital	44	★★★★
St Francis Hospital	50	★★★★

Both Aspirus Iron River and St. Francis Hospitals are CAHs offering narrower ranges of services than does DCHS.

CORE MEASURES

Core measures are used to track a variety of evidence-based and heavily researched standards of care designed to improve clinical outcomes for patients. Core measures of care represent the percentage of patients who received all recommended treatments and preventive measures based on their clinical condition.

TIMELY AND EFFECTIVE CARE MEASURES

Measures of timely and effective care (also known as “process of care” measures) show (1) the percentage of hospital patients who receive treatments known to get the best results for certain common, serious medical conditions or surgical procedures, and (2) how quickly hospitals treat patients who come to the hospital with certain medical emergencies. These measures reflect accepted standards of care, based on current scientific evidence. According to CMS, they are regularly reviewed and revised to ensure that they are up-to-date. The Hospital’s timely and effective care measures for which statistically sufficient data were reported, with comparisons to State and national averages, are presented in the table below.

<i>Survey of Patients' Experiences</i> <i>Discharges between April 1, 2017 and March 31, 2018</i> <i>Greater Percentages are Favorable</i>			
		<i>Averages</i>	
	<i>DCHS</i>	<i>State</i>	<i>U.S.</i>
Patients who reported that their nurses "Always" communicated well	79%	82%	80%
Patients who reported that their doctors "Always" communicated well	81%	81%	81%
Patients who reported that they "Always" received help as soon as they wanted	72%	73%	70%
Patients who reported that staff "Always" explained about medicines before giving it to them	65%	66%	66%
Patients who reported that their room and bathroom were "Always" clean	81%	75%	75%
Patients who reported that the area around their room was "Always" quiet at night	64%	60%	62%
Patients who reported that YES, they were given information about what to do during their recovery at home	91%	89%	87%
Patients who "Strongly Agree" they understood their care when they left the hospital	55%	54%	53%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	74%	74%	73%
Patients who reported YES, they would definitely recommend the hospital	68%	72%	72%
Source: CMS Hospital Compare website accessed August 9, 2016			
Note: Small differences between DCHS's scores and State and U.S. average scores might not be statistically significant			

<i>Timely and Effective Care Measures</i> <i>Discharges between April 1, 2017 and March 31, 2018 unless Otherwise Noted</i> <i>Greater Percentages and Fewer Minutes are Favorable unless Otherwise Noted</i> <i>(measures for which DCHS reported statistically insufficient data are excluded)</i>			
		<i>Averages</i>	
	<i>DCHS</i>	<i>State</i>	<i>U.S.</i>
<i>Timely Heart Attack Care</i>			
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG	6	7	8
Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department	95%	96%	95%
<i>Emergency Department Care</i>			
Average (median) time patients who came to the emergency department with broken bones had to wait before getting pain medication (fewer is better)	45	45	40
Percentage of patients who left the emergency department before being seen (discharges between January 1 and December 31, 2017)	1%	2%	2%
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	50%	73%	73%
Average (median) time (in minutes) patients spent in the emergency department, before they were admitted to the hospital as an inpatient (fewer is better) ²	220	2230	210
Average (median) time (in minutes) patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room (fewer is better) ²	60	60	56
Average (median) time (in minutes) patients spent in the emergency department before leaving from the visit (fewer is better) ²	140	117	112
Average (median) time (in minutes) patients spent in the emergency department before they were seen by a healthcare professional (fewer is better) ²	20	15	16
<i>Preventative Care</i> <i>(discharges between October 1, 2017 and March 31, 2018)</i>			
Patients assessed and given influenza vaccination ³	99%	94%	93%
Healthcare workers given influenza vaccination	81%	91%	89%
<i>Cancer Care</i>			
Percentage of patients receiving appropriate radiation therapy for cancer that has spread to the bone	86%	90%	86%
<i>Pregnancy and Delivery Care</i>			
Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary (lower is better) ³ (discharges between January 1 and December 31, 2017)	0%	1%	2%

<i>Timely and Effective Care Measures</i> <i>Discharges between April 1, 2017 and March 31, 2018 unless Otherwise Noted</i> <i>Greater Percentages and Fewer Minutes are Favorable unless Otherwise Noted</i> <i>(measures for which DCHS reported statistically insufficient data are excluded)</i>			
		<i>Averages</i>	
	<i>DCHS</i>	<i>State</i>	<i>U.S.</i>
<i>Timely & Effective Sepsis Care</i>			
Percentage of patients who received appropriate care for severe sepsis and septic shock	44%	49%	51%
<i>Colonoscopy Follow-Up</i> <i>(discharges between April 1 and December 31, 2017)</i>			
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy	99%	93%	83%
Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe	94%	94%	90%
Source: CMS Hospital Compare website accessed June 19, 2019 Note: Small differences between DCHS's scores and State and U.S. average scores might not be statistically significant ¹ Results are based on a shorter time period than required ² Compared to low-volume hospitals – those having fewer than 20,000 ED patients annually ³ Data submitted were based on a sample of cases/patients			

OTHER CMS HOSPITAL COMPARE MEASURES

According to the CMS Hospital Compare results announced in February 2019, certain surgical complication rates, healthcare-associated infection rates, readmission rates and death rates for which DCHS reported statistically sufficient data were no different than national norms. DCHS' value of care with respect to heart attack, heart failure hip/knee replacement and pneumonia patients were also no different than national norms.

HOSPITAL IMPROVEMENT INNOVATION NETWORK

DCHS participates in a Hospital Improvement Innovation Network (HIIN) sponsored by the Michigan Health and Hospital Association (MHA) and in conjunction with the Illinois and Wisconsin State Hospital Associations. HIINs operate at the regional, state, national or hospital system level to help identify solutions already working and to disseminate them to other hospitals and providers. HIINs are designed to:

- develop learning collaboratives for hospitals;
- provide a wide array of initiatives and activities to improve patient safety;
- conduct intensive training programs to help hospitals make patient care safer;

- provide technical assistance to help hospitals achieve quality measurement goals; and
- establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.

The HIIN in which DCHS participates is sanctioned by CMS.

DCHS is able to compare certain quality of care measures against peer groups comprised of all MHA member hospitals and all HIIN hospitals over several reporting periods. In general, DCHS has performed well against these peer groups in most reporting periods.

D R A F T

30-Day Readmission Rates (lower percentages are better)								
	to Same Hospital or Elsewhere				to Same Hospital			
		80 th Percentile				80 th Percentile		
FFY	DCHS	National	Jurisdiction ¹	State	DCHS	National	Jurisdiction ¹	State
2019Q1	13.1%	19.8%	20.5%	20.8%	8.0%	14.7%	15.0%	15.4%
2018Q4	14.6%	20.0%	20.1%	20.8%	11.6%	14.8%	15.1%	15.5%
2018Q3	7.4%	19.9%	18.7%	20.2%	N/A	14.6%	14.8%	15.3%
2018Q2	8.8%	19.8%	20.0%	20.9%	N/A	14.6%	15.2%	15.3%
2018Q1	13.0%	20.0%	19.4%	20.1%	9.6%	14.9%	15.1%	15.1%
2017Q4	11.1%	19.9%	19.8%	20.4%	7.3%	14.7%	14.7%	15.3%
2017Q3	15.9%	19.8%	19.7%	20.1%	11.0%	14.6%	15.4%	15.4%
2017Q2	12.2%	19.9%	20.1%	21.4%	8.7%	14.7%	15.5%	16.0%
2017Q1	11.9%	19.9%	19.3%	20.1%	8.3%	14.8%	15.3%	15.5%
2016Q4	12.5%	19.9%	19.7%	19.9%	9.4%	14.8%	15.2%	15.7%
2016Q3	12.9%	19.7%	19.3%	20.2%	10.8%	14.6%	15.0%	15.2%
2016Q2	11.3%	19.9%	19.5%	20.6%	8.6%	14.7%	15.2%	16.1%

Source: Program for Evaluating Payment Patterns Electronic Report (PEPPER)

¹ 85 Michigan and 90 Indiana short-term acute care hospitals in the J8 Wisconsin Physicians Service Insurance Corporation jurisdiction

HOME CARE QUALITY METRICS

DCHS Home Care earned a “4½-Star” rating from CMS in its latest assessment of patient care quality among home care agencies released on May 17, 2019.

<i>CMS Home Care CAHPS Survey Results</i> <i>For All Measures, Higher Percentages are Favorable</i> <i>except those relating to Preventing Unplanned Hospital Care</i> <i>May 17, 2019 Quarterly Update</i>			
	<i>DCHS Home Care</i>	<i>Averages</i>	
		<i>State</i>	<i>U.S.</i>
Patient survey summary star rating	★★★★½	★★★★½	★★★★½
<i>Managing Daily Activities</i>			
Improvement in walking or moving around	80.9%	75.2%	76.3%
Improvement in getting in and out of bed	76.2%	75.2%	75.6%
Improvement in bathing	83.1%	78.4%	78.5%
<i>Managing Pain and Treating Symptoms</i>			
How often patients had less pain moving around	86.1%	78.6%	79.3%
How often patients breathing improved	85.7%	76.9%	78.4%
How often patients wounds improved or healed	94.5%	89.9%	91.2%
How often patients developed new or worsened pressure ulcers	0.4%	0.4%	0.4%
<i>Preventing Harm</i>			
How often was patients care started timely	99.7%	91.4%	94.6%
How often were patients or their caregivers taught about their medications	99.5%	97.3%	98.3%
How often patients got better at taking their medications	76.5%	67.6%	67.6%
How often patients assessed for risk of falling	100.0%	99.6%	99.6%
How often patients assessed for depression	100.0%	97.9%	97.5%
How often patients assessed for influenza vaccine	78.7%	78.9%	78.6%
How often patients assessed for pneumococcal vaccine	86.5%	81.3%	81.6%
For diabetic patients, how often a physician wrote an order for foot care and was taught about foot care	100.0%	97.7%	97.8%
How often physician-recommended actions to address medication issues were completed timely	99.2%	92.7%	92.6%
<i>Preventing Unplanned Hospital Care</i>			
How often patients needed urgent, unplanned care in the ED (not admitted)	14.0%	12.5%	13.0%
How often patients were admitted to hospital	15.4%	15.9%	15.8%
Source: Medicare.gov Home Health Compare website accessed July 1, 2019			

<i>CMS Home Care CAHPS Survey Results</i> <i>All Measures are Favorable except Preventing Unplanned Hospital Care</i> <i>May 17, 2019 Quarterly Update</i>			
	<i>DCHS Homecare</i>	<i>Averages</i>	
		<i>State</i>	<i>U.S.</i>
Patient survey summary star rating	★★★★		
How often the home health team gave care in a professional way	90%	89%	88%
How well did the home health team communicate with patients	89%	84%	85%
Did the home health team discuss medicines, pain, and home safety with patients	83%	83%	83%
How do patients rate the overall care from the home health agency	88%	82%	83%
Would patients recommend the home health agency to friends and family	83%	74%	77%
Source: Medicare.gov Home Health Compare website accessed July 1, 2019			

BCBSM QUALITY AND VALUE INCENTIVES

DCHS participates in BCBSM's Physician Group Incentive Program (PGIP). The PGIP, together with the qualification of certain DCHS physician practices as patient-centered medical homes (PCMHs) provides for enhanced payment rates. DCHS realized \$106,976 of incentive payments during FY2018 from the PGIP, PCMH and other BCBSM programs.

DCHS participates in the BCBSM Collaborative Quality Initiative (CQI) program. DCHS earned an additional payment of \$588,000 in recognition of its active participation in the CQI program during FY2018.

DICKINSON COUNTY HEALTHCARE SYSTEM

CAGE Number: 1CNF0

Evidence of SAM Registration:

From: samadmin@sam.gov [mailto:samadmin@sam.gov]

Sent: Wednesday, January 30, 2019 11:46 AM

To: Patti Mattson

Cc: Patti Mattson

Subject: Registration Activated for DICKINSON CO HEALTHCARE SYSTEM / 829127757 / 1CNF0 in the U.S. Government's System for Award Management (SAM)

This email was sent by an automated administrator. Please do not reply to this message.

Dear Patti Mattson,

The registration for DICKINSON CO HEALTHCARE SYSTEM / 829127757 / 1CNF0 is now active in the U.S. Government's System for Award Management (SAM). If you did not provide a Commercial and Government Entity (CAGE) Code during the registration process, one has been assigned to you by the Defense Logistics Agency (DLA) CAGE Program.

In order to remain eligible to do business with the Federal government, you must renew your entity's registration in SAM every year. The annual renewal date for the registration is 2020-01-30 11:53:00.

APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED	Applicant Identifier	
☐ Construction	Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier	
☐ Non-Construction	☒ Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier	
5. APPLICANT INFORMATION				
Legal Name: Dickinson County Healthcare System		Organizational Unit: Department:		
Organizational DUNS: 8291277570000		Division:		
Address: Street: 1721 Stephenson Avenue		Name and telephone number of person to be contacted on matters involving this application (give area code)		
City: Iron Mountain		Prefix: Mr.	First Name: Jerry	
County: Dickinson		Middle Name L.		
State: Michigan		Last Name Worden		
Zip Code 49801	Suffix:			
Country: United States		Email: Jerry.Worden@dchs.org		
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 38-2780429		Phone Number (give area code) (906) 569-3384		Fax Number (give area code) (906) 776-5703
8. TYPE OF APPLICATION: ☒ New ☐ Continuation ☐ Revision If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐ Other (specify)		7. TYPE OF APPLICANT: (See back of form for Application Types) G - Special District Other (specify)		
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 10-766		9. NAME OF FEDERAL AGENCY: USDA Rural Development		
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Dickinson County and surrounding areas		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Replace roof on hospital building, acquire modern medical and information system equipment and refinance outstanding debt.		
13. PROPOSED PROJECT Start Date: Ending Date: 12/31/2020		14. CONGRESSIONAL DISTRICTS OF: a. Applicant First b. Project First		
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?		
a. Federal	\$ 24,650,000.00	a. Yes. ☒ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:		
b. Applicant	\$ 0.00	b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372		
c. State	\$ 0.00	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW		
d. Local	\$ 0.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?		
e. Other	\$ 0.00	☐ Yes If "Yes" attach an explanation. ☒ No		
f. Program Income	\$ 0.00			
g. TOTAL	\$ 24,650,000.00			
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.				
a. Authorized Representative				
Prefix Ms.	First Name Margaret	Middle Name		
Last Name Minerick	Suffix			
b. Title Chairperson	c. Telephone Number (give area code) (906) 282-3961			
d. Signature of Authorized Representative	e. Date Signed 07/25/2019			

INSTRUCTIONS FOR THE SF-424

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0043), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

This is a standard form used by applicants as a required face sheet for pre-applications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:	Item:	Entry:
1.	Select Type of Submission.	11.	Enter a brief descriptive title of the project. If more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of this project.
2.	Date application submitted to Federal agency (or State if applicable) and applicant's control number (if applicable).	12.	List only the largest political entities affected (e.g., State, counties, cities).
3.	State use only (if applicable).	13.	Enter the proposed start date and end date of the project.
4.	Enter Date Received by Federal Agency Federal identifier number: If this application is a continuation or revision to an existing award, enter the present Federal Identifier number. If for a new project, leave blank.	14.	List the applicant's Congressional District and any District(s) affected by the program or project
5.	Enter legal name of applicant, name of primary organizational unit (including division, if applicable), which will undertake the assistance activity, enter the organization's DUNS number (received from Dun and Bradstreet), enter the complete address of the applicant (including country), and name, telephone number, e-mail and fax of the person to contact on matters related to this application.	15.	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.
6.	Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.	16.	Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernmental review process.
7.	Select the appropriate letter in the space provided. A. State B. County C. Municipal D. Township E. Interstate F. Intermunicipal G. Special District H. Independent School District I. State Controlled Institution of Higher Learning J. Private University K. Indian Tribe L. Individual M. Profit Organization N. Other (Specify) O. Not for Profit Organization	17.	This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes.
8.	Select the type from the following list: "New" means a new assistance award. "Continuation" means an extension for an additional funding/budget period for a project with a projected completion date. "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation. If a revision enter the appropriate letter: A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration	18.	To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)
9.	Name of Federal agency from which assistance is being requested with this application.		
10.	Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.		

OMB Approval No. 0348-0041			
BUDGET INFORMATION - Construction Programs			
NOTE: Certain Federal assistance programs require additional computations to arrive at the Federal share of project costs eligible for participation. If such is the case, you will be notified.			
COST CLASSIFICATION	a. Total Cost	b. Costs Not Allowable for Participation	c. Total Allowable Costs (Columns a-b)
1. Administrative and legal expenses	\$ 402,068.00	\$	\$ 402,068.00
2. Land, structures, rights-of-way, appraisals, etc.	\$ 0.00	\$	\$ 0.00
3. Relocation expenses and payments	\$ 0.00	\$	\$ 0.00
4. Architectural and engineering fees	\$ 0.00	\$	\$ 0.00
5. Other architectural and engineering fees	\$ 0.00	\$	\$ 0.00
6. Project inspection fees	\$ 0.00	\$	\$ 0.00
7. Site work	\$ 0.00	\$	\$ 0.00
8. Demolition and removal	\$ 0.00	\$	\$ 0.00
9. Construction	\$ 786,700.00	\$	\$ 786,700.00
10. Equipment	\$ 13,586,232.00	\$	\$ 13,586,232.00
11. Miscellaneous	\$ 9,875,000.00	\$	\$ 9,875,000.00
12. SUBTOTAL (sum of lines 1 -11)	\$ 24,650,000.00	\$ 0.00	\$ 24,650,000.00
13. Contingencies	\$	\$	\$ 0.00
14. SUBTOTAL	\$ 24,650,000.00	\$ 0.00	\$ 24,650,000.00
15. Project (program) income	\$	\$	\$ 0.00
16. TOTAL PROJECT COSTS (subtract #15 from #14)	\$ 24,650,000.00	\$ 0.00	\$ 24,650,000.00
FEDERAL FUNDING			
17. Federal assistance requested, calculate as follows: (Consult Federal agency for Federal percentage share.) Enter the resulting Federal share.		Enter eligible costs from line 16c Multiply X 100 %	

ASSURANCES - CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0042), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will not dispose of, modify the use of, or change the terms of the real property title, or other interest in the site and facilities without permission and instructions from the awarding agency. Will record the Federal interest in the title of real property in accordance with awarding agency directives and will include a covenant in the title of real property acquired in whole or in part with Federal assistance funds to assure non-discrimination during the useful life of the project.
4. Will comply with the requirements of the assistance awarding agency with regard to the drafting, review and approval of construction plans and specifications.
5. Will provide and maintain competent and adequate engineering supervision at the construction site to ensure that the complete work conforms with the approved plans and specifications and will furnish progress reports and such other information as may be required by the assistance awarding agency or State.
6. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
7. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
8. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
9. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
10. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

11. Will comply, or has already complied, with the requirements of Titles 11 and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal and federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
12. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
13. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333) regarding labor standards for federally-assisted construction subagreements.
14. Will comply with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
15. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91- 190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
16. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
17. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
18. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-1 33, "Audits of States, Local Governments, and Non-Profit Organizations."
19. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Chairperson
APPLICANT ORGANIZATION Dickinson County Healthcare System	DATE SUBMITTED 07-25-2019

DICKINSON COUNTY HEALTHCARE SYSTEM
Supporting Schedules for SF-424

9 Construction

DMERoof Repair	29,500
Hospital Roof Repair	717,200
Lab Hood Renovation	10,000
Retail Pharmacy	<u>30,000</u>
	786,700

10 Equipment

Departmental Equipment Replacements	3,861,690
Carestream Retrofit CR2DR	112,000
Radiology Hologic DEXA	62,000
Dual Head Spect/CT	690,588
CT	640,673
Linear Accelerator for Radiation Oncology	3,242,323
MRI	1,623,668
Information Systems Software & Equipment	<u>3,353,290</u>
	13,586,232

FIRST RIVER ADVISORY L.L.C.

241 SOUTH 6TH STREET, SUITE 1705
PHILADELPHIA, PENNSYLVANIA 19106-3733

OFFICE TELEPHONE – (215) 568-9303
SHELLEY J. ARONSON > aronson@firstriver.com
ANNE S. MORSE > morse@firstriver.com



July 19, 2019

Mr. Peter VanSteen, Transportation Planner
Central U.P. Regional Planning and Development Commission
2950 College Avenue
Escanaba, MI 49829

RE: APPLICATION FOR FEDERAL ASSISTANCE
USDA RURAL DEVELOPMENT

Dear Mr. VanSteen:

Attached is a copy of a draft SF 424 Application for Federal Assistance relating to the application by Dickinson County Healthcare System (DCHS) for a Community Facilities Direct Loan (the CF Loan) to finance projects consisting of certain facility improvements and equipment acquisitions together with the refinancing of certain outstanding indebtedness. The SF 424 will be executed next week after the DCHS Board adopts a resolution authorizing the execution of various documents. First River Advisory is serving as Financial Advisor to DCHS in connection with this financing.

DCHS is initiating the Executive Order 12372, "Intergovernmental Review of Federal Programs" process on behalf of the U.S. Department of Agriculture, Rural Development (Agency). The Agency is being asked to consider providing financial assistance (the proposed CF Loan) and your comments are invited on this proposal regarding:

1. Consistency with local government planning goals;
2. Extent to which the proposal duplicates, runs counter to, or needs to be coordinated with other activities, or might be revised to increase its effectiveness;
3. Contribution to achieving local government goals relating to natural and human resources, or economic and community development;
4. Extent of environmental impacts and alternatives that should be considered in the Agency's environmental review;

5. Influence on area growth or delivery of services, including any disproportionate effects on minority groups;
6. Impacts on energy resource supply and demand;
7. Possible displacement of people or businesses; and
8. Location in a Coastal Zone or Coastal Barrier Resource Area and consistency with any State coastal management plan.

Please send your comments directly to the Agency at Rural Development, 2003 Minneapolis Avenue, Gladstone, MI 49837, with copies to the applicant and me. If you choose not to respond within 60 days of this correspondence, the Agency will assume that you have chosen not to respond and may proceed with its decision. Please contact me if you require additional information or have any questions.

Cordially,



APPLICATION FOR FEDERAL ASSISTANCE

Version 7/03

1. TYPE OF SUBMISSION: Application		2. DATE SUBMITTED	Applicant Identifier	
☐ Construction	Pre-application	3. DATE RECEIVED BY STATE	State Application Identifier	
☐ Non-Construction	☒ Construction	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier	
5. APPLICANT INFORMATION				
Legal Name:		Organizational Unit:		
Dickinson County Healthcare System		Department:		
Organizational DUNS: 8291277570000		Division:		
Address:		Name and telephone number of person to be contacted on matters involving this application (give area code)		
Street: 1721 Stephenson Avenue		Prefix: Mr.	First Name: Jerry	
City: Iron Mountain		Middle Name L.		
County: Dickinson		Last Name Worden		
State: Michigan	Zip Code 49801	Suffix:		
Country: United States		Email: Jerry.Worden@dchs.org		
6. EMPLOYER IDENTIFICATION NUMBER (EIN):		Phone Number (give area code)	Fax Number (give area code)	
38-2780429		(906) 569-3384	(906) 776-5703	
8. TYPE OF APPLICATION:		7. TYPE OF APPLICANT: (See back of form for Application Types)		
☐ New ☐ Continuation ☐ Revision		G - Special District		
If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.)		Other (specify)		
Other (specify)		9. NAME OF FEDERAL AGENCY: USDA Rural Development		
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:		
TITLE (Name of Program): Community Facilities Loan & Grant program		Replace roof on hospital building, acquire modern medical and information system equipment and refinance outstanding debt.		
12. AREAS AFFECTED BY PROJECT (Cities, Counties, States, etc.): Dickinson County and surrounding areas		14. CONGRESSIONAL DISTRICTS OF:		
13. PROPOSED PROJECT		a. Applicant First b. Project First		
Start Date: Ending Date: 12/31/2020		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?		
15. ESTIMATED FUNDING:		a. Yes. ☐ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:		
a. Federal	\$ 24,650,000.00	b. No. ☐ PROGRAM IS NOT COVERED BY E. O. 12372		
b. Applicant	\$ 0.00	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW		
c. State	\$ 0.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?		
d. Local	\$ 0.00	☐ Yes If "Yes" attach an explanation. ☐ No		
e. Other	\$ 0.00			
f. Program Income	\$ 0.00			
g. TOTAL	\$ 24,650,000.00			
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.				
a. Authorized Representative				
Prefix Ms.	First Name Margaret	Middle Name		
Last Name Minerick	Suffix			
b. Title Chairperson		c. Telephone Number (give area code) (906) 282-3961		
d. Signature of Authorized Representative		e. Date Signed 07/25/2019		

INSTRUCTIONS FOR THE SF-424

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0043), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

This is a standard form used by applicants as a required face sheet for pre-applications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:	Item:	Entry:
1.	Select Type of Submission.	11.	Enter a brief descriptive title of the project. If more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of this project.
2.	Date application submitted to Federal agency (or State if applicable) and applicant's control number (if applicable).	12.	List only the largest political entities affected (e.g., State, counties, cities).
3.	State use only (if applicable).	13.	Enter the proposed start date and end date of the project.
4.	Enter Date Received by Federal Agency Federal identifier number: If this application is a continuation or revision to an existing award, enter the present Federal Identifier number. If for a new project, leave blank.	14.	List the applicant's Congressional District and any District(s) affected by the program or project
5.	Enter legal name of applicant, name of primary organizational unit (including division, if applicable), which will undertake the assistance activity, enter the organization's DUNS number (received from Dun and Bradstreet), enter the complete address of the applicant (including country), and name, telephone number, e-mail and fax of the person to contact on matters related to this application.	15.	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.
6.	Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.	16.	Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernmental review process.
7.	Select the appropriate letter in the space provided. A. State B. County C. Municipal D. Township E. Interstate F. Intermunicipal G. Special District H. Independent School District I. State Controlled Institution of Higher Learning J. Private University K. Indian Tribe L. Individual M. Profit Organization N. Other (Specify) O. Not for Profit Organization	17.	This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes.
8.	Select the type from the following list: "New" means a new assistance award. "Continuation" means an extension for an additional funding/budget period for a project with a projected completion date. "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation. If a revision enter the appropriate letter: A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration	18.	To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)
9.	Name of Federal agency from which assistance is being requested with this application.		
10.	Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.		

OMB Approval No. 0348-0041			
BUDGET INFORMATION - Construction Programs			
NOTE: Certain Federal assistance programs require additional computations to arrive at the Federal share of project costs eligible for participation. If such is the case, you will be notified.			
COST CLASSIFICATION	a. Total Cost	b. Costs Not Allowable for Participation	c. Total Allowable Costs (Columns a-b)
1. Administrative and legal expenses	\$ 402,068.00	\$	\$ 402,068.00
2. Land, structures, rights-of-way, appraisals, etc.	\$ 0.00	\$	\$ 0.00
3. Relocation expenses and payments	\$ 0.00	\$	\$ 0.00
4. Architectural and engineering fees	\$ 0.00	\$	\$ 0.00
5. Other architectural and engineering fees	\$ 0.00	\$	\$ 0.00
6. Project inspection fees	\$ 0.00	\$	\$ 0.00
7. Site work	\$ 0.00	\$	\$ 0.00
8. Demolition and removal	\$ 0.00	\$	\$ 0.00
9. Construction	\$ 786,700.00	\$	\$ 786,700.00
10. Equipment	\$ 13,586,232.00	\$	\$ 13,586,232.00
11. Miscellaneous	\$ 9,875,000.00	\$	\$ 9,875,000.00
12. SUBTOTAL (sum of lines 1 -11)	\$ 24,650,000.00	\$ 0.00	\$ 24,650,000.00
13. Contingencies	\$	\$	\$ 0.00
14. SUBTOTAL	\$ 24,650,000.00	\$ 0.00	\$ 24,650,000.00
15. Project (program) income	\$	\$	\$ 0.00
16. TOTAL PROJECT COSTS (subtract #15 from #14)	\$ 24,650,000.00	\$ 0.00	\$ 24,650,000.00
FEDERAL FUNDING			
17. Federal assistance requested, calculate as follows: (Consult Federal agency for Federal percentage share.) Enter the resulting Federal share.		Enter eligible costs from line 16c Multiply X 100 %	

ASSURANCES - CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0042), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will not dispose of, modify the use of, or change the terms of the real property title, or other interest in the site and facilities without permission and instructions from the awarding agency. Will record the Federal interest in the title of real property in accordance with awarding agency directives and will include a covenant in the title of real property acquired in whole or in part with Federal assistance funds to assure non-discrimination during the useful life of the project.
4. Will comply with the requirements of the assistance awarding agency with regard to the drafting, review and approval of construction plans and specifications.
5. Will provide and maintain competent and adequate engineering supervision at the construction site to ensure that the complete work conforms with the approved plans and specifications and will furnish progress reports and such other information as may be required by the assistance awarding agency or State.
6. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
7. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
8. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
9. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
10. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

11. Will comply, or has already complied, with the requirements of Titles 11 and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal and federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
12. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
13. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333) regarding labor standards for federally-assisted construction subagreements.
14. Will comply with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
15. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91- 190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
16. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
17. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
18. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-1 33, "Audits of States, Local Governments, and Non-Profit Organizations."
19. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL		TITLE Chairperson
APPLICANT ORGANIZATION Dickinson County Healthcare System		DATE SUBMITTED 07-25-2019

Availability of Other Commercial Credit Certification

Applicants must certify in writing that they are unable to finance the proposed project from their own resources or through commercial credit at reasonable rates and terms that will allow them to maintain user rates comparable to other similar systems.

Applicants must sign this certification which provides documentation of contact with a lending institution. Offers or denials of commercial credit should be documented below with the name of lending institution, name of contact, rates and terms available and reason why credit would not be available.

Commercial credit financing in the amount of \$15,000,000 was discussed with the following lending institutions:

Lender:	The First National Bank & Trust of Iron Mountain	Interest Rate:	No offer	Term:	10 years
Contact:	Russell Kassin, Senior Vice President, Chief Lending Officer				
Lender:	The Stephenson National Bank & Trust	Interest Rate:	No offer	Term:	10 years
Contact:	Charlie Cappaert, Vice President and Chief Lending Officer				
Lender:	Fifth Third Bank	Interest Rate:	No offer	Term:	No offer
Contact:	Leigh Daul, Special Asset Group Workout Officer				

Details of First National Bank & Trust of Iron Mountain and Stephenson National Bank & Trust denials are addressed in their letters, attached. DCHS is already in default on a Fifth Third Bank loan; Fifth Third declines to take on any additional credit exposure.

The undersigned certifies, to the best of his knowledge and belief, that:

1. The organization is unable to finance the proposed project from its own resources or through commercial credit at reasonable rates and terms.
2. No outstanding judgment has been obtained and recorded by the United States of America in a Federal Court (other than in the United States Tax Court).

Dickinson County Healthcare System

Name of Organization

Jerry L. Worden

Name and Signature of Authorized Official

July 19, 2019

Date



First National Bank & Trust

Member FDIC

July 19, 2019

Dickinson County Healthcare System
Mr. Jerry Worden, CPA
1721 S. Stephenson Street
Iron Mountain, MI 49801

Dear Mr. Worden,

Thank you for the opportunity to review and discuss your loan proposal regarding your financing needs. We understand you are requesting \$15 million at a fixed rate for the purchase of equipment.

Based on your proposal we would not be able to provide financing for 15 years on equipment without a significant guaranty. Our loan policy allows equipment financing up to 10 years maximum and we would have to demonstrate the equipment useful life meets or exceeds the term of the loan. Based on your projections a 10 year amortization would reduce your cash flow and ability to service the debt. Additionally, the historical losses, leverage and lack of liquidity would prohibit The First National Bank & Trust Co of Iron Mountain from approving this loan at this time.

If you have any additional questions please contact me at (906)-774-2200.

Sincerely,

Russell Kassin
Senior Vice President, Chief Lending Officer
(906)774-2200



Financial Solutions from Advisors You Trust

July 19, 2019

Dickinson County Healthcare System
Mr. Jerry Worden, CPA
1721 S. Stephenson Street
Iron Mountain MI 49801

Dear Mr. Worden,

Thank you for the opportunity to review and discuss your loan proposal regarding your financing needs. We understand you are requesting \$15 million at a fixed rate for the purchase of equipment.

Based on your proposal we would not be able to provide financing for 15 years on equipment without a significant guaranty. Our loan policy allows equipment financing up to 10 years maximum and we would have to demonstrate the equipment useful life meets or exceeds the term of the loan. Based on your projections a 10 year amortization would reduce your cash flow and ability to service the debt. Additionally, the historical losses, leverage and lack of liquidity would prohibit Stephenson National from approving this loan at this time.

If you have any additional questions please contact me at (715) 735-2332.

Sincerely,

Charlie Cappaert
Vice President and Chief Lending Officer
(715) 735-2332

www.snbt.com • bank@snbt.com • 800-924-1732

1820 Hall Avenue, Marinette, WI 54143 | 715-732-1732 • 704 Main Street, Wausaukee, WI 54177 | 715-856-5116

606 Henriette Avenue, Crivitz, WI 54114 | 715-854-2541 • Inside Piggly Wiggly, Crivitz, WI 54114 | 715-854-2220

N18630 Hwy 141, Pembine, WI 54156 | 715-324-5217 • 101 Bralick Way, Oconto, WI 54153 | 920-834-7628 • 1111 Tenth Street, Menominee, MI 49858 | 906-863-2526

Marquette Trust & Investment Services 115 S. Lakeshore Blvd Ste D, Marquette, MI 49855 | 906-273-1501

July 19, 2019

Dickinson County Healthcare System
Mr. Jerry Worden, CPA
1721 S. Stephenson Street
Iron Mountain, MI 49801

Dear Mr. Worden,

Thank you for the opportunity to review and discuss your loan proposal regarding your financing needs. We understand you are requesting \$15 million with a 90% Rural Housing Guaranty at a fixed rate for the purchase of equipment.

Based on the information provided and our discussion, we would not be able to provide financing at this time. Although there have been many financial improvements over the past six months the historical losses from 2018, lack liquidity and high leverage would prohibit The First National Bank & Trust Co of Iron Mountain to make this loan. We also would not be able to provide a fixed rate option that was requested as we are limited to 3 and 5 year rate locks. Additionally, because of the size and scope of this loan it would be quite difficult to find participations to purchase a share of this loan.

If you have any additional questions please contact me at (906)-774-2200.

Sincerely,



Russell Kassin
Senior Vice President, Chief Lending Officer
(906)774-2200



Financial Solutions from Advisors You Trust

July 19, 2019

Dickinson County Healthcare System
Mr. Jerry Worden, CPA
1721 S. Stephenson Street
Iron Mountain MI 49801

Dear Mr. Worden,

Thank you for the opportunity to review and discuss your loan proposal regarding your financing needs. We understand you are requesting \$15 million with a 90% Rural Housing Guaranty at a fixed rate for the purchase of equipment.

Based on the information provided and our discussion, we would not be able to provide financing at this time. Although there have been many financial improvements over the past six months the historical losses from 2018, lack liquidity and high leverage would prohibit Stephenson National Bank to make this loan. We also would not be able to provide a fixed rate option that was requested as we are limited to 3 and 5 year rate locks. Additionally, because of the size and scope of this loan it would be quite difficult to find participants to purchase a share of this loan.

If you have any additional questions please contact me at (715) 735-2332.

Sincerely,

Charlie Cappaert
Vice President and Chief Lending Officer
(715) 735-2332

www.snbt.com • bank@snbt.com • 800-924-1732

1820 Hall Avenue, Marinette, WI 54143 | 715-732-1732 • 704 Main Street, Wausau, WI 54177 | 715-856-5116

606 Henriette Avenue, Crivitz, WI 54114 | 715-854-2541 • Inside Piggly Wiggly, Crivitz, WI 54114 | 715-854-2220

N18630 Hwy 141, Pembine, WI 54156 | 715-324-5217 • 101 Bralick Way, Oconto, WI 54153 | 920-834-7628 • 1111 Tenth Street, Menominee, MI 49858 | 906-863-2526

Marquette Trust & Investment Services 115 S. Lakeshore Blvd Ste D, Marquette, MI 49855 | 906-273-1501



Financial Statements
December 31, 2018 and 2017

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2018 and 2017

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	3
Financial Statements	
Statements of Net Position	10
Statements of Revenues, Expenses, and Changes in Net Position	11
Statements of Cash Flows	12
Notes to Financial Statements	14
Required Supplementary Information	
Schedule of Net Pension Liability	37
Schedule of Changes in Net Pension Liability	38
Schedule of Contributions	39



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County) (Healthcare System), which comprise the statements of net position as of December 31, 2018 and 2017, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements, which collectively comprise the Healthcare System's basic 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2018 and 2017, and the results of its operations, changes in net position, and cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Emphasis of Matter Regarding Going Concern

The accompanying financial statements have been prepared assuming that the Healthcare System will continue as a going concern. As discussed in Note 15 to the financial statements, the Healthcare System has suffered recurring losses from operations. These conditions raise substantial doubt about its ability to continue as a going concern. Management's plans in regard to these matters are also described in Note 15. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to that matter.

Other Matters**Required Supplementary Information**

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 3 through 9, and the Schedules of the Healthcare System's Share of the Net Pension Liability, the Changes in Net Pension Liability, and Contributions on pages 37 through 39 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated June 27, 2019 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the effectiveness of the Healthcare System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and in considering the Healthcare System's internal control over financial reporting and compliance.



Fargo, North Dakota
June 27, 2019

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2018, 2017, and 2016. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2018

The Healthcare System's net position increased in 2018 by \$4.750 million or 72.2% with a gain before capital contributions of \$4.750 million, comprised of an operating gain of \$5.501 million and nonoperating expenses in excess of nonoperating revenue of \$752 thousand. There were no contributions for capital purposes in 2018. During 2018, the Healthcare System's total operating revenues of \$104.146 million was very close to the amount for 2017. The resulting operating income for 2018 of \$5.501 million compared to an operating loss of (\$12.324) million for 2017 which was 5.3% of operating revenue.

Year Ended December 31, 2017

The Healthcare System's net position decreased in 2017 by \$13.141 million or 82.7% with a loss before capital contributions of \$13.242 million, comprised of an operating loss of \$12.3 million and nonoperating expenses in excess of nonoperating revenue of \$919 thousand. There were \$102 thousand of contributions for capital purposes in 2017. During 2018, the Healthcare System's total operating revenues of \$104.258 million was 5.8% lower than the amount in 2016. The resulting operating loss for 2017 of (\$12.324) million compared to an operating loss of (\$2.807) million for 2016 which was (11.8)% of operating revenue.

Year Ended December 31, 2016

The Healthcare System's net position decreased in 2016 by \$3.182 million or 16.7% with a loss before capital contributions of \$3.223 million, comprised of an operating loss of \$2.807 million and non-operating expenses in excess of non-operating revenue of \$416 thousand. There were \$41 thousand of contributions for capital purposes in 2016. During 2016, the Healthcare System's total operating revenues of \$110.642 million was about equal to the amount in 2015. The resulting operating loss for 2016 of (\$2.807) million compared to an operating income of \$4.479 million for 2015 which was (2.5)% of operating revenue.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Statement of Net Position includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all non-operating revenue and expense items, capital contributions and the net change in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Financial Analysis of the System

The condensed statements of net position of the Healthcare System as of December 31, 2018, 2017, and 2016 are summarized in the following table.

Condensed Statements of Net Position
December 31, 2018, 2017, and 2016 (in Thousands)

	2018	2017	2016
Total current assets (includes the current portion of restricted assets)	\$ 26,911	\$ 25,375	\$ 36,599
Cash and investments internally designated for other purposes	-	-	1,899
Cash and investments restricted by bond indentures	2,332	2,000	2,000
Capital assets, net	31,079	34,207	34,623
Other assets	625	3,241	2,558
Total Assets	60,947	64,823	77,679
Total Deferred Outflows of Resources	6,210	6,194	8,871
Total Assets and Deferred Outflows	\$ 67,157	\$ 71,017	\$ 86,550
 Total current liabilities	 \$ 26,904	 \$ 28,283	 \$ 13,668
Long-term debt, net of current portion	5,894	4,713	19,124
Other long-term liabilities	450	600	500
Net pension liability	20,306	26,501	36,901
Total Liabilities	53,554	60,097	70,193
Total Deferred Inflows of Resources	6,096	8,162	459
Total Net Position	7,507	2,758	15,898
Total Liabilities, Deferred Inflows of Resources, and Net Position	\$ 67,157	\$ 71,017	\$ 86,550

Current Assets and Liabilities

Net patient accounts receivable decreased to 55 days' of net revenue at December 31, 2018 compared to 56 days' of net revenue at December 31, 2017 and compared to 57 days' of net revenue at December 31, 2016. The slight decrease in 2016 can be attributed to the outsourcing of self-pay collections to AmeriEBO which continued in 2017.

Total current assets increased 6.1% in 2018 and decreased 30.7% in 2017 compared to each prior year. The increase in 2018 was primarily the result of the increase in cash due to improvements in operations and the decrease in 2017 was the result of a decrease in cash due to losses from operations.

Current liabilities decreased 4.9% in 2018 while current liabilities increased 106.9% in 2017 primarily as a result of the 2015 bank note being recorded as a current liability. Current liabilities decreased 18.2% in 2016 as a result of a decrease in trade accounts receivable. The Healthcare System's current ratio (current assets divided by current liabilities) was 1.00 at December 31, 2018 and 0.90 at December 31, 2017.

Total Cash and Investments

The number of days of total cash and investments was 30.8 at December 31, 2018 and 18.7 at December 31, 2017.

The total cash and investments at December 31, 2018 were \$8.5 million including restricted funds of \$2.3 million. Total cash and investments at December 31, 2017 were \$6.0 million including restricted funds of \$2.0 million. During 2018, the \$2.0 million debt service reserve fund was applied to the loan balance. In addition, the majority of the investment in joint ventures was sold and transferred to Fifth Third and is recorded as noncurrent cash and investments on the Statements of Net Position.

Long-Term Debt

The Healthcare System had long-term debt of \$5.9 million at December 31, 2018 and \$4.7 million at December 31, 2017 (net of current maturities of \$14.7 million in 2018 and \$16.0 million in 2017). In 2018, the Healthcare System was overpaid its Medicare prospective interim payments and a 36-month extended repayment schedule was negotiated. The Healthcare System recorded a Net Pension Liability of \$20.306 million in 2018 and \$26.501 million in 2017 as required by GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*. The debt service coverage ratio for the years ended December 31, 2018 and 2017 was 1.63 and (2.92) respectively.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Components of Net Position (in thousands)

	December 31,		
	2018	2017	2016
Invested in capital assets, net of related debt Restricted by revenue bond indentures, expendable for debt service	\$ 10,726	\$ 13,829	\$ 13,989
Unrestricted	2,332	2,000	2,000
	(5,551)	(13,071)	(91)
Total net position	<u>\$ 7,507</u>	<u>\$ 2,758</u>	<u>\$ 15,898</u>

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2018, 2017, and 2016 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2018, 2017, and 2016 (in Thousands)

	2018		2017		2016	
Revenue and (expenses):						
Net patient service revenue	\$ 99,346	95.4%	\$ 101,328	97.2%	\$ 103,797	93.8%
Other revenue	4,801	4.6%	2,930	2.8%	6,845	6.2%
Total operating revenue	<u>104,147</u>	100.0%	<u>104,258</u>	100.0%	<u>110,642</u>	100.0%
Total operating expenses	<u>98,645</u>	94.7%	<u>116,582</u>	111.8%	<u>113,450</u>	102.5%
Operating income (loss)	<u>5,502</u>	5.3%	<u>(12,324)</u>	-11.8%	<u>(2,808)</u>	-2.5%
Investment income	14	0.0%	(4)	0.0%	92	0.1%
Change in unrealized gains and losses on investments	-	0.0%	34	0.0%	(31)	0.0%
Gain on investment in joint ventures	165	0.2%	683	0.7%	495	0.4%
Change in fair market value of forward purchase agreement	-	0.0%	-	0.0%	-	0.0%
Interest and amortization expense	(1,017)	-1.0%	(945)	-0.9%	(994)	-0.9%
Other non-operating revenue and expenses (net)	<u>85</u>	0.1%	<u>(686)</u>	-0.7%	<u>22</u>	0.0%
Non-operating expenses in excess of revenue	<u>(753)</u>	-0.7%	<u>(918)</u>	-0.9%	<u>(416)</u>	-0.4%
Income (loss) before capital contributions	4,749	<u>4.6%</u>	(13,242)	<u>-12.7%</u>	(3,224)	<u>-2.9%</u>
Capital contributions	<u>-</u>		<u>102</u>		<u>41</u>	
Increase (decrease) in net position	<u>4,749</u>		<u>(13,140)</u>		<u>(3,183)</u>	
Net position, beginning of year	<u>2,758</u>		<u>15,898</u>		<u>19,081</u>	
Net position - end of year	<u>\$ 7,507</u>		<u>\$ 2,758</u>		<u>\$ 15,898</u>	

Results of Operations

The overall income from operations of \$5.501 million or 5.3% of revenue for 2018 was favorable compared to 2017. The overall loss on operations of (\$12.324) million or (11.8)% of revenue for 2017 increased from an operating loss of (\$2.807) million or (2.5)% of revenue for 2016. The net non-operating expenses in excess of non-operating revenue for 2018 decreased to \$752 thousand from 2017, which was \$917 thousand. The net increase in 2017 was the result of the write down of an asset related to architectural fees for a medical office building project that was abandoned as well as an increase in the market value of the healthcare system's ownership share in the Upper Peninsula Health Plan. The net result for 2018 was a gain of \$4.750 million; for 2017 was a loss of (\$13.242) million; and for 2016 was a loss of (\$3.223) million, before capital contributions. The Healthcare System's financial statements have been prepared assuming the Healthcare System will continue as a going concern, which contemplates the realization of assets and satisfaction of liabilities in the normal course of business. These conditions raise substantial doubt as to the Healthcare System's ability to continue as a going concern within one year after the date the financial statements are issued as discussed in Note 15 of the financial statements.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2018 comprised 23.5% of the total net patient revenue and the activities of the Healthcare System, down from 25.5% for 2017. The operating performance of DCMH was affected by a decline in acute discharges of 16.2% between 2017 and 2018. Net inpatient revenue decreased 9.9% and the all-payer case mix index decreased to 1.347 from 1.377 in 2017.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 59.2% of total Healthcare System net patient revenue and its operating activities for 2018. The comparable percentage for 2017 was 57.5%. Net outpatient revenue increased 0.9% in 2018. Total outpatient visits dropped 7.97% in 2018, in large part due to expansion of services by a competitor.

The net patient revenue of the Rural Health Clinics (RHC's) and other clinics comprised about 17.3% of the total net patient revenue of the Healthcare System for 2018 and 17.0% for 2017. The revenue growth was 0.3% in 2018.

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2018 and 2017 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2018 and 2017 (in Thousands)

	2018	2017	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 51,552	\$ 65,570	\$ (14,018)	-21.4%
Supplies and pharmaceuticals	20,965	21,512	(547)	-2.5%
Professional fees and other purchased services	22,732	25,637	(2,905)	-11.3%
Depreciation and amortization	3,396	3,863	(467)	-12.1%
Total	<u>\$ 98,645</u>	<u>\$ 116,582</u>	<u>\$ (17,937)</u>	<u>-15.4%</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

With the decrease in volumes, the Healthcare System made reductions in all categories of operating expenses, as well. Employee compensation and benefits decreased \$14.0 million or 21.4%. The annual average total paid full-time equivalent (FTE) positions of 664.9 for 2018 decreased by 9.8% from the 2017 amount of 736.8. Pension expense decreased by \$8.446 million due to a decrease in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the Healthcare System. Health insurance expense decreased by \$786 thousand or 7.6% due to a decrease in the number of FTEs.

The cost of supplies and pharmaceuticals decreased \$547 thousand or 2.5%, due to a decrease in volumes.

Professional fees, purchased services and other expenses for 2018 decreased \$2.904 million or 11.3%. This was mainly the result of higher pharmaceutical costs, collection fees, and legal fee, offset by declines in medical professional fees, administrative supplies. Depreciation and amortization expense for 2018 decreased \$467 thousand as a result of minimal capital spending the last several years.

The components of operating expenses for the Healthcare System for the years ended December 31, 2017 and 2016 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2017 and 2016 (in Thousands)

	2017	2016	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 65,570	\$ 64,944	\$ 626	1.0%
Supplies and pharmaceuticals	21,512	20,322	1,190	5.9%
Professional fees and other purchased services	25,637	23,597	2,040	8.6%
Depreciation and amortization	3,863	4,587	(724)	-15.8%
Total	<u>\$ 116,582</u>	<u>\$ 113,450</u>	<u>\$ 3,132</u>	<u>2.8%</u>

Employee compensation and benefits increased \$626 thousand or 1.0%. The annual average total paid full-time equivalent (FTE) positions of 736.8 for 2017 increased by 1.0% from the 2016 amount of 729.6. Pension expense decreased by (\$2.307) million or 34.4% due to a decrease in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the Healthcare System. Health insurance expense increased by \$2.593 million or 27.2% due to an increase in the annual premium as a result of unfavorable claims experience in the prior year. This was offset by more favorable reimbursement rates.

The cost of supplies and pharmaceuticals increased \$1.2 million or 5.9%, due to an increase in pharmaceutical expense, specifically related to chemotherapy drugs.

Professional fees, purchased services and other expenses for 2017 increased \$2.04 million or 8.6%. This was mainly the result of higher medical professional fees, collection fees, legal fees, hardware and software maintenance contracts, dues & subscriptions and the abandoned asset that was mentioned previously offset by a reduction in other professional fees. Depreciation and amortization expense for 2017 decreased \$724 thousand or 15.8% as a result of minimal capital spending the last several years.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from health care services, and nonoperating revenue, which is principally from investment income.

(This page left blank intentionally.)

	<u>2018</u>	<u>2017</u>
Assets and Deferred Outflows of Resources		
Current Assets		
Cash and cash equivalents	\$ 6,153,802	\$ 3,996,289
Receivables		
Patient, net of estimated uncollectibles of		
\$2,434,000 in 2018 and \$2,180,000 in 2017	15,711,112	16,035,874
Estimated third-party settlements	532,300	903,646
Other	1,927,377	1,107,427
Supplies and other current assets	<u>2,586,837</u>	<u>3,331,865</u>
Total current assets	<u>26,911,428</u>	<u>25,375,101</u>
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	<u>2,331,744</u>	<u>2,000,000</u>
Capital Assets		
Capital assets not being depreciated	2,465,230	2,570,562
Depreciable capital assets, net of accumulated depreciation	<u>28,613,486</u>	<u>31,636,620</u>
Total capital assets	<u>31,078,716</u>	<u>34,207,182</u>
Other Assets		
Investment in joint ventures	<u>624,956</u>	<u>3,241,090</u>
Total assets	<u>60,946,844</u>	<u>64,823,373</u>
Deferred Outflows of Resources		
Refunding costs	210,398	378,722
Pension related deferred outflows	<u>6,000,081</u>	<u>5,814,711</u>
Total deferred outflows of resources	<u>6,210,479</u>	<u>6,193,433</u>
Total assets and deferred outflows	<u>\$ 67,157,323</u>	<u>\$ 71,016,806</u>

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Net Position
December 31, 2018 and 2017

	<u>2018</u>	<u>2017</u>
Liabilities, Deferred Inflows of Resources, and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 14,668,902	\$ 16,044,068
Accounts payable		
Trade	4,675,635	3,921,364
Accrued expenses		
Salaries, wages, and related liabilities	2,206,780	2,430,123
Compensated absences	4,207,001	5,233,857
Other accrued liabilities	<u>1,145,113</u>	<u>653,474</u>
Total current liabilities	<u>26,903,431</u>	<u>28,282,886</u>
Long-Term Liabilities		
Long-term debt, less current maturities	5,894,143	4,712,619
Reserve for loss on general and professional liabilities claims	450,000	600,000
Net pension liability	<u>20,306,492</u>	<u>26,501,314</u>
Total long-term liabilities	<u>26,650,635</u>	<u>31,813,933</u>
Total liabilities	<u>53,554,066</u>	<u>60,096,819</u>
Deferred Inflows of Resources		
Pension related deferred inflows	<u>6,095,952</u>	<u>8,162,240</u>
Net Position		
Invested in capital assets, net of related debt	10,726,069	13,829,217
Restricted - expendable for debt service	2,331,744	2,000,000
Unrestricted	<u>(5,550,508)</u>	<u>(13,071,470)</u>
Total net position	<u>7,507,305</u>	<u>2,757,747</u>
Total liabilities and net position	<u><u>\$ 67,157,323</u></u>	<u><u>\$ 71,016,806</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2018 and 2017

	<u>2018</u>	<u>2017</u>
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$4,437,004 in 2018 and \$3,547,462 in 2017	\$ 99,345,707	\$ 101,328,450
Supplies and 340B program revenue	2,278,241	385,681
Electronic health record incentive revenue	-	513,328
Other revenue	<u>2,522,409</u>	<u>2,030,797</u>
Total operating revenues	<u>104,146,357</u>	<u>104,258,256</u>
Operating Expenses		
Salaries and wages	44,541,254	46,991,997
Employee benefits	7,010,648	18,577,980
Supplies and pharmaceuticals	20,964,784	21,512,059
Medical and other professional fees	11,641,644	12,090,328
Purchased services and other	11,090,825	13,546,566
Depreciation	<u>3,396,059</u>	<u>3,863,153</u>
Total operating expenses	<u>98,645,214</u>	<u>116,582,083</u>
Operating Income (Loss)	<u>5,501,143</u>	<u>(12,323,827)</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	66,866	48,390
Interest and amortization expense	(1,017,081)	(945,071)
Gain (Loss) on disposal of capital assets	19,663	(734,296)
Investment income	14,105	(4,396)
Gain on investment in joint ventures	164,862	683,042
Change in unrealized gains and losses on investments	<u>-</u>	<u>33,741</u>
Nonoperating revenues (expenses), net	<u>(751,585)</u>	<u>(918,590)</u>
Revenues in Excess of (Less Than) Expenses Before Capital Contributions	4,749,558	(13,242,417)
Capital Contributions	<u>-</u>	<u>101,854</u>
Change in Net Position	4,749,558	(13,140,563)
Net Position, Beginning of Year	<u>2,757,747</u>	<u>15,898,310</u>
Net Position, End of Year	<u><u>\$ 7,507,305</u></u>	<u><u>\$ 2,757,747</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2018 and 2017

	<u>2018</u>	<u>2017</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 100,041,815	\$ 102,055,459
Payments to suppliers and contractors	(41,687,991)	(46,091,034)
Payments to or on behalf of employees	(61,248,581)	(65,353,964)
Other receipts	<u>3,980,700</u>	<u>2,222,862</u>
Net Cash From (Used For) Operating Activities	<u>1,085,943</u>	<u>(7,166,677)</u>
Noncapital Financing Activity		
Unrestricted general contributions	<u>66,866</u>	<u>48,390</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(251,485)	(4,174,211)
Repayment of long-term debt	(4,492,742)	(2,122,362)
Interest paid, including capitalized interest	(1,033,189)	(1,007,648)
Capital contributions	-	101,854
Proceeds from the sale of capital assets	19,663	54,963
Proceeds from the issuance of long term debt	<u>4,299,100</u>	<u>1,698,551</u>
Net Cash Used For Capital and Capital Related Financing Activities	<u>(1,458,653)</u>	<u>(5,448,853)</u>
Investing Activities		
Purchases of investments	(2,331,744)	(30,792,140)
Proceeds from sales and maturities of investments	2,000,000	32,738,101
Proceeds from sales of joint ventures	2,780,996	-
Investment income	<u>14,105</u>	<u>(4,396)</u>
Net Cash From Investing Activities	<u>2,463,357</u>	<u>1,941,565</u>
Net Increase (Decrease) in Cash and Cash Equivalents	2,157,513	(10,625,575)
Cash and Cash Equivalents, Beginning of Year	<u>3,996,289</u>	<u>14,621,864</u>
Cash and Cash Equivalents, End of Year	<u><u>\$ 6,153,802</u></u>	<u><u>\$ 3,996,289</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2018 and 2017

	<u>2018</u>	<u>2017</u>
Reconciliation of Operating Loss to Net Cash from Operating Activities		
Operating loss	\$ 5,501,143	\$ (12,323,827)
Adjustments to reconcile operating income to net cash flows from operating activities		
Depreciation	3,396,059	3,863,153
Provision for bad debts	4,437,004	3,547,462
Amortization of refunding costs	168,324	168,324
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(4,112,242)	(3,053,148)
Other receivables	(819,950)	(706,944)
Supplies and other current assets	745,028	565,648
Deferred outflows of resources	(185,370)	2,508,938
Accounts payable - trade	754,271	110,337
Estimated third-party payor settlements	371,346	232,695
Accrued expenses	(758,560)	516,887
Reserve for loss on general and professional liabilities claims, net	(150,000)	100,000
Net pension liability	(6,194,822)	(10,399,399)
Deferred inflows of resources	<u>(2,066,288)</u>	<u>7,703,197</u>
Net Cash From (Used For) Operating Activities	<u>\$ 1,085,943</u>	<u>\$ (7,166,677)</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$16,108 and \$62,577 during 2018 and 2017.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

The financial statements of the Dickinson County Healthcare System (Healthcare System) have been prepared in accordance with generally accepted accounting principles in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the Healthcare System are described below.

Reporting Entity

Dickinson County Hospital, a Michigan public county hospital, was formed by a vote of the electorate of Dickinson County, Michigan, on July 29, 1947, under the provisions of 1913 PA 350. On October 10, 1990, the Dickinson County Board of Commissioners reorganized Dickinson County Hospital under 1987 PA 230, becoming Dickinson County Memorial Hospital System, a Michigan county health facilities public corporation. The Dickinson County Healthcare System Board of Trustees, with approval of the county board of commissioners, filed conversion Articles of Incorporation on June 27, 2017. Under Sec. 103 (d) of 1987 PA 230, the restructured corporation under Sec. 305a of 1987 PA 230 remains a municipal health facilities corporation. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of the county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare system is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one-hundred-year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

Basis of Presentation

The statement of net position displays the Healthcare System's assets, deferred outflows, and liabilities, with the difference reported as net position. Net position is reported in the following categories/components:

Invested in capital assets, net of related debt consists of net capital assets reduced by the outstanding balances of any related debt obligations and deferred inflows of resources attributable to the acquisition, construction or improvement of those assets or the related debt obligations and increased by balances of deferred outflows of resources related to those assets or debt obligations.

Restricted – expendable for debt service results when constraints placed on net position use are externally imposed by the issuers of debt held by the Healthcare System.

Unrestricted net position consists of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the Healthcare System's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired. For purposes of the statement of cash flows, the Healthcare System considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at lower of cost (first in, first out) or net realizable value and are expensed when used.

Noncurrent Cash and Investments

Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Funds that are available for obligations classified as current liabilities are reported in current assets.

Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when earned.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation in the financial statements. Contributed capital assets are reported at their estimated fair value at the time of their donation. The estimated useful lives of capital assets are as follows.

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position and are excluded from expenses in excess of revenues. 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 net position.

Investment in Joint Ventures

Joint ventures in which the Healthcare System has an equity interest and either an ongoing financial interest or an ongoing financial responsibility are reported originally at cost and adjusted for changes in the equity interest in accordance with the joint venture agreement and for any other transactions, such as a return on capital. Equity earnings from joint ventures are included in nonoperating revenues (expenses).

Deferred Outflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The Healthcare System has two items that qualify for reporting in this category, which are the loss on defeasance of bonds and unrecognized items not yet charged to pension expense. The loss on defeasance of bonds results from the retirement of the Hospital Revenue and Refunding Bonds, Series 1999. The loss on defeasance of bonds amount is systematically and rationally amortized over the remaining life of the old obligation or the life of the new obligation, whichever is shorter and is included in interest and amortization expense.

Deferred Inflows of Resources

Deferred inflows of resources represent an increase in net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The deferred inflows of resources reported in the financial statements consist of the unamortized portion of the difference between expected and actual experience of pension plan assets.

Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions and pension expense, information about the fiduciary net position of the Dickinson County Healthcare System Pension Plan (Plan) and additions to/deductions from the Plan's net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours.

Operating Revenues and Expenses

The Healthcare System's statement of revenues, expenses, and changes in net position distinguishes between operating and non-operating revenues and expenses. Operating revenues and expenses of the Healthcare System result from exchange transactions associated with providing health care services - the Healthcare System's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as non-operating.

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates and discounted charges. 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.

Charity Care

The Healthcare System provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Healthcare System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was \$908,000 and \$959,000 for the years ended December 31, 2018 and 2017, respectively, calculated by multiplying the ratio of cost to gross charges for the Healthcare System by the gross uncompensated charges associated with providing charity care to its patients.

Grants and Contributions

The Healthcare System may receive grants as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after expenses in excess of revenues.

Electronic Health Record Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified Electronic Health Records (EHR) technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare and Medicaid share; and (3) a transition factor applicable to that payment year (Medicare only).

The Healthcare System recognizes EHR incentive payments as revenue when there is reasonable assurance that the Healthcare System will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

The Healthcare System recognized revenue of \$513,328 for the year ended December 31, 2017, related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2015. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on prospectively determined rates. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System's Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2015. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System's Blue Cross cost reports have been settled by Blue Cross through December 31, 2017. Clinical services are reimbursed based on a fixed fee schedule.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Concentration of gross revenues by major payor accounted for the following percentages of the Healthcare System's patient service revenues for the years ended December 31, 2018 and 2017:

	2018	2017
Medicare	47%	47%
Medicaid	12%	12%
Blue Cross	23%	23%
Self-pay and other	18%	18%
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2018 and 2017 decreased \$522,945 and \$1,014,602, respectively, due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations. During 2017, the Healthcare System also recorded an additional \$748,771 of allowances for 2015 and 2016 related to the reopening of previously finalized cost reports (Note 12).

Recovery Audit Contractor

The Centers for Medicare and Medicaid Services (CMS) has implemented a Recovery Audit Contractor (RAC) program under which claims are reviewed by contractors for validity, accuracy, and proper documentation. A demonstration project completed in several other states resulted in the identification of potential overpayments, some being significant. The potential exists that the Healthcare System may incur a liability for a claims overpayment at a future date. The Healthcare System is unable to determine the extent of the liability of overpayments, if any. As the outcome of such potential reviews is unknown and cannot be reasonably estimated, it is the Healthcare System's policy to adjust revenue for deductions from overpayment amounts or additions from underpayment amounts determined under the RAC audits at the time a change in reimbursement is agreed upon between the Healthcare System and CMS.

340B Program

Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the 340B Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

In order to qualify for the program, the hospital needs to have a large percentage of indigent volume, which is defined by the program to include Medicaid patients, Medicaid-eligible patients, and Medicare SSI patients. While indigent volumes are the qualifying factor, this program covers all payers for qualifying services. The program provides for reduced pharmaceutical costs for hospital outpatients. It also allows for contracts with retail pharmacies. Effective July 2016, the Healthcare System was eliminated as a participant in the program. As of July 2017, the Healthcare System was readmitted to the program.

The financial statements include an estimated reserve of \$16,667 and \$188,356 as of December 31, 2018 and 2017, in accordance with generally accepted accounting principles related to this program. This amount is included in accounts payable on the statement of net position.

Note 3 - Deposits, Investments, and Investment Income

The carrying amounts of the Healthcare System's deposits and investments as of December 31, 2018 and 2017 are as follows:

	<u>2018</u>	<u>2017</u>
Carrying amount		
Deposits	<u>\$ 8,485,546</u>	<u>\$ 5,996,289</u>
Deposits and investments are reported in the following statement of net position captions:		
	<u>2018</u>	<u>2017</u>
Cash and cash equivalents	\$ 6,153,802	\$ 3,996,289
Restricted under indenture agreement for debt service (1) (Note 8)	<u>2,331,744</u>	<u>2,000,000</u>
Total	<u>\$ 8,485,546</u>	<u>\$ 5,996,289</u>

(1) Under the terms of the 2015 bank note, the Healthcare System is required to maintain \$2,000,000 in a debt service reserve account until March 30, 2020. During 2018, the bank applied the \$2,000,000 to the end of the note. Then seized the proceeds from the sale of the joint venture and restricted the Healthcare System's access to those funds.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2018 and 2017

Deposits

The Healthcare System had bank balances at December 31, 2018 and 2017 as follows:

	2018	2017
Insured (FDIC)	\$ 3,140,819	\$ 1,035,719
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	2,500,000	2,500,000
Uncollateralized	3,553,892	2,796,849
Total	<u>\$ 9,194,711</u>	<u>\$ 6,332,568</u>
Carrying value	<u>\$ 8,485,546</u>	<u>\$ 5,996,289</u>

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk.

Investment Income

Investment income and gains and losses on cash equivalents consist of the following for the years ended December 31, 2018 and 2017:

	2018	2017
Interest income and realized gains and losses	<u>\$ 14,105</u>	<u>\$ (4,396)</u>
Change in unrealized gains and losses on investments	<u>\$ -</u>	<u>\$ 33,741</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2018 and 2017

Note 4 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2018 are as follows:

	Balance December 31, 2017	Additions	Transfers and Retirements	Balance December 31, 2018
Capital assets not being depreciated				
Land	\$ 2,359,299	\$ -	\$ -	\$ 2,359,299
Construction in progress	211,263	122,272	(227,604)	105,931
Total capital assets, not being depreciated	<u>\$ 2,570,562</u>	<u>\$ 122,272</u>	<u>\$ (227,604)</u>	<u>\$ 2,465,230</u>
Capital assets being depreciated				
Land improvements	\$ 986,885	\$ -	\$ -	\$ 986,885
Buildings and improvements	48,364,139	125,000	-	48,489,139
Equipment	53,205,421	20,318	197,855	53,423,594
Total capital assets being depreciated	<u>102,556,445</u>	<u>145,318</u>	<u>197,855</u>	<u>102,899,618</u>
Less accumulated depreciation for				
Land improvements	(648,815)	(54,900)	-	(703,715)
Buildings and improvements	(25,035,930)	(1,058,790)	-	(26,094,720)
Equipment	(45,235,080)	(2,282,369)	29,752	(47,487,697)
Total accumulated depreciation	<u>(70,919,825)</u>	<u>(3,396,059)</u>	<u>29,752</u>	<u>(74,286,132)</u>
Net capital assets being depreciated	<u>\$ 31,636,620</u>	<u>\$ (3,250,741)</u>	<u>\$ 227,607</u>	<u>\$ 28,613,486</u>
Capital assets, net	<u>\$ 34,207,182</u>			<u>\$ 31,078,716</u>

Construction in progress at December 31, 2018 represents deposits on equipment not yet placed into service.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2018 and 2017

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2017 are as follows:

	Balance December 31, 2016	Additions	Transfers and Retirements	Balance December 31, 2017
Capital assets not being depreciated				
Land	\$ 2,359,299	\$ -	\$ -	\$ 2,359,299
Construction in progress	1,343,224	3,301,336	(4,433,297)	211,263
Total capital assets, not being depreciated	<u>\$ 3,702,523</u>	<u>\$ 3,301,336</u>	<u>\$ (4,433,297)</u>	<u>\$ 2,570,562</u>
Capital assets being depreciated				
Land improvements	\$ 908,961	\$ 77,924	\$ -	\$ 986,885
Buildings and improvements	46,133,371	2,543,888	(313,120)	48,364,139
Equipment	51,798,175	2,037,711	(630,465)	53,205,421
Total capital assets being depreciated	<u>98,840,507</u>	<u>4,659,523</u>	<u>(943,585)</u>	<u>102,556,445</u>
Less accumulated depreciation for				
Land improvements	(597,656)	(51,159)	-	(648,815)
Buildings and improvements	(24,284,733)	(1,038,309)	287,112	(25,035,930)
Equipment	(43,037,835)	(2,773,685)	576,440	(45,235,080)
Total accumulated depreciation	<u>(67,920,224)</u>	<u>(3,863,153)</u>	<u>863,552</u>	<u>(70,919,825)</u>
Net capital assets being depreciated	<u>\$ 30,920,283</u>	<u>\$ 796,370</u>	<u>\$ (80,033)</u>	<u>\$ 31,636,620</u>
Capital assets, net	<u>\$ 34,622,806</u>			<u>\$ 34,207,182</u>

Note 5 - Investments in Joint Venture

Upper Peninsula Health Plan, LLC

Upper Peninsula Health Plan, LLC (UPHP), licensed by the state of Michigan, was formed as a qualified health plan on August 1, 1988 and became a health maintenance organization (HMO) on June 21, 2000. UPHP is owned by 13 health centers, including not-for-profit community hospitals, for-profit community hospitals, and tribal, health centers, each with a different percentage of ownership. The net gain on these investments, totaling approximately \$129,579 in 2018 and \$647,400 in 2017, is included in nonoperating revenue. The Healthcare System received distributions from these investments of \$405,951 and \$0 in 2018 and 2017. Separate financial statements of Upper Peninsula Health Plan, LLC are prepared and are available from Upper Peninsula Health Plan, LLC. During 2018, the Healthcare System sold 80% of its ownership in Upper Peninsula Health Plan, LLC.

Upper Peninsula Managed Care, LLC

Upper Peninsula Managed Care, LLC (UPMC), formed on July 29, 1996, is owned by 13 health centers, including not-for-profit community hospitals, for-profit community hospitals, and tribal health centers, each with a different percent of ownership. UPMC is a Physicians Hospital Organization (PHO), which serves as a management company for Upper Peninsula Health Plan, LLC. The net gain (loss) on these investments, totaling approximately \$35,283 in 2018 and \$35,700 in 2017, is included in nonoperating revenue. The Healthcare System received distributions from these investments of \$43,301 and \$0 in 2018 and 2017. Separate financial statements of Upper Peninsula Managed Care, LLC are prepared and are available from Upper Peninsula Managed Care, LLC. During 2018, the Healthcare System sold 80% of its ownership in Upper Peninsula Managed Care, LLC.

Note 6 - Lease Obligations

The Healthcare System leases certain medical and other equipment and office space under noncancelable long-term lease agreements. Certain leases have been recorded as capitalized leases and others as operating leases. Total lease expense for the years ended December 31, 2018 and 2017 for all operating leases was \$874,799 and \$1,021,231, respectively. The capitalized leased assets consist of:

	2018	2017
Major movable equipment	\$ 203,895	\$ 203,895
Less accumulated amortization	(107,611)	(39,646)
	<u>\$ 96,284</u>	<u>\$ 164,249</u>

Minimum future lease payments for the operating leases are as follows:

<u>Years Ending December 31,</u>	<u>Capital Leases</u>	<u>Operating Leases</u>
2019	\$ 73,096	\$ 282,842
2020	36,650	39,700
2021	-	13,200
Total minimum lease payments	109,746	<u>\$ 335,742</u>
Less interest	(3,802)	
Present value of minimum lease payments - Note 7	<u>\$ 105,944</u>	

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2018 and 2017

Note 7 - Long-Term Debt

A schedule of changes in the Healthcare System's long-term debt for 2018 and 2017 is as follows:

	Balance December 31, 2017	Additions	Reductions	Balance December 31, 2018	Amounts Due Within One Year
Hospital Revenue					
Bonds, Series 2004	\$ 3,187,662	\$ -	\$ (199,023)	\$ 2,988,639	\$ 210,582
Bank note, 2015	15,538,750	-	(3,775,000)	11,763,750	11,763,750
Cameron land contract	332,031	-	(97,051)	234,980	101,510
Hospital Revenue					
Bonds, Series 2016	1,350,000	-	(74,402)	1,275,598	76,382
Bellin promissory note	176,717	-	(69,258)	107,459	71,155
Bellin revolving note	-	1,750,000	-	1,750,000	1,750,000
Wisconsin Physicians Service Insurance Corporation note	-	2,549,100	(212,425)	2,336,675	625,943
Total bonds and notes	20,585,160	4,299,100	(4,427,159)	20,457,101	14,599,322
Capital Leases	171,527	-	(65,583)	105,944	69,580
Total long-term debt	<u>\$ 20,756,687</u>	<u>\$ 4,299,100</u>	<u>\$ (4,492,742)</u>	<u>\$ 20,563,045</u>	<u>\$ 14,668,902</u>
	Balance December 31, 2016	Additions	Reductions	Balance December 31, 2017	Amounts Due Within One Year
Hospital Revenue					
Bonds, Series 2004	\$ 3,375,756	\$ -	\$ (188,094)	\$ 3,187,662	\$ 199,023
Bank note, 2015	17,232,500	-	(1,693,750)	15,538,750	15,538,750
Batti land contract	81,423	-	(81,423)	-	-
Cameron land contract	424,819	-	(92,788)	332,031	97,051
Hospital Revenue					
Bonds, Series 2016	66,000	1,284,000	-	1,350,000	74,402
Bellin promissory note	-	210,656	(33,939)	176,717	69,159
Total bonds and notes	21,180,498	1,494,656	(2,089,994)	20,585,160	15,978,385
Capital Leases	-	203,895	(32,368)	171,527	65,683
Total long-term debt	<u>\$ 21,180,498</u>	<u>\$ 1,698,551</u>	<u>\$ (2,122,362)</u>	<u>\$ 20,756,687</u>	<u>\$ 16,044,068</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2018 and 2017

The terms and due dates of the Healthcare System's long-term debt at December 31, 2018 and 2017 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) – due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
- Bank note – On March 31, 2015, the Healthcare System entered into a 3.59%, 60 month note payable. The note payable is due in monthly principal installments ranging from \$128,570 to \$160,000 to March 15, 2020, with a balloon payment of \$9,395,000 on March 30, 2020, and is secured by certain equipment. The proceeds of this note were used to defease the Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999. (1)
- Cameron land contract – On March 6, 2013, the Healthcare System entered into a 4.5%, 97 month note payable. The note payable is due in monthly installments of \$9,167 to March 2021, and is secured by certain equipment.
- 2.63%, Dickinson County Healthcare System, Hospital Revenue Bond, Series 2016 (Series 2016 Bond) – due in monthly installments of \$9,085 including interest, to December 2032, secured by certain property and equipment.
- Bellin promissory note – On May 22, 2017, the Healthcare System entered into a 2.7%, 36 month note. The note is due in monthly installments of \$6,098 including interest, to May 22, 2020 and is unsecured.
- Bellin revolving note – On March 9, 2018, the Healthcare System entered into a 7.75%, matured on March 9, 2019. Interest only payments due monthly with principal due at maturity and is unsecured. (1)
- Wisconsin Physicians Service Insurance Corporation note – On December 27, 2018, the Healthcare System entered into a 10.125%, 36 month extended repayment schedule. The note is due in monthly installments ranging from \$75,535 to \$76,113, including interest, to January 2022, and is unsecured.

(1) The Series 2004 Bonds loan, the 3.59% Bank Note, and the Bellin revolving agreements place limits on the incurrence of additional borrowings and require the Healthcare System satisfy certain measures of financial performance. As of December 31, 2018, certain financial measures were not met. The Healthcare System obtained a waiver for the Series 2004 Bonds loan, but did not receive a waiver on the 3.59% Bank Note or the Bellin revolving note and as such those balances are reported as current.

Scheduled principal and interest payments on long-term debt are as follows:

Years Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2019	\$ 14,668,902	\$ 830,597	\$ 15,499,499
2020	1,238,328	316,604	1,554,932
2021	1,296,033	215,103	1,511,136
2022	332,101	151,245	483,346
2023	348,792	134,554	483,346
2024-2028	2,027,670	389,063	2,416,733
2029-2033	651,219	27,543	678,762
Total	<u>\$ 20,563,045</u>	<u>\$ 2,064,709</u>	<u>\$ 22,627,754</u>

Note 8 - Defined Benefit Pension Plan

Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year. The plan was closed to all new entrants effective February 22, 2013.

On January 27, 2018 the Plan was frozen (no additional benefits to accrue) for all non-Michigan Nurses Association (MNA) participants. On February 10, 2018 the Plan was frozen for all MNA participants. For the non-MNA participants, any benefit payment commencement date on or after February 2, 2018 was paid in one lump sum. For the MNA participants, any benefit payment commencement date on or after March 2, 2018 will be paid in one lump sum.

The most recent actuarial valuation was made as of January 1, 2019. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2018 and 2017 was \$22,034,260 and \$21,852,633, respectively. The Healthcare System's total actual payroll for the years ended December 31, 2018 and 2017 was \$44,541,254 and \$46,991,997, respectively.

Current membership in the Plan consists of the following at December 31:

	2018	2017
Inactive plan members or beneficiaries currently receiving benefits	382	345
Inactive plan members entitled to but not yet receiving benefits	115	113
Active plan members	247	348
	<u>744</u>	<u>806</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. 50% of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2018 and 2017 were 18.02% and 17.00%, respectively, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2018 and 2017 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2017 and 2016. The required funding, had the plan not been frozen, would have been at 18.02%. However, once the plan was frozen, funding related to "normal costs" was frozen as well and the contributions continued for the rest of the plan costs.

The Healthcare System's contributions to the plan for the years ended December 31, 2018 and 2017 were \$2,157,163 and \$3,621,532, respectively.

Net Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions – At December 31, 2018, the Healthcare System reported a liability of \$20,306,492 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2019, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2019. At December 31, 2017, the Healthcare System reported a liability of \$26,501,314 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2018, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2018.

For the years ended December 31, 2018 and 2017, the Healthcare System recognized pension expense of \$(6,106,484) and \$3,763,498, respectively. At December 31, 2018 and 2017, the Healthcare System reported deferred outflows of resources and deferred inflows of resources related to pension from the following sources:

	December 31, 2018	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	\$ 350,508	\$ 1,235,767
Changes in Assumptions	2,749,841	2,692,806
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	2,899,732	2,167,379
Total	<u>\$ 6,000,081</u>	<u>\$ 6,095,952</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2018 and 2017

	December 31, 2017	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	\$ 831,242	\$ 271,284
Changes in Assumptions	3,133,159	4,994,350
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	<u>1,850,310</u>	<u>2,896,606</u>
Total	<u>\$ 5,814,711</u>	<u>\$ 8,162,240</u>

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

<u>Years Ended December 31</u>	<u>Amount</u>
2019	\$ (416,987)
2020	(5,490)
2021	(191,871)
2022	<u>518,477</u>
	<u>\$ (95,871)</u>

Actuarial Assumptions

The total pension liability in the January 1, 2019 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Discount Rate	7.25%
Salary Increases	No longer applicable; plan benefits are frozen
Contribution Timing	Mid-year
Accrued Hours	For valuation purposes, no accrued PTO or leave balances are considered.

The actuarial assumptions used in the January 1, 2019 valuation were based on the results of actuarial experience studies with dates corresponding to those listed above.

The mortality table used is the RP-2014 Healthy Annuitant Mortality Table for males and females, adjusted for mortality improvement back to the observation period base year of 2006. Mortality rates for a particular calendar year are determined by applying the MP-2015 mortality improvement scale to the above described tables.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation for each major asset class is summarized in the following table:

<u>Asset Class</u>	<u>Asset Allocation</u>
Cash, deposits, money market funds	2.0%
International equity	17.0%
U.S. equity	49.0%
Fixed income	29.0%
Private real estate	3.0%
	100%

Discount Rate - The discount rate used to measure the total pension liability was 7.25%. The projection of cash flows used to determine the discount rate assumed that employee contributions will be made at the contractually required rate and that contributions from the Healthcare System will be made at contractually required rates, actuarially determined. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Changes in the Net Pension Liability

	2018	2017
Total Pension Liability		
Service Cost	\$ 63,657	\$ 888,094
Interest on the Total Pension Liability	5,270,685	5,903,941
Benefit Changes	(8,228,166)	-
Difference between Expected and Actual Experience	(1,603,622)	164,402
Assumption Changes	1,175,267	(7,295,894)
Benefit Payments	(12,302,517)	(3,080,964)
Net Change in Total Pension Liability	(15,624,696)	(3,420,421)
Total Pension Liability - Beginning	76,395,222	79,815,643
Total Pension Liability - Ending (a)	<u>\$ 60,770,526</u>	<u>\$ 76,395,222</u>
Total Fiduciary Net Position		
Employer Contributions	\$ 2,157,163	\$ 3,621,532
Employee Contributions	-	-
Pension Plan Net Investment Income	769,218	6,771,041
Benefit Payments	(12,302,517)	(3,080,964)
Pension Plan Administrative Expense	(53,738)	-
Other	-	(332,631)
Net Change in Plan Fiduciary Net Position	(9,429,874)	6,978,978
Plan Fiduciary Net Position - Beginning	49,893,908	42,914,930
Plan Fiduciary Net Position - Ending (b)	<u>\$ 40,464,034</u>	<u>\$ 49,893,908</u>
Net Pension Liability - Ending (a) - (b)	<u>\$ 20,306,492</u>	<u>\$ 26,501,314</u>
Plan Fiduciary Net Position as a Percentage of		
Total Pension Liability	66.58%	65.31%
Covered Employee Payroll	22,034,260	21,852,633
Net Pension Liability as a Percentage of		
Covered Employee Payroll	92.16%	121.27%

Sensitivity of the Healthcare System's Net Pension Liability to Changes in the Discount Rate - The following presents the Healthcare System's net pension liability calculated using the discount rate of 7.25%, as well as what the Healthcare System's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.25%) or 1 percentage-point higher (8.25%) than the current rate.

	1% Decrease (6.25%)	Discount Rate (7.25%)	1% Increase (8.25%)
Healthcare System's Net Pension Liability	\$ 25,434,680	\$ 20,306,492	\$ 15,832,358

Pension Plan Fiduciary Net Position – Detailed information about the pension plan's fiduciary net position is available in the separately issued actuarial report of the Dickinson County Healthcare System Retirement Plan.

Note 9 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Lincoln Financial Group Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

The DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 10 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees who were not currently vested in the defined benefit pension plan were transitioned to the new defined contribution plan design. Non-vested MNA (nursing staff) transitioned effective May 1, 2011 and non-vested, non-union staff transitioned effective September 4, 2011. Concurrently, all MNA and non-union new hires became members of the new DC plan. Lastly, non-vested AFSCME staff were transitioned effective February 23, 2013 and concurrently, all AFSCME new hires became DC plan members.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1 to 3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 10), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$1,126,016 and \$639,598 for the years ended December 31, 2018 and 2017.

Note 11 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000 for claims that were in process prior to August 1, 2018. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. For new medical claims reported subsequent to July 31, 2018, there is no deductible. The Healthcare System also has excess layered coverage of \$5 million. The policies end August 1, 2019.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis. The Healthcare System's estimate of general and professional liability includes a provision for known claims. The Healthcare System's liability for known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2018 and 2017. Amounts included as expense for general and professional liability for the years ended December 31, 2018 and 2017, which include claims and premiums paid, were \$235,961 and \$311,193, respectively.

The reserve for loss on professional liability claims at December 31, 2018 and 2017 and activity for the years then ended is as follows:

Balance December 31, 2016	Additions	Reductions	Balance December 31, 2017	Additions	Reductions	Balance December 31, 2018
\$ 500,000	\$ 100,000	\$ -	\$ 600,000	\$ -	\$ (150,000)	\$ 450,000

Note 12 - Contingencies

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Rural Health Clinic (RHC) Contingent liability

During 2017, the Healthcare System received an adjustment report from Medicare for its 2015 cost report in which the Medicare Administrative Contractor asserted a change in RHC reimbursement. This change in reimbursement affects 2015 through 2017 with a potential effect on Wisconsin Medicaid reimbursement. The hospital received the notice of program reimbursement (final settlement) for the 2015 Medicare cost report and appealed the issue to the Provider Reimbursement Review Board. The Healthcare System booked a contingent liability of \$1,122,436 in 2017 related to this matter. During 2018, the Healthcare System reduced the liability to \$728,909 as of December 31, 2018.

Litigations, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 13 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2018 and 2017 was as follows:

	2018	2017
Medicare	32%	40%
Blue Cross	21%	19%
Medicaid	9%	11%
Commercial insurance and other	25%	21%
Self pay	13%	9%
	100%	100%

The Healthcare System is subject to collective bargaining agreements for approximately 58.7% of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association was set to expire in February 2019 and the parties agreed to extend the collective bargaining agreement until August 28, 2019 or until such time that the parties ratify a successful agreement. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2020.

Note 14 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$41,702 and \$41,130 for the years ended December 31, 2018 and 2017. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2018 was approximately \$16,443,504.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the beneficiaries and timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 15 - Financial Condition

The Healthcare System's financial statements have been prepared assuming the Healthcare System will continue as a going concern, which contemplates the realization of assets and satisfaction of liabilities in the normal course of business. While the Healthcare System experienced an increase in total net position to \$7,507,305 as of December 31, 2018 from \$2,757,747 as of December 31, 2017, conditions still exist that raise substantial doubt as to the Healthcare System's ability to continue as a going concern within one year after the date the financial statements are issued. The current ratio was 1.0 and .9 for the years ended December 31, 2018 and 2017. Days cash on hand was 30.7 and 18.7 for the years ended December 31, 2018 and 2017. The current ratio and days cash on hand suggests a serious liquidity problem exists.

As of December 31, 2018, the Healthcare System had debt covenant violations and was considered to be in default on their 2015 bank note. As such, the 2015 bank note is reported as a current liability. The average payment period increased from 88 days as of December 31, 2017 to 97 days as of December 31, 2018. The Healthcare System also had long-term debt to net position of 273.9% as of December 31, 2018 and 752.7% as of December 31, 2017.

The Healthcare System has contracted with certain interim administrative contractors in an effort to stabilize cash and restructure to position the organization favorably for the future. The Healthcare System is now in a more favorable cash position and each of the months from December 2018 through April 2019 resulted in revenues in excess of expenses before capital contributions. During this period in time, there has been a reduction in workforce due to resignations, with many positions not being filled. In addition, several board members are new and are actively involved. Subsequent to year end, the Bellin Loan became due, but will not be paid off at this time due to restrictions by Fifth Third Bank.

The financial statements do not include any adjustments to reflect the possible future effects on the profitability and classification of assets and the amounts and classification of liabilities that may result from the possible inability of the Healthcare System to continue as a going concern.



Required Supplementary Information
December 31, 2018 and 2017

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Net Pension Liability
Required Supplementary Information

**Schedule of the Healthcare System's Net Pension Liability
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Total Pension Liability</u>	<u>Plan Net Position</u>	<u>Net Pension Liability</u>	<u>Plan Net Position as a % of Total Pension Liability</u>	<u>Covered Payroll</u>	<u>Net Pension Liability as a % of Covered Payroll</u>
2018	\$ 60,770,526	\$ 40,464,034	\$ 20,306,492	66.58%	\$ 22,034,260	92.16%
2017	76,395,222	49,893,908	26,501,314	65.31%	21,852,633	121.27%
2016	79,815,643	42,914,930	36,900,713	53.77%	22,992,042	160.49%
2015	71,398,459	39,423,168	31,975,291	55.22%	24,384,165	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2019.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Changes in Net Pension Liability
Required Supplementary Information

**Schedule of the Healthcare System's Changes in Net Pension Liability
Last 10 Fiscal Years***

	2018	2017	2016	2015
Total Pension Liability				
Service Cost	\$ 63,657	\$ 888,094	\$ 1,026,573	\$ 1,046,769
Interest on the Total Pension Liability	5,270,685	5,903,941	5,284,471	4,955,073
Benefit Changes	(8,228,166)	-	-	-
Difference between Expected and Actual Experience	(1,603,622)	164,402	(459,009)	2,005,318
Assumption Changes	1,175,267	(7,295,894)	5,469,421	-
Benefit Payments	(12,302,517)	(3,080,964)	(2,904,272)	(4,305,902)
Net Change in Total Pension Liability	(15,624,696)	(3,420,421)	8,417,184	3,701,258
Total Pension Liability - Beginning	76,395,222	79,815,643	71,398,459	67,697,201
Total Pension Liability - Ending (a)	<u>\$ 60,770,526</u>	<u>\$ 76,395,222</u>	<u>\$ 79,815,643</u>	<u>\$ 71,398,459</u>
Total Fiduciary Net Position				
Employer Contributions	\$ 2,157,163	\$ 3,621,532	\$ 3,654,952	\$ 3,760,071
Employee Contributions	-	-	-	-
Pension Plan Net Investment Income	769,218	6,771,041	3,073,918	(1,060,011)
Benefit Payments	(12,302,517)	(3,080,964)	(2,904,272)	(4,305,902)
Pension Plan Administrative Expense	(53,738)	-	-	-
Other	-	(332,631)	(332,836)	(330,941)
Net Change in Plan Fiduciary Net Position	(9,429,874)	6,978,978	3,491,762	(1,936,783)
Plan Fiduciary Net Position - Beginning	49,893,908	42,914,930	39,423,168	41,359,952
Plan Fiduciary Net Position - Ending (b)	<u>\$ 40,464,034</u>	<u>\$ 49,893,908</u>	<u>\$ 42,914,930</u>	<u>\$ 39,423,169</u>
Net Pension Liability - Ending (a) - (b)	<u>\$ 20,306,492</u>	<u>\$ 26,501,314</u>	<u>\$ 36,900,713</u>	<u>\$ 31,975,290</u>
Plan Fiduciary Net Position as a Percentage of				
Total Pension Liability	66.58%	65.31%	53.77%	55.22%
Covered Employee Payroll	22,034,260	21,852,633	22,992,042	24,384,165
Net Pension Liability as a Percentage of				
Covered Employee Payroll	92.16%	121.27%	160.49%	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2019.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Contributions
Required Supplementary Information

**Schedule of the Healthcare System's Contributions
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Actuarially Determined Contribution</u>	<u>Actual Contribution</u>	<u>Contribution Deficiency (Excess)</u>	<u>Covered Payroll</u>	<u>Actual Contribution as a % of Covered Payroll</u>
2018	3,946,471	2,157,163	\$ 1,789,308	22,034,260	9.79%
2017	3,950,762	3,621,532	329,230	21,852,633	16.57%
2016	3,628,060	3,654,952	(26,892)	22,992,042	15.90%
2015	3,760,071	3,760,071	-	24,274,184	15.49%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2019.

Notes to Schedule of Contributions

Valuation Date: January 1, 2019
Notes Actuarial determined contribution rates are calculated as of January 1 which is 12 months prior to the beginning of the fiscal year in which contributions are reported.

Methods and Assumptions Used to Determine Contribution Rates for Fiscal Year Ending December 31, 2018:

Actuarial Cost Method:	Entry Age Normal
Amortization Method:	Level percentage of payroll, closed
Remaining Amortization Period:	2013 ERIP: 2 years; Other: 30 years
Asset Valuation Method:	5-Year smoothed market; 15% corridor
Inflation:	Not applicable
Salary Increases:	Not applicable
Investment Rate of Return:	7.50%
Retirement Age:	65 years
Mortality:	The mortality table used is the RP-2014 Healthy Annuitant Mortality Table for males and females, adjusted for mortality improvement back to the observation period base year of 2006. Mortality rates for a particular calendar year are determined by applying the MP-2015 mortality improvement scale to the above described tables.

Other Information:

Notes Retirement rates were updated for the January 1, 2018 valuation based on evaluation of actual plan experience. Benefit accruals were frozen as of January 27, 2018 for non-MNA members and February 10, 2018 for MNA members. Effective for retirements after February 1, 2018 for non-MNA members and March 1, 2018 for MNA members, the only available form of payment for benefits is lump sum.



Financial Statements

December 31, 2017 and 2016

Dickinson County Healthcare System

(A Component Unit of Dickinson County)

Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2017 and 2016

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	4
Financial Statements	
Statements of Net Position	17
Statements of Revenues, Expenses, and Changes in Net Position	18
Statements of Cash Flows	19
Notes to Financial Statements	21
Required Supplementary Information	
Schedule of Net Pension Liability	48
Schedule of Changes in Net Pension Liability	49
Schedule of Contributions	50



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County) (Healthcare System), which comprise the statements of net position as of December 31, 2017 and 2016, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements, which collectively comprise the Healthcare System's basic 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2017 and 2016, and the results of its operations, changes in net position, and cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Correction of Error

As discussed in Note 16 to the financial statements, certain errors resulting in an understatement of amounts previously reported for investment in joint ventures, gain on investment in joint ventures, and beginning net position as of December 31, 2016, were discovered by management of the Healthcare System during the current year. Accordingly, amounts reported for investment in joint ventures, gain on investment in joint ventures, and beginning net position have been restated in the 2016 financial statements now presented, and an adjustment has been made to net position as of December 31, 2016, to correct the error. Our opinion is not modified with respect to that matter.

Emphasis of Matter Regarding Going Concern

The accompanying financial statements have been prepared assuming that the Healthcare System will continue as a going concern. As discussed in Note 17 to the financial statements, the Healthcare System has suffered recurring losses from operations and a significant decline in cash flow. These conditions raise substantial doubt about its ability to continue as a going concern. Management's plans in regard to these matters are also described in Note 17. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to that matter.

Other Matters**Required Supplementary Information**

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 4 through 16, and the Schedules of the Healthcare System's Share of the Net Pension Liability, the Changes in Net Pension Liability, and Contributions on pages 48 through 50 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated June 20, 2018 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the effectiveness of the Healthcare System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and in considering the Healthcare System's internal control over financial reporting and compliance.

A handwritten signature in black ink that reads "Erik Bailly LLP". The signature is written in a cursive, flowing style.

Fargo, North Dakota
June 20, 2018

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2017, 2016, and 2015. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2017

The Healthcare System's net position decreased in 2017 by \$13.140 million or 82.7% with a loss before capital contributions of \$13.242 million, comprised of an operating loss of \$12.3 million and nonoperating expenses in excess of nonoperating revenue of \$918 thousand. There were \$102 thousand of contributions for capital purposes in 2017. During 2017, the Healthcare System's total operating revenues of \$104.258 million was 5.8% lower than the amount in 2016. The resulting operating loss for 2017 of (\$12.324) million compared to an operating loss of (\$2.808) million for 2016 which was (11.8)% of operating revenue.

Awards and special recognitions continued in 2017. They were as follows:

- **Earned 3 Governor's Awards of Excellence**
 - Outstanding Achievement in Lowering the Risk of Infection: Hospitals
 - Outstanding Achievement in Effective Reporting and Measurement: Hospital Value-based Purchasing (HVBP) Acute Care Hospitals
 - Outstanding Achievement in Effective Reporting and Measurement: Hospital Value-based Purchasing (HVBP) Acute Care Hospitals – Enhanced Award
- **Attained an "A" rating from the Leapfrog Group.** The Leapfrog Group recognized Dickinson County Healthcare System with a Patient Safety Grade of "A" for the eleventh consecutive reporting period, which translates into 5 years of this highest ranking
- **Recognized by the Economic Alliance of Michigan (EAM)** with their *Excellence in Patient Safety Award* for consistently providing safe healthcare according to the standards set forth by the Leapfrog Group
- **Received national Healthgrades Awards for Clinical Excellence as follows:**
 - **Cardiac**
 - Five-Star Recipient for Treatment of Heart Attack for 8 Years in a Row (2010-2017)
 - Five-Star Recipient for Treatment of Heart Failure in 2017
 - **Pulmonary**
 - Recipient of the Healthgrades 2016 Pulmonary Care Excellence Award™
 - Named Among the Top 10% in the Nation for Overall Pulmonary Services in 2017
 - Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease in 2017
 - Five-Star Recipient for Treatment of Pneumonia for 3 Years in a Row (2015-2017)
 - **Gastrointestinal**
 - Recipient of the Healthgrades 2017 Gastrointestinal Care Excellence Award™
 - Named Among the Top 10% in the Nation for Overall GI Services in 2017
 - Five-Star Recipient for Treatment of GI Bleed in 2017
 - Five-Star Recipient for Treatment of Bowel Obstruction in 2017

- **Critical Care**
Five-Star Recipient for the Treatment of Sepsis for 4 years in a Row (2014-2017)
- **Patient Safety**
Recipient of the Healthgrades Patient Safety Excellence Award™ 3 years in a Row (2014-2017)
Named Among the Top 5% in Nation for Patient Safety in (2016-2017)

The following service enhancements were completed in 2017:

- Successfully recruited three new physicians for its Medical Staff in the past year, which has allowed for the continuation and expansion of healthcare services within the region. They include the following:
 - Jeremy Stayton, M.D. – Surgery and Endoscopy
 - Douglas Calvin, M.D. – Radiation Oncology
 - Eric Johnson, M.D. – Emergency Department
- Added a new, on campus OB/GYN clinic.

Year Ended December 31, 2016

The Healthcare System's net position decreased in 2016 by \$3.183 million or 16.7% with a loss before capital contributions of \$3.224 million, comprised of an operating loss of \$2.808 million and non-operating expenses in excess of non-operating revenue of \$416 thousand. There were \$41 thousand of contributions for capital purposes in 2016. During 2016, the Healthcare System's total operating revenues of \$110.642 million was about equal to the amount in 2015. The resulting operating loss for 2016 of (\$2.808) million compared to an operating income of \$4.479 million for 2015 which was (2.5)% of operating revenue.

Awards and special recognitions continued in 2016. They were as follows:

- Received a National Patient Safety score of "A" from the Leapfrog Group for the tenth consecutive six-month reporting period.
- Received national *Healthgrades* Awards for clinical excellence as follows:
 - Cardiac – Five-Star Recipient for Treatment of Heart Attack for 7 Years in a Row (2010-2016)
 - Cardiac – Five-Star Recipient for Treatment of Heart Failure (2016)
 - Recipient of the Pulmonary Care Excellence Award (2016)
 - Named among Top 10% in the Nation for Overall Pulmonary Services (2016)
 - Pulmonary – Five Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease (2016)
 - Pulmonary – Five Star Recipient for Treatment of Pneumonia for 2 years in a row (2015-2016)
 - Critical Care – Five-Star Recipient for Treatment for Sepsis for 3 Years in a Row (2014-2016)
 - Critical Care – Five-Star Recipient for Treatment of Respiratory Failure (2016)
 - Recipient of the Gastrointestinal Care Excellence Award (2016)
 - Named among the Top 10% in the Nation for Overall GI Services (2016)
 - Gastrointestinal – Five Star Recipient for Treatment of GI Bleed (2016)
 - Gastrointestinal – Five-Star Recipient for Treatment of Bowel Obstruction (2016)
 - Patient Safety – Recipient of Patient Safety Excellence Award™ and Named Among the Top 5% in the Nation for Patient Safety in 2016

- I-Vantage Health Analytics' Group – Top 100 Rural & Community Hospitals/ The top 4% of U.S. Hospitals
- CMS – 4 Star Rating
- Named “The Best & Safest Hospital the State has to offer!” by the Economic Alliance of Michigan
- Recognized by the Michigan Senate with Resolution No. 197 for our dedicated efforts to improve the quality of healthcare and patient safety in our community

The following service enhancements were completed in 2016:

- Successfully recruited five new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - o Anh Tran, M.D. – Neurology
 - o Robyne Camana – Radiology
 - o Ryan Hart, D.O. – Emergency Department
 - o Hugh “Gunner” Deery, M.D. – Infectious Disease
 - o Raymond Fedderly, M.D. – Pediatric Cardiology
 - o Kaylynn Saigh, D.D.S. – Pediatric Dentistry
 - o Robert Han – Hospitalist
 - o Gerald Pruitt – Hospitalist
- 3-D Mammography with Tomosynthesis
- Relocation of the Diabetes and Wellness Center to the YMCA building
- Additional Rehabilitation Services including Vestibular Rehabilitation and Pelvic Health

Year Ended December 31, 2015

The Healthcare System's net position increased in 2015 by \$3.247 million or 23.7% with revenues before capital contributions of \$3.198 million, comprised of an operating income of \$4.479 million and non-operating expenses in excess of non-operating revenue of \$1.281 million. There were \$49 thousand of contributions for capital purposes in 2015. During 2015, the Healthcare System's total operating revenues of \$110.736 million was 15.7% higher than the amount in 2014. The resulting operating income for 2015 of \$4.479 million was 4.0% of total operating revenue compared to an operating income of \$4.929 million for 2014 which was 5.1% of operating revenue.

Awards and special recognitions were, as in the previous year, again plentiful in 2015. They were as follows:

- Received a National Patient Safety score of “A” from the Leapfrog Group for the seventh consecutive six-month reporting period.
- Received recognition from The Joint Commission as a *Top Performer on Key Quality Measures* specifically in the areas of Pneumonia Treatment, Surgical Care, VTE, Immunization, AMI, and Heart Failure

- Received national *Healthgrades* Awards for clinical excellence as follows:
 - o Cardiac – Five-Star Recipient for Treatment of Heart Attack for 6 Years in a Row (2010-2015)
 - o Critical Care – Five-Star Recipient for Treatment of Sepsis for 2 Years in a Row (2014-2015)
 - o Patient Safety – Recipient of Patient Safety Excellence Award™ and Named Among the Top 10% in the Nation for Patient Safety in 2015

The following service enhancements were completed in 2015:

- Successfully recruiting six new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - o Kristine Bobish, D.O. – Cardiology
 - o Jennifer Hwang, D.O. – Internal Medicine
 - o Daniel Kreider, M.D. – Radiology
 - o Theodore Parsons, M.D. – Pathology
 - o Brian Shukri, D.O. – Radiology
 - o John Simmons, D.O. – Radiation Oncology
- Added the independent Cecconi-Terrian-Donohue General Surgery Practice to the compliment of Dickinson owned clinics.
- Expanded Home Medical Equipment Services to Delta County
- Established a Smoke-Free Campus including all outlying clinics
- Expanded the Patient Portal to include communication with all Dickinson owned medical clinics

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Statement of Net Position includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all non-operating revenue and expense items, capital contributions and the net increase in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Financial Analysis of the System

The condensed statements of net position of the Healthcare System as of December 31, 2017, 2016, and 2015 are summarized in the following table.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Condensed Statements of Net Position
December 31, 2017, 2016, and 2015 (in Thousands)

	2017	2016 (restated)	2015 (restated)
Total current assets (includes the current portion of restricted assets)	\$ 25,375	\$ 36,599	\$ 40,515
Cash and investments internally designated for other purposes	-	1,899	2,291
Cash and investments restricted by bond indentures	2,000	2,000	2,000
Capital assets, net	34,207	34,623	36,336
Other assets	3,241	2,558	2,122
	<u>64,823</u>	<u>77,679</u>	<u>83,264</u>
Total Assets	64,823	77,679	83,264
Total Deferred Outflows of Resources	6,194	8,871	6,191
	<u>6,194</u>	<u>8,871</u>	<u>6,191</u>
Total Assets and Deferred Outflows	<u>\$ 71,017</u>	<u>\$ 86,550</u>	<u>\$ 89,455</u>
	<u>71,017</u>	<u>86,550</u>	<u>89,455</u>
Total current liabilities	\$ 28,283	\$ 13,668	\$ 16,715
Long-term debt, net of current portion	4,713	19,124	21,159
Other long-term liabilities	600	500	500
Net pension liability	26,501	36,901	31,975
	<u>60,097</u>	<u>70,193</u>	<u>70,349</u>
Total Liabilities	60,097	70,193	70,349
Total Deferred Inflows of Resources	8,162	459	25
	<u>8,162</u>	<u>459</u>	<u>25</u>
Total Net Position	<u>2,758</u>	<u>15,898</u>	<u>19,081</u>
	<u>2,758</u>	<u>15,898</u>	<u>19,081</u>
Total Liabilities, Deferred Inflows of Resources, and Net Position	<u>\$ 71,017</u>	<u>\$ 86,550</u>	<u>\$ 89,455</u>
	<u>71,017</u>	<u>86,550</u>	<u>89,455</u>

Current Assets and Liabilities

Net patient accounts receivable remained stable at 58 days' of net revenue at December 31, 2017 compared to 58 days' of net revenue at December 31, 2016 and compared to 60 days' of net revenue at December 31, 2015. The slight decrease in 2016 can be attributed to the outsourcing of self-pay collections to AmeriEBO which continued in 2017.

Total current assets decreased 30.1% in 2017 and decreased 9.6% in 2016 compared to each prior year. The decrease in 2017 was the result of a decrease in cash and cash equivalents.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Current liabilities increased 106.9% in 2017 primarily as a result of the 2015 bank note being recorded as a current liability while current liabilities decreased 18.2% in 2016 as a result of a decrease in trade accounts receivable. The Healthcare System's current ratio (current assets divided by current liabilities) was .90 at December 31, 2017 and 2.66 at December 31, 2016.

Total Cash and Investments

The number of days of total cash and investments was 18.7 at December 31, 2017 and 60.3 at December 31, 2016.

The total cash and investments at December 31, 2017 were \$6.0 million including restricted funds of \$2.0 million. Total cash and investments at December 31, 2016 were \$18.5 million including restricted funds of \$2.0 million.

Long-Term Debt

The Healthcare System had long-term debt of \$4.7 million at December 31, 2017 and \$19.1 million at December 31, 2016 (net of current maturities of \$16.0 million in 2017 and \$2.1 million in 2016). In 2015, the 1999 Revenue and Refunding Bonds were paid off with a \$20 million term loan through Fifth Third Bank of Grand Rapids, Michigan. Long-term debt at December 31, 2017 represents 14.8% of total long-term liabilities and 7.8% of total liabilities as compared to 33.8% of total long-term liabilities and 27.2% of total liabilities at December 31, 2016. The Healthcare System recorded a Net Pension Liability of \$26.501 million in 2017 and \$36.901 million in 2016 as required by GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*. The debt service coverage ratio for the years ended December 31, 2017 and 2016 was (2.92) and .60 respectively.

Net Position

Total net position decreased in 2017 and 2016. Likewise, unrestricted net position decreased from 2016 to 2017 and from 2015 to 2016. The decrease in the unrestricted component for 2017 was the result of unfavorable operations for the year in both the revenue and expenses. The decrease in the unrestricted component for 2016 was a result of the requirement to record the Net Pension Liability as defined by GASB 68 as it relates to the Healthcare System's defined benefit pension plan. The amount invested in capital assets, net of related debt remained constant in all years as the Healthcare System made capital purchases only for those items required by HITECH and for equipment that was no longer usable. The restricted amount for debt service represents funds held by Fifth Third Bank in 2015, 2016 and 2017 as required by the term loan agreement. These components are presented in the following table.

Components of Net Position (in thousands)

	December 31,		
	2017	2016 (restated)	2015 (restated)
Invested in capital assets, net of related debt	\$ 13,829	\$ 13,989	\$ 13,726
Restricted by revenue bond indentures, expendable for debt service	2,000	2,000	2,000
Unrestricted	(13,071)	(91)	3,355
Total net position	<u>\$ 2,758</u>	<u>\$ 15,898</u>	<u>\$ 19,081</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2017, 2016, and 2015 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2017, 2016, and 2015 (in Thousands)

	2017		2016 (restated)		2015 (restated)	
Revenue and (expenses):						
Net patient service revenue	\$ 101,328	97.2%	\$ 103,797	93.8%	\$ 101,437	91.6%
Other revenue	2,930	2.8%	6,845	6.2%	9,299	8.4%
Total operating revenue	104,258	100.0%	110,642	100.0%	110,736	100.0%
Total operating expenses	116,582	111.8%	113,450	102.5%	106,257	96.0%
Operating income (loss)	(12,324)	-11.8%	(2,808)	-2.5%	4,479	4.0%
Investment income	(4)	0.0%	92	0.1%	193	0.2%
Change in unrealized gains and losses on investments	34	0.0%	(31)	0.0%	(85)	-0.1%
Gain on investment in joint ventures	683		495	0.4%	-	0.0%
Change in fair market value of forward purchase agreement	-	0.0%	-	0.0%	35	0.0%
Interest and amortization expense	(945)	-0.9%	(994)	-0.9%	(1,392)	-1.3%
Other non-operating revenue and expenses (net)	(686)	-0.7%	22	0.0%	(32)	0.0%
Non-operating expenses in excess of revenue	(918)	-0.9%	(416)	-0.4%	(1,281)	-1.2%
Income (loss) before capital contributions	(13,242)	-12.7%	(3,224)	-2.9%	3,198	2.9%
Capital contributions	102		41		49	
Increase (decrease) in net position	(13,140)		(3,183)		3,247	
Net position, beginning of year, as previously stated	15,898		19,081		39,288	
Restatement - recognition of net pension liability and related deferred inflows and outflows	-		-		25,577	
Net position - beginning of year as restated	15,898		19,081		15,834	
Net position - end of year	\$ 2,758		\$ 15,898		\$ 19,081	

Results of Operations

Overall loss on operations of (\$12.324) million or (11.8)% of revenue for 2017 increased from an operating loss of (\$2.808) million or (2.5)% of revenue for 2016. The net non-operating expenses in excess of non-operating revenue for 2017 increased to \$918 thousand from \$416 thousand in 2016. The net increase in 2017 was the result of the write down of an asset related to architectural fees for a medical office building project that was abandoned as well as an increase in the market value of the healthcare system's ownership share in the Upper Peninsula Health Plan. The net decrease in 2016 was due to lower interest expense as a result of refinancing of debt. The net result for 2017 was a loss of (\$13.242) million or (12.7)% of total operating revenue before capital contributions. The net result for 2016 was a loss of (\$3.224) million or (2.9)% of total operating revenue before capital contributions. The Healthcare System's financial statements have been prepared assuming the Healthcare System will continue as a going concern, which contemplates the realization of assets and satisfaction of liabilities in the normal course of business. These conditions raise substantial doubt as to the Healthcare System's ability to continue as a going concern within one year after the date the financial statements are issued as discussed in Note 17 of the financial statements.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2017 comprised 25.7% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2016 was 25.3%. The operating performance of DCMH was affected by inpatient discharges increasing by 5.1% to 2,803 from 2,668 in 2016, while acute adult and pediatric inpatient days also increased by 5.2% to 9,308 from 8,844 in 2016. Net inpatient revenue decreased 1.4% and the all-payer case mix index decreased to 1.380 from 1.427 in 2016.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 57.4% of total Healthcare System net patient revenue and its operating activities for 2017. The comparable percentage for 2016 was 59.6%. Net outpatient revenue decreased 6.8% in 2017 and increased 2.4% in 2016. Total outpatient visits were 204,522 in 2017 and 198,645 in 2016. As a percent, the largest increase in outpatient visits was seen in day surgeries and other ancillary visits mainly in laboratory and imaging.

The net patient revenue of the Rural Health Clinics (RHC's) and other Provider Based RHC's comprised about 16.9% of the total net patient revenue of the Healthcare System for 2017 and 15.1% for 2016. The revenue growth was 7.8% in 2017 as a result of a change in accounting method for recording revenue generated by the providers in the Dickinson Orthopedic Practice. The revenue growth was 10.0% in 2016 as a result of adding three mid-level providers and the full year effect of bringing on a general surgery and endoscopy practice July 2015. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute to the losses on operations. There are two facilities in northeast Wisconsin and ten off-campus practices in Michigan in addition to another twelve practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from health care services, and nonoperating revenue, which is principally from investment income.

Operating Revenue

Total gross revenues for all patient services performed by the Healthcare System were \$313 million in 2017 and \$298 million in 2016. The overall increase reflects the year-to-year difference in patient volumes and service mix changes. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care and other free care services measured as unpaid gross revenues of 0.8% in 2017 and 2016, respectively, to patients who documented their inability to pay. Bad debt provisions were 1.1% of gross revenue in 2017 and 0.9% in 2016. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 65.0% in 2017 and 63.4% in 2016.

The resulting net patient services revenue was 32.4% of gross revenue in 2017 and 34.9% in 2016. Net patient service revenue decreased (\$2.468) million in 2017 as a result of a decrease in the case mix index as well as loss of full cost reimbursement for the healthcare system's rural health clinics for years 2015-2017. This determination by CMS is being contested. Net patient service revenue increased \$2.360 million or 2.3% in 2016 as a result of higher outpatient and physician visits and case mix index. Other operating revenue decreased \$3.915 million or 57.2% from 2016 to 2017 and decreased \$2.453 million or 26.4% from 2015 to 2016. This was the result of losing eligibility to participate in the 340B drug program from July 26, 2016 until July 1, 2017 as well as a 50% reduction in electronic health record incentive payments in 2017.

Nonoperating Revenue/Expense

Investment loss was (\$4.0) thousand for 2017 due to continued weak interest rates and the depletion of the healthcare system's long term investments. Investment income was \$92 thousand for 2016 due to weak interest rates and the depletion of the healthcare system's short term investments. The change in unrealized gains and losses on investments was \$34 thousand in 2017 and (\$31) thousand in 2016. Gain on investment in the Upper Peninsula Health Plan (UPHP) was \$683 thousand in 2017 and \$495 thousand in 2016. The healthcare system has a 5.4% ownership in UPHP. Interest and amortization expense was (\$945) thousand in 2017 and (\$994) thousand in 2016. The Healthcare System capitalized interest expense amounts of \$65 thousand in 2017 and \$73 thousand in 2016. Unrestricted general contributions remained constant in 2017 and 2016 at \$48 thousand and \$50 thousand respectively. Loss on disposal of capital assets increased to (\$734) thousand in 2017 from (\$28) thousand in 2016 due to the write down of an asset related to architectural fees for a medical office building project that was abandoned.

Capital Contributions

There were \$102 thousand in capital contributions in 2017 for the café remodel and other building improvement projects sponsored by the Hospital Foundation. There were \$41 thousand in capital contributions in 2016 for 2 infant warmers, a conference table and chairs, and imaging hardware.

Forward Purchase Agreement

In 2015 an increase of \$35 thousand in market value was recognized prior to the termination of the agreement as part of the payoff of the 1999 Revenue and Refunding Bonds.

Expenditure of Funds

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2017 and 2016 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2017 and 2016 (in Thousands)

	2017	2016	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 65,570	\$ 64,944	\$ 626	1.0%
Supplies and pharmaceuticals	21,512	20,322	1,190	5.9%
Professional fees and other purchased services	25,637	23,597	2,040	8.6%
Depreciation and amortization	3,863	4,587	(724)	-15.8%
Total	<u>\$ 116,582</u>	<u>\$ 113,450</u>	<u>\$ 3,132</u>	<u>2.8%</u>

Employee compensation and benefits increased \$626 thousand or 1.0%. The annual average total paid full-time equivalent (FTE) positions of 736.8 for 2017 increased by 1.0% from the 2016 amount of 729.6. Pension expense decreased by (\$2.307) million or 34.4% due to a decrease in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the Healthcare System. Health insurance expense increased by \$2.593 million or 27.2% due to an increase in the annual premium as a result of unfavorable claims experience in the prior year. This was offset by more favorable reimbursement rates.

The cost of supplies and pharmaceuticals increased \$1.2 million or 5.9%, due to an increase in pharmaceutical expense, specifically related to chemotherapy drugs.

Professional fees, purchased services and other expenses for 2017 increased \$2.04 million or 8.6%. This was mainly the result of higher medical professional fees, collection fees, legal fees, hardware and software maintenance contracts, dues & subscriptions and the abandoned asset that was mentioned previously offset by a reduction in other professional fees. Depreciation and amortization expense for 2017 decreased \$724 thousand or 15.8% as a result of minimal capital spending the last several years.

The components of operating expenses for the Healthcare System for the years ended December 31, 2016 and 2015 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2016 and 2015 (in Thousands)

	2016	2015	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 64,944	\$ 60,226	\$ 4,718	7.8%
Supplies and pharmaceuticals	20,322	19,722	600	3.0%
Professional fees and other purchased services	23,597	21,801	1,796	8.2%
Depreciation and amortization	4,587	4,507	80	1.8%
Total	<u>\$ 113,450</u>	<u>\$ 106,256</u>	<u>\$ 7,194</u>	<u>6.8%</u>

Employee compensation and benefits increased \$4.718 million or 7.8%. The annual average total paid full-time equivalent (FTE) positions of 729.6 for 2016 increased by 3.6% from the 2015 amount of 704.6. Pension expense increased by \$1.458 million or 27.8% due to an increase in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the Healthcare System. Health insurance expense also increased by \$1.560 million or 24.1% due to a change in carrier. This was offset by more favorable reimbursement rates.

The cost of supplies and pharmaceuticals increased \$600 thousand or 3.0%, due to an increase in pharmaceutical expense, specifically related to chemotherapy drugs. The Healthcare System took over operation of a Hematology/Oncology practice in December 2014.

Professional fees, purchased services and other expenses for 2016 increased \$1.796 million or 8.2%. This was mainly the result of higher medical professional fees in the Emergency Department, Radiation Oncology, Hospitalist Program and Pediatric Clinic. Depreciation and amortization expense for 2016 increased \$80 thousand or 1.8%.

Capital Expenditures

Fiscal Year 2017

Total capital spending increased by approximately 45.2% from 2016 levels. Major purchases and construction projects included the following: Pharmacy renovation, OBGYN Clinic, Orthopedic Office, Medical Park Office Building, OR Management System, PACS System including additional SAN, Radiation Oncology Software and Licenses, and parking lot and road paving.

Fiscal Year 2016

Total capital spending decreased by approximately 21.5% from 2015 levels. Major purchases included the following: 3D Mammography Unit and numerous information technology equipment and software upgrades.

Fiscal Year 2015

Total capital spending increased by approximately 20% from 2014 levels. Major purchases included the following: Land parcel adjacent to the main campus, ultrasound machine, various building improvements and numerous information technology equipment and software upgrades.

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The current budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2017 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 113,099	\$ (8,841)	-8%
Total operating expenses	(114,419)	(2,163)	-2%
Operating income	(1,320)	(11,004)	834%
Net nonoperating revenue and gains, (expenses and losses)	(498)	(420)	-84%
Income before capital contributions	(1,818)	(11,424)	628%
Capital contributions	50	52	104%
Increase in net position	\$ (1,768)	\$ (11,372)	643%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were favorable by approximately 1.4%, while total hospital outpatient visits were favorable by approximately 1.8%. These modest volume increases were offset by unanticipated revenue reductions such as a lower case mix index and the CMS Rural Health Clinic reimbursement issue that was previously mentioned. Expenses were unfavorable to budget by \$2.163 million or 2% as a result of increased salary and wage expense. FTE's were 2.2% over budget mainly as a result of increased staffing in the Emergency Department, Convenience Care Clinic, Operating Room, Medical/Surgical/Pediatrics, Ambulatory Care Unit/Infusion/Endoscopy and Radiology. The variance in other net non-operating items was caused principally by a higher loss on the sale of capital assets, higher unrealized losses on investments and lower unrestricted general contributions.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2017, 2016, and 2015 (in Thousands)

	2017	2016	2015
Budget	\$ 2,641	\$ 11,929	\$ 5,366
Actual	4,182	2,864	3,650
Variance	\$ (1,541)	\$ 9,065	\$ 1,716
Variance %	-58.4%	76.0%	32.0%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. For the past three years only items of a critical nature or required by HITECH have been purchased. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

The Healthcare System saw more high deductible health plans for its patients in 2017. This contributed to a \$1.024 million or 19.8% increase in total uncompensated care from 2016. Uncompensated care with bad debt and charity write-offs totaled 2.0% of gross charges in 2017 compared to 1.7% in 2016 and 1.9% in 2015. In February 2018, the most recent data available, the unemployment rate in Dickinson County was 5.6% compared to 8.3% over the entire Upper Peninsula and 5.2% for the State of Michigan. The same statistics for February 2017 were 5.4%, 7.9% and 5.3%, respectively.

On July 1, 2015, the Healthcare System joined the Greater Michigan Rural ACO with the assistance of the National Rural Accountable Care Consortium, now known as Caravan Health. The ACO consists of 9 healthcare systems (3 located in the Upper Peninsula) and several independent practices. This agreement runs through December 31, 2018. Participation in the Greater Michigan Rural ACO was terminated early on December 31, 2017. Effective January 1, 2018, the Healthcare System is a member of the NextGen ACO. This agreement runs through December 31, 2019.

On November 1, 2016, the Healthcare System joined Bellin Health Partners, a clinically integrated network, with members in Northeastern Wisconsin and the Upper Peninsula of Michigan. The network consists of hundreds of independent physicians, Bellin Health of Green Bay, WI, Dickinson County Healthcare System, Oconto Hospital and Holy Family Memorial Hospital of Manitowish, WI.

The mission of the network is to build a partnership and structure of interdependence for all members to create value through improved patient experience and high quality, affordable care that has a positive impact on the health and wellbeing of the communities. The network strives to create trusted relationships in order to drive innovation and value to the communities it serves, in a sustainable fashion.

(This page left blank intentionally.)

	<u>2017</u>	<u>2016</u> (restated)
Assets and Deferred Outflows of Resources		
Current Assets		
Cash and cash equivalents	\$ 3,996,289	\$ 14,621,864
Short-term investments	-	12,838
Receivables		
Patient, net of estimated uncollectibles of \$2,180,000 in 2017 and \$3,097,000 in 2016	16,035,874	16,530,188
Estimated third-party settlements	903,646	1,136,341
Other	1,107,427	400,483
Supplies and other current assets	<u>3,331,865</u>	<u>3,897,513</u>
Total current assets	<u>25,375,101</u>	<u>36,599,227</u>
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	2,000,000	2,000,000
Other long-term investments	<u>-</u>	<u>1,899,382</u>
Total noncurrent cash and investments	<u>2,000,000</u>	<u>3,899,382</u>
Capital Assets		
Capital assets not being depreciated	2,570,562	3,702,523
Depreciable capital assets, net of accumulated depreciation	<u>31,636,620</u>	<u>30,920,283</u>
Total capital assets	<u>34,207,182</u>	<u>34,622,806</u>
Other Assets		
Investment in joint ventures	<u>3,241,090</u>	<u>2,558,048</u>
Total assets	<u>64,823,373</u>	<u>77,679,463</u>
Deferred Outflows of Resources		
Refunding costs	378,722	547,046
Pension related deferred outflows	<u>5,814,711</u>	<u>8,323,649</u>
Total deferred outflows of resources	<u>6,193,433</u>	<u>8,870,695</u>
Total assets and deferred outflows	<u><u>\$ 71,016,806</u></u>	<u><u>\$ 86,550,158</u></u>

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Net Position
December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u> (restated)
Liabilities, Deferred Inflows of Resources, and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 16,044,068	\$ 2,056,056
Accounts payable		
Trade	3,921,364	3,811,027
Accrued expenses		
Salaries, wages, and related liabilities	2,430,123	2,192,991
Compensated absences	5,233,857	5,067,712
Other accrued liabilities	653,474	539,864
Total current liabilities	<u>28,282,886</u>	<u>13,667,650</u>
Long-Term Liabilities		
Long-term debt, less current maturities	4,712,619	19,124,442
Reserve for loss on general and professional liabilities claims	600,000	500,000
Net pension liability	<u>26,501,314</u>	<u>36,900,713</u>
Total long-term liabilities	<u>31,813,933</u>	<u>56,525,155</u>
Total liabilities	<u>60,096,819</u>	<u>70,192,805</u>
Deferred Inflows of Resources		
Pension related deferred inflows	<u>8,162,240</u>	<u>459,043</u>
Net Position		
Invested in capital assets, net of related debt	13,829,217	13,989,354
Restricted - expendable for debt service	2,000,000	2,000,000
Unrestricted	<u>(13,071,470)</u>	<u>(91,044)</u>
Total net position	<u>2,757,747</u>	<u>15,898,310</u>
Total liabilities and net position	<u><u>\$ 71,016,806</u></u>	<u><u>\$ 86,550,158</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u> (restated)
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$3,547,462 in 2017 and \$2,662,566 in 2016	\$ 101,328,450	\$ 103,796,942
Supplies and 340B program revenue	385,681	3,720,844
Electronic health record incentive revenue	513,328	1,055,660
Other revenue	<u>2,030,797</u>	<u>2,068,778</u>
Total operating revenues	<u>104,258,256</u>	<u>110,642,224</u>
Operating Expenses		
Salaries and wages	46,991,997	46,346,813
Employee benefits	18,577,980	18,596,944
Supplies and pharmaceuticals	21,512,059	20,322,014
Medical and other professional fees	12,090,328	10,673,365
Purchased services and other	13,546,566	12,923,493
Depreciation	<u>3,863,153</u>	<u>4,587,047</u>
Total operating expenses	<u>116,582,083</u>	<u>113,449,676</u>
Operating Loss	<u>(12,323,827)</u>	<u>(2,807,452)</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	48,390	50,137
Interest and amortization expense	(945,071)	(994,234)
Loss on disposal of capital assets	(734,296)	(27,663)
Investment income	(4,396)	91,980
Gain on investment in joint ventures	683,042	495,115
Change in unrealized gains and losses on investments	<u>33,741</u>	<u>(31,119)</u>
Nonoperating revenues (expenses), net	<u>(918,590)</u>	<u>(415,784)</u>
Expenses in Excess of Revenues Before Capital Contributions	(13,242,417)	(3,223,236)
Capital Contributions	<u>101,854</u>	<u>41,000</u>
Decrease in Net Position	(13,140,563)	(3,182,236)
Net Position, Beginning of Year	<u>15,898,310</u>	<u>19,080,546</u>
Net Position, End of Year	<u><u>\$ 2,757,747</u></u>	<u><u>\$ 15,898,310</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u> (restated)
Operating Activities		
Receipts from and on behalf of patients	\$ 102,055,459	\$ 102,369,512
Payments to suppliers and contractors	(46,091,034)	(46,604,961)
Payments to or on behalf of employees	(65,353,964)	(61,979,848)
Other receipts	<u>2,222,862</u>	<u>9,442,912</u>
Net Cash From (Used For) Operating Activities	<u>(7,166,677)</u>	<u>3,227,615</u>
Noncapital Financing Activity		
Unrestricted general contributions	<u>48,390</u>	<u>50,137</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(4,174,211)	(2,863,550)
Repayment of long-term debt	(2,122,362)	(2,211,045)
Interest paid, including capitalized interest	(1,007,648)	(1,067,467)
Capital contributions	101,854	41,000
Proceeds from the sale of capital assets	54,963	35,000
Proceeds from the issuance of long term debt	<u>1,698,551</u>	<u>66,000</u>
Net Cash Used For Capital and Capital Related Financing Activities	<u>(5,448,853)</u>	<u>(6,000,062)</u>
Investing Activities		
Purchases of investments	(30,792,140)	(97,542,937)
Proceeds from sales and maturities of investments	32,738,101	102,451,997
Distributions from joint ventures	-	59,500
Investment income	<u>(4,396)</u>	<u>91,980</u>
Net Cash From Investing Activities	<u>1,941,565</u>	<u>5,060,540</u>
Net Increase (Decrease) in Cash and Cash Equivalents	(10,625,575)	2,338,230
Cash and Cash Equivalents, Beginning of Year	<u>14,621,864</u>	<u>12,283,634</u>
Cash and Cash Equivalents, End of Year	<u>\$ 3,996,289</u>	<u>\$ 14,621,864</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income	\$ (12,323,827)	\$ (2,807,452)
Adjustments to reconcile operating income to net cash flows from operating activities		
Depreciation	3,863,153	4,587,047
Provision for bad debts	3,547,462	2,662,566
Amortization of refunding costs	168,324	168,324
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(3,053,148)	(2,496,038)
Other receivables	(706,944)	2,597,630
Supplies and other current assets	565,648	77,224
Deferred outflows of resources	2,508,938	(2,847,940)
Accounts payable - trade	110,337	(3,068,255)
Estimated third-party payor settlements	232,695	(1,593,958)
Accrued expenses	516,887	589,380
Reserve for loss on general and professional liabilities claims, net	100,000	-
Net pension liability	(10,399,399)	4,925,422
Deferred inflows of resources	<u>7,703,197</u>	<u>433,665</u>
Net Cash From (Used For) Operating Activities	<u>\$ (7,166,677)</u>	<u>\$ 3,227,615</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$62,577 and \$73,233 during 2017 and 2016.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

The financial statements of the Dickinson County Healthcare System (Healthcare System) have been prepared in accordance with generally accepted accounting principles in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the Healthcare System are described below.

Reporting Entity

Dickinson County Healthcare System (Healthcare System) was formed as a county public healthcare system in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public healthcare system was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public healthcare system. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

Basis of Presentation

The statement of net position displays the Healthcare System's assets, deferred outflows, and liabilities, with the difference reported as net position. Net position is reported in the following categories/components:

Invested in capital assets, net of related debt consists of net capital assets reduced by the outstanding balances of any related debt obligations and deferred inflows of resources attributable to the acquisition, construction or improvement of those assets or the related debt obligations and increased by balances of deferred outflows of resources related to those assets or debt obligations.

Restricted - expendable for debt service results when constraints placed on net position use are externally imposed by the issuers of debt held by the Healthcare System.

Unrestricted net position consists of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the Healthcare System's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired. For purposes of the statement of cash flows, the Healthcare System considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Short-term Investments

Short-term investments include investments with an average maturity of three to twelve months, excluding noncurrent cash and investments. Short-term investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Noncurrent Cash and Investments

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available, or estimated fair value using quoted market prices for similar securities. Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when earned.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation in the financial statements. Contributed capital assets are reported at their estimated fair value at the time of their donation. The estimated useful lives of capital assets are as follows.

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position, and are excluded from expenses in excess of revenues. 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 net position.

Investment in Joint Ventures

Joint ventures in which the Healthcare System has an equity interest and either an ongoing financial interest or an ongoing financial responsibility are reported originally at cost and adjusted for changes in the equity interest in accordance with the joint venture agreement and for any other transactions, such as a return on capital. Equity earnings from joint ventures are included in nonoperating revenues (expenses).

Deferred Outflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The Healthcare System has two items that qualify for reporting in this category, which are the loss on defeasance of bonds and unrecognized items not yet charged to pension expense. The loss on defeasance of bonds results from the retirement of the Hospital Revenue and Refunding Bonds, Series 1999. The loss on defeasance of bonds amount is systematically and rationally amortized over the remaining life of the old obligation or the life of the new obligation, whichever is shorter and is included in interest and amortization expense.

Deferred Inflows of Resources

Deferred inflows of resources represent an increase in net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The deferred inflows of resources reported in the financial statements consist of the unamortized portion of the difference between expected and actual experience of pension plan assets.

Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions and pension expense, information about the fiduciary net position of the Dickinson County Healthcare System Pension Plan (Plan) and additions to/deductions from the Plan's net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Operating Revenues and Expenses

The Healthcare System's statement of revenues, expenses, and changes in net position distinguishes between operating and non-operating revenues and expenses. Operating revenues and expenses of the Healthcare System result from exchange transactions associated with providing health care services - the Healthcare System's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as non-operating.

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Charity Care

The Healthcare System provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Healthcare System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was \$959,000 and \$897,000 for the years ended December 31, 2017 and 2016, respectively, calculated by multiplying the ratio of cost to gross charges for the Healthcare System by the gross uncompensated charges associated with providing charity care to its patients.

Grants and Contributions

The Healthcare System may receive grants as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after expenses in excess of revenues.

Electronic Health Record Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified Electronic Health Records (EHR) technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare and Medicaid share; and (3) a transition factor applicable to that payment year (Medicare only).

The Healthcare System recognizes EHR incentive payments as revenue when there is reasonable assurance that the Healthcare System will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

The Healthcare System recognized revenue of \$513,328 and \$1,055,660 for the years ended December 31, 2017 and 2016, respectively, related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2015. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on prospectively determined rates. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System's Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2014. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System's Blue Cross cost reports have been settled by Blue Cross through December 31, 2016. Clinical services are reimbursed based on a fixed fee schedule.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Concentration of gross revenues by major payor accounted for the following percentages of the Healthcare System's patient service revenues for the years ended December 31, 2017 and 2016:

	2017	2016
Medicare	47%	47%
Medicaid	12%	12%
Blue Cross	23%	23%
Self-pay and other	18%	18%
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2017 and 2016 decreased \$1,014,602 and increased \$1,082,174, respectively, due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations. The Healthcare System also recorded an additional \$748,771 of allowances for 2015 and 2016 related to the reopening of previously finalized cost reports (Note 13).

Recovery Audit Contractor

The Centers for Medicare and Medicaid Services (CMS) has implemented a Recovery Audit Contractor (RAC) program under which claims are reviewed by contractors for validity, accuracy, and proper documentation. A demonstration project completed in several other states resulted in the identification of potential overpayments, some being significant. The potential exists that the Healthcare System may incur a liability for a claims overpayment at a future date. The Healthcare System is unable to determine the extent of the liability of overpayments, if any. As the outcome of such potential reviews is unknown and cannot be reasonably estimated, it is the Healthcare System's policy to adjust revenue for deductions from overpayment amounts or additions from underpayment amounts determined under the RAC audits at the time a change in reimbursement is agreed upon between the Healthcare System and CMS.

340B Program

Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the 340B Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

In order to qualify for the program, the hospital needs to have a large percentage of indigent volume, which is defined by the program to include Medicaid patients, Medicaid-eligible patients, and Medicare SSI patients. While indigent volumes are the qualifying factor, this program covers all payers for qualifying services. The program provides for reduced pharmaceutical costs for hospital outpatients. It also allows for contracts with retail pharmacies. Effective July 2016, the Healthcare System was eliminated as a participant in the program. As of July 2017, the Healthcare System was readmitted to the program.

The financial statements include an estimated reserve of \$188,356 as of December 31, 2016, in accordance with generally accepted accounting principles related to this program. This amount is included in accounts payable on the statement of net position.

Note 3 - Deposits, Investments, and Investment Income

The carrying amounts of the Healthcare System's deposits and investments as of December 31, 2017 and 2016 are as follows:

	<u>2017</u>	<u>2016</u>
Carrying amount		
Deposits	\$ 5,996,289	\$ 16,621,864
Investments	<u>-</u>	<u>1,912,220</u>
Total	<u><u>\$ 5,996,289</u></u>	<u><u>\$ 18,534,084</u></u>

Deposits and investments are reported in the following statement of net position captions:

	<u>2017</u>	<u>2016</u>
Cash and cash equivalents	\$ 3,996,289	\$ 14,621,864
Temporary investments	-	12,838
Restricted under indenture agreement for debt service (1) (Note 8)	2,000,000	2,000,000
Other long-term investments	<u>-</u>	<u>1,899,382</u>
Total	<u><u>\$ 5,996,289</u></u>	<u><u>\$ 18,534,084</u></u>

(1) Under the terms of the 2015 bank note, the Healthcare System is required to maintain \$2,000,000 in a debt service reserve account until March 30, 2020.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2017 and 2016

Deposits

The Healthcare System had bank balances at December 31, 2017 and 2016 as follows:

	2017	2016
Insured (FDIC)	\$ 1,035,719	\$ 7,309,694
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	2,500,000	2,500,000
Uncollateralized	2,796,849	7,316,788
Total	<u>\$ 6,332,568</u>	<u>\$ 17,126,482</u>
Carrying value	<u>\$ 5,996,289</u>	<u>\$ 16,621,864</u>

Investments

The Healthcare System's investments are reported at fair value. During 2017, the Healthcare System redeemed all investments carried at fair value. The Healthcare System had the following investments and maturities at December 31, 2016:

December 31, 2016

Investment Type	Carrying Amount	Rating	Investment Maturities (in Years)		
			Less Than 1	1-5	6-10
Federal Home Loan Mortgage Corporation	\$ 500,663	Aaa	\$ -	\$ 500,663	\$ -
Federal Home Loan Bank	483,775	Aaa	-	483,775	-
Federal Farm Credit Bank	272,975	Aaa	-	272,975	-
U.S. Treasuries	486,405	Aaa	-	486,405	-
Freddie Mac	155,565	Aaa	155,565	-	-
Accrued interest	12,837		12,837	-	-
Total	<u>\$ 1,912,220</u>		<u>\$ 168,402</u>	<u>\$ 1,743,818</u>	<u>\$ -</u>

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk.

Concentration of Credit Risk

The Healthcare System will limit credit risk, the risk of loss due to the failure of the security issuer or backer, by diversifying in the investment portfolio so that potential losses on individual securities will be minimized. The Healthcare System does not have a formally adopted investment policy for managing concentration of credit risk. However, more than 5% of the Healthcare System's investments are invested in the following securities:

	<u>2016</u>
Federal Home Loan Bank	25.3%
Federal Home Loan Mortgage Corporation	26.2%
US Treasuries	25.4%
Federal Farm Credit Bank	14.3%
Freddie Mac	8.1%

Custodial Credit Risk

Custodial credit risk is the risk that in the event of a bank or investment company failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. At December 31, 2016, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in the Healthcare System's name.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2017 and 2016:

	2017	2016
Interest income and realized gains and losses	\$ (4,396)	\$ 151,480
Change in unrealized gains and losses on investments	\$ 33,741	\$ (31,119)

Note 4 - Fair Value of Assets

The Healthcare System has determined the fair value of certain assets and liabilities in accordance with generally accepted accounting principles, which provides a framework for measuring fair value.

Fair value is defined as the exchange price that would be received for 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. Valuation techniques should maximize the use of observable inputs and minimize the use of unobservable inputs.

A fair value hierarchy has been established, which prioritizes the valuation inputs into three broad levels. Level 1 inputs consist of quoted prices in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the related asset or liability. Level 3 inputs are unobservable inputs related to the asset or liability.

In some cases, the inputs used to measure the fair value of an asset or a liability might be categorized within different levels of the fair value hierarchy. In those cases, the fair value measurement is categorized in its entirety in the same level of the fair value hierarchy as the lowest level input that is significant to the entire measurement. Assessing the significance of a particular input to the entire measurement requires judgment, taking into account factors specific to the asset or liability.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2017 and 2016

Assets and liabilities measured at fair value on a recurring basis and the related fair values of these assets and liabilities at December 31, 2016 are as follows:

	Total	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
December 31, 2016				
Federal Home Loan				
Mortgage Corporation	\$ 500,663	\$ -	\$ 500,663	\$ -
Federal Home Loan Bank	483,775	-	483,775	-
Federal Farm Credit Bank	272,975	-	272,975	-
U.S. Treasuries	486,405	-	486,405	-
Freddie Mac	155,565	-	155,565	-
Accrued interest	12,837	-	12,837	-
	<u>\$ 1,912,220</u>	<u>\$ -</u>	<u>\$ 1,912,220</u>	<u>\$ -</u>

Federal Home Loan Mortgage Corporation securities, Federal Home Loan Bank securities, Federal Farm Credit Bank securities, US Treasuries, Freddie Mac securities, and the related accrued interest on these items are estimated using a variety of techniques including quoted market price of similar items, broker/dealer quotes, and models using market interest rates or yield curves.

Note 5 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2017 are as follows:

	Balance December 31, 2016	Additions	Transfers and Retirements	Balance December 31, 2017
Capital assets not being depreciated				
Land	\$ 2,359,299	\$ -	\$ -	\$ 2,359,299
Construction in progress	1,343,224	3,301,336	(4,433,297)	211,263
Total capital assets, not being depreciated	<u>\$ 3,702,523</u>	<u>\$ 3,301,336</u>	<u>\$ (4,433,297)</u>	<u>\$ 2,570,562</u>
Capital assets being depreciated				
Land improvements	\$ 908,961	\$ 77,924	\$ -	\$ 986,885
Buildings and improvements	46,133,371	2,543,888	(313,120)	48,364,139
Equipment	51,798,175	2,037,711	(630,465)	53,205,421
Total capital assets being depreciated	<u>98,840,507</u>	<u>4,659,523</u>	<u>(943,585)</u>	<u>102,556,445</u>
Less accumulated depreciation for				
Land improvements	(597,656)	(51,159)	-	(648,815)
Buildings and improvements	(24,284,733)	(1,038,309)	287,112	(25,035,930)
Equipment	(43,037,835)	(2,773,685)	576,440	(45,235,080)
Total accumulated depreciation	<u>(67,920,224)</u>	<u>(3,863,153)</u>	<u>863,552</u>	<u>(70,919,825)</u>
Net capital assets being depreciated	<u>\$ 30,920,283</u>	<u>\$ 796,370</u>	<u>\$ (80,033)</u>	<u>\$ 31,636,620</u>
Capital assets, net	<u>\$ 34,622,806</u>			<u>\$ 34,207,182</u>

Construction in progress at December 31, 2017, represents costs related to various projects. The total estimated cost to complete the projects approximately \$165,000, which will be funded from working capital.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2017 and 2016

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2016 are as follows:

	Balance December 31, 2015	Additions	Transfers and Retirements	Balance December 31, 2016
Capital assets not being depreciated				
Land	\$ 2,373,796	\$ -	\$ (14,497)	\$ 2,359,299
Construction in progress	1,354,539	1,457,001	(1,468,316)	1,343,224
Total capital assets, not being depreciated	<u>\$ 3,728,335</u>	<u>\$ 1,457,001</u>	<u>\$ (1,482,813)</u>	<u>\$ 3,702,523</u>
Capital assets being depreciated				
Land improvements	\$ 908,961	\$ -	\$ -	\$ 908,961
Buildings and improvements	45,821,041	312,330	-	46,133,371
Equipment	49,827,782	2,651,263	(680,870)	51,798,175
Total capital assets being depreciated	<u>96,557,784</u>	<u>2,963,593</u>	<u>(680,870)</u>	<u>98,840,507</u>
Less accumulated depreciation for				
Land improvements	(552,378)	(45,278)	-	(597,656)
Buildings and improvements	(23,011,627)	(1,273,106)	-	(24,284,733)
Equipment	(40,386,381)	(3,268,663)	617,209	(43,037,835)
Total accumulated depreciation	<u>(63,950,386)</u>	<u>(4,587,047)</u>	<u>617,209</u>	<u>(67,920,224)</u>
Net capital assets being depreciated	<u>\$ 32,607,398</u>	<u>\$ (1,623,454)</u>	<u>\$ (63,661)</u>	<u>\$ 30,920,283</u>
Capital assets, net	<u>\$ 36,335,733</u>			<u>\$ 34,622,806</u>

Note 6 - Investments in Joint Venture

Upper Peninsula Health Plan, LLC

Upper Peninsula Health Plan, LLC (UPHP), licensed by the state of Michigan, was formed as a qualified health plan on August 1, 1988 and became a health maintenance organization (HMO) on June 21, 2000. UPHP is owned by 13 health centers, including not-for-profit community hospitals, for-profit community hospitals, and tribal, health centers, each with a different percentage of ownership. The net gain on these investments, totaling approximately \$647,400 in 2017 and \$480,500 in 2016, is included in nonoperating revenue. The Healthcare System received no distributions from these investments in 2017 and 2016. Separate financial statements of Upper Peninsula Health Plan, LLC are prepared and are available from Upper Peninsula Health Plan, LLC.

Upper Peninsula Managed Care, LLC

Upper Peninsula Managed Care, LLC (UPMC), formed on July 29, 1996, is owned by 13 health centers, including not-for-profit community hospitals, for-profit community hospitals, and tribal health centers, each with a different percent of ownership. UPMC is a Physicians Hospital Organization (PHO), which serves as a management company for Upper Peninsula Health Plan, LLC. The net gain (loss) on these investments, totaling approximately \$35,700 in 2017 and \$(44,900) in 2016, is included in nonoperating revenue. The Healthcare System received distributions of \$0 and \$59,500 from these investments in 2017 and 2016. Separate financial statements of Upper Peninsula Managed Care, LLC are prepared and are available from Upper Peninsula Managed Care, LLC.

Note 7 - Lease Obligations

The Healthcare System leases certain medical and other equipment and office space under noncancelable long-term lease agreements. Certain leases have been recorded as capitalized leases and others as operating leases. Total lease expense for the years ended December 31, 2017 and 2016 for all operating leases was \$1,021,230 and \$1,046,341, respectively. The capitalized leased assets consist of:

	2017	2016
Major movable equipment	\$ 203,895	\$ -
Less accumulated amortization	(39,646)	-
	<u>\$ 164,249</u>	<u>\$ -</u>

Minimum future lease payments for the operating leases are as follows:

<u>Years Ending December 31,</u>	<u>Capital Leases</u>	<u>Operating Leases</u>
2018	\$ 73,992	\$ 648,343
2019	73,992	262,871
2020	34,687	39,700
2021	-	13,200
2022	-	-
	<u>182,671</u>	<u>\$ 964,114</u>
Total minimum lease payments	182,671	\$ 964,114
Less interest	(11,144)	
Present value of minimum lease payments - Note 8	<u>\$ 171,527</u>	

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2017 and 2016

Note 8 - Long-Term Debt

A schedule of changes in the Healthcare System's long-term debt for 2017 and 2016 is as follows:

	Balance December 31, 2016	Additions	Reductions	Balance December 31, 2017	Amounts Due Within One Year
Hospital Revenue					
Bonds, Series 2004	\$ 3,375,756	\$ -	\$ (188,094)	\$ 3,187,662	\$ 199,023
Bank note, 2015	17,232,500	-	(1,693,750)	15,538,750	15,538,750
Batti land contract	81,423	-	(81,423)	-	-
Cameron land contract	424,819	-	(92,788)	332,031	97,051
Hospital Revenue					
Bonds, Series 2016	66,000	1,284,000		1,350,000	74,402
Bellin promissory note	-	210,656	(33,939)	176,717	69,159
Total bonds and notes	21,180,498	1,494,656	(2,089,994)	20,585,160	15,978,385
Capital Leases	-	203,895	(32,368)	171,527	65,683
Total long-term debt	<u>\$ 21,180,498</u>	<u>\$ 1,698,551</u>	<u>\$ (2,122,362)</u>	<u>\$ 20,756,687</u>	<u>\$ 16,044,068</u>
	Balance December 31, 2015	Additions	Reductions	Balance December 31, 2016	Amounts Due Within One Year
Hospital Revenue					
Bonds, Series 2004	\$ 3,553,522	\$ -	\$ (177,766)	\$ 3,375,756	\$ 188,094
Hospital Revenue					
Bonds, Series 2016	-	66,000		66,000	-
Bank note, 2015	18,841,250	-	(1,608,750)	17,232,500	1,693,751
Batti land contract	152,962	-	(71,539)	81,423	81,423
Cameron land contract	513,532	-	(88,713)	424,819	92,788
Total bonds and notes	23,061,266	66,000	(1,946,768)	21,180,498	2,056,056
Capital Leases	264,277	-	(264,277)	-	-
Total long-term debt	<u>\$ 23,325,543</u>	<u>\$ 66,000</u>	<u>\$ (2,211,045)</u>	<u>\$ 21,180,498</u>	<u>\$ 2,056,056</u>

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2017 and 2016 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
- Bank note – On March 31, 2015, the Healthcare System entered into a 3.59%, 60 month note payable. The note payable is due in monthly principal installments ranging from \$128,570 to \$160,000 to March 15, 2020, with a balloon payment of \$1,411,812 on March 30, 2020, and is secured by certain equipment. The proceeds of this note were used to defease the Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999. (1)
- Batti land contract – Paid in full during 2017
- Cameron land contract – On March 6, 2013, the Healthcare System entered into a 4.5%, 97 month note payable. The note payable is due in monthly installments of \$9,167 to March 2021, and is secured by certain equipment.
- 2.63%, Dickinson County Healthcare System, Hospital Revenue Bond, Series 2016 (Series 2016 Bond) – due in monthly installments of \$9,085 including interest, to December 2032, secured by certain property and equipment.
- Belin promissory note – On May 22, 2017, the Healthcare System entered into a 2.7%, 36 month note. The note is due in monthly installments of \$6,098 including interest, to May 22, 2020 and is unsecured.

(1) The Series 2004 Bonds loan and 3.59% Bank Note agreements place limits on the incurrence of additional borrowings and require the Healthcare System satisfy certain measures of financial performance. As of December 31, 2017, certain financial measures were not met. The Healthcare System obtained a waiver for the Series 2004 Bonds loan, but did not receive a waiver on the 3.59% Bank Note and as such that balance is reported as current.

Scheduled principal and interest payments on long-term debt are as follows:

Years Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2018	\$ 16,044,068	\$ 762,888	\$ 16,806,956
2019	530,266	210,259	740,525
2020	462,069	186,441	648,510
2021	343,559	167,289	510,848
2022	332,101	151,245	483,346
2023-2027	1,929,654	487,078	2,416,732
2028-2032	1,114,970	64,083	1,179,053
Total	<u>\$ 20,756,687</u>	<u>\$ 2,029,283</u>	<u>\$ 22,785,970</u>

Note 9 - Defined Benefit Pension Plan

Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year. The plan was closed to all new entrants effective February 22, 2013.

On January 27, 2018 the Plan was frozen (no additional benefits to accrue) for all non-Michigan Nurses Association (MNA) participants. On February 10, 2018 the Plan was frozen for all MNA participants. For the non-MNA participants, any benefit payment commencement date on or after February 2, 2018 will be paid in one lump sum. For the MNA participants, any benefit payment commencement date on or after March 2, 2018 will be paid in one lump sum. Furthermore, for all participants the Plan will be terminated on May 31, 2018. At such time, then current retirees will have the option of electing a lump sum payment equal to the present value of their remaining accrued benefit. For those choosing a continuation of their monthly benefit payment, an annuity will be purchased from an insurance company. For all active and terminated vested participants not in retirement status, a mandatory lump sum will be paid equal to the present value of their accrued benefit. All lump sums will be paid on July 10, 2018.

The most recent actuarial valuation was made as of January 1, 2018. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2017 and 2016 was \$21,852,633 and \$22,992,042, respectively. The Healthcare System's total actual payroll for the years ended December 31, 2017 and 2016 was \$46,991,997 and \$46,346,813, respectively.

Current membership in the Plan consists of the following at December 31:

	2017	2016
Inactive plan members or beneficiaries currently receiving benefits	348	325
Inactive plan members entitled to but not yet receiving benefits	113	114
Active plan members	345	379
	<u>806</u>	<u>818</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. 50% of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2017 and 2016 were 17.00% and 15.13%, respectively, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2017 and 2016 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2017 and 2016.

The Healthcare System's contributions to the plan for the years ended December 31, 2017 and 2016 were \$3,621,532 and \$3,654,952, respectively.

Net Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions – At December 31, 2017, the Healthcare System reported a liability of \$26,501,314 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2018, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2018. At December 31, 2016, the Healthcare System reported a liability of \$36,900,713 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2017, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2017.

For the years ended December 31, 2017 and 2016, the Healthcare System recognized pension expense of \$3,763,498 and \$6,139,207, respectively. At December 31, 2017 and 2016, the Healthcare System reported deferred outflows of resources and deferred inflows of resources related to pension from the following sources:

	December 31, 2017	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	\$ 831,242	\$ 271,284
Changes in Assumptions	3,133,159	4,994,350
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	1,850,310	2,896,606
Total	<u>\$ 5,814,711</u>	<u>\$ 8,162,240</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2017 and 2016

	December 31, 2016	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	\$ 1,147,575	\$ 377,834
Changes in Assumptions	4,301,290	-
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	<u>2,874,784</u>	<u>81,209</u>
Total	<u><u>\$ 8,323,649</u></u>	<u><u>\$ 459,043</u></u>

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

<u>Years Ended December 31</u>	<u>Amount</u>
2018	\$ (463,800)
2019	(793,151)
2020	(381,654)
2021	<u>(708,924)</u>
	<u><u>\$ (2,347,529)</u></u>

Actuarial Assumptions

The total pension liability in the January 1, 2018 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Rate of Inflation	3.5% annually
Salary Increases	5.3% - 0.0% plus inflation.
Long-Term Investment Rate of Return	7.50%

The actuarial assumptions used in the January 1, 2018 valuation were based on the results of actuarial experience studies with dates corresponding to those listed above.

The mortality table used is the RP-2014 Healthy Annuitant Mortality Table for males and females, adjusted for mortality improvement back to the observation period base year of 2006. Mortality rates for a particular calendar year are determined by applying the MP-2015 mortality improvement scale to the above described tables.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation for each major asset class is summarized in the following table:

<u>Asset Class</u>	<u>Asset Allocation</u>
Cash, deposits, money market funds	0.9%
Large Core	7.7%
Large Growth	18.4%
All Cap Value	16.8%
Small/Mid	13.2%
International	12.3%
Emerging Markets	3.9%
Fixed income	24.7%
Global FI	2.1%
	100%

Discount Rate - The discount rate used to measure the total pension liability was 7.5%. The projection of cash flows used to determine the discount rate assumed that employee contributions will be made at the contractually required rate and that contributions from the Healthcare System will be made at contractually required rates, actuarially determined. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2017 and 2016

Changes in the Net Pension Liability

	2017	2016
Total Pension Liability		
Service Cost	\$ 888,094	\$ 1,026,573
Interest on the Total Pension Liability	5,903,941	5,284,471
Benefit Changes	-	-
Difference between Expected and Actual Experience	164,402	(459,009)
Assumption Changes	(7,295,894)	5,469,421
Benefit Payments	(3,080,964)	(2,904,272)
Net Change in Total Pension Liability	(3,420,421)	8,417,184
Total Pension Liability - Beginning	79,815,643	71,398,459
Total Pension Liability - Ending (a)	<u>\$ 76,395,222</u>	<u>\$ 79,815,643</u>
Total Fiduciary Net Position		
Employer Contributions	\$ 3,621,532	\$ 3,654,952
Employee Contributions	-	-
Pension Plan Net Investment Income	6,771,041	3,073,918
Benefit Payments	(3,080,964)	(2,904,272)
Pension Plan Administrative Expense	-	-
Other	(332,631)	(332,836)
Net Change in Plan Fiduciary Net Position	6,978,978	3,491,762
Plan Fiduciary Net Position - Beginning	42,914,930	39,423,168
Plan Fiduciary Net Position - Ending (b)	<u>\$ 49,893,908</u>	<u>\$ 42,914,930</u>
Net Pension Liability - Ending (a) - (b)	<u>\$ 26,501,314</u>	<u>\$ 36,900,713</u>
Plan Fiduciary Net Position as a Percentage of		
Total Pension Liability	65.31%	53.77%
Covered Employee Payroll	21,852,633	22,992,042
Net Pension Liability as a Percentage of		
Covered Employee Payroll	121.27%	160.49%

Sensitivity of the Healthcare System's Net Pension Liability to Changes in the Discount Rate - The following presents the Healthcare System's net pension liability calculated using the discount rate of 7.5%, as well as what the Healthcare System's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1 percentage-point higher (8.5%) than the current rate.

	1% Decrease (6.50%)	Discount Rate (7.50%)	1% Increase (8.50%)
Healthcare System's Net Pension Liability	\$ 35,631,281	\$ 26,501,314	\$ 18,827,462

Pension Plan Fiduciary Net Position – Detailed information about the pension plan's fiduciary net position is available in the separately issued actuarial report of the Dickinson County Healthcare System Retirement Plan.

Note 10 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Lincoln Financial Group Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

The DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 11 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees who were not currently vested in the defined benefit pension plan were transitioned to the new defined contribution plan design. Non-vested MNA (nursing staff) transitioned effective May 1, 2011 and non-vested, non-union staff transitioned effective September 4, 2011. Concurrently, all MNA and non-union new hires became members of the new DC plan. Lastly, non-vested AFSCME staff were transitioned effective February 23, 2013 and concurrently, all AFSCME new hires became DC plan members.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1 to 3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 10), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$639,598 and \$567,763 for the years ended December 31, 2017 and 2016.

Note 12 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$5 million. The policies end August 1, 2018.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis. The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2017 and 2016. Amounts included as expense for general and professional liability for the years ended December 31, 2017 and 2016, which include claims and premiums paid, were \$311,193 and \$236,383, respectively.

The reserve for loss on professional liability claims at December 31, 2017 and 2016 and activity for the years then ended is as follows:

Balance December 31, 2015	Additions	Reductions	Balance December 31, 2016	Additions	Reductions	Balance December 31, 2017
\$ 500,000	\$ -		\$ 500,000	\$ 100,000	\$ -	\$ 600,000

Note 13 - Contingencies

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Rural Health Clinic (RHC) Contingent liability

During 2017, the Healthcare System received an adjustment report from Medicare for its 2015 cost report in which the Medicare Administrative Contractor asserted a change in RHC reimbursement. This change in reimbursement affects 2015 through 2017 with a potential effect on Wisconsin Medicaid reimbursement. The hospital received the notice of program reimbursement (final settlement) for the 2015 Medicare cost report and will appeal the issue to the Provider Reimbursement Review Board. The Healthcare System booked a contingent liability of \$1,122,436 related to this matter.

Litigations, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 14 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2017 and 2016 was as follows:

	2017	2016
Medicare	40%	38%
Blue Cross	19%	18%
Medicaid	11%	12%
Commercial insurance and other	21%	22%
Self pay	9%	10%
	100%	100%

The Healthcare System is subject to collective bargaining agreements for approximately 59.0% of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in February 2019. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2020.

Note 15 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$41,130 and \$42,909 for the years ended December 31, 2017 and 2016. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2017 was approximately \$17,365,535.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the beneficiaries and timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 16 - Correction of an Error

During the year ended December 31, 2017, management of the Healthcare System determined that there were two unrecorded investments in joint ventures that resulted in errors in the December 31, 2016 financial statements (see Note 6). As such, the December 31, 2016 financial statements will be restated to correct these errors. The following is a summary of the effects of the correction of an error in the Healthcare System's December 31, 2016 financial statements.

	Amounts as Previously Reported	Correction of Error	Amounts as Restated
Statement of Net Position			
As of December 31, 2016			
Assets and Deferred Outflows of Resources			
Investments in joint ventures	\$ -	\$ 2,558,048	\$ 2,558,048
Total assets	75,121,415	2,558,048	77,679,463
Total assets and deferred outflows	83,992,110	2,558,048	86,550,158
Liabilities, Deferred Inflows of Resources, and Net Position			
Net position - unrestricted	(2,649,092)	2,558,048	(91,044)
Total net position	13,340,262	2,558,048	15,898,310
Total liabilities and net position	83,992,110	2,558,048	86,550,158
Statement of Revenues, Expenses, and Changes in Net Position			
For the year ended December 31, 2016			
Nonoperating Revenues (Expenses)			
Investment income	151,480	(59,500)	91,980
Gain on Investment in Joint Venture	-	495,115	495,115
Nonoperating revenues (expenses), net	(851,399)	435,615	(415,784)
Expenses in Excess of Revenues			
Before Capital Contributions	(3,658,851)	435,615	(3,223,236)
Decrease in Net Position	(3,617,851)	435,615	(3,182,236)
Net Position, Beginning of Year	16,958,113	2,122,433	19,080,546
Net Position, End of Year	13,340,262	2,558,048	15,898,310
Statement of Cash Flows			
For the year ended December 31, 2016			
Investing Activities			
Distributions from joint ventures	-	59,500	59,500
Investment income	151,480	(59,500)	91,980

Note 17 - Financial Condition

The Healthcare System's financial statements have been prepared assuming the Healthcare System will continue as a going concern, which contemplates the realization of assets and satisfaction of liabilities in the normal course of business. The Healthcare System has experienced expenses in excess of revenues before capital contributions of \$13,242,417 for the year ended December 31, 2017 and \$3,223,236 for the year ended December 31, 2016. During the years ended December 31, 2017 and 2016, the Healthcare System has experienced an overall decrease in net position of \$13,140,563 and \$3,182,236. The current ratio was .90 and 2.68 for the years ended December 31, 2017 and 2016. The days cash on hand decreased from 60.2 days as of December 31, 2016 to 18.7 days as of December 31, 2017. The current ratio and days cash on hand suggests a serious liquidity problem exists.

As of December 31, 2017, the Healthcare System had debt covenant violations and was considered to be in default on their 2015 bank note. As such, the 2015 bank note is reported as a current liability. This caused the average payment period to increase to 88 days as of December 31, 2017 up from 44 days as of December 31, 2016. The Healthcare System also had long-term debt to net position of 752.7% as of December 31, 2017 and 133.2% as of December 31, 2016. These conditions raise substantial doubt as to the Healthcare System's ability to continue as a going concern within one year after the date the financial statements are issued.

The Healthcare System is currently in discussions with an interested party, related to an asset purchase agreement. In addition, significant expense reductions (approximately \$4 million) were assumed in the 2018 budget. As well, post budget, another \$6 million in cost saving measures have been implemented.

The financial statements do not include any adjustments to reflect the possible future effects on the profitability and classification of assets and the amounts and classification of liabilities that may result from the possible inability of the Healthcare System to continue as a going concern.

Note 18 - Subsequent Events

Subsequent to December 31, 2017, the Healthcare System received \$1,750,000 from Bellin Memorial Hospital, Inc. as part of a revolving note, maturing March 2019 with a variable interest rate of the Prime Rate plus 3.0%.



Required Supplementary Information
December 31, 2017 and 2016

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Net Pension Liability
Required Supplementary Information

**Schedule of the Healthcare System's Net Pension Liability
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Total Pension Liability</u>	<u>Plan Net Position</u>	<u>Net Pension Liability</u>	<u>Plan Net Position as a % of Total Pension Liability</u>	<u>Covered Payroll</u>	<u>Net Pension Liability as a % of Covered Payroll</u>
2017	\$ 76,395,222	\$ 49,893,908	\$ 26,501,314	65.31%	\$ 21,852,633	121.27%
2016	79,815,643	42,914,930	36,900,713	53.77%	22,992,042	160.49%
2015	71,398,459	39,423,168	31,975,291	55.22%	24,384,165	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2018.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Changes in Net Pension Liability
Required Supplementary Information

**Schedule of the Healthcare System's Changes in Net Pension Liability
Last 10 Fiscal Years***

	2017	2016	2015
Total Pension Liability			
Service Cost	\$ 888,094	\$ 1,026,573	\$ 1,046,769
Interest on the Total Pension Liability	5,903,941	5,284,471	4,955,073
Benefit Changes	-	-	-
Difference between Expected and Actual			
Experience	164,402	(459,009)	2,005,318
Assumption Changes	(7,295,894)	5,469,421	-
Benefit Payments	(3,080,964)	(2,904,272)	(4,305,902)
Net Change in Total Pension Liability	(3,420,421)	8,417,184	3,701,258
Total Pension Liability - Beginning	79,815,643	71,398,459	67,697,201
Total Pension Liability - Ending (a)	<u>\$ 76,395,222</u>	<u>\$ 79,815,643</u>	<u>\$ 71,398,459</u>
Total Fiduciary Net Position			
Employer Contributions	\$ 3,621,532	\$ 3,654,952	\$ 3,760,071
Employee Contributions	-	-	-
Pension Plan Net Investment Income	6,771,041	3,073,918	(1,060,011)
Benefit Payments	(3,080,964)	(2,904,272)	(4,305,902)
Pension Plan Administrative Expense	-	-	-
Other	(332,631)	(332,836)	(330,941)
Net Change in Plan Fiduciary Net Position	6,978,978	3,491,762	(1,936,783)
Plan Fiduciary Net Position - Beginning	42,914,930	39,423,168	41,359,952
Plan Fiduciary Net Position - Ending (b)	<u>\$ 49,893,908</u>	<u>\$ 42,914,930</u>	<u>\$ 39,423,169</u>
Net Pension Liability - Ending (a) - (b)	<u>\$ 26,501,314</u>	<u>\$ 36,900,713</u>	<u>\$ 31,975,290</u>
Plan Fiduciary Net Position as a Percentage of			
Total Pension Liability	65.31%	53.77%	55.22%
Covered Employee Payroll	21,852,633	22,992,042	24,384,165
Net Pension Liability as a Percentage of			
Covered Employee Payroll	121.27%	160.49%	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2018.



Financial Statements

December 31, 2016 and 2015

Dickinson County Healthcare System

(A Component Unit of Dickinson County)

Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2016 and 2015

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	3
Financial Statements	16
Statements of Net Position	16
Statements of Revenues, Expenses, and Changes in Net Position	17
Statements of Cash Flows	18
Notes to Financial Statements	20
Required Supplementary Information.....	45
Schedule of Net Pension Liability	45
Schedule of Changes in Net Pension Liability	46
Schedule of Contributions	47



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County) (Healthcare System), which comprise the statements of net position as of December 31, 2016 and 2015, and the related statements of revenues, expenses, and changes in net position 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2016 and 2015, and the results of its operations, changes in net position, and cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 3 through 15, and the Schedules of the Healthcare System's Share of the Net Pension Liability, the Changes in Net Pension Liability, and Contributions on pages 45 through 47 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated April 21, 2017 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

A handwritten signature in black ink that reads "Erik Sully LLP". The signature is written in a cursive, flowing style. To the right of the signature is a vertical yellow line.

Fargo, North Dakota
April 21, 2017

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2016, 2015, and 2014. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2016

The Healthcare System's net position decreased in 2016 by \$3.617 million or 21.3% with a loss before capital contributions of \$3.659 million, comprised of an operating loss of \$2.807 million and nonoperating expenses in excess of nonoperating revenue of \$851 thousand. There were \$41 thousand of contributions for capital purposes in 2016. During 2016, the Healthcare System's total operating revenues of \$110.642 million was about equal to the amount in 2015. The resulting operating loss for 2016 of (\$2.807) million compared to an operating income of \$4.479 million for 2015 which was 4.0% of operating revenue.

Awards and special recognitions continued in 2016. They were as follows:

- Received a National Patient Safety score of "A" from the Leapfrog Group for the tenth consecutive six-month reporting period.
- Received national *Healthgrades* Awards for clinical excellence as follows:
 - Cardiac – Five-Star Recipient for Treatment of Heart Attack for 7 Years in a Row (2010-2016)
 - Cardiac – Five-Star Recipient for Treatment of Heart Failure (2016)
 - Recipient of the Pulmonary Care Excellence Award (2016)
 - Named among Top 10% in the Nation for Overall Pulmonary Services (2016)
 - Pulmonary – Five-Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease (2016)
 - Pulmonary – Five-Star Recipient for Treatment of Pneumonia for 2 years in a row (2015-2016)
 - Critical Care – Five-Star Recipient for Treatment of Sepsis for 3 Years in a Row (2014-2016)
 - Critical Care – Five-Star Recipient for Treatment of Respiratory Failure (2016)
 - Recipient of the Gastrointestinal Care Excellence Award (2016)
 - Named among the Top 10% in the Nation for Overall GI Services (2016)
 - Gastrointestinal – Five-Star Recipient for Treatment of GI Bleed (2016)
 - Gastrointestinal – Five-Star Recipient for Treatment of Bowel Obstruction (2016)
 - Patient Safety – Recipient of Patient Safety Excellence Award™ and Named Among the Top 5% in the Nation for Patient Safety in 2016
- I-Vantage Health Analytics' Group – Top 100 Rural & Community Hospitals / The top 4% of U.S. Hospitals
- CMS – 4 Star Rating
- Named "The Best & Safest Hospital the State has to offer!" by the Economic Alliance of Michigan.
- Recognized by the Michigan Senate with Resolution No. 197 for our dedicated efforts to improve the quality of healthcare and patient safety in our community.

The following service enhancements were completed in 2016:

- Successfully recruited five new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - Anh Tran, M.D. – Neurology
 - Robyne Camana – Radiology
 - Ryan Hart, D.O. – Emergency Department
 - Hugh “Gunner” Deery, M.D. – Infectious Disease
 - Raymond Fedderly, M.D. – Pediatric Cardiology
 - Kaylynn Saigh, D.D.S. – Pediatric Dentistry
 - Robert Han – Hospitalist
 - Gerald Pruitt – Hospitalist
- 3-D Mammography with Tomosynthesis
- Relocation of the Diabetes and Wellness Center to the YMCA building.
- Additional Rehabilitation Services including Vestibular Rehabilitation and Pelvic Health.

Year Ended December 31, 2015

The Healthcare System's net position increased in 2015 by \$3.247 million or 23.7% with revenues before capital contributions of \$3.198 million, comprised of an operating income of \$4.479 million and nonoperating expenses in excess of nonoperating revenue of \$1.281 million. There were \$49 thousand of contributions for capital purposes in 2015. During 2015, the Healthcare System's total operating revenues of \$110.736 million was 15.7% higher than the amount in 2014. The resulting operating income for 2015 of \$4.479 million was 4.0% of total operating revenue compared to an operating income of \$4.929 million for 2014 which was 5.1% of operating revenue.

Awards and special recognitions were again plentiful in 2015. They were as follows:

- Received a National Patient Safety score of “A” from the Leapfrog Group for the seventh consecutive six-month reporting period.
- Received recognition from The Joint Commission as a *Top Performer on Key Quality Measures* specifically in the areas of Pneumonia Treatment, Surgical Care, VTE, Immunizations, AMI and Heart Failure.
- Received national *Healthgrades* Awards for clinical excellence as follows:
 - Cardiac – Five-Star Recipient for Treatment of Heart Attack for 6 Years in a Row (2010-2015)
 - Critical Care – Five-Star Recipient for Treatment of Sepsis for 2 Years in a Row (2014-2015)
 - Patient Safety – Recipient of Patient Safety Excellence Award™ and Named Among the Top 10% in the Nation for Patient Safety in 2015

The following service enhancements were completed in 2015:

- Successfully recruited six new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - Kristine Bobish, DO – Cardiology
 - Jennifer Hwang, DO – Internal Medicine
 - Daniel Kreider, MD – Radiology
 - Theodore Parsons, MD – Pathology
 - Brian Shukri, DO – Radiology
 - John Simmons, DO – Radiation Oncology
- Added the independent Cecconi-Terrian-Donohue General Surgery Practice to the compliment of Dickinson owned clinics.
- Expanded Home Medical Equipment Services to Delta County.
- Established a Smoke-Free Campus including all outlying clinics.
- Expanded the Patient Portal to include communication with all Dickinson owned medical clinics.

Year Ended December 31, 2014

The Healthcare System's net position increased in 2014 by \$4.836 million or 14.0% with revenues before capital contributions of \$4.796 million, comprised of an operating income of \$4.929 million and nonoperating expenses in excess of nonoperating revenue of \$133 thousand. There were \$40 thousand of contributions for capital purposes in 2014. During 2014, the Healthcare System's total operating revenues of \$95.737 million was 6.6% higher than the amount in 2013. The resulting operating income for 2014 of \$4.929 million was 5.1% of total operating revenue compared to an operating income of \$41 thousand for 2013 which was 0.05% of operating revenue.

The following major projects and service enhancements were completed in 2014. 2014 has been a year like none other for DCHS as evidenced by the following accomplishments and recognitions received by the Healthcare System:

- Ranked 5th out of 142 hospitals in the State of Michigan by Consumer Reports in the areas of patient safety, patient outcomes, patient experience, and hospital practices - over 4,000 hospitals nationwide were compared.
- Received two Governor's Awards for Excellence - the *Inpatient Clinical Achievement Award* and the *Healthcare Associated Infection Prevention Award*.
- Received a National Safety score of "A" from the Leapfrog Group for the fifth consecutive six-month reporting period.
- Received official recognition from the Michigan State Legislature & Governor Snyder for the above accomplishments.
- Received recognition from The Joint Commission as a *Top Performer on Key Quality Measures* specifically in the areas of Pneumonia Treatment and Surgical Care.

- Michigan Works! and the Dickinson Area Chamber Alliance awarded Dickinson County Healthcare System with the *Large Business of the Year Award* for 2014.
- The Upper Peninsula Economic Development Alliance awarded Dickinson County Healthcare System their "Award of Excellence" for 2014 – 2015.
- Acquired Dr. Morel's Medical Oncology Practice from Marquette General Hospital.
- Successfully recruited five new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - Joel Johnson, MD – Vascular Surgeon
 - Breion Tafoya, MD – Pulmonologist
 - Kevin Diehl, DO – Radiologist
 - David Timm, MD – Radiologist
 - Jeffrey Kreyer, MD – General Surgeon
- Employee Cindy Yelich, RN received national recognition by the American Association of Diabetes Educators as Diabetes Educator of the Year in the State of Michigan.
- Completed Meaningful Use Stage 1, year 2 reporting period successfully and received 2nd incentive payment for the hospital and a number of providers. Also implemented solutions to meet Stage 2 requirements. (Patient Portal IP, Patient Portal ED, Direct Messaging, Truven Pat Education, Rules Engine for Clinician Alerts, Paragon Connect, Paragon Audit Server, Paragon Quality eMeasures). Began Stage 2 reporting period on October 1, 2014 and it runs for 365 days (9/30/2015) before we can attest and receive our next incentive payment.
- Implemented the Vocera nurse communication system to improve communications throughout the organization.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Statement of Net Position includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all nonoperating revenue and expense items, capital contributions and the net increase in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Financial Analysis of the System

The condensed statements of net position of the Healthcare System as of December 31, 2016, 2015, and 2014 are summarized in the following table.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Condensed Statements of Net Position
December 31, 2016, 2015, and 2014 (in Thousands)

	2016	2015	2014
Total current assets (includes the current portion of restricted assets)	\$ 36,599	\$ 40,515	\$ 34,300
Cash and investments internally designated for other purposes	1,899	2,291	3,508
Cash and investments restricted by bond indentures	2,000	2,000	1,726
Capital assets, net	34,623	36,336	37,344
Total Assets	75,121	81,142	76,878
Total Deferred Outflows of Resources	8,871	6,191	898
Total Assets and Deferred Outflows	\$ 83,992	\$ 87,333	\$ 77,776
 Total current liabilities	 \$ 13,668	 \$ 16,715	 \$ 14,914
Long-term debt, net of current portion	19,124	21,160	22,866
Other long-term liabilities	500	500	708
Net pension liability	36,901	31,975	-
Total Liabilities	70,193	70,350	38,488
Total Deferred Inflows of Resources	459	25	-
Total Net Position	13,340	16,958	39,288
Total Liabilities, Deferred Inflows of Resources, and Net Position	\$ 83,992	\$ 87,333	\$ 77,776

Current Assets and Liabilities

Net patient accounts receivable decreased to 58 days' of net revenue at December 31, 2016 compared to 60 days' of net revenue at December 31, 2015 and compared to 57 days' of net revenue at December 31, 2014. The slight decrease in 2016 can be attributed to the outsourcing of self-pay collections to AmeriEBO. The 2015 increase was the result of the assimilation of a Medical Oncology practice under DCHS ownership as well as the implementation of ICD10 on October 1, 2015.

Total current assets decreased 9.6% in 2016 and increased 18.1% in 2015 compared to each prior year. The decrease in 2016 was the result of a decrease in cash and cash equivalents and other receivables related to the 340B program. The 2015 increase was due to an increase in cash and cash equivalents and patient accounts receivable and a decrease in estimated third party settlements.

Current liabilities decreased 18.2% in 2016 as a result of a decrease in trade accounts payable while current liabilities increased 12.1% in 2015 as a result of an increase in trade accounts receivable and compensated absences. The Healthcare System's current ratio (current assets divided by current liabilities) was 2.66 at December 31, 2016 and 2.42 at December 31, 2015.

Total Cash and Investments

The number of days of total cash and investments was 60.3 at December 31, 2016 and 72.9 at December 31, 2015.

The total cash and investments at December 31, 2016 were \$18.5 million including restricted funds of \$2.0 million. Total cash and investments at December 31, 2015 were \$21.1 million including restricted funds of \$2.0 million.

Long-Term Debt

The Healthcare System had long-term debt of \$19.1 million at December 31, 2016 and \$21.2 million at December 31, 2015 (net of current maturities of \$2.1 million in 2016 and \$2.2 million in 2015). In 2015, the 1999 Revenue and Refunding Bonds were paid off with a \$20 million term loan through Fifth Third Bank of Grand Rapids, Michigan. Long-term debt at December 31, 2016 represents 33.8% of total long-term liabilities and 27.2% of total liabilities as compared to 39.5% of total long-term liabilities and 30.1% of total liabilities at December 31, 2015. The Healthcare System recorded a Net Pension Liability of \$36.901 million in 2016 and \$31.975 million in 2015 as required by GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*. The debt service coverage ratio for the years ended December 31, 2016 and 2015 was .60 and 2.83 respectively.

Net Position

Total net position decreased in 2016 and in 2015. Likewise, unrestricted net position decreased from 2015 to 2016 and decreased from 2014 to 2015. The decrease in the unrestricted component for 2015 and 2016 was a result of the requirement to record the Net Pension Liability as defined by GASB 68 as it relates to the Healthcare System's defined benefit pension plan. The amount invested in capital assets, net of related debt remained constant in both years as the Healthcare System made capital purchases only for those items required by HITECH and for equipment that was no longer usable. The restricted amount for debt service represents funds held by Fifth Third Bank in 2015 and 2016 as required by the term loan agreement and the trustee for the Series 1999 bonds in 2014. These components are presented in the following table.

Components of Net Position (in thousands)

	December 31,		
	2016	2015	2014
Invested in capital assets, net of related debt	\$ 13,989	\$ 13,725	\$ 13,297
Restricted by revenue bond indentures, expendable for debt service	2,000	2,000	3,463
Unrestricted	(2,649)	1,233	22,528
Total net position	<u>\$ 13,340</u>	<u>\$ 16,958</u>	<u>\$ 39,288</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2016, 2015, and 2014 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2016, 2015, and 2014 (in Thousands)

	2016		2015		2014	
Revenue and (expenses):						
Net patient service revenue	\$ 103,797	93.8%	\$ 101,437	91.6%	\$ 86,772	90.6%
Other revenue	6,845	6.2%	9,299	8.4%	8,965	9.4%
Total operating revenue	110,642	100.0%	110,736	100.0%	95,737	100.0%
Total operating expenses	113,450	102.5%	106,257	96.0%	90,808	94.9%
Operating income (loss)	(2,808)	-2.5%	4,479	4.0%	4,929	5.1%
Investment income	151	0.1%	193	0.2%	340	0.4%
Change in unrealized gains and losses on investments	(31)	0.0%	(85)	-0.1%	40	0.0%
Change in fair market value of forward purchase agreement	-	0.0%	35	0.0%	252	0.2%
Interest and amortization expense	(994)	-0.9%	(1,392)	-1.3%	(1,622)	-1.7%
Other non-operating revenue and expenses (net)	23	0.0%	(32)	0.0%	857	0.9%
Non-operating expenses in excess of revenue	(851)	-0.8%	(1,281)	-1.2%	(133)	-0.1%
Income (loss) before capital contributions	(3,659)	<u>-3.3%</u>	3,198	<u>2.9%</u>	4,796	<u>5.0%</u>
Capital contributions	41		49		40	
Increase (decrease) in net position	(3,618)		3,247		4,836	
Net position, beginning of year, as previously stated	16,958		39,288		-	
Restatement - recognition of net pension liability and related deferred inflows and outflows	-		25,577		-	
Net position - beginning of year as restated	16,958		13,711		34,452	
Net position - end of year	<u>\$ 13,340</u>		<u>\$ 16,958</u>		<u>\$ 39,288</u>	

Results of Operations

Overall loss on operations of (\$2.808) million or (2.5)% of revenue for 2016 decreased from an operating income of \$4.479 million or 4.0% of revenue for 2015. The net nonoperating expenses in excess of nonoperating revenue for 2016 decreased to \$851 thousand from \$1.28 million in 2015. The net decrease in 2016 was due to lower interest expense as a result of refinancing of debt. The net increase in 2015 was the result of a reduction in donations, lower investment returns and reduction in market value of investments. The net result for 2016 was a loss of (\$3.659) million or (3.3)% of total operating revenue before capital contributions. The net result for 2015 was income of \$3.198 million or 2.9% of total operating revenue before capital contributions.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2016 comprised 25.3% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2015 was 26.4%. The operating performance of DCMH was affected by inpatient discharges decreasing by 4.5% to 2,668 from 2,795 in 2015, while acute adult and pediatric inpatient days also decreased by 7.5% to 8,844 from 9,566 in 2015. Net inpatient revenue decreased 2.1% and the all-payer case mix index increased to 1.427 from 1.391 in 2015.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 59.6% of total Healthcare System net patient revenue and its operating activities for 2016. The comparable percentage for 2015 was 59.5%. Net outpatient revenue increased 2.4% in 2016 and increased 32.5% in 2015. Total outpatient visits were 198,645 in 2016 and 190,335 in 2015. As a percent, the largest increase in outpatient visits was seen in Observation visits.

The net patient revenue of the Rural Health Clinics (RHC's) and other Provider Based RHC's comprised about 15.1% of the total net patient revenue of the Healthcare System for 2016 and 14.1% for 2015. The revenue growth was 10.0% in 2016 as a result of adding three mid-level providers and the full year effect of bringing on a general surgery and endoscopy practice July 2015. The revenue growth was 19.7% in 2015 as a result of adding three physicians and one mid-level provider. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute to the losses on operations. There are two facilities in northeast Wisconsin and eleven off-campus practices in Michigan in addition to another eleven practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from health care services, and nonoperating revenue, which is principally from investment income.

Operating Revenue

Total gross revenues for all patient services performed by the Healthcare System were \$298 million in 2016 and \$279 million in 2015. The overall increase reflects the year-to-year difference in patient volumes and service mix changes. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care and other free care services measured as unpaid gross revenues of 0.8% in 2016 and 2015 to patients who documented their inability to pay. Bad debt provisions were 0.9% of gross revenue in 2016 and 1.0% in 2015. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 63.4% in 2016 and 61.8% in 2015.

The resulting net patient services revenue was 34.9% of gross revenue in 2016 and 36.3% in 2015. Net patient service revenue increased \$2.360 million or 2.3% in 2016 as a result of higher outpatient and physician visits and case mix index. Net patient service revenue increased \$14.665 million or 16.9% in 2015 as a result of an increase in patient volumes and case mix index as well as a more favorable payor mix.

Other operating revenue decreased \$2.453 million or 26.4% from 2015 to 2016. This was the result of losing eligibility to participate in the 340B drug program for approximately 6 months of 2016. Other operating revenue increased \$334 thousand or 3.7% from 2014 to 2015 due to an increase in 340B retail pharmacy program revenue offset by a further reduction in Electronic Health Record incentive payments.

Nonoperating Revenue

Investment income was \$151 thousand for 2016 and \$193 thousand for 2015 due to continued weak interest rates. The change in unrealized gains and losses on investments was (\$31) thousand in 2016 and (\$85) thousand in 2015.

Capital Contributions

There were \$41 thousand in capital contributions in 2016 for 2 infant warmers, a conference table and chairs and imaging hardware. There were \$49 thousand in capital contributions in 2015 for a mammography software upgrade and the replacement of televisions in all patient rooms.

Forward Purchase Agreement

An increase in market value of \$252 thousand was recorded in 2014. In 2015 an increase of \$35 thousand in market value was recognized prior to the termination of the agreement as part of the payoff of the 1999 Revenue and Refunding Bonds.

Expenditure of Funds

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2016 and 2015 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2016 and 2015 (in Thousands)

	2016	2015	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 64,944	\$ 60,226	\$ 4,718	7.8%
Supplies and pharmaceuticals	20,322	19,722	600	3.0%
Professional fees and other purchased services	23,597	21,801	1,796	8.2%
Depreciation and amortization	4,587	4,507	80	1.8%
Total	<u>\$ 113,450</u>	<u>\$ 106,256</u>	<u>\$ 7,194</u>	<u>6.8%</u>

Employee compensation and benefits increased \$4.718 million or 7.8%. The annual average total paid full-time equivalent (FTE) positions of 729.6 for 2016 increased by 3.5% from the 2015 amount of 704.6. Pension expense increased by \$1.458 million or 27.8% due to an increase in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the Healthcare System. Health insurance expense also increased by \$1.560 million or 24.1% due to a change in carrier. This was offset by more favorable reimbursement rates.

The cost of supplies and pharmaceuticals increased \$600 thousand or 3.0%, due to an increase in pharmaceutical expense, specifically related to chemotherapy drugs. The Healthcare System took over operation of a Hematology/Oncology practice in December 2014.

Professional fees, purchased services and other expenses for 2016 increased \$1.796 million or 8.2%. This was mainly the result of higher medical professional fees in the Emergency Department, Radiation Oncology, Hospitalist Program and Pediatric Clinic. Depreciation and amortization expense for 2016 increased \$80 thousand or 1.8%.

The components of operating expenses for the Healthcare System for the years ended December 31, 2015 and 2014 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2015 and 2014 (in Thousands)

	2015	2014	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 60,226	\$ 52,985	\$ 7,241	13.7%
Supplies and pharmaceuticals	19,722	13,316	6,406	48.1%
Professional fees and other purchased services	21,801	19,584	2,217	11.3%
Depreciation and amortization	4,507	4,923	(416)	-8.5%
Total	<u>\$ 106,256</u>	<u>\$ 90,808</u>	<u>\$ 15,448</u>	<u>17.0%</u>

Employee compensation and benefits increased \$7.241 million or 13.7%. The annual average total paid full-time equivalent (FTE) positions of 704.6 for 2015 increased by 5.0% from the 2014 amount of 671.3. Pension expense increased by \$1.096 million or 26.4% due to an increase in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the healthcare system. Health insurance expense also increased by \$2.029 million or 45.6% due to a change in carrier. This was offset by more favorable reimbursement rates.

The cost of supplies and pharmaceuticals increased \$6.406 million or 48.1%, due to an increase in pharmaceutical expense, specifically related to chemotherapy drugs. The healthcare system took over operation of a Hematology/Oncology practice in December 2014.

Professional fees, purchased services and other expenses for 2015 increased \$2.217 million or 11.3%. This was mainly the result of higher medical professional fees in the Emergency Department and Pediatric Clinic as well as increased software maintenance and 340B retail fees. Depreciation and amortization expense for 2015 decreased \$416 thousand or 8.5%, principally due to several assets reaching the end of their useful life.

Nonoperating Expense Items

Interest expense was \$994 thousand in 2016 and \$1.4 million in 2015. The Healthcare System capitalized interest expense amounts of \$73 thousand in 2016 and \$32 thousand in 2015.

Capital Expenditures

Fiscal Year 2016

Total capital spending decreased by approximately 21.5% from 2015 levels. Major purchases included the following: 3D Mammography Unit and numerous information technology equipment and software upgrades.

Fiscal Year 2015

Total capital spending increased by approximately 20% from 2014 levels. Major purchases included the following: Land parcel adjacent to the main campus, ultrasound machine, various building improvements and numerous information technology equipment and software upgrades.

Fiscal Year 2014

Total capital spending increased slightly in 2014 from 2013 levels. Major projects included the following: Meaningful use and other information technology initiatives - \$1.329 million, real estate - \$537 thousand, xray system - \$355 thousand, various remodel projects - \$104 thousand, vehicles - \$82 thousand.

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The current budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2016 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 109,151	\$ 1,491	1%
Total operating expenses	(110,558)	(2,892)	-3%
Operating income	(1,407)	(1,401)	100%
Net nonoperating revenue and gains, (expenses and losses)	(731)	(120)	-16%
Income before capital contributions	(2,138)	(1,521)	71%
Capital contributions	45	(4)	-9%
Increase in net position	\$ (2,093)	\$ (1,525)	73%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were unfavorable by approximately 4.5%, while total hospital outpatient visits were favorable by approximately 4.4%. Expenses were unfavorable to budget by \$2.892 million or 3% as a result of increased salary and wage and pension expense as well as locum tenens fees. FTE's were 0.5% over budget partly as a result of increased volumes in the Wound Center and Emergency Department. The variance in other net non-operating items was caused principally by a higher loss on the sale of capital assets, higher unrealized losses on investments and lower unrestricted general contributions.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2016, 2015, and 2014 (in Thousands)

	2016	2015	2014
Budget	\$ 11,929	\$ 5,366	\$ 4,211
Actual	2,864	3,650	3,014
Variance	\$ 9,065	\$ 1,716	\$ 1,197
Variance %	76.0%	32.0%	28.4%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. For the past three years only items of a critical nature or required by HITECH have been purchased. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

The Healthcare System continued to see the service volume trend of declining inpatient stays and increased outpatient and physician office visits. Uncompensated care with bad debt and charity write-offs totaled 1.7% of gross charges in 2016 compared to 1.9% in 2015 and 3.5% in 2014. In February 2017, the most recent data available, the unemployment rate (not seasonally adjusted) in Dickinson County was 5.4% compared to 7.9% over the entire Upper Peninsula and 5.3% for the State of Michigan. The same statistics for February 2016 were 5.3%, 7.0% and 5.0%, respectively.

On July 1, 2015, the Healthcare System joined the Greater Michigan Rural ACO with the assistance of the National Rural Accountable Care Consortium, now known as Caravan Health. The ACO consists of 9 healthcare systems (3 located in the Upper Peninsula) and several independent practices. This agreement runs through December 31, 2018.

On November 1, 2016, the Healthcare System joined Bellin Health Partners, a clinically integrated network, with members in Northeastern Wisconsin and the Upper Peninsula of Michigan. The network consists of hundreds of independent physicians, Bellin Health of Green Bay, WI, Dickinson County Healthcare System, Oconto Hospital and Holy Family Memorial Hospital of Manitowac, WI.

The mission of the network is to build a partnership and structure of interdependence for all members to create value through improved patient experience and high quality, affordable care that has a positive impact on the health and wellbeing of the communities. The network strives to create trusted relationships in order to drive innovation and value to the communities it serves, in a sustainable fashion.

(This page left blank intentionally.)

	2016	2015
Assets and Deferred Outflows of Resources		
Current Assets		
Cash and cash equivalents	\$ 14,621,864	\$ 12,283,634
Short-term investments	12,838	4,561,593
Receivables		
Patient, net of estimated uncollectibles of		
\$3,097,000 in 2016 and \$3,536,000 in 2015	16,530,188	16,696,716
Estimated third-party settlements	1,136,341	-
Other	400,483	2,998,113
Supplies and other current assets	3,897,513	3,974,737
Total current assets	36,599,227	40,514,793
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	2,000,000	2,000,000
Other long-term investments	1,899,382	2,290,806
Total noncurrent cash and investments	3,899,382	4,290,806
Capital Assets		
Capital assets not being depreciated	3,702,523	3,728,335
Depreciable capital assets, net of accumulated depreciation	30,920,283	32,607,398
Total capital assets	34,622,806	36,335,733
Total assets	75,121,415	81,141,332
Deferred Outflows of Resources		
Refunding costs	547,046	715,370
Pension related deferred outflows	8,323,649	5,475,709
Total deferred outflows of resources	8,870,695	6,191,079
Total assets and deferred outflows	\$ 83,992,110	\$ 87,332,411

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Net Position
December 31, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Liabilities, Deferred Inflows of Resources, and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 2,056,056	\$ 2,166,773
Accounts payable		
Trade	3,811,027	6,879,282
Estimated third-party payor settlements	-	457,617
Accrued expenses		
Salaries, wages, and related liabilities	2,192,991	1,876,039
Compensated absences	5,067,712	4,931,902
Other accrued liabilities	539,864	403,246
Total current liabilities	<u>13,667,650</u>	<u>16,714,859</u>
Long-Term Liabilities		
Long-term debt, less current maturities	19,124,442	21,158,770
Reserve for loss on general and professional liabilities claims	500,000	500,000
Net pension liability	<u>36,900,713</u>	<u>31,975,291</u>
Total long-term liabilities	<u>56,525,155</u>	<u>53,634,061</u>
Total liabilities	<u>70,192,805</u>	<u>70,348,920</u>
Deferred Inflows of Resources		
Pension related deferred inflows	<u>459,043</u>	<u>25,378</u>
Net Position		
Invested in capital assets, net of related debt	13,989,354	13,725,560
Restricted - expendable for debt service	2,000,000	2,000,000
Unrestricted	<u>(2,649,092)</u>	<u>1,232,553</u>
Total net position	<u>13,340,262</u>	<u>16,958,113</u>
Total liabilities and net position	<u>\$ 83,992,110</u>	<u>\$ 87,332,411</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$2,662,566 in 2016 and \$2,918,450 in 2015	\$ 103,796,942	\$ 101,436,763
Supplies and 340B program revenue	3,720,844	6,874,147
Electronic health record incentive revenue	1,055,660	258,190
Other revenue	<u>2,068,778</u>	<u>2,166,614</u>
Total operating revenues	<u>110,642,224</u>	<u>110,735,714</u>
Operating Expenses		
Salaries and wages	46,346,813	44,587,101
Employee benefits	18,596,944	15,639,062
Supplies and pharmaceuticals	20,322,014	19,722,447
Medical and other professional fees	10,673,365	8,348,086
Purchased services and other	12,923,493	13,453,231
Depreciation	<u>4,587,047</u>	<u>4,506,635</u>
Total operating expenses	<u>113,449,676</u>	<u>106,256,562</u>
Operating Income (Loss)	<u>(2,807,452)</u>	<u>4,479,152</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	50,137	146,062
Interest and amortization expense	(994,234)	(1,391,850)
Loss on disposal of capital assets	(27,663)	(177,913)
Investment income	151,480	193,373
Change in fair market value of forward purchase agreement	-	34,839
Change in unrealized gains and losses on investments	<u>(31,119)</u>	<u>(85,446)</u>
Nonoperating revenues (expenses), net	<u>(851,399)</u>	<u>(1,280,935)</u>
Revenues in Excess of (Less Than) Expenses Before Capital Contributions	(3,658,851)	3,198,217
Capital Contributions	<u>41,000</u>	<u>48,917</u>
Increase (Decrease) in Net Position	(3,617,851)	3,247,134
Net Position, Beginning of Year	<u>16,958,113</u>	<u>13,710,979</u>
Net Position, End of Year	<u><u>\$ 13,340,262</u></u>	<u><u>\$ 16,958,113</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 102,369,512	\$ 100,880,395
Payments to suppliers and contractors	(46,604,961)	(41,239,438)
Payments to or on behalf of employees	(61,979,848)	(58,533,517)
Other receipts	<u>9,442,912</u>	<u>9,348,840</u>
Net Cash From Operating Activities	<u>3,227,615</u>	<u>10,456,280</u>
Noncapital Financing Activity		
Unrestricted general contributions	<u>50,137</u>	<u>146,062</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(2,863,550)	(3,649,947)
Repayment of long-term debt	(2,211,045)	(21,880,461)
Interest paid, including capitalized interest	(1,067,467)	(1,356,393)
Capital contributions	41,000	48,917
Proceeds from the sale of capital assets	35,000	6,066
Proceeds from the issuance of long term debt	<u>66,000</u>	<u>20,000,000</u>
Net Cash Used For Capital and Capital Related Financing Activities	<u>(6,000,062)</u>	<u>(6,831,818)</u>
Investing Activities		
Purchases of investments	(97,542,937)	(59,355,553)
Proceeds from sales and maturities of investments	102,451,997	57,714,203
Investment income	<u>151,480</u>	<u>193,373</u>
Net Cash From (Used For) Investing Activities	<u>5,060,540</u>	<u>(1,447,977)</u>
Net Increase in Cash and Cash Equivalents	2,338,230	2,322,547
Cash and Cash Equivalents, Beginning of Year	<u>12,283,634</u>	<u>9,961,087</u>
Cash and Cash Equivalents, End of Year	<u><u>\$ 14,621,864</u></u>	<u><u>\$ 12,283,634</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income	\$ (2,807,452)	\$ 4,479,152
Adjustments to reconcile operating income to net cash flows from operating activities		
Depreciation	4,587,047	4,506,635
Provision for bad debts	2,662,566	2,918,450
Amortization of refunding costs	168,324	182,407
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(2,496,038)	(6,140,820)
Other receivables	2,597,630	49,889
Supplies and other current assets	77,224	(394,217)
Deferred outflows of resources	(2,847,940)	(4,681,096)
Accounts payable - trade	(3,068,255)	752,592
Estimated third-party payor settlements	(1,593,958)	2,666,002
Accrued expenses	589,380	695,764
Reserve for loss on general and professional liabilities claims, net	-	(208,000)
Net pension liability	4,925,422	5,638,041
Deferred inflows of resources	433,665	(8,519)
Net Cash From Operating Activities	<u>\$ 3,227,615</u>	<u>\$ 10,456,280</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$73,233 and \$32,417 during 2016 and 2015.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

The financial statements of the Dickinson County Healthcare System (Healthcare System) have been prepared in accordance with generally accepted accounting principles in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the Healthcare System are described below.

Reporting Entity

Dickinson County Healthcare System (Healthcare System) was formed as a county public healthcare system in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public healthcare system was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public healthcare system. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

Basis of Presentation

The statement of net position displays the Healthcare System's assets, deferred outflows, and liabilities, with the difference reported as net position. Net position is reported in the following categories/components:

Invested in capital assets, net of related debt consists of net capital assets reduced by the outstanding balances of any related debt obligations and deferred inflows of resources attributable to the acquisition, construction or improvement of those assets or the related debt obligations and increased by balances of deferred outflows of resources related to those assets or debt obligations.

Restricted - expendable for debt service results when constraints placed on net position use are externally imposed by the issuers of debt held by the Healthcare System.

Unrestricted net position consists of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the Healthcare System's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired. For purposes of the statement of cash flows, the Healthcare System considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Short-term Investments

Short-term investments include investments with an average maturity of three to twelve months, excluding noncurrent cash and investments. Short-term investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Noncurrent Cash and Investments

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available, or estimated fair value using quoted market prices for similar securities. Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when earned.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation in the financial statements. Contributed capital assets are reported at their estimated fair value at the time of their donation. The estimated useful lives of capital assets are as follows.

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position, and are excluded from revenues in excess of (less than) expenses. 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 net position.

Deferred Outflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The Healthcare System has two items that qualify for reporting in this category, which are the loss on defeasance of bonds and unrecognized items not yet charged to pension expense. The loss on defeasance of bonds results from the retirement of the Hospital Revenue and Refunding Bonds, Series 1999. The loss on defeasance of bonds amount is systematically and rationally amortized over the remaining life of the old obligation or the life of the new obligation, whichever is shorter and is included in interest and amortization expense.

Deferred Inflows of Resources

Deferred inflows of resources represent an increase in net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The deferred inflows of resources reported in the financial statements consist of the unamortized portion of the difference between expected and actual experience of pension plan assets.

Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions and pension expense, information about the fiduciary net position of the Dickinson County Healthcare System Pension Plan (Plan) and additions to/deductions from the Plan's net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Operating Revenues and Expenses

The Healthcare System's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues and expenses of the Healthcare System result from exchange transactions associated with providing health care services - the Healthcare System's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as nonoperating.

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Charity Care

The Healthcare System provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Healthcare System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was \$897,000 and \$837,000 for the years ended December 31, 2016 and 2015, calculated by multiplying the ratio of cost to gross charges for the Healthcare System by the gross uncompensated charges associated with providing charity care to its patients.

Grants and Contributions

The Healthcare System may receive grants as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after revenues in excess of (less than) expenses.

Electronic Health Record Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified Electronic Health Records (EHR) technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare and Medicaid share; and (3) a transition factor applicable to that payment year (Medicare only).

The Healthcare System recognizes EHR incentive payments as revenue when there is reasonable assurance that the Healthcare System will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

The Healthcare System recognized revenue of \$1,055,660 and \$258,190 for the years ended December 31, 2016 and 2015 related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2013. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on prospectively determined rates. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System's Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2012. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System's Blue Cross cost reports have been settled by Blue Cross through December 31, 2015. Clinical services are reimbursed based on a fixed fee schedule.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Concentration of gross revenues by major payor accounted for the following percentages of the Healthcare System's patient service revenues for the years ended December 31, 2016 and 2015:

	2016	2015
Medicare	47%	47%
Medicaid	12%	12%
Blue Cross	23%	21%
Self-pay and other	18%	20%
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2016 and 2015 increased \$1,082,174 and \$1,295,425 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations.

Recovery Audit Contractor

The Centers for Medicare and Medicaid Services (CMS) has implemented a Recovery Audit Contractor (RAC) program under which claims are reviewed by contractors for validity, accuracy, and proper documentation. A demonstration project completed in several other states resulted in the identification of potential overpayments, some being significant. The potential exists that the Healthcare System may incur a liability for a claims overpayment at a future date. The Healthcare System is unable to determine the extent of the liability of overpayments, if any. As the outcome of such potential reviews is unknown and cannot be reasonably estimated, it is the Healthcare System's policy to adjust revenue for deductions from overpayment amounts or additions from underpayment amounts determined under the RAC audits at the time a change in reimbursement is agreed upon between the Healthcare System and CMS.

340B Program

Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the 340B Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

In order to qualify for the program, the hospital needs to have a large percentage of indigent volume, which is defined by the program to include Medicaid patients, Medicaid-eligible patients, and Medicare SSI patients. While indigent volumes are the qualifying factor, this program covers all payers for qualifying services. The program provides for reduced pharmaceutical costs for hospital outpatients. It also allows for contracts with retail pharmacies. As of July 2016, the Healthcare System is no longer a participant in the program.

The financial statements include an estimated reserve of \$188,356 and \$2,252,112 as of December 31, 2016 and 2015 in accordance with generally accepted accounting principles related to this program. This amount is included in accounts payable on the statement of net position. Actual results could differ from those estimates.

Note 3 - Deposits, Investments, and Investment Income

The carrying amounts of the Healthcare System's deposits and investments as of December 31, 2016 and 2015 are as follows:

	2016	2015
Carrying amount		
Deposits	\$ 16,621,864	\$ 14,283,634
Investments	1,912,220	6,852,399
Total	<u>\$ 18,534,084</u>	<u>\$ 21,136,033</u>

Deposits and investments are reported in the following statement of net position captions:

	2016	2015
Cash and cash equivalents	\$ 14,621,864	\$ 12,283,634
Temporary investments	12,838	4,561,593
Restricted under indenture agreement for debt service (1) (Note 7)	2,000,000	2,000,000
Other long-term investments	1,899,382	2,290,806
Total	<u>\$ 18,534,084</u>	<u>\$ 21,136,033</u>

(1) Under the terms of the 2015 bank note, the Healthcare System is required to maintain \$2,000,000 in a debt service reserve account until March 30, 2020.

Deposits

The Healthcare System had bank balances at December 31, 2016 and 2015 as follows:

	2016	2015
Insured (FDIC)	\$ 7,309,694	\$ 5,054,513
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	2,500,000	2,500,000
Uncollateralized	7,316,788	6,929,411
Total	<u>\$ 17,126,482</u>	<u>\$ 14,483,924</u>
Carrying value	<u>\$ 16,621,864</u>	<u>\$ 14,283,634</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

Investments

The Healthcare System's investments are reported at fair value. The Healthcare System had the following investments and maturities at December 31, 2016 and 2015:

December 31, 2016

Investment Type	Carrying Amount	Rating	Investment Maturities (in Years)		
			Less Than 1	1-5	6-10
Federal Home Loan Mortgage Corporation	\$ 500,663	Aaa	\$ -	\$ 500,663	\$ -
Federal Home Loan Bank	483,775	Aaa	-	483,775	-
Federal Farm Credit Bank	272,975	Aaa	-	272,975	-
U.S. Treasuries	486,405	Aaa	-	486,405	-
Freddie Mac	155,565	Aaa	155,565	-	-
Accrued interest	12,837		12,837	-	-
Total	<u>\$ 1,912,220</u>		<u>\$ 168,402</u>	<u>\$ 1,743,818</u>	<u>\$ -</u>

December 31, 2015

Investment Type	Carrying Amount	Rating	Investment Maturities (in Years)		
			Less Than 1	1-5	6-10
Certificates of Deposit (1)	\$ 4,501,218		\$ 4,501,218	\$ -	\$ -
Equities	43,404		43,404	-	-
Federal Home Loan Mortgage Corporation	512,350	Aaa	-	512,350	-
Federal Home Loan Bank	748,400	Aaa	255,125	493,275	-
Federal Farm Credit Bank	277,775	Aaa	-	277,775	-
U.S. Treasuries	591,495	Aaa	105,715	-	485,780
Freddie Mac	161,040	Aaa	-	161,040	-
Accrued interest	16,717		16,717	-	-
Total	<u>\$ 6,852,399</u>		<u>\$ 4,922,179</u>	<u>\$ 1,444,440</u>	<u>\$ 485,780</u>

- (1) The certificates of deposit were purchased through the Certificate of Deposit Account Registry Service (CDARS) program. They are reported at fair value and have been included in investments. The entire amount above is insured by the FDIC.

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk.

Concentration of Credit Risk

The Healthcare System will limit credit risk, the risk of loss due to the failure of the security issuer or backer, by diversifying in the investment portfolio so that potential losses on individual securities will be minimized. The Healthcare System does not have a formally adopted investment policy for managing concentration of credit risk. However, more than 5% of the Healthcare System's investments are invested in the following securities:

	2016	2015
Certificates of Deposit	0.0%	65.7%
Federal Home Loan Bank	25.3%	10.9%
Federal Home Loan Mortgage Corporation	26.2%	7.5%
US Treasuries	25.4%	8.6%
Federal Farm Credit Bank	14.3%	4.1%
Freddie Mac	8.1%	2.4%

Custodial Credit Risk

Custodial credit risk is the risk that in the event of a bank or investment company failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. At December 31, 2016 and 2015, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in the Healthcare System's name.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2016 and 2015:

	2016	2015
Interest income and realized gains and losses	\$ 151,480	\$ 123,860
Interest income on proceeds of borrowed funds	-	69,513
Total investment income	<u>\$ 151,480</u>	<u>\$ 193,373</u>
Change in unrealized gains and losses on investments	<u>\$ (31,119)</u>	<u>\$ (85,446)</u>

Note 4 - Fair Value of Assets

The Healthcare System has determined the fair value of certain assets and liabilities in accordance with generally accepted accounting principles, which provides a framework for measuring fair value.

Fair value is defined as the exchange price that would be received for 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. Valuation techniques should maximize the use of observable inputs and minimize the use of unobservable inputs.

A fair value hierarchy has been established, which prioritizes the valuation inputs into three broad levels. Level 1 inputs consist of quoted prices in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the related asset or liability. Level 3 inputs are unobservable inputs related to the asset or liability.

In some cases, the inputs used to measure the fair value of an asset or a liability might be categorized within different levels of the fair value hierarchy. In those cases, the fair value measurement is categorized in its entirety in the same level of the fair value hierarchy as the lowest level input that is significant to the entire measurement. Assessing the significance of a particular input to the entire measurement requires judgment, taking into account factors specific to the asset or liability.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

Assets and liabilities measured at fair value on a recurring basis and the related fair values of these assets and liabilities at December 31, 2016 and 2015 are as follows:

	Total	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
December 31, 2016				
Federal Home Loan Mortgage Corporation	\$ 500,663	\$ -	\$ 500,663	\$ -
Federal Home Loan Bank	483,775	-	483,775	-
Federal Farm Credit Bank	272,975	-	272,975	-
U.S. Treasuries	486,405	-	486,405	-
Freddie Mac	155,565	-	155,565	-
Accrued interest	12,837	-	12,837	-
	<u>\$ 1,912,220</u>	<u>\$ -</u>	<u>\$ 1,912,220</u>	<u>\$ -</u>
December 31, 2015				
Certificates of Deposit	\$ 4,501,218	\$ -	\$ 4,501,218	\$ -
Equities	43,404	43,404	-	-
Federal Home Loan Mortgage Corporation	512,350	-	512,350	-
Federal Home Loan Bank	748,400	-	748,400	-
Federal Farm Credit Bank	277,775	-	277,775	-
U.S. Treasuries	591,495	-	591,495	-
Freddie Mac	161,040	-	161,040	-
Accrued interest	16,717	-	16,717	-
	<u>\$ 6,852,399</u>	<u>\$ 43,404</u>	<u>\$ 6,808,995</u>	<u>\$ -</u>

The fair value of equities are determined by reference to quoted market prices. Federal Home Loan Mortgage Corporation securities, Federal Home Loan Bank securities, Federal Farm Credit Bank securities, US Treasuries, Freddie Mac securities, and the related accrued interest on these items are estimated using a variety of techniques including quoted market price of similar items, broker/dealer quotes, and models using market interest rates or yield curves.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

Note 5 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2016 are as follows:

	Balance December 31, 2015	Additions	Transfers and Retirements	Balance December 31, 2016
Capital assets not being depreciated				
Land	\$ 2,373,796	\$ -	\$ (14,497)	\$ 2,359,299
Construction in progress	1,354,539	1,457,001	(1,468,316)	1,343,224
Total capital assets, not being depreciated	<u>\$ 3,728,335</u>	<u>\$ 1,457,001</u>	<u>\$ (1,482,813)</u>	<u>\$ 3,702,523</u>
Capital assets being depreciated				
Land improvements	\$ 908,961	\$ -	\$ -	\$ 908,961
Buildings and improvements	45,821,041	312,330	-	46,133,371
Equipment	49,827,782	2,651,263	(680,870)	51,798,175
Total capital assets being depreciated	<u>96,557,784</u>	<u>2,963,593</u>	<u>(680,870)</u>	<u>98,840,507</u>
Less accumulated depreciation for				
Land improvements	(552,378)	(45,278)	-	(597,656)
Buildings and improvements	(23,011,627)	(1,273,106)	-	(24,284,733)
Equipment	(40,386,381)	(3,268,663)	617,209	(43,037,835)
Total accumulated depreciation	<u>(63,950,386)</u>	<u>(4,587,047)</u>	<u>617,209</u>	<u>(67,920,224)</u>
Net capital assets being depreciated	<u>\$ 32,607,398</u>	<u>\$ (1,623,454)</u>	<u>\$ (63,661)</u>	<u>\$ 30,920,283</u>
Capital assets, net	<u>\$ 36,335,733</u>			<u>\$ 34,622,806</u>

Construction in progress at December 31, 2016, represents costs related to various projects. The total estimated cost to complete the projects approximately \$1,852,000, which will be funded from working capital.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2015 are as follows:

	Balance December 31, 2014	Additions	Transfers and Retirements	Balance December 31, 2015
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ 750,584	\$ 2,373,796
Construction in progress	874,422	1,602,315	(1,122,198)	1,354,539
Total capital assets, not being depreciated	<u>\$ 2,497,634</u>	<u>\$ 1,602,315</u>	<u>\$ (371,614)</u>	<u>\$ 3,728,335</u>
Capital assets being depreciated				
Land improvements	\$ 1,012,585	\$ 5,437	\$ (109,061)	\$ 908,961
Buildings and improvements	45,652,398	149,815	18,828	45,821,041
Equipment	50,618,552	1,930,029	(2,720,799)	49,827,782
Total capital assets being depreciated	<u>97,283,535</u>	<u>2,085,281</u>	<u>(2,811,032)</u>	<u>96,557,784</u>
Less accumulated depreciation for				
Land improvements	(672,539)	(43,765)	163,926	(552,378)
Buildings and improvements	(21,740,354)	(1,283,122)	11,849	(23,011,627)
Equipment	(40,024,293)	(3,179,748)	2,817,660	(40,386,381)
Total accumulated depreciation	<u>(62,437,186)</u>	<u>(4,506,635)</u>	<u>2,993,435</u>	<u>(63,950,386)</u>
Net capital assets being depreciated	<u>\$ 34,846,349</u>	<u>\$ (2,421,354)</u>	<u>\$ 182,403</u>	<u>\$ 32,607,398</u>
Capital assets, net	<u>\$ 37,343,983</u>			<u>\$ 36,335,733</u>

Note 6 - Lease Obligations

The Healthcare System leases certain medical and other equipment and office space under noncancelable long-term lease agreements. Total lease expense for the years ended December 31, 2016 and 2015 for all operating leases was \$1,046,341 and \$1,030,528.

Minimum future lease payments for the operating leases are as follows:

<u>Years Ending December 31,</u>	<u>Amount</u>
2017	\$ 731,304
2018	468,843
2019	169,645
2020	4,126
Total minimum lease payments	<u>\$ 1,373,918</u>

Note 7 - Long-Term Debt

A schedule of changes in the Healthcare System's long-term debt for 2016 and 2015 is as follows:

	<u>Balance December 31, 2015</u>	<u>Additions</u>	<u>Reductions</u>	<u>Balance December 31, 2016</u>	<u>Amounts Due Within One Year</u>
Hospital Revenue					
Bonds, Series 2004	\$ 3,553,522	\$ -	\$ (177,766)	\$ 3,375,756	\$ 188,094
Bank note, 2015	18,841,250	-	(1,608,750)	17,232,500	1,693,751
Batti land contract	152,962	-	(71,539)	81,423	81,423
Cameron land contract	513,532	-	(88,713)	424,819	92,788
Hospital Revenue Bonds, Series 2016	<u>-</u>	<u>66,000</u>	<u>-</u>	<u>66,000</u>	<u>-</u>
Total bonds and notes	23,061,266	66,000	(1,946,768)	21,180,498	2,056,056
Capital Leases	<u>264,277</u>	<u>-</u>	<u>(264,277)</u>	<u>-</u>	<u>-</u>
Total long-term debt	<u>\$ 23,325,543</u>	<u>\$ 66,000</u>	<u>\$ (2,211,045)</u>	<u>\$ 21,180,498</u>	<u>\$ 2,056,056</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

	Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 3,721,530	\$ -	\$ (168,008)	\$ 3,553,522	\$ 177,768
Hospital Revenue and Refunding Bonds, Series 1999	20,005,000	-	(20,005,000)	-	-
Original issue discount	(77,735)	-	77,735	-	-
Bank note, 2015	-	20,000,000	(1,158,750)	18,841,250	1,608,750
Batti land contract	221,359	-	(68,397)	152,962	71,539
Cameron land contract	598,348	-	(84,816)	513,532	88,713
Total bonds and notes	24,468,502	20,000,000	(21,407,236)	23,061,266	1,946,770
Capital Leases	477,360	-	(213,083)	264,277	220,003
Total long-term debt	<u>\$ 24,945,862</u>	<u>\$ 20,000,000</u>	<u>\$ (21,620,319)</u>	<u>\$ 23,325,543</u>	<u>\$ 2,166,773</u>

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2016 and 2015 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
- Bank note – On March 31, 2015, the Healthcare System entered into a 3.59%, 60 month note payable. The note payable is due in monthly principal installments ranging from \$128,570 to \$160,000 to March 15, 2020, with a balloon payment of \$1,411,812 on March 30, 2020, and is secured by certain equipment. The proceeds of this note were used to defease the Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999. (1)
- Batti land contract – On December 28, 2012, the Healthcare System entered into a 4.5%, 60 month note payable. The note payable is due in monthly installments of \$6,413 to December 2017, and is secured by certain equipment.
- Cameron land contract – On March 6, 2013, the Healthcare System entered into a 4.5%, 97 month note payable. The note payable is due in monthly installments of \$9,167 to March 2021, and is secured by certain equipment.
- 2.63%, Dickinson County Healthcare System, Hospital Revenue Bond, Series 2016 (Series 2016 Bond) – due in monthly installments of \$9,085 including interest, to December 2032, secured by certain property and equipment. The Healthcare System may draw up to \$1,350,000.

- (1) The Series 2004 Bonds loan and 3.59% Bank Note agreements place limits on the incurrence of additional borrowings and require the Healthcare System satisfy certain measures of financial performance.

Scheduled principal and interest payments on long-term debt are as follows:

Years Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2017	\$ 2,056,056	\$ 796,676	\$ 2,852,732
2018	2,137,072	717,171	2,854,243
2019	2,200,843	635,709	2,836,552
2020	12,203,989	277,305	12,481,294
2021	263,056	138,778	401,834
2022-2026	1,400,853	470,808	1,871,661
2027-2030	918,629	72,742	991,371
Total	<u>\$ 21,180,498</u>	<u>\$ 3,109,189</u>	<u>\$ 24,289,687</u>

Note 8 - Defined Benefit Pension Plan

Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year. The plan was closed to all new entrants effective February 22, 2013.

The most recent actuarial valuation was made as of January 1, 2017. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2016 and 2015 was \$22,992,042 and \$24,384,165. The Healthcare System's total actual payroll for the years ended December 31, 2016 and 2015 was \$46,346,813 and \$44,587,101.

Current membership in the Plan consists of the following at December 31:

	2016	2015
Inactive plan members or beneficiaries currently receiving benefits	325	315
Inactive plan members entitled to but not yet receiving benefits	114	117
Active plan members	<u>379</u>	<u>397</u>
	<u>818</u>	<u>829</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. 50% of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2016 and 2015 were 15.13% and 15.49%, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2016 and 2015 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2015 and 2014.

The Healthcare System's contributions to the plan for the years ended December 31, 2016 and 2015 were \$3,654,952 and \$3,760,071, respectively.

Net Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions – At December 31, 2016, the Healthcare System reported a liability of \$36,900,713 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2017, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2017. At December 31, 2015, the Healthcare System reported a liability of \$31,975,291 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2016, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2016.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

For the years ended December 31, 2016 and 2015, the Healthcare System recognized pension expense of \$6,139,207 and \$4,708,497, respectively. At December 31, 2016 and 2015, the Healthcare System reported deferred outflows of resources and deferred inflows of resources related to pension from the following sources:

	December 31, 2016	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	\$ 1,147,575	\$ 377,834
Changes in Assumptions	4,301,290	-
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	2,874,784	81,209
Total	<u>\$ 8,323,649</u>	<u>\$ 459,043</u>

	December 31, 2015	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	\$ 1,576,446	\$ 25,378
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	3,899,263	-
Total	<u>\$ 5,475,709</u>	<u>\$ 25,378</u>

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

<u>Years Ended January 1,</u>	<u>Amount</u>
2018	\$ 2,494,628
2019	2,494,807
2020	2,165,452
2021	709,719
	<u>\$ 7,864,606</u>

Actuarial Assumptions

The total pension liability in the January 1, 2017 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Rate of Inflation	1.5% for 2 years, 3.5% thereafter
Salary Increases	5.3% - 0.0% plus inflation.
Long-Term Investment Rate of Return	7.50%

The actuarial assumptions used in the January 1, 2017 valuation were based on the results of actuarial experience studies with dates corresponding to those listed above.

The mortality table used is the RP-2014 Healthy Annuitant Mortality Table for males and females, adjusted for mortality improvement back to the observation period base year of 2006. Mortality rates for a particular calendar year are determined by applying the MP-2015 mortality improvement scale to the above described tables.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation for each major asset class is summarized in the following table:

<u>Asset Class</u>	<u>Asset Allocation</u>
Cash, deposits, money market funds	2%
Domestic equity	45%
International equity	15%
Fixed income	38%
	<u>100%</u>

Discount Rate - The discount rate used to measure the total pension liability was 7.5%. The projection of cash flows used to determine the discount rate assumed that employee contributions will be made at the contractually required rate and that contributions from the Healthcare System will be made at contractually required rates, actuarially determined. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2016 and 2015

Changes in the Net Pension Liability

Total Pension Liability		
Service Cost	\$ 1,026,573	\$ 1,046,769
Interest on the Total Pension Liability	5,284,471	4,955,073
Benefit Changes	-	-
Difference between Expected and Actual Experience	(459,009)	2,005,318
Assumption Changes	5,469,421	-
Benefit Payments	(2,904,272)	(4,305,902)
Net Change in Total Pension Liability	8,417,184	3,701,258
Total Pension Liability - Beginning	71,398,459	67,697,201
Total Pension Liability - Ending (a)	<u>\$ 79,815,643</u>	<u>\$ 71,398,459</u>
Total Fiduciary Net Position		
Employer Contributions	\$ 3,654,952	\$ 3,760,071
Employee Contributions	-	-
Pension Plan Net Investment Income	3,073,918	(1,060,011)
Benefit Payments	(2,904,272)	(4,305,902)
Pension Plan Administrative Expense	-	-
Other	(332,836)	(330,941)
Net Change in Plan Fiduciary Net Position	3,491,762	(1,936,783)
Plan Fiduciary Net Position - Beginning	39,423,168	41,359,951
Plan Fiduciary Net Position - Ending (b)	<u>\$ 42,914,930</u>	<u>\$ 39,423,168</u>
Net Pension Liability - Ending (a) - (b)	<u>\$ 36,900,713</u>	<u>\$ 31,975,291</u>
Plan Fiduciary Net Position as a Percentage of		
Total Pension Liability	53.77%	55.22%
Covered Employee Payroll	\$ 22,992,042	24,384,165
Net Pension Liability as a Percentage of		
Covered Employee Payroll	160.49%	131.13%

Sensitivity of the Healthcare System's Net Pension Liability to Changes in the Discount Rate - The following presents the Healthcare System's net pension liability calculated using the discount rate of 7.5%, as well as what the Healthcare System's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1 percentage-point higher (8.5%) than the current rate.

	1% Decrease (6.50%)	Discount Rate (7.50%)	1% Increase (8.50%)
Healthcare System's Net Pension Liability	\$ 47,616,497	\$ 36,900,713	\$ 27,891,824

Pension Plan Fiduciary Net Position – Detailed information about the pension plan's fiduciary net position is available in the separately issued actuarial report of the Dickinson County Healthcare System Retirement Plan.

Note 9 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Lincoln Financial Group Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

The DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 10 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees who were not currently vested in the defined benefit pension plan were transitioned to the new defined contribution plan design. Non-vested MNA (nursing staff) transitioned effective May 1, 2011 and non-vested, non-union staff transitioned effective September 4, 2011. Concurrently, all MNA and non-union new hires became members of the new DC plan. Lastly, non-vested AFSCME staff were transitioned effective February 23, 2013 and concurrently, all AFSCME new hires became DC plan members.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1 to 3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 9), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$567,763 and \$543,462 for the years ended December 31, 2016 and 2015.

Note 11 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$5 million. The policies end August 1, 2017.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis. The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2016 and 2015. Amounts included as expense for general and professional liability for the years ended December 31, 2016 and 2015, which include claims and premiums paid, were \$236,066 and \$92,488.

The reserve for loss on professional liability claims at December 31, 2016 and 2015 and activity for the years then ended is as follows:

Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015	Additions	Reductions	Balance December 31, 2016
\$ 708,000	\$ -	\$ (208,000)	\$ 500,000	\$ -	\$ -	\$ 500,000

Note 12 - Contingencies

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Litigations, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 13 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2016 and 2015 was as follows:

	2016	2015
Medicare	38%	38%
Blue Cross	18%	17%
Medicaid	12%	10%
Commercial insurance and other	22%	26%
Self pay	10%	9%
	<u>100%</u>	<u>100%</u>

The Healthcare System is subject to collective bargaining agreements for approximately 60.7% of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in February 2019. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2017.

Note 14 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$42,909 and \$47,134 for the years ended December 31, 2016 and 2015. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2016 was approximately \$15,121,086.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.



Required Supplementary Information
December 31, 2016 and 2015

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Net Pension Liability
Required Supplementary Information

**Schedule of the Healthcare System's Net Pension Liability
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Total Pension Liability</u>	<u>Plan Net Position</u>	<u>Net Pension Liability</u>	<u>Plan Net Position as a % of Total Pension Liability</u>	<u>Covered Payroll</u>	<u>Net Pension Liability as a % of Covered Payroll</u>
2016	\$ 79,815,643	\$ 42,914,930	\$ 36,900,713	53.77%	\$ 22,992,042	160.49%
2015	71,398,459	39,423,168	31,975,291	55.22%	24,384,165	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2017.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Changes in Net Pension Liability
Required Supplementary Information

**Schedule of the Healthcare System's Changes in Net Pension Liability
Last 10 Fiscal Years***

Fiscal year ending December 31,	2016	2015
Total Pension Liability		
Service Cost	\$ 1,026,573	\$ 1,046,769
Interest on the Total Pension Liability	5,284,471	4,955,073
Benefit Changes	-	-
Difference between Expected and Actual Experience	(459,009)	2,005,318
Assumption Changes	5,469,421	-
Benefit Payments	(2,904,272)	(4,305,902)
Net Change in Total Pension Liability	8,417,184	3,701,258
Total Pension Liability - Beginning	71,398,459	67,697,201
Total Pension Liability - Ending (a)	<u>\$ 79,815,643</u>	<u>\$ 71,398,459</u>
Total Fiduciary Net Position		
Employer Contributions	\$ 3,654,952	\$ 3,760,071
Employee Contributions	-	-
Pension Plan Net Investment Income	3,073,918	(1,060,011)
Benefit Payments	(2,904,272)	(4,305,902)
Pension Plan Administrative Expense	-	-
Other	(332,836)	(330,941)
Net Change in Plan Fiduciary Net Position	3,491,762	(1,936,783)
Plan Fiduciary Net Position - Beginning	39,423,168	41,359,951
Plan Fiduciary Net Position - Ending (b)	<u>\$ 42,914,930</u>	<u>\$ 39,423,168</u>
Net Pension Liability - Ending (a) - (b)	<u>\$ 36,900,713</u>	<u>\$ 31,975,291</u>
Plan Fiduciary Net Position as a Percentage of		
Total Pension Liability	53.77%	55.22%
Covered Employee Payroll	\$ 22,992,042	24,384,165
Net Pension Liability as a Percentage of		
Covered Employee Payroll	160.49%	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2017.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Contributions
Required Supplementary Information

**Schedule of the Healthcare System's Contributions
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Actuarially Determined Contribution</u>	<u>Actual Contribution</u>	<u>Contribution Deficiency (Excess)</u>	<u>Covered Payroll</u>	<u>Actual Contribution as a % of Covered Payroll</u>
2016	\$ 3,628,060	\$ 3,654,952	\$ (26,892)	\$ 23,979,247	15.24%
2015	3,760,071	3,760,071	-	24,274,184	15.49%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2017.

Notes to Schedule of Contributions

Valuation Date:

January 1, 2017

Notes

Actuarial determined contribution rates are calculated as of January 1 which is 12 months prior to the beginning of the fiscal year in which contributions are reported.

Methods and Assumptions Used to Determine Contribution Rates:

Actuarial Cost Method:	Projected Unit Credit
Amortization Method:	Level Dollar, Closed
Remaining Amortization Period:	2013 ERIP: 2 years Other: 30 years
Asset Valuation Method:	5-Year smoothed market; 25% corridor
Inflation:	1.5% for 2 years, 3.5% thereafter
Salary Increases:	5.3% - 0.0% plus inflation
Investment Rate of Return:	7.5%
Retirement Age:	Experience-based table of rates that are specific to the type of eligibility condition.
Mortality:	The mortality table used is the RP-2014 Healthy Annuitant Mortality Table for males and females, adjusted for mortality improvement back to the observation period base year of 2006. Mortality rates for a particular calendar year are determined by applying the MP-2015 mortality improvement scale to the above described tables.

Other Information:

Notes

There were no benefit changes during the year. The mortality assumption was updated for the January 1, 2017 valuation.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Contributions
Required Supplementary Information

**Schedule of the Healthcare System's Contributions
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Actuarially Determined Contribution</u>	<u>Actual Contribution</u>	<u>Contribution Deficiency (Excess)</u>	<u>Covered Payroll</u>	<u>Actual Contribution as a % of Covered Payroll</u>
2017	\$ 3,946,471	\$ 3,621,532	\$ 324,939	\$ 21,852,633	16.57%
2016	3,628,060	3,654,952	(26,892)	22,992,042	15.90%
2015	3,760,071	3,760,071	-	24,274,184	15.49%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2018.

Notes to Schedule of Contributions

Valuation Date: January 1, 2018
Notes: Actuarial determined contribution rates are calculated as of January 1 which is 12 months prior to the beginning of the fiscal year in which contributions are reported.

Methods and Assumptions Used to Determine Contribution Rates:

Actuarial Cost Method: Entry Age Normal
 Amortization Method: Level percentage of payroll, closed
 Remaining Amortization Period: 2013 ERIP: 1 year
 Other: 29 years
 Asset Valuation Method: 5-Year smoothed market; 15% corridor
 Inflation: 3.5% annually
 Salary Increases: 5.3% - 0.0% plus inflation
 Investment Rate of Return: 7.5%
 Retirement Age: 65 years
 Mortality: The mortality table used is the RP-2014 Healthy Annuitant Mortality Table for males and females, adjusted for mortality improvement back to the observation period base year of 2006. Mortality rates for a particular calendar year are determined by applying the MP-2015 mortality improvement scale to the above described tables.

Other Information:

Notes: There were no benefit changes during the year. The mortality assumption was updated for the January 1, 2017 valuation. Retirement rates were updated for the January 1, 2018 valuation based on evaluation of actual plan experience.



Financial Statements

December 31, 2015 and 2014

Dickinson County Healthcare System

(A Component Unit of Dickinson County)

Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2015 and 2014

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	4
Financial Statements	
Statements of Net Position	19
Statements of Revenues, Expenses, and Changes in Net Position	20
Statements of Cash Flows	21
Notes to Financial Statements	23
Supplementary Information	
Schedule of Net Pension Liability	50
Schedule of Changes in Net Pension Liability	51
Schedule of Contributions	52



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County) (Healthcare System), which comprise the statements of net position as of December 31, 2015 and 2014, and the related statements of revenues, expenses, and changes in net position 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion on the 2015 Financial Statements

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2015, and the results of its operations, changes in net position, and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Basis for Qualified Opinion on 2014 Financial Statements

The Healthcare System has elected not to restate the December 31, 2014 financial statements related to the implementation of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*. If this standard had been implemented effective January 1, 2014, beginning net position as of January 1, 2014 would have decreased by \$25,368,928, deferred outflows of resources would have increased by \$794,613, deferred inflows of resources would have increased by \$33,897, net pension liability would have increased by \$26,337,250, pension expense would have increased by \$207,606, and ending net position would have decreased by \$25,576,534 for the year ended December 31, 2014.

Qualified Opinion on 2014 Financial Statements

In our opinion, except for the effects on the 2014 financial statement of not implementing GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* as of January 1, 2014 as described in the Basis for Qualified Opinion paragraph, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2014, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters – 2014 Financial Statements

In our report dated April 29, 2015, we expressed an unmodified opinion on the financial statements as of and for the year ended December 31, 2014. As reported above, the Healthcare System has elected not to restate the 2014 financial statements to reflect the implementation of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*. Accordingly, our present qualified opinion on the 2014 financial statements, as presented herein, is different than that expressed in our previously issued report.

Adoption of Accounting Standard

As discussed in Notes 1 and 14 to the financial statements, the Healthcare System has adopted the provisions of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* and GASB Statement No. 71 *Pension Transition for Contributions Made Subsequent to the Measurement Date*, which has resulted in a restatement of the net position as of January 1, 2015. The 2014 financial statements have not been restated to reflect this change; accordingly our on the December 31, 2014 financial statements was qualified with respect to this matter as reported above. Our opinion on the 2015 financial statements has not been modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 4 through 18 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated April 29, 2016 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

A handwritten signature in black ink that reads "Erik Sully LLP". The signature is written in a cursive, flowing style. To the right of the signature is a thin vertical yellow line.

Fargo, North Dakota

April 29, 2016

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2015, 2014, and 2013. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2015

The Healthcare System's net position increased in 2015 by \$3.247 million or 23.7% with revenues before capital contributions of \$3.198 million, comprised of an operating income of \$4.479 million and nonoperating expenses in excess of nonoperating revenue of \$1.281 million. There were \$49 thousand contributions for capital purposes in 2015. During 2015, the Healthcare System's total operating revenues of \$110.736 million was 15.7% higher than the amount in 2014. The resulting operating income for 2015 of \$4.479 million was 4.0% of total operating revenue compared to an operating income of \$4.929 million for 2014 which was 5.1% of operating revenue.

Awards and special recognitions were again plentiful in 2015. They were as follows:

- Received a National Patient Safety score of "A" from the Leapfrog Group for the seventh consecutive six-month reporting period.
- Received recognition from The Joint Commission as a *Top Performer on Key Quality Measures* specifically in the areas of Pneumonia Treatment, Surgical Care, VTE, Immunizations, AMI and Heart Failure.
- Received national *Healthgrades* Awards for clinical excellence as follows:
 - Cardiac : Five-Star Recipient for Treatment of Heart Attack for 6 Years in a Row (2010-2015)
 - Critical Care: Five-Star Recipient for Treatment of Sepsis for 2 Years in a Row (2014-2015)
 - Patient Safety: Recipient of Patient Safety Excellence Award™ and Named Among the Top 10% in the Nation for Patient Safety in 2015

The following service enhancements were completed in 2015:

- Successfully recruited six new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - Kristine Bobish, DO – Cardiology
 - Jennifer Hwang, DO – Internal Medicine
 - Daniel Kreider, MD – Radiology
 - Theodore Parsons, MD – Pathology
 - Brian Shukri, DO – Radiology
 - John Simmons, DO – Radiation Oncology

- Added the independent Cecconi-Terrian-Donohue General Surgery Practice to the compliment of Dickinson owned clinics.
- Expanded Home Medical Equipment Services to Delta County.
- Established a Smoke-Free Campus including all outlying clinics.
- Expanded the Patient Portal to include communication with all Dickinson owned medical clinics.

Year Ended December 31, 2014

The Healthcare System's net position increased in 2014 by \$4.836 million or 14.0% with revenues before capital contributions of \$4.796 million, comprised of an operating income of \$4.929 million and nonoperating expenses in excess of nonoperating revenue of \$133 thousand. There were \$40 thousand contributions for capital purposes in 2014. During 2014, the Healthcare System's total operating revenues of \$95.737 million was 6.6% higher than the amount in 2013. The resulting operating income for 2014 of \$4.929 million was 5.1% of total operating revenue compared to an operating income of \$41 thousand for 2013 which was 0.05% of operating revenue.

The following major projects and service enhancements were completed in 2014. 2014 has been a year like none other for DCHS as evidenced by the following accomplishments and recognitions received by the Healthcare System:

- Ranked 5th out of 142 hospitals in the State of Michigan by Consumer Reports in the areas of patient safety, patient outcomes, patient experience, and hospital practices - over 4,000 hospitals nationwide were compared.
- Received two Governor's Awards for Excellence - the *Inpatient Clinical Achievement Award* and the *Healthcare Associated Infection Prevention Award*.
- Received a National Safety score of "A" from the Leapfrog Group for the fifth consecutive six-month reporting period.
- Received official recognition from the Michigan State Legislature & Governor Snyder for the above accomplishments.
- Received recognition from The Joint Commission as a *Top Performer on Key Quality Measures* specifically in the areas of Pneumonia Treatment and Surgical Care.
- Michigan Works! and the Dickinson Area Chamber Alliance awarded Dickinson County Healthcare System with the *Large Business of the Year Award* for 2014.
- The Upper Peninsula Economic Development Alliance awarded Dickinson County Healthcare System their "Award of Excellence" for 2014 – 2015.

- Acquired Dr. Morel's Medical Oncology Practice from Marquette General Hospital.
- Successfully recruited five new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - o Joel Johnson, MD – Vascular Surgeon
 - o Breion Tafoya, MD – Pulmonologist
 - o Kevin Diehl, DO – Radiologist
 - o David Timm, MD – Radiologist
 - o Jeffrey Kreyer, MD – General Surgeon
- Employee Cindy Yelich, RN received national recognition by the American Association of Diabetes Educators as Diabetes Educator of the Year in the State of Michigan.
- Completed Meaningful Use Stage 1, year 2 reporting period successfully and received 2nd incentive payment for the hospital and a number of providers. Also implemented solutions to meet Stage 2 requirements. (Patient Portal IP, Patient Portal ED, Direct Messaging, Truven Pat Education, Rules Engine for Clinician Alerts, Paragon Connect, Paragon Audit Server, Paragon Quality eMeasures). Began Stage 2 reporting period on October 1, 2014 and it runs for 365 days (9/30/2015) before we can attest and receive our next incentive payment.
- Implemented the Vocera nurse communication system to improve communications throughout the organization.

Year Ended December 31, 2013

The Healthcare System's net position decreased in 2013 by \$1.501 million or 4.2% with losses before capital contributions and deferred financing cost adjustment of \$1.526 million, comprised of an operating income of \$41 thousand and nonoperating expenses in excess of nonoperating revenue of \$1.567 million. There were \$25 thousand contributions for capital purposes in 2013. During 2013, the Healthcare System's total operating revenues of \$89.8 million was 6.5% higher than the amount in 2012. The resulting operating income for 2013 of \$41 thousand was 0.05% of total operating revenue compared to an operating income of \$865 thousand for 2012 which was 1.0% of operating revenue.

The following major projects and service enhancements were completed in 2013:

- The Healthcare System expanded participation in the 340B program by entering into retail pharmacy agreements with two local retail pharmacies.
- Providers added include the following: Dr. Cameron – Ears, Nose and Throat, Dr. Venditti – Orthopedics and Dr. Cook – Gynecology.
- Offered an early retirement window, along with implementing volume related staffing changes and completing successful contract negotiations with both the Michigan Nurses Association and American Federation of State, County and Municipal Employee union.
- Became an affiliate member of St. Joseph's Hospital Med Assets purchasing network along with the renegotiation of several standalone purchasing contracts.

- Began outsourcing laundry services as well as transitioning the lifeline program to Phillips Lifeline.
- New electronic medical record (EMR) technology was implemented in the Emergency Department (ED) and After Hours Clinic. Triage renovations were also completed to give those patients entering the ED a better understanding of the triage process and flow. The expanded triage area also allows those who are wheelchair bound a more comfortable process.
- In order to prepare for electronic results reporting and EMR interface, Cardiac Diagnostics purchased new equipment including electrocardiographs and treadmills for stress tests. This allows a more efficient ordering process and will eventually be 100% electronic.
- Completed Meaningful Use Stage 1, year 1 reporting period successfully and received 1st incentive payment for hospital and a number of our providers. Also implemented Physician Documentation system for inpatients, live in January 2014. This is necessary to meet the requirements of future stages of meaningful use.
- The separate central nurse stations in the medical and surgical units were combined into one central location as a response to declining inpatient volumes. Processes were implemented to assure this change had no detrimental effect on patient care.
- Purchased a Visera Pro Laryngoscope which allows physicians to have better clarity when assessing patients. The equipment also has video and picture taking capabilities to easily compare pre and post procedure analysis, and is smaller in size making it much easier for physicians to use.
- The Dickinson Ear, Nose & Throat Clinic introduced **Real-Ear technology** to its audiology services. *Real-Ear* technology is currently the most accurate measurement equipment in the field of hearing aids. It allows for a recording of the hearing aid output directly at the patient's ear drum. When the exact output of the hearing in the patient's ear is known, corrections can be made in the manufacturer's software to ensure that the hearing aid prescription exactly matches the hearing loss. With *Real-Ear* measurement, each patient's specific individual ear canal resonance and physical properties are taken into account rather than relying on average calculated data. Patient satisfaction with hearing aids increases, and the incidence of returned hearing aids has reduced dramatically.
- Dickinson Home Health began a **Hospital to Home program** in collaboration with Dickinson Memorial Hospital's nursing units. The new program provides one free follow-up home visit to at-risk, non-homebound patients in order to provide a successful transition from hospital to home. A home health nurse focuses on medication reconciliation, home safety and community referrals as needed.
- Attained an "A" rating from the Leapfrog Group - Again
The Leapfrog Group, an independent national nonprofit organization, again awarded Dickinson Memorial Hospital a grade of A and congratulated hospital staff for their "commitment to patient safety and for making critical safety information available to healthcare consumers through participation in national performance measurement and public-reporting programs." The Leapfrog Group calculates a single safety score, based upon 26 measures of publicly available hospital safety data, which represents a hospital's overall capacity to keep patients safe from infections, injuries, and medical and medication errors.

- The **Radiation Oncology Center at Dickinson Memorial Hospital received national accreditation**, an accomplishment that places it in an elite group of only 11 centers in the state of Michigan to do so. There are only 12 accredited centers in Wisconsin; Appleton being the closest one. National accreditation assures patients that the radiation treatments they receive locally meet the most stringent of national standards for safety and quality.
- The September 2013 issue of Consumer Reports magazine rated Dickinson Memorial Hospital as one of the better hospitals to choose when surgery was needed. Dickinson was one of 17 hospitals in the State of Michigan to receive an above average rating. The study was based upon a review of Medicare claims and clinical data for nearly 2,500 hospitals across the country for 27 kinds of surgeries combined – large and small hospitals in each state were compared.
- Construction was completed on the new medical office building on the west side of the hospital campus for the relocation of the Dickinson Occupational Clinic and the expansion of the wound care program to become The Center for Wound Healing and Hyperbaric Medicine. The Dickinson Pediatric Clinic was also expanded to twice its former size to add a telehealth room and an ImPACT testing room.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Statement of Net Position includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all nonoperating revenue and expense items, capital contributions and the net increase in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Financial Analysis of the System

The condensed statements of net position of the Healthcare System as of December 31, 2015, 2014, and 2013 are summarized in the following table.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Condensed Statements of Net Position
December 31, 2015, 2014, and 2013 (in Thousands)

	2015	2014	2013
Total current assets (includes the current portion of restricted assets)	\$ 40,515	\$ 34,300	\$ 24,739
Cash and investments internally designated for other purposes	2,291	3,508	5,228
Cash and investments restricted by bond indentures	2,000	1,726	1,806
Capital assets, net	36,336	37,344	39,215
Total Assets	81,142	76,878	70,988
Total Deferred Outflows of Resources	6,191	898	1,062
Total Assets and Deferred Outflows	\$ 87,333	\$ 77,776	\$ 72,050
 Total current liabilities	 \$ 16,715	 \$ 14,914	 \$ 12,012
Long-term debt, net of current portion	21,160	22,866	24,932
Other long-term liabilities	500	708	654
Net pension liability	31,975	-	-
Total Liabilities	70,350	38,488	37,598
Total Deferred Inflows of Resources	25	-	-
Total Net Position	16,958	39,288	34,452
Total Liabilities, Deferred Inflows of Resources, and Net Position	\$ 87,333	\$ 77,776	\$ 72,050

Current Assets and Liabilities

Net patient accounts receivable increased to 58 days' of net revenue at December 31, 2015 compared to 53 days' of net revenue at December 31, 2014 and compared to 55 days' of net revenue at December 31, 2013. The 2015 increase was the result of the assimilation of a Medical Oncology practice under DCHS ownership as well as the implementation of ICD10 on October 1, 2015. The 2014 decrease can be attributed to the development of the Patient Financial Counselor position, which helped patients with high deductible health plans or no insurance to meet their financial obligations.

Total current assets increased 18.1% in 2015 and increased 38.7% in 2014 compared to each prior year. The 2015 increase was due to an increase in cash and cash equivalents and patient accounts receivable and a decrease in estimated third party settlements. The 2014 increase is primarily due to an increase in cash and cash equivalents, estimated third party settlements, and supplies and other current assets.

Current liabilities increased 12.1% in 2015 as a result of an increase in trade accounts payable and compensated absences while current liabilities increased 24.2% in 2014 for the same reasons. The Healthcare System's current ratio (current assets divided by current liabilities) was 2.42 at December 31, 2015 and 2.30 at December 31, 2014.

Total Cash and Investments

The number of days of total cash and investments was 72.9 at December 31, 2015 and 67.5 at December 31, 2014. Excluding the restricted amounts, the ratios for 2015 and 2014 were 66.0 days and 53.9 days, respectively.

The total cash and investments at December 31, 2015 were \$21.1 million including restricted funds of \$2.0 million. Total cash and investments at December 31, 2014 were \$17.2 million including restricted funds of \$3.5 million.

Long-Term Debt

The Healthcare System had long-term debt of \$21.2 million at December 31, 2015 and \$22.9 million at December 31, 2014 (net of current maturities of \$2.2 million in 2015 and \$2.1 million in 2014). In 2015, the 1999 Revenue and Refunding Bonds were paid off with a \$20 million term loan through Fifth Third Bank of Grand Rapids, Michigan. Long-term debt at December 31, 2015 represents 39.5% of total long-term liabilities and 30.1% of total liabilities as compared to 97.0% of total long-term liabilities and 59.4% of total liabilities at December 31, 2014. The Healthcare System recorded a Net Pension Liability of \$31.975 million as required in 2015 by GASB Statement No. 68, *Accounting and Financial Reporting for Pensions*. The debt service coverage ratio for the years ended December 31, 2015 and 2014 was 2.99 and 2.67 respectively.

Net Position

Total net position decreased in 2015 and increased in 2014. Likewise, unrestricted net position decreased from 2014 to 2015 and increased from 2013 to 2014. The decrease in the unrestricted component for 2015 was a result of the requirement to record the Net Pension Liability as defined by GASB 68 as it relates to the Healthcare System's defined benefit pension plan. The increase in the unrestricted component for 2014 was a result of the profitability of the Healthcare System. The amount invested in capital assets, net of related debt remained constant in both years as the Healthcare System made capital purchases only for those items required by HITECH and for equipment that was no longer usable. The restricted amount for debt service represents funds held by Fifth Third Bank in 2015 as required by the term loan agreement and the trustee for the Series 1999 bonds in 2014 and 2013. These components are presented in the following table.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Components of Net Position (in thousands)

	December 31,		
	2015	2014	2013
Invested in capital assets, net of related debt	\$ 13,725	\$ 13,297	\$ 12,725
Restricted by revenue bond indentures, expendable for debt service	2,000	3,463	3,462
Unrestricted	1,233	22,528	18,265
Total net position	<u>\$ 16,958</u>	<u>\$ 39,288</u>	<u>\$ 34,452</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2015, 2014, and 2013 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2015, 2014, and 2013 (in Thousands)

	2015		2014		2013	
Revenue and (expenses):						
Net patient service revenue	\$ 101,437	91.6%	\$ 86,772	90.6%	\$ 77,904	86.8%
Other revenue	9,299	8.4%	8,965	9.4%	11,868	13.2%
Total operating revenue	110,736	100.0%	95,737	100.0%	89,772	100.0%
Total operating expenses	106,257	96.0%	90,808	94.9%	89,731	100.0%
Operating income	4,479	4.0%	4,929	5.1%	41	0.0%
Investment income	193	0.2%	340	0.4%	386	0.4%
Change in unrealized gains and losses on investments	(85)	-0.1%	40	0.0%	(192)	-0.2%
Change in fair market value of forward purchase agreement	35	0.0%	252	0.3%	(627)	-0.7%
Interest and amortization expense	(1,392)	-1.3%	(1,622)	-1.7%	(1,696)	-1.9%
Other non-operating revenue and expenses (net)	(32)	0.0%	857	0.9%	563	0.6%
Non-operating expenses in excess of revenue	(1,281)	-1.2%	(133)	-0.1%	(1,567)	-1.7%
Income (loss) before capital contributions	3,198	2.9%	4,796	5.0%	(1,526)	-1.7%
Capital contributions	49		40		25	
Increase (decrease) in net position	3,247		4,836		(1,501)	
Net position, beginning of year, as previously stated	39,288		-		-	
Restatement - recognition of net pension liability and related deferred inflows and outflows	25,577		-		-	
Net position - beginning of year as restated	13,711		34,452		35,953	
Net position - end of year	\$ 16,958		\$ 39,288		\$ 34,452	

Results of Operations

Overall results of operations of \$4.479 million or 4.0% of revenue for 2015 decreased from \$4.929 million or 5.1% of revenue for 2014. The net nonoperating expenses in excess of nonoperating revenue for 2015 increased to \$1.28 million from \$133 thousand in 2014. The net increase in 2015 was the result of a reduction in donations, lower investment returns and reduction in market value of investments. The net decrease in 2014 was due to improvement in the market value of the forward purchase agreement and other investments. The net result for 2015 was income of \$3.198 million or 2.9% of total operating revenue before capital contributions. The net result for 2014 was income of \$4.796 million or 5.0% of total operating revenue before capital contributions.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2015 comprised 26.4% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2014 was 33.7%. The operating performance of DCMH was affected by inpatient discharges decreasing by 14.9% to 2,795 from 3,286 in 2014, while acute adult and pediatric inpatient days also decreased by 16% to 9,566 from 11,383 in 2014. Net inpatient revenue decreased 8.5% and the all-payer case mix index increased to 1.391 from 1.342 in 2014.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 59.5% of total Healthcare System net patient revenue and its operating activities for 2015. The comparable percentage for 2014 was 52.5%. Net outpatient revenue increased 32.5% in 2015 and increased 6.6% in 2014. Total outpatient visits were 190,335 in 2015 and 179,516 in 2014. As a percent, the largest increase in outpatient visits was seen in day surgeries, radiation oncology visits and series (Rehabilitation and Home Health) visits.

The net patient revenue of the Rural Health Clinics (RHC's) and other Provider Based RHC's comprised about 14.1% of the total net patient revenue of the Healthcare System for 2015 and 13.8% for 2014. The revenue growth was 19.7% in 2015 as a result of adding three physicians and one mid-level provider and 11.4% in 2014 as a result of converting the remaining free standing clinics to either RHC's or Provider Based RHC's. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute losses on operations. There are two facilities in northeast Wisconsin and twelve off-campus practices in Michigan in addition to eleven practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson Area Community Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from health care services, and nonoperating revenue, which is principally from investment income.

Operating Revenue

Total gross revenues for all patient services performed by the Healthcare System were \$279 million in 2015 and \$259 million in 2014. The overall increase reflects the year-to-year difference in patient volumes and service mix changes. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care and other free care services measured as unpaid gross revenues of 0.8% in 2015 and 1.3% in 2014 to patients who documented their inability to pay. Bad debt provisions were 1.0% of gross revenue in 2015 and 2.2% in 2014. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 61.8% in 2015 and 63.0% in 2014.

The resulting net patient services revenue was 36.3% of gross revenue in 2015 and 33.5% in 2014. Net patient service revenue increased \$14.665 million or 16.9% in 2015 and \$8.868 million or 11.4% in 2014 as a result of an increase in patient volumes and case mix index as well as a more favorable payor mix.

Other operating revenue increased \$334 thousand or 3.7% from 2014 to 2015 due to an increase in 340B retail pharmacy program revenue offset by a further reduction in Electronic Health Record incentive payments. Other operating revenue decreased \$2.9 million or 24.5% from 2013 to 2014 as a result of a reduction in Electronic Health Record incentive payments in year two of implementation as well as some reduction in 340B retail pharmacy program revenue.

Nonoperating Revenue

Investment income was \$193 thousand for 2015 and \$340 thousand for 2014 due to continued weak interest rates. The change in unrealized gains and losses on investments was (\$85) thousand in 2015 and \$40 thousand in 2014.

Capital Contributions

There were \$49 thousand in capital contributions in 2015 for a mammography software upgrade and the replacement of televisions in all patient rooms and \$40 thousand in 2014 for pediatric room renovations, infusion chairs and equipment for the mock code blue program.

Forward Purchase Agreement

A decrease in market value of \$627 thousand was recorded in 2013 and an increase in market value of \$252 thousand was recorded in 2014. In 2015 an increase of \$35 thousand in market value was recognized prior to the termination of the agreement as part of the payoff of the 1999 Revenue and Refunding Bonds.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Expenditure of Funds

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2015 and 2014 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2015 and 2014 (in Thousands)

	2015	2014	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 60,226	\$ 52,985	\$ 7,241	13.7%
Supplies and pharmaceuticals	19,722	13,316	6,406	48.1%
Professional fees and other purchased services	21,801	19,584	2,217	11.3%
Depreciation and amortization	4,507	4,923	(416)	-8.5%
Total	<u>\$ 106,256</u>	<u>\$ 90,808</u>	<u>\$ 15,448</u>	<u>17.0%</u>

Employee compensation and benefits increased \$7.241 million or 13.7%. The annual average total paid full-time equivalent (FTE) positions of 704.6 for 2015 increased by 5.0% from the 2014 amount of 671.3. Pension expense increased by \$1.096 million or 26.4% due to an increase in the unfunded liability required by GASB 68 to be reflected in the current year pension expense of the Healthcare System. Health insurance expense also increased by \$1.658 million or 29.0% due to a change in carrier. This was offset by more favorable reimbursement rates.

The cost of supplies and pharmaceuticals increased \$6.407 million or 48.1%, due to an increase in pharmaceutical expense, specifically related to chemotherapy drugs. The Healthcare System took over operation of a Hematology/Oncology practice in December 2014.

Professional fees, purchased services and other expenses for 2015 increased \$2.217 million or 11.3%. This was mainly the result of higher medical professional fees in the Emergency Department and Pediatric Clinic as well as increased software maintenance and 340B retail fees. Depreciation and amortization expense for 2015 decreased \$416 thousand or 8.5%, principally due to several assets reaching the end of their useful life.

The components of operating expenses for the Healthcare System for the years ended December 31, 2014 and 2013 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2014 and 2013 (in Thousands)

	2014	2013	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 52,985	\$ 52,561	\$ 424	0.8%
Supplies and pharmaceuticals	13,316	12,732	584	4.6%
Professional fees and other purchased services	19,584	19,400	184	0.9%
Depreciation and amortization	4,923	5,038	(115)	-2.3%
Total	<u>\$ 90,808</u>	<u>\$ 89,731</u>	<u>\$ 1,077</u>	<u>1.2%</u>

Employee compensation and benefits increased \$424 thousand or 0.8%. The annual average total paid full-time equivalent (FTE) positions of 671.3 for 2014 increased by 0.6% from the 2013 amount of 667.0. Pension expense increased by \$157 thousand or 3.9% but health insurance expense decreased by \$1.074 million or 19.4% due to changes in plan design.

The cost of supplies and pharmaceuticals increased \$584 thousand or 4.6%, related to an increase in operating room cases of 162 or 5.7%. Specifically, orthopedic cases increased by 83 or 9.4% from 2013 to 2014 which resulted in increased orthopedic supply costs.

Professional fees, purchased services and other expenses for 2014 increased \$184 thousand or 0.9%. This was mainly the result of higher fees for hardware maintenance contracts, dues and subscriptions, repairs and minor equipment. Depreciation and amortization expense for 2014 decreased \$115 thousand or 2.3%, principally due to several assets reaching the end of their useful life.

Nonoperating Expense Items

Interest expense was \$1.4 million in 2015 and \$1.6 million in 2014. The Healthcare System capitalized interest expense amounts of \$32 thousand in 2015 and \$54 thousand in 2014.

Capital Expenditures

Fiscal Year 2015

Total capital spending increased by approximately 20% from 2014 levels. Major purchases included the following: Land parcel adjacent to the main campus, ultrasound machine, various building improvements and numerous information technology equipment and software upgrades.

Fiscal Year 2014

Total capital spending increased slightly in 2014 from 2013 levels. Major projects included the following: Meaningful use and other information technology initiatives - \$1.329 million, real estate - \$537 thousand, x ray system - \$355 thousand, various remodel projects - \$104 thousand, vehicles - \$82 thousand.

Fiscal Year 2013

Total capital spending decreased in 2013 from 2012 levels. Major projects included the following: Purchase of two suites in the Dickinson Medical Building - \$1.278 million; T System electronic medical record in the Emergency Department and After Hours Clinic - \$451 thousand; additional HVAC system in computer room - \$134 thousand; Quality eMeasures and other meaningful use initiatives - \$231 thousand.

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The current budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2015 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 100,784	\$ 9,952	10%
Total operating expenses	(98,146)	(8,110)	-8%
Operating income	2,638	1,842	70%
Net nonoperating revenue and gains, (expenses and losses)	(747)	(534)	-71%
Income before capital contributions	1,891	1,308	69%
Capital contributions	26	23	88%
Increase in net position	\$ 1,917	\$ 1,331	69%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were unfavorable by approximately 15.7%, while total hospital outpatient visits were favorable by approximately 3.4%. Expenses were unfavorable to budget by \$8.110 million or 8.3% as a result of increased salary and wage, pension and pharmaceutical expense as well as locum tenens fees. FTE's were 2.1% over budget partly as a result of increased volumes in the Emergency Department and Convenience Care Clinic as well as the unanticipated employment of Radiation Oncology employees who had been previously leased from UP Health System – Marquette. The variance in other net non-operating items was caused principally by higher interest expense, loss on the sale of capital assets and lower investment earnings.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2015, 2014, and 2013 (in Thousands)

	2015	2014	2013
Budget	\$ 5,366	\$ 4,211	\$ 8,425
Actual	3,650	3,014	2,817
Variance	\$ 1,716	\$ 1,197	\$ 5,608
Variance %	32.0%	28.4%	66.6%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. The variance in 2013 was due to management's actions to limit capital spending by eliminating or deferring several budgeted projects including a new medical office building on the east side of campus and phase 2 of an energy project. However, in 2014 and 2015 as a result of operations, projects that could be justified with a return on investment were again initiated. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

Payor mix improved in 2015 as a result of Consumers Mutual Insurance Company entering the local large group employer market. The Healthcare System continued to see the service volume trend of declining inpatient stays and increased outpatient and physician office visits. Uncompensated care with bad debt and charity write-offs totaled 1.9% of gross charges in 2015 while uncompensated care with bad debt and charity write-offs totaled 3.5% of gross charges in 2014. In February 2016, the most recent data available, the unemployment rate (not seasonally adjusted) in Dickinson County was 5.3% compared to 7.0% over the entire Upper Peninsula and 5.0% for the State of Michigan. The same statistics for February 2015 were 6.4%, 8.3% and 6.1%, respectively.

The Upper Peninsula experienced several healthcare system acquisitions over the last several years. Bell Memorial Hospital and Portage Health joined Lifepoint Hospitals out of Brentwood, Tennessee in 2013. In 2014, Northstar Health System in Iron River, MI became part of the Aspirus Health System. Also, in 2014, the Healthcare System engaged Newpoint Healthcare Advisors to assist in determining what strategic partnerships may be beneficial to our community. That engagement is ongoing.

(This page left blank intentionally.)

	2015	2014
Assets and Deferred Outflows of Resources		
Current Assets		
Cash and cash equivalents	\$ 12,283,634	\$ 9,734,000
Short-term investments	4,561,593	517,121
Current portion of restricted assets	-	1,737,268
Receivables		
Patient, net of estimated uncollectibles of		
\$3,536,000 in 2015 and \$4,026,000 in 2014	16,696,716	13,474,346
Estimated third-party settlements	-	2,208,385
Other	2,998,113	3,048,002
Supplies and other current assets	3,974,737	3,580,520
Total current assets	40,514,793	34,299,642
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	2,000,000	1,726,034
Other long-term investments	2,290,806	3,508,320
Total noncurrent cash and investments	4,290,806	5,234,354
Capital Assets		
Capital assets not being depreciated	3,728,335	2,497,634
Depreciable capital assets, net of accumulated depreciation	32,607,398	34,846,349
Total capital assets	36,335,733	37,343,983
Total assets	81,141,332	76,877,979
Deferred Outflows of Resources		
Refunding costs	715,370	897,777
Pension related deferred outflows - Note 7	5,475,709	-
Total deferred outflows of resources	6,191,079	897,777
Total assets and deferred outflows	\$ 87,332,411	\$ 77,775,756

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Net Position
December 31, 2015 and 2014

	<u>2015</u>	<u>2014</u>
Liabilities, Deferred Inflows of Resources, and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 2,166,773	\$ 2,079,304
Accounts payable		
Trade	6,879,282	6,126,690
Estimated third-party payor settlements	457,617	-
Accrued expenses		
Salaries, wages, and related liabilities	1,876,039	1,569,334
Compensated absences	4,931,902	4,494,387
Other accrued liabilities	403,246	451,702
Interest	-	192,268
Total current liabilities	<u>16,714,859</u>	<u>14,913,685</u>
Long-Term Liabilities		
Long-term debt, less current maturities	21,158,770	22,866,558
Reserve for loss on general and professional liabilities claims	500,000	708,000
Net pension liability	<u>31,975,291</u>	<u>-</u>
Total long-term liabilities	<u>53,634,061</u>	<u>23,574,558</u>
Total liabilities	<u>70,348,920</u>	<u>38,488,243</u>
Deferred Inflows of Resources		
Pension related deferred inflows - Note 7	<u>25,378</u>	<u>-</u>
Net Position		
Invested in capital assets, net of related debt	13,725,560	13,295,898
Restricted - expendable for debt service	2,000,000	3,463,302
Unrestricted	<u>1,232,553</u>	<u>22,528,313</u>
Total net position	<u>16,958,113</u>	<u>39,287,513</u>
Total liabilities and net position	<u>\$ 87,332,411</u>	<u>\$ 77,775,756</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2015 and 2014

	<u>2015</u>	<u>2014</u>
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$2,918,450 in 2015 and \$5,818,017 in 2014	\$ 101,436,763	\$ 86,772,084
Supplies and 340b program revenue	6,874,147	5,378,057
Electronic health record incentive revenue	258,190	1,330,083
Other revenue	<u>2,166,614</u>	<u>2,257,116</u>
Total operating revenues	<u>110,735,714</u>	<u>95,737,340</u>
Operating Expenses		
Salaries and wages	44,587,101	40,445,741
Employee benefits	15,639,062	12,539,508
Supplies and pharmaceuticals	19,722,447	13,315,544
Medical and other professional fees	8,348,086	6,954,706
Purchased services and other	13,453,231	12,629,618
Depreciation	<u>4,506,635</u>	<u>4,922,810</u>
Total operating expenses	<u>106,256,562</u>	<u>90,807,927</u>
Operating Income	<u>4,479,152</u>	<u>4,929,413</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	146,062	859,658
Interest and amortization expense	(1,391,850)	(1,622,856)
Loss on disposal of capital assets	(177,913)	(2,778)
Investment income	193,373	340,006
Change in fair market value of forward purchase agreement	34,839	251,980
Change in unrealized gains and losses on investments	<u>(85,446)</u>	<u>40,336</u>
Nonoperating revenues (expenses), net	<u>(1,280,935)</u>	<u>(133,654)</u>
Revenues in Excess of Expenses Before Capital Contributions	3,198,217	4,795,759
Capital Contributions	<u>48,917</u>	<u>39,818</u>
Increase in Net Position	<u>3,247,134</u>	<u>4,835,577</u>
Net Position, Beginning of Year, as Previously Stated	39,287,513	34,451,936
Restatement - Recognition of Net Pension Liability and Related Deferred Outflows and Inflows as of January 1, 2015 - Note 15	<u>(25,576,534)</u>	<u>-</u>
Net Position Beginning of Year, as Restated	<u>13,710,979</u>	<u>34,451,936</u>
Net Position, End of Year	<u>\$ 16,958,113</u>	<u>\$ 39,287,513</u>
See Notes to Financial Statements		20

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2015 and 2014

	<u>2015</u>	<u>2014</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 100,880,395	\$ 83,303,246
Payments to suppliers and contractors	(41,421,845)	(31,048,497)
Payments to or on behalf of employees	(58,533,517)	(52,031,902)
Other receipts	<u>9,348,840</u>	<u>9,407,551</u>
Net Cash From Operating Activities	<u>10,273,873</u>	<u>9,630,398</u>
Noncapital Financing Activity		
Unrestricted general contributions	<u>146,062</u>	<u>859,658</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(3,649,947)	(3,014,258)
Repayment of long-term debt	(21,698,054)	(2,620,473)
Interest paid, including capitalized interest	(1,356,393)	(1,512,919)
Capital contributions	48,917	39,818
Proceeds from the sale of capital assets	6,066	11,000
Proceeds from the issuance of long term debt	<u>20,000,000</u>	<u>-</u>
Net Cash Used For Capital and Capital Related Financing Activities	<u>(6,649,411)</u>	<u>(7,096,832)</u>
Investing Activities		
Purchases of investments	(59,355,553)	(13,452,724)
Proceeds from sales and maturities of investments	57,714,203	15,578,357
Investment income	<u>193,373</u>	<u>340,006</u>
Net Cash From (Used For) Investing Activities	<u>(1,447,977)</u>	<u>2,465,639</u>
Net Increase in Cash and Cash Equivalents	2,322,547	5,858,863
Cash and Cash Equivalents, Beginning of Year	<u>9,961,087</u>	<u>4,102,224</u>
Cash and Cash Equivalents, End of Year	<u><u>\$ 12,283,634</u></u>	<u><u>\$ 9,961,087</u></u>
Reconciliation of Cash and Cash Equivalents to the Balance Sheets		
Cash and cash equivalents in current assets	\$ 12,283,634	\$ 9,734,000
Cash and cash equivalents in noncurrent cash and investments	<u>-</u>	<u>227,087</u>
Total cash and cash equivalents	<u><u>\$ 12,283,634</u></u>	<u><u>\$ 9,961,087</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2015 and 2014

	<u>2015</u>	<u>2014</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income	\$ 4,479,152	\$ 4,929,413
Adjustments to reconcile operating income to net cash flows from operating activities		
Depreciation	4,506,635	4,922,810
Provision for bad debts	2,918,450	5,818,017
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(6,140,820)	(6,535,186)
Other receivables	49,889	442,295
Supplies and other current assets	(394,217)	(1,252,015)
Deferred outflows of resources	(4,681,096)	-
Accounts payable - trade	752,592	3,153,115
Estimated third-party payor settlements	2,666,002	(2,751,669)
Accrued expenses	695,764	849,618
Reserve for loss on general and professional liabilities claims, net	(208,000)	54,000
Net pension liability	5,638,041	-
Deferred inflows of resources	(8,519)	-
Net Cash From Operating Activities	<u>\$ 10,273,873</u>	<u>\$ 9,630,398</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$32,417 and \$51,798 during 2015 and 2014.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

The financial statements of the Dickinson County Healthcare System (Healthcare System) have been prepared in accordance with generally accepted accounting principles in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the Healthcare System are described below.

Reporting Entity

Dickinson County Healthcare System (Healthcare System) was formed as a county public Healthcare System in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public Healthcare System was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public Healthcare System. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

Basis of Presentation

The statement of net position displays the Healthcare System's assets, deferred outflows, and liabilities, with the difference reported as net position. Net position is reported in the following categories/components:

Net investment in capital assets, net of related debt consists of net capital assets reduced by the outstanding balances of any related debt obligations and deferred inflows of resources attributable to the acquisition, construction or improvement of those assets or the related debt obligations and increased by balances of deferred outflows of resources related to those assets or debt obligations.

Restricted - expendable for debt service results when constraints placed on net position use are externally imposed by the issuers of debt held by the Healthcare System.

Unrestricted net position consists of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the Healthcare System's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired. For purposes of the statement of cash flows, the Healthcare System considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Short-term Investments

Short-term investments include investments with an average maturity of three to twelve months, excluding internally designated and restricted cash and investments. Short-term investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Noncurrent Cash and Investments

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available or estimated fair value using quoted market prices for similar securities. Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and principal and interest funds and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when earned.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation in the financial statements. Contributed capital assets are reported at their estimated fair value at the time of their donation. The estimated useful lives of capital assets are as follows.

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position, and are excluded from revenues in excess of expenses. 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 net position.

Deferred Outflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The Healthcare System has two items that qualify for reporting in this category, which are the loss on defeasance of bonds and unrecognized items not yet charged to pension expense. The loss on defeasance of bonds results from the retirement of the Hospital Revenue and Refunding Bonds, Series 1999. The loss on defeasance of bonds amount is systematically and rationally amortized over the remaining life of the old obligation or the life of the new obligation, whichever is shorter.

Deferred Inflows of Resources

Deferred inflows of resources represent an increase in net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The deferred inflows of resources reported in the financial statements consist of the unamortized portion of the difference between expected and actual experience of pension plan assets.

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Bond Discounts

Bonds payable are reported net of the applicable bond discount. Bond discounts are amortized over the life of the debt using the effective interest method. Amortization is included in interest expense.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Operating Revenues and Expenses

The Healthcare System's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues and expenses of the Healthcare System result from exchange transactions associated with providing health care services - the Healthcare System's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as nonoperating.

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Charity Care

The Healthcare System provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Healthcare System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was \$837,000 and \$1,025,000 for the years ended December 31, 2015 and 2014, calculated by multiplying the ratio of cost to gross charges for the Healthcare System by the gross uncompensated charges associated with providing charity care to its patients.

Grants and Contributions

The Healthcare System may receive grants as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after revenues in excess of expenses.

Electronic Health Record Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified Electronic Health Records (EHR) technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare and Medicaid share; and (3) a transition factor applicable to that payment year (Medicare only).

The Healthcare System recognizes EHR incentive payments as revenue when there is reasonable assurance that the Healthcare System will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

The Healthcare System recognized revenue of \$258,190 and \$1,330,083 for the years ended December 31, 2015 and 2014 related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements.

Implementation of GASB Statement No. 68 and GASB Statement No. 71

As of January 1, 2015, the Healthcare System adopted GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* and GASB Statement No. 71 *Pension Transition for Contributions Made Subsequent to the Measurement Date*. The implementation of these standards requires governments calculate and report the costs and obligations associated with pensions in their basic financial statements. Employers are required to recognize pension amounts for all benefits provided through the plan which include the net pension liability, deferred outflows of resources, deferred inflows of resources, and pension expense. The effect of the implementation of these standards on beginning net position is disclosed in Note 15 and the additional disclosures required by these standards are included in Note 7.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System’s Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2012. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on prospectively determined rates. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System’s Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2012. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System’s Blue Cross cost reports have been settled by Blue Cross through December 31, 2014. Clinical services are reimbursed based on a fixed fee schedule.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Concentration of gross revenues by major payor accounted for the following percentages of the Healthcare System’s patient service revenues for the years ended December 31, 2015 and 2014:

	2015	2014
Medicare	47%	47%
Medicaid	12%	11%
Blue Cross	21%	25%
Self-pay and other	20%	17%
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2015 and 2014 increased approximately \$1,295,425 and \$1,460,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations.

RAC

The Centers for Medicare and Medicaid Services (CMS) has implemented a Recovery Audit Contractor (RAC) program under which claims are reviewed by contractors for validity, accuracy, and proper documentation. A demonstration project completed in several other states resulted in the identification of potential overpayments, some being significant. The potential exists that the Healthcare System may incur a liability for a claims overpayment at a future date. The Healthcare System is unable to determine the extent of the liability of overpayments, if any. As the outcome of such potential reviews is unknown and cannot be reasonably estimated, it is the Healthcare System's policy to adjust revenue for deductions from overpayment amounts or additions from underpayment amounts determined under the RAC audits at the time a change in reimbursement is agreed upon between the Healthcare System and CMS.

340B Program

Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

In order to qualify for the program, the hospital needs to have a large percentage of indigent volume, which is defined by the program to include Medicaid patients, Medicaid-eligible patients, and Medicare SSI patients. While indigent volumes are the qualifying factor, this program covers all payers for qualifying services. The program provides for reduced pharmaceutical costs for hospital outpatients. It also allows for contracts with retail pharmacies.

The financial statements include an estimated reserve of \$2,252,112 and \$2,781,342 as of December 31, 2015 and 2014 in accordance with generally accepted accounting principles related to this program. This amount is included in accounts payable on the statement of net position. Actual results could differ from those estimates.

Note 3 - Deposits, Investments, and Investment Income

The carrying amounts of the Healthcare System's deposits and investments as of December 31, 2015 and 2014 are as follows:

	<u>2015</u>	<u>2014</u>
Carrying amount		
Deposits	\$ 14,283,634	\$ 9,961,087
Investments	6,852,399	5,992,795
Forward purchase contract (1)	<u>-</u>	<u>1,268,861</u>
Total	<u>\$ 21,136,033</u>	<u>\$ 17,222,743</u>

Deposits and investments are reported in the following statement of net position captions:

	<u>2015</u>	<u>2014</u>
Cash and cash equivalents	\$ 12,283,634	\$ 9,734,000
Temporary investments	4,561,593	517,121
Restricted assets - current portion (Note 6)	-	1,737,268
Restricted under indenture agreement for debt service (1) (2) (Note 6)	2,000,000	1,726,034
Other long-term investments	<u>2,290,806</u>	<u>3,508,320</u>
Total	<u>\$ 21,136,033</u>	<u>\$ 17,222,743</u>

- (1) A forward purchase contract was entered into in 1999 by the Healthcare System relating to certain trustee held funds associated with the Series 1999 bonds. The contract provided a fixed rate of return of 5.775% on the Debt Service Fund and the Reserve Fund investments, a notional value of approximately \$2,823,000 as of December 31, 2014 and an estimated fair value of approximately \$1,269,000 at December 31, 2014. The forward purchase contract is included in other long-term investments in the accompanying financial statements. The forward purchase contract was liquidated on May 1, 2015.
- (2) Under the terms of the 2015 bank note, the Healthcare System is required to maintain \$2,000,000 in a debt service reserve account until March 30, 2020.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

Deposits

The Healthcare System had bank balances at December 31, 2015 and 2014 as follows:

	2015	2014
Insured (FDIC)	\$ 5,054,513	\$ 4,637,902
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	2,500,000	1,000,000
Uncollateralized	6,929,411	4,188,133
Total	<u>\$ 14,483,924</u>	<u>\$ 9,826,035</u>
Carrying value	<u>\$ 14,283,634</u>	<u>\$ 9,961,087</u>

Investments

The Healthcare System's investments are reported at fair value. The Healthcare System had the following investments and maturities at December 31, 2015 and 2014:

December 31, 2015

Investment Type	Carrying Amount	Rating	<i>Investment Maturities (in Years)</i>		
			Less Than 1	1-5	6-10
Certificates of Deposit	\$ 4,501,218		\$ 4,501,218	\$ -	\$ -
Equities	43,404		43,404	-	-
Federal Home Loan Mortgage Corporation	512,350	Aaa	-	512,350	-
Federal Home Loan Bank	748,400	Aaa	255,125	493,275	-
Federal Farm Credit Bank	277,775	Aaa	-	277,775	-
U.S. Treasuries	591,495	Aaa	105,715	-	485,780
Freddie Mac	161,040	Aaa	-	161,040	-
Accrued interest	16,717		16,717	-	-
Total	<u>\$ 6,852,399</u>		<u>\$ 4,922,179</u>	<u>\$ 1,444,440</u>	<u>\$ 485,780</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

December 31, 2014

Investment Type	Carrying Amount	Rating	Investment Maturities (in Years)		
			Less Than 1	1-5	6-10
Certificates of deposit (1)	\$ 500,000		\$ 500,000	\$ -	\$ -
Commercial paper	3,236,215		3,236,215	-	-
Forward Purchase Agreement	1,268,861		1,268,861	-	-
Federal National Mortgage Association	199,886	Aaa	199,886	-	-
Federal Home Loan Mortgage Corporation	524,213	Aaa	-	524,213	-
Federal Home Loan Bank	763,561	Aaa	-	541,235	222,326
Federal Farm Credit Bank	283,655	Aaa	-	-	283,655
U.S. Treasuries	301,077	Aaa-mf	301,077	-	-
Freddie Mac	167,067	Aaa	-	167,067	-
Accrued interest	17,121		17,121	-	-
	<u>\$ 7,261,656</u>		<u>\$ 5,523,160</u>	<u>\$ 1,232,515</u>	<u>\$ 505,981</u>

- (1) The certificates of deposit were purchased through the Certificate of Deposit Account Registry Service (CDARS) program. They are reported at fair value and have been included in investments. The entire amount above is insured by the FDIC.

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk.

Concentration of Credit Risk

The Healthcare System will limit credit risk, the risk of loss due to the failure of the security issuer or backer, by diversifying in the investment portfolio so that potential losses on individual securities will be minimized. The Healthcare System does not have a formally adopted investment policy for managing concentration of credit risk. However, more than 5% of the Healthcare System's investments are invested in the following securities:

	2015	2014
Certificates of Deposit	65.7%	44.0%
Fortis Funding LLC - Commercial paper	0.0%	31.7%
Federal Home Loan Bank	10.9%	7.5%
Federal Home Loan Mortgage Corporation	7.5%	5.1%
US Treasuries	8.6%	0.0%

Custodial Credit Risk

Custodial credit risk is the risk that in the event of a bank or investment company failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. At December 31, 2015 and 2014, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in other than the Healthcare System's name.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2015 and 2014:

	2015	2014
Interest income and realized gains and losses	\$ 123,860	\$ 117,571
Interest income on proceeds of borrowed funds	69,513	222,435
Total investment income	<u>\$ 193,373</u>	<u>\$ 340,006</u>
Change in unrealized gains and losses on investments	<u>\$ (85,446)</u>	<u>\$ 40,336</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

Note 4 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2015 are as follows:

	Balance December 31, 2014	Additions	Transfers and Retirements	Balance December 31, 2015
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ 750,584	\$ 2,373,796
Construction in progress	874,422	1,602,315	(1,122,198)	1,354,539
	<u>2,497,634</u>	<u>1,602,315</u>	<u>(371,614)</u>	<u>3,728,335</u>
Total capital assets, not being depreciated				
Capital assets being depreciated				
Land improvements	\$ 1,012,585	\$ 5,437	\$ (109,061)	\$ 908,961
Buildings and improvements	45,652,398	149,815	18,828	45,821,041
Equipment	50,618,552	1,930,029	(2,720,799)	49,827,782
	<u>97,283,535</u>	<u>2,085,281</u>	<u>(2,811,032)</u>	<u>96,557,784</u>
Total capital assets being depreciated				
Less accumulated depreciation for				
Land improvements	(672,539)	(43,765)	163,926	(552,378)
Buildings and improvements	(21,740,354)	(1,283,122)	11,849	(23,011,627)
Equipment	(40,024,293)	(3,179,748)	2,817,660	(40,386,381)
	<u>(62,437,186)</u>	<u>(4,506,635)</u>	<u>2,993,435</u>	<u>(63,950,386)</u>
Total accumulated depreciation				
Net capital assets being depreciated	<u>\$ 34,846,349</u>	<u>\$ (2,421,354)</u>	<u>\$ 182,403</u>	<u>\$ 32,607,398</u>
Capital assets, net	<u>\$ 37,343,983</u>			<u>\$ 36,335,733</u>

Construction in progress at December 31, 2015, represents costs related to various projects. The total estimated cost to complete the projects approximately \$600,000, which will be funded from working capital.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2014 are as follows:

	Balance December 31, 2013	Additions	Transfers and Retirements	Balance December 31, 2014
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ -	\$ 1,623,212
Construction in progress	779,764	1,430,143	(1,335,485)	874,422
Total capital assets, not being depreciated	<u>\$ 2,402,976</u>	<u>\$ 1,430,143</u>	<u>\$ (1,335,485)</u>	<u>\$ 2,497,634</u>
Capital assets being depreciated				
Land improvements	\$ 1,012,585	\$ -	\$ -	\$ 1,012,585
Buildings and improvements	44,985,456	490,805	176,137	45,652,398
Equipment	48,408,407	1,343,749	866,396	50,618,552
Total capital assets being depreciated	<u>94,406,448</u>	<u>1,834,554</u>	<u>1,042,533</u>	<u>97,283,535</u>
Less accumulated depreciation for				
Land improvements	(625,491)	(47,048)	-	(672,539)
Buildings and improvements	(20,478,148)	(1,262,206)	-	(21,740,354)
Equipment	(36,491,270)	(3,613,556)	80,533	(40,024,293)
Total accumulated depreciation	<u>(57,594,909)</u>	<u>(4,922,810)</u>	<u>80,533</u>	<u>(62,437,186)</u>
Net capital assets being depreciated	<u>\$ 36,811,539</u>	<u>\$ (3,088,256)</u>	<u>\$ 1,123,066</u>	<u>\$ 34,846,349</u>
Capital assets, net	<u>\$ 39,214,515</u>			<u>\$ 37,343,983</u>

Note 5 - Lease Obligations

The Healthcare System leases certain medical and other equipment and office space under noncancelable long-term lease agreements. Total lease expense for the years ended December 31, 2015 and 2014 for all operating leases was \$1,030,528 and \$866,808. The capitalized leased assets consist of:

	<u>2015</u>	<u>2014</u>
Major movable equipment	\$ 901,220	\$ 901,220
Less accumulated amortization	<u>(285,392)</u>	<u>(195,270)</u>
	<u><u>\$ 615,828</u></u>	<u><u>\$ 705,950</u></u>

Minimum future lease payments for the capital and operating leases are as follows:

<u>Years Ending December 31,</u>	<u>Capital Leases</u>	<u>Operating Leases</u>
2016	\$ 225,252	\$ 717,329
2017	44,478	351,260
2018	-	250,461
	<u>-</u>	<u>90,370</u>
Total minimum lease payments	269,730	<u>\$ 1,409,420</u>
Less interest	<u>(5,453)</u>	
Present value of minimum lease payments - Note 6	<u><u>\$ 264,277</u></u>	

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

Note 6 - Long-Term Debt

A schedule of changes in the Healthcare System's long-term debt for 2015 and 2014 is as follows:

	Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 3,721,530	\$ -	\$ (168,008)	\$ 3,553,522	\$ 177,768
Hospital Revenue and Refunding Bonds, Series 1999	20,005,000	-	(20,005,000)	-	-
Original issue discount	(77,735)	-	77,735	-	-
Bank note	-	20,000,000	(1,158,750)	18,841,250	1,608,750
Batti land contract	221,359	-	(68,397)	152,962	71,539
Cameron land contract	598,348	-	(84,816)	513,532	88,713
Total bonds and notes	24,468,502	20,000,000	(21,407,236)	23,061,266	1,946,770
Capital Leases (Note 5)	477,360	-	(213,083)	264,277	220,003
Total long-term debt	<u>\$ 24,945,862</u>	<u>\$ 20,000,000</u>	<u>\$ (21,620,319)</u>	<u>\$ 23,325,543</u>	<u>\$ 2,166,773</u>
	Balance December 31, 2013	Additions	Reductions	Balance December 31, 2014	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 3,880,314	\$ -	\$ (158,784)	\$ 3,721,530	\$ 168,007
Hospital Revenue and Refunding Bonds, Series 1999	21,455,000	-	(1,450,000)	20,005,000	1,545,000
Original issue discount	(91,972)	-	14,237	(77,735)	-
Batti land contract	286,752	-	(65,393)	221,359	68,397
Cameron land contract	679,439	-	(81,091)	598,348	84,816
Total bonds and notes	26,209,533	-	(1,741,031)	24,468,502	1,866,220
Capital Leases (Note 5)	1,342,565	-	(865,205)	477,360	213,084
Total long-term debt	<u>\$ 27,552,098</u>	<u>\$ -</u>	<u>\$ (2,606,236)</u>	<u>\$ 24,945,862</u>	<u>\$ 2,079,304</u>

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2015 and 2014 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
 - 5.70% to 5.80% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999 (Series 1999 Bonds). The Series 1999 Bonds were paid off on May 1, 2015.
 - Original Issue Discount - Associated with the Series 1999 Bonds issuance. This amount was removed when the Series 1999 bonds were paid off.
 - Bank note – On March 31, 2015, the Healthcare System entered into a 3.59%, 60 month note payable. The note payable is due in monthly principal installments ranging from \$128,570 to \$160,000 to March 15, 2020, with a balloon payment on March 30, 2020, and is secured by certain equipment. The proceeds of this note were used to defease the Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999. (1)
 - Batti land contract – On December 28, 2012, the Healthcare System entered into a 4.5%, 60 month note payable. The note payable is due in monthly installments of \$6,413 to December 2017, and is secured by certain equipment.
 - Cameron land contract – On March 6, 2013, the Healthcare System entered into a 4.5%, 97 month note payable. The note payable is due in monthly installments of \$9,167 to March 2021, and is secured by certain equipment.
 - Capital Leases
 - o MRT Equipment Note Payable – During 2012, the Healthcare System placed in service certain equipment financed by Wells Fargo Equipment Finance, Inc. and recorded a corresponding liability. On November 15, 2012, the Healthcare System entered into a 3.2%, 52 month note payable with Wells Fargo Equipment Finance, Inc. The note payable is due in monthly installments of \$18,771 to March 2017, and is secured by certain equipment.
 - o Seimens Note Payable – During 2012, the Healthcare System placed in service certain equipment provided by Seimens and recorded a corresponding liability. On May 14, 2012, the Healthcare System entered into a 0.8%, 3 year note payable with Seimens. The note payable was due in yearly installments of \$664,227 to May 2014, and was secured by certain equipment.
- (1) The Series 2004 Bonds loan and 3.59% Bank Note agreements place limits on the incurrence of additional borrowings and require the Healthcare System satisfy certain measures of financial performance.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

Scheduled principal and interest payments on long-term debt are as follows:

Years Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2016	\$ 2,166,773	\$ 878,744	\$ 3,045,517
2017	2,100,328	796,881	2,897,209
2018	2,071,072	717,171	2,788,243
2019	2,200,843	635,709	2,836,552
2020	12,203,989	277,305	12,481,294
2021-2025	1,351,240	547,923	1,899,163
2026-2030	1,231,298	134,405	1,365,703
Total	<u>\$ 23,325,543</u>	<u>\$ 3,988,138</u>	<u>\$ 27,313,681</u>

Note 7 - Defined Benefit Pension Plan

Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year. The plan was closed to all new entrants effective February 22, 2013.

The most recent actuarial valuation was made as of January 1, 2016. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2015 and 2014 was approximately \$24,384,000 and \$24,688,000. The Healthcare System's total actual payroll for the years ended December 31, 2015 and 2014 was \$44,587,101 and \$40,445,741.

Current membership in the Plan consists of the following at December 31:

	2015	2014
Inactive plan members or beneficiaries currently receiving benefits	315	305
Inactive plan members entitled to but not yet receiving benefits	117	185
Active plan members	<u>397</u>	<u>420</u>
	<u>829</u>	<u>910</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. 50% of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2015 and 2014 were 15.49% and 13.22%, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2015 and 2014 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2014 and 2013.

The Healthcare System's contributions to the plan for the year ended December 31, 2015 were \$3,760,071.

Net Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions – At December 31, 2015, the Healthcare System reported a liability of \$31,975,291 for the net pension liability. The Healthcare System's net pension liability was measured as of January 1, 2016, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of January 1, 2016.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

For the year ended December 31, 2015, the Healthcare System recognized pension expense of \$4,708,497. At December 31, 2015, the Healthcare System reported deferred outflows of resources and deferred inflows of resources related to pension from the following sources:

	<u>Deferred Outflows of Resources</u>	<u>Deferred Inflows of Resources</u>
Differences Between Expected and Actual Experience	\$ 1,576,446	\$ 25,378
Net Difference Between Projected and Actual Earnings on Pension Plan Investments	<u>3,899,263</u>	<u>-</u>
Total	<u><u>\$ 5,475,709</u></u>	<u><u>\$ 25,378</u></u>

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

<u>Years Ended January 1,</u>	<u>Amount</u>
2017	\$ 1,444,831
2018	1,444,831
2019	1,445,012
2020	<u>1,115,657</u>
	<u><u>\$ 5,450,331</u></u>

Actuarial Assumptions

The total pension liability in the January 1, 2016 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Rate of Inflation	1.5% for 2 years, 3.5% thereafter
Salary Increases	5.3% - 0.0% plus inflation.
Long-Term Investment Rate of Return	7.50%

The actuarial assumptions used in the January 1, 2016 valuation were based on the results of actuarial experience studies with dates corresponding to those listed above.

Mortality rates were based on the RP-2000 Mortality Table for Males or Females, as appropriate.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation for each major asset class is summarized in the following table:

<u>Asset Class</u>	<u>Asset Allocation</u>
Cash, deposits, money market funds	2%
Stocks	19%
Corporate fixed income	7%
Government securities	8%
Mutual funds	49%
Net unsettled purchases/sales	15%
	100%

Discount Rate - The discount rate used to measure the total pension liability was 7.5%. The projection of cash flows used to determine the discount rate assumed that employee contributions will be made at the contractually required rate and that contributions from the Healthcare System will be made at contractually required rates, actuarially determined. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

Fiscal year ending December 31,	<u>2015</u>
Total Pension Liability	
Service Cost	\$ 1,046,769
Interest on the Total Pension Liability	4,955,073
Benefit Changes	-
Difference between Expected and Actual Experience	2,005,318
Assumption Changes	-
Benefit Payments	<u>(4,305,902)</u>
Net Change in Total Pension Liability	3,701,258
Total Pension Liability - Beginning	<u>67,697,201</u>
Total Pension Liability - Ending (a)	<u><u>\$ 71,398,459</u></u>
Total Fiduciary Net Position	
Employer Contributions	\$ 3,760,071
Employee Contributions	-
Pension Plan Net Investment Income	(1,060,011)
Benefit Payments	(4,305,902)
Pension Plan Administrative Expense	-
Other	<u>(330,941)</u>
Net Change in Plan Fiduciary Net Position	(1,936,783)
Plan Fiduciary Net Position - Beginning	<u>41,359,951</u>
Plan Fiduciary Net Position - Ending (b)	<u><u>\$ 39,423,168</u></u>
Net Pension Liability - Ending (a) - (b)	<u><u>\$ 31,975,291</u></u>
Plan Fiduciary Net Position as a Percentage of	
Total Pension Liability	55.22%
Covered Employee Payroll	\$ 24,384,165
Net Pension Liability as a Percentage of	
Covered Employee Payroll	131.13%

Sensitivity of the Healthcare System's Net Pension Liability to Changes in the Discount Rate - The following presents the Healthcare System's net pension liability calculated using the discount rate of 7.5%, as well as what the Healthcare System's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1 percentage-point higher (8.5%) than the current rate.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2015 and 2014

	1% Decrease (6.50%)	Discount Rate (7.50%)	1% Increase (8.50%)
	<u> </u>	<u> </u>	<u> </u>
Healthcare System's Net Pension Liability	\$ 41,165,713	\$ 31,975,291	\$ 24,205,409

Pension Plan Fiduciary Net Position – Detailed information about the pension plan’s fiduciary net position is available in the separately issued actuarial report of the Dickinson County Healthcare System Retirement Plan.

Note 8 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Lincoln Financial Group Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

The DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 9 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees who were not currently vested in the defined benefit pension plan were transitioned to the new defined contribution plan design. Non-vested MNA (nursing staff) transitioned effective May 1, 2011 and non-vested, non-union staff transitioned effective September 4, 2011. Concurrently, all MNA and non-union new hires became members of the new DC plan. Lastly, non-vested AFSCME staff were transitioned effective February 23, 2013 and concurrently, all AFSCME new hires became DC plan members.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1 to 3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 8), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$543,462 and \$419,128 for the years ended December 31, 2015 and 2014.

Note 10 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$3 million. The policies end August 1, 2016.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis. The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2015 and 2014. Amounts included as expense for general and professional liability for the years ended December 31, 2015 and 2014, which include claims and premiums paid, were \$92,488 and \$364,658.

The reserve for loss on professional liability claims at December 31, 2015 and 2014 and activity for the years then ended is as follows:

Balance December 31, 2013	Additions	Reductions	Balance December 31, 2014	Additions	Reductions	Balance December 31, 2015
\$ 654,000	\$ 54,000	\$ -	\$ 708,000	\$ -	\$ (208,000)	\$ 500,000

Note 11 - Contingencies

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Litigations, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 12 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2015 and 2014 was as follows:

	2015	2014
Medicare	38%	38%
Blue Cross	17%	22%
Medicaid	10%	10%
Commercial insurance and other	26%	21%
Self pay	9%	9%
	<u>100%</u>	<u>100%</u>

The Healthcare System is subject to collective bargaining agreements for approximately 60.1% of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in February 2019. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2017.

Note 13 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$47,134 and \$37,788 for the years ended December 31, 2015 and 2014. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2015 was approximately \$14,127,000.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 14 - Adoption of New Standard

As of January 1, 2015, the Healthcare System adopted GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* and GASB Statement No. 71 *Pension Transition for Contributions Made Subsequent to the Measurement Date*. The implementation of these standards requires governments calculate and report the cost and obligations associated with pensions in their financial statements, including additional note disclosures and required supplementary information. Beginning net position was restated to retroactively report the beginning net pension liability and deferred outflows and inflows of resources as follows:

	<u>Net Position</u>
Net Position January 1, 2015, as Previously Stated	<u>\$ 39,287,513</u>
Net Pension Liability at January 1, 2015	(26,337,250)
Deferred Outflows of Resources Related to Difference Between Projected and Actual Earnings on Pension Plan Investments	794,613
Deferred Inflows of Resources related to difference between Expected and Actual Experience	<u>(33,897)</u>
Restatement - Recognition of Net Pension Liability and Related Deferred Outflows and Inflows as of January 1, 2015	<u>(25,576,534)</u>
Net Position at January 1, 2015 as Restated	<u><u>\$ 13,710,979</u></u>



Required Supplementary Information
December 31, 2015 and 2014

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Net Pension Liability
Required Supplementary Information

**Schedule of the Medical Center's Net Pension Liability
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Total Pension Liability</u>	<u>Plan Net Position</u>	<u>Net Pension Liability</u>	<u>Plan Net Position as a % of Total Pension Liability</u>	<u>Covered Payroll</u>	<u>Net Pension Liability as a % of Covered Payroll</u>
2015	\$ 71,398,459	\$ 39,423,168	\$ 31,975,291	55.22%	\$ 24,384,165	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2016.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Changes in Net Pension Liability
Required Supplementary Information

Schedule of the Medical Center's Changes in Net Pension Liability

Last 10 Fiscal Years*

Fiscal year ending December 31,	<u>2015</u>
Total Pension Liability	
Service Cost	\$ 1,046,769
Interest on the Total Pension Liability	4,955,073
Benefit Changes	-
Difference between Expected and Actual Experience	2,005,318
Assumption Changes	-
Benefit Payments	<u>(4,305,902)</u>
Net Change in Total Pension Liability	3,701,258
Total Pension Liability - Beginning	<u>67,697,201</u>
 Total Pension Liability - Ending (a)	 <u><u>\$ 71,398,459</u></u>
Total Fiduciary Net Position	
Employer Contributions	\$ 3,760,071
Employee Contributions	-
Pension Plan Net Investment Income	(1,060,011)
Benefit Payments	(4,305,902)
Pension Plan Administrative Expense	-
Other	<u>(330,941)</u>
Net Change in Plan Fiduciary Net Position	(1,936,783)
Plan Fiduciary Net Position - Beginning	<u>41,359,951</u>
 Plan Fiduciary Net Position - Ending (b)	 <u><u>\$ 39,423,168</u></u>
 Net Pension Liability - Ending (a) - (b)	 <u><u>\$ 31,975,291</u></u>
 Plan Fiduciary Net Position as a Percentage of	
Total Pension Liability	55.22%
Covered Employee Payroll	\$ 24,384,165
Net Pension Liability as a Percentage of	
Covered Employee Payroll	131.13%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2016.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Schedule of Contributions
Required Supplementary Information

**Schedule of the Medical Center's Contributions
Last 10 Fiscal Years***

<u>FY Ending December 31,</u>	<u>Actuarially Determined Contribution</u>	<u>Actual Contribution</u>	<u>Contribution Deficiency (Excess)</u>	<u>Covered Payroll</u>	<u>Actual Contribution as a % of Covered Payroll</u>
2015	\$ 3,760,071	\$ 3,760,071	\$ -	\$ 24,384,165	15.42%

*Complete data for this schedule is not available prior to 2015.

Data reported is measured as of January 1, 2016.

Notes to Schedule of Contributions

Valuation Date: January 1, 2016
Notes Actuarial determined contribution rates are calculated as of January 1 which is 12 months prior to the beginning of the fiscal year in which contributions are reported.

Methods and Assumptions Used to Determine Contribution Rates:

Actuarial Cost Method:	Projected Unit Credit
Amortization Method:	Level Dollar, Closed
Remaining Amortization Period:	2010 ERIP: 1-year 2013 ERIP: 3 years Other: 17 years
Asset Valuation Method:	5-Year smoothed market; 25% corridor
Inflation:	1.5% for 2 years, 3.5% thereafter
Salary Increases:	5.3% - 0.0% plus inflation
Investment Rate of Return:	7.5%
Retirement Age:	Experience-based table of rates that are specific to the type of eligibility condition.
Mortality:	The mortality table used is 100% of the RP 2000 Mortality Table for males and females projected 15 years from base year 2000 to year 2015 with scale AA. The base table is projected to the valuation date and the provision for future mortality improvement is 3 years of additional projection with scale AA.

Other Information:

Notes There were no benefit changes during the year.



Financial Statements

December 31, 2014 and 2013

Dickinson County Healthcare System

(A Component Unit of Dickinson County)

Iron Mountain, Michigan

Dickinson County Healthcare System

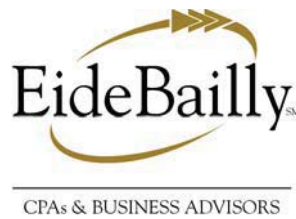
Table of Contents

December 31, 2014 and 2013

Independent Auditor's Report.....	1

Financial Statements

Statements of Net Position	18
Statements of Revenues, Expenses, and Changes in Net Position	19
Statements of Cash Flows	20
Notes to Financial Statements	22



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County), which comprise the statements of net position as of December 31, 2014 and 2013, and the related statements of revenues, expenses, and changes in net position 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's 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.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2014 and 2013, and the results of its operations, changes in net position, and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 3 through 17 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated April 29, 2015 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

A handwritten signature in black ink that reads "Eide Bailly LLP". The signature is written in a cursive, flowing style.

Fargo, North Dakota
April 29, 2015

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2014, 2013, and 2012. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2014

The Healthcare System's net position increased in 2014 by \$4.836 million or 14.0% with revenues before capital contributions of \$4.796 million, comprised of an operating income of \$4.929 million and nonoperating expenses in excess of nonoperating revenue of \$133 thousand. There were \$40 thousand contributions for capital purposes in 2014. During 2014, the Healthcare System's total operating revenues of \$95.737 million was 6.6% higher than the amount in 2013. The resulting operating income for 2014 of \$4.929 million was 5.1% of total operating revenue compared to an operating income of \$41 thousand for 2013 which was 0.05% of operating revenue.

The following major projects and service enhancements were completed in 2014. 2014 has been a year like none other for DCHS as evidenced by the following accomplishments and recognitions received by the Healthcare System:

- Ranked 5th out of 142 hospitals in the State of Michigan by Consumer Reports in the areas of patient safety, patient outcomes, patient experience, and hospital practices - over 4,000 hospitals nationwide were compared.
- Received two Governor's Awards for Excellence - the *Inpatient Clinical Achievement Award* and the *Healthcare Associated Infection Prevention Award*.
- Received a National Safety score of "A" from the Leapfrog Group for the fifth consecutive six-month reporting period.
- Received official recognition from the Michigan State Legislature & Governor Snyder for the above accomplishments.
- Received recognition from The Joint Commission as a *Top Performer on Key Quality Measures* specifically in the areas of Pneumonia Treatment and Surgical Care.
- Michigan Works! and the Dickinson Area Chamber Alliance awarded Dickinson County Healthcare System with the *Large Business of the Year Award* for 2014.
- The Upper Peninsula Economic Development Alliance awarded Dickinson County Healthcare System their "Award of Excellence" for 2014 – 2015.
- Acquired Dr. Morel's Medical Oncology Practice from Marquette General Hospital.

- Successfully recruited five new physicians for its Medical Staff in the past year, which has allowed for the expansion of healthcare services within the region. They include the following:
 - o Joel Johnson, MD – Vascular Surgeon
 - o Breion Tafoya, MD – Pulmonologist
 - o Kevin Diehl, DO – Radiologist
 - o David Timm, MD – Radiologist
 - o Jeffrey Kreyer, MD – General Surgeon
- Employee Cindy Yelich, RN received national recognition by the American Association of Diabetes Educators as Diabetes Educator of the Year in the State of Michigan.
- Completed Meaningful Use Stage 1, year 2 reporting period successfully and received 2nd incentive payment for the hospital and a number of providers. Also implemented solutions to meet Stage 2 requirements. (Patient Portal IP, Patient Portal ED, Direct Messaging, Truven Pat Education, Rules Engine for Clinician Alerts, Paragon Connect, Paragon Audit Server, Paragon Quality eMeasures). Began Stage 2 reporting period on October 1, 2014 and it runs for 365 days (9/30/2015) before we can attest and receive our next incentive payment.
- Implemented the Vocera nurse communication system to improve communications throughout the organization.

Year Ended December 31, 2013

The Healthcare System's net position decreased in 2013 by \$1.501 million or 4.2% with losses before capital contributions and deferred financing cost adjustment of \$1.526 million, comprised of an operating income of \$41 thousand and nonoperating expenses in excess of nonoperating revenue of \$1.567 million. There were \$25 thousand contributions for capital purposes in 2013. During 2013, the Healthcare System's total operating revenues of \$89.8 million was 6.5% higher than the amount in 2012. The resulting operating income for 2013 of \$41 thousand was 0.05% of total operating revenue compared to an operating income of \$865 thousand for 2012 which was 1.0% of operating revenue.

The following major projects and service enhancements were completed in 2013:

- The Healthcare System expanded participation in the 340B program by entering into retail pharmacy agreements with two local retail pharmacies.
- Providers added include the following: Dr. Cameron – Ears, Nose and Throat, Dr. Venditti – Orthopedics and Dr. Cook – Gynecology.
- Offered an early retirement window, along with implementing volume related staffing changes and completing successful contract negotiations with both the Michigan Nurses Association and American Federation of State, County and Municipal Employee union.
- Became an affiliate member of St. Joseph's Hospital Med Assets purchasing network along with the renegotiation of several standalone purchasing contracts.
- Began outsourcing laundry services as well as transitioning the lifeline program to Phillips Lifeline.

- New electronic medical record (EMR) technology was implemented in the Emergency Department (ED) and After Hours Clinic. Triage renovations were also completed to give those patients entering the ED a better understanding of the triage process and flow. The expanded triage area also allows those who are wheelchair bound a more comfortable process.
- In order to prepare for electronic results reporting and EMR interface, Cardiac Diagnostics purchased new equipment including electrocardiographs and treadmills for stress tests. This allows a more efficient ordering process and will eventually be 100% electronic.
- Completed Meaningful Use Stage 1, year 1 reporting period successfully and received 1st incentive payment for hospital and a number of our providers. Also implemented Physician Documentation system for inpatients, live in January 2014. This is necessary to meet the requirements of future stages of meaningful use.
- The separate central nurse stations in the medical and surgical units were combined into one central location as a response to declining inpatient volumes. Processes were implemented to assure this change had no detrimental effect on patient care.
- Purchased a Visera Pro Laryngoscope which allows physicians to have better clarity when assessing patients. The equipment also has video and picture taking capabilities to easily compare pre and post procedure analysis, and is smaller in size making it much easier for physicians to use.
- The Dickinson Ear, Nose & Throat Clinic introduced **Real-Ear technology** to its audiology services. *Real-Ear* technology is currently the most accurate measurement equipment in the field of hearing aids. It allows for a recording of the hearing aid output directly at the patient's ear drum. When the exact output of the hearing in the patient's ear is known, corrections can be made in the manufacturer's software to ensure that the hearing aid prescription exactly matches the hearing loss. With *Real-Ear* measurement, each patient's specific individual ear canal resonance and physical properties are taken into account rather than relying on average calculated data. Patient satisfaction with hearing aids increases, and the incidence of returned hearing aids has reduced dramatically.
- Dickinson Home Health began a **Hospital to Home program** in collaboration with Dickinson Memorial Hospital's nursing units. The new program provides one free follow-up home visit to at-risk, non-homebound patients in order to provide a successful transition from hospital to home. A home health nurse focuses on medication reconciliation, home safety and community referrals as needed.
- Attained an "A" rating from the Leapfrog Group - Again
The Leapfrog Group, an independent national nonprofit organization, again awarded Dickinson Memorial Hospital a grade of A and congratulated hospital staff for their "commitment to patient safety and for making critical safety information available to healthcare consumers through participation in national performance measurement and public-reporting programs." The Leapfrog Group calculates a single safety score, based upon 26 measures of publicly available hospital safety data, which represents a hospital's overall capacity to keep patients safe from infections, injuries, and medical and medication errors.

- The **Radiation Oncology Center at Dickinson Memorial Hospital received national accreditation**, an accomplishment that places it in an elite group of only 11 centers in the state of Michigan to do so. There are only 12 accredited centers in Wisconsin; Appleton being the closest one. National accreditation assures patients that the radiation treatments they receive locally meet the most stringent of national standards for safety and quality.
- The September 2013 issue of Consumer Reports magazine rated Dickinson Memorial Hospital as one of the better hospitals to choose when surgery was needed. Dickinson was one of 17 hospitals in the State of Michigan to receive an above average rating. The study was based upon a review of Medicare claims and clinical data for nearly 2,500 hospitals across the country for 27 kinds of surgeries combined – large and small hospitals in each state were compared.

Year Ended December 31, 2012

The Healthcare System's net position increased in 2012 by \$1.689 million or 4.9% with losses before capital contributions and forward purchase agreement adjustment of (\$154) thousand, comprised of an operating income of \$865 thousand and nonoperating expenses in excess of nonoperating revenue of \$1.019 million. There were \$186 thousand contributions for capital purposes in 2012. As a result of a change in the method of recording the forward purchase agreement, an unrealized gain of \$1.657 million was recorded in 2012 for prior years. During 2012, the Healthcare System's total operating revenues of \$84.3 million was 10.1% higher than the amount in 2011. The resulting operating income for 2012 of \$865 thousand was 1.0% of total operating revenue compared to an operating loss of \$1.034 million for 2011 which was (1.4%) of operating revenue.

The following major projects and service enhancements were completed in 2012:

- The Healthcare System expanded participation in the 340B program by entering into retail pharmacy agreements with three local retail pharmacies. In addition, 2012 was the first full year of hospital outpatient drug cost savings.
- Providers added include the following: Dr. Shaker – Cardiology and Dr. Scott – Urology.
- New medical record technology was implemented throughout the patient care units in Dickinson Memorial Hospital. These included Medication Administration and Computerized Physician Order Entry which are necessary to meet Stage 1 Meaningful Use requirements.
- Installed the Practice Partner Electronic Health Record at Dickinson Cardiology Services, UP Sleep Disorders Center, Dickinson Internal Medicine Clinic, Dickinson Podiatry Services, Dickinson OB/GYN Clinic.
- Installed the following systems/modules: OB Fetal Monitoring, Dietary Room Service, Wound Care, EEG system, Public Wireless Network, and OR Tracking Board
- Upgraded the following systems: Paragon (4 times), Practice Partner, Lawson LBI, Lawson Applications, McKesson Document Interface, Single Sign On, Cactus – Physician Credentialing, Intellicode, eMail Encryption, Misys/Tiger (2 times), EC2000, Pathways Compliance Advisor, and Pathways Contract Management.

- Networked the following new clinics: Wound Care, Urology, Bellin, Cardiology – Marquette, Cardiology – Iron River, UP Sleep Disorder, and Dickinson Medical Services at Bayside
- Interfaces developed include results to MGHS Practice Partner, results to Michigan-Wisconsin Family Practice Associates PC eMDs, radiology billing, dietary system orders/ADT's, and Misys/Tiger financial interface.
- A new CT scanner was installed that contains a flash CT mode which allows split second scanning with a 60% dose reduction. The dual source CT enables early detection of calcification in cardiac arteries and the dual energy CT determines the chemical composition of kidney stones. It also contains an industry leading bariatric option for patients up to 660 pounds.
- Radiation Oncology Technology was upgraded to Rapid Arc which provides greater treatment accuracy and greater patient comfort. The hardware upgrade to the linear accelerator enables finer shaping of the radiation beam for more precise treatment of cancer cells while preserving healthy tissue.
- The Dickinson Pediatric Clinic added concussion management, providing ImPACT testing. Baseline tests were provided to children in grades 5-8 thanks to a donation from Dickinson Memorial Hospital Foundation. Pediatric Neurology services were also added through telehealth appointments with Dr. Arndt of Helen DeVos Children's Hospital in Grand Rapids. He is a noted specialist in children's seizure disorders. Pediatric Nephrology services were also added through quarterly visits by Dr. Haws from the Marshfield Clinic.
- Services were expanded into Delta County, at Cedar Hill-Bayside Clinic in Gladstone. These services include Podiatry and Dermatology.
- A surgical tracking system was developed and implemented whereby patients undergoing a surgical procedure are assigned a number that is shared with family members. The number is displayed on computer screens located in the Surgical Lounge and Cafeteria showing the different stages of the surgical process for each patient. This enables family members to track their loved one's progress.
- The Healthcare System's Laboratory and Imaging services were added to the Bellin Clinic on Woodward Avenue.
- The following Physician Practices attained designation as provider based clinics: Dickinson Cardiology Services, Dickinson Podiatry Services, Dickinson Dermatology Services and Barry D. Johnson, MD Neurology Clinic.

- The Dietary department became Food and Nutrition Services and launched the new Room Service program. The kitchen was revamped from its emphasis on bulk cooking to short order meal preparation. The patient can eat whatever they like whenever they like by ordering their meals from a designated anytime within a 12 hour time frame. Patient satisfaction scores climbed from the 30th to the 98th percentile with temperature and quality of food ranked in the 99th percentile.
- The Healthcare System attained an “A” rating from the Leapfrog Group, an independent national non-profit organization. They calculate a single safety score, based upon 26 measures of publicly available hospital safety data, which represents a hospital’s overall capacity to keep patients safe from infections, injuries, and medical and medication errors.
- Construction was completed on the new medical office building on the west side of the hospital campus for the relocation of the Dickinson Occupational Clinic and the expansion of the wound care program to become The Center for Wound Healing and Hyperbaric Medicine. The Dickinson Pediatric Clinic was also expanded to twice its former size to add a telehealth room and an ImPACT testing room.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Statement of Net Position includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all nonoperating revenue and expense items, capital contributions and the net increase in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Financial Analysis of the System

The condensed statements of net position of the Healthcare System as of December 31, 2014, 2013, and 2012 are summarized in the following table.

Condensed Statements of Net Position
December 31, 2014, 2013, and 2012 (in Thousands)

	2014	2013	2012
Total current assets (includes the current portion of restricted assets)	\$ 34,300	\$ 24,739	\$ 23,530
Cash and investments internally designated for other purposes	3,508	5,228	8,424
Cash and investments restricted by bond indentures	1,726	1,806	1,878
Other Assets	-	-	736
Capital assets, net	37,344	39,215	41,373
Total Assets	76,878	70,988	75,941
Total Deferred Outflows of Resources	898	1,062	1,237
Total Assets and Deferred Outflows	\$ 77,776	\$ 72,050	\$ 77,178
Total current liabilities	\$ 14,914	\$ 12,012	\$ 13,032
Long-term debt, net of current portion	22,866	24,932	26,857
Other long-term liabilities	708	654	1,336
Total Liabilities	38,488	37,598	41,225
Total Net Position	39,288	34,452	35,953
Total Liabilities and Net Position	\$ 77,776	\$ 72,050	\$ 77,178

Current Assets and Liabilities

Net patient accounts receivable decreased to 53 days' of net revenue at December 31, 2014 compared to 55 days' of net revenue at December 31, 2013 and compared to 47 days' of net revenue at December 31, 2012. The 2014 decrease can be attributed to the development of the Patient Financial Counselor position, which helped patients with high deductible health plans or no insurance to meet their financial obligations. The 2013 increase was the result of a delay in certification of a new Independent Diagnostic Testing Facility and an Independent Laboratory as well as the start up of several new specialty physician practices and the inability to maintain a full complement of billing staff.

Total current assets increased 38.7% in 2014 and increased 5.1% in 2013 compared to each prior year. The 2014 increase is primarily due to an increase in cash and cash equivalents, estimated third party settlements, and supplies and other current assets while the 2013 increase is primarily due to an increase in patient accounts receivable.

Current liabilities increased 24.2% in 2014 as a result of the increase in compensated absences and accounts payable while current liabilities decreased 7.8% in 2013 as a result of a reduction in trade accounts payable and estimated third-party settlements. The Healthcare System's current ratio (current assets divided by current liabilities) was 2.30 at December 31, 2014 and 2.06 at December 31, 2013.

Total Cash and Investments

The number of days of total cash and investments was 67.5 at December 31, 2014 and 51.8 at December 31, 2013. Excluding the restricted amounts, the ratios for 2014 and 2013 were 52.8 days and 38.1 days, respectively.

The total cash and investments at December 31, 2014 were \$17.2 million including restricted funds of \$3.5 million. Total cash and investments at December 31, 2013 were \$13.2 million including restricted funds of \$3.5 million.

Long-Term Debt

The Healthcare System had long-term debt of \$22.9 million at December 31, 2014 and \$24.9 million at December 31, 2013 (net of current maturities of \$2.1 million in 2014 and \$2.6 million in 2013). In 2013, a land contract was entered into to purchase a physician office suite in the Dickinson Medical Building. Long-term debt at December 31, 2014 represents 97.0% of total long-term liabilities and 59.4% of total liabilities as compared to 97.4% of total long-term liabilities and 66.3% of total liabilities at December 31, 2013. The debt service coverage ratio for the years ended December 31, 2014 and 2013 was 2.67 and 1.45 respectively.

Net Position

Total net position increased in 2014 and decreased in 2013. Likewise, unrestricted net position increased from 2013 to 2014 and decreased from 2012 to 2013. The increase in the unrestricted component for 2014 was a result of the profitability of the Healthcare System. The decrease in the unrestricted component for 2013 on the other hand, was due to the unfavorable financial results of the Healthcare System in that year. The amount invested in capital assets, net of related debt remained constant in both years as the Healthcare System made capital purchases only for those items required by HITECH and for equipment that was no longer usable. The restricted amount for debt service represents the funds held by the trustee for the Series 1999 bonds. This amount has remained constant over the two year period. These components are presented in the following table.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

Components of Net Position (in thousands)

	December 31,		
	2014	2013	2012
Invested in capital assets, net of related debt Restricted by revenue bond indentures, expendable for debt service	\$ 13,297	\$ 12,725	\$ 13,332
Unrestricted	3,463	3,462	3,456
	<u>22,528</u>	<u>18,265</u>	<u>19,165</u>
Total net position	<u>\$ 39,288</u>	<u>\$ 34,452</u>	<u>\$ 35,953</u>

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2014, 2013, and 2012 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2014, 2013, and 2012 (in Thousands)

	2014		2013		2012	
Revenue and (expenses):						
Net patient service revenue	\$ 86,772	90.6%	\$ 77,904	86.8%	\$ 77,801	92.3%
Other revenue	8,965	9.4%	11,868	13.2%	6,469	7.7%
Total operating revenue	<u>95,737</u>	100.0%	<u>89,772</u>	100.0%	<u>84,270</u>	100.0%
Total operating expenses	<u>90,808</u>	94.9%	<u>89,731</u>	100.0%	<u>83,405</u>	99.0%
Operating income	<u>4,929</u>	5.1%	<u>41</u>	0.0%	<u>865</u>	1.0%
Investment income	340	0.4%	386	0.4%	681	0.8%
Change in unrealized gains and losses on investments	40	0.0%	(192)	-0.2%	7	0.0%
Change in fair market value of forward purchase agreement	252	0.3%	(627)	-0.7%	(13)	0.0%
Interest and amortization expense	(1,622)	-1.7%	(1,697)	-1.9%	(1,719)	-2.0%
Other non-operating revenue and expenses (net)	<u>857</u>	0.9%	<u>563</u>	0.6%	<u>25</u>	0.0%
Non-operating expenses in excess of revenue	<u>(133)</u>	-0.1%	<u>(1,567)</u>	-1.7%	<u>(1,019)</u>	-1.2%
Income (loss) before capital contributions	<u>4,796</u>	<u>5.0%</u>	<u>(1,526)</u>	<u>-1.7%</u>	<u>(154)</u>	<u>-0.2%</u>
Forward purchase agreement adjust	-		-		1,657	
Capital contributions	<u>40</u>		<u>25</u>		<u>186</u>	
Increase (decrease) in net position	<u>4,836</u>		<u>(1,501)</u>		<u>1,689</u>	
Net position - beginning of year	<u>34,452</u>		<u>35,953</u>		<u>34,264</u>	
Net position - end of year	<u>\$ 39,288</u>		<u>\$ 34,452</u>		<u>\$ 35,953</u>	

Results of Operations

Overall results of operations of \$4.929 million or 5.1% of revenue for 2014 increased from \$41 thousand or 0.05% of revenue for 2013. The net nonoperating expenses in excess of nonoperating revenue for 2014 decreased to \$133 thousand from \$1.567 million in 2013. The net decrease in 2014 was due to improvement in the market value of the forward purchase agreement and other investments. The net increase in 2013 was due to the change in unrealized gains and losses on investments and the change in fair market value of the forward purchase agreement. The net result for 2014 was income of \$4.796 million or 5.0% of total operating revenue before capital contributions. The net result for 2013 was a loss of (\$1.526) million or (1.7%) of total operating revenue before capital contributions.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2014 comprised 33.7% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2013 was 31.4%. The operating performance of DCMH was affected by inpatient discharges increasing by 7.1% to 3,286 from 3,069 in 2013, while acute adult and pediatric inpatient days also increased by 7.1% to 11,383 from 10,624 in 2013. Net inpatient revenue increased 19.7% and the all-payer case mix index increased to 1.342 from 1.153 in 2013. Discharges decreased 4.7% in 2013 while net inpatient revenue decreased 6.7%.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 52.5% of total Healthcare System net patient revenue and its operating activities for 2014. The comparable percentage for 2013 was 54.8%. Net outpatient revenue increased 6.6% in 2014 and decreased 1.5% in 2013. Total outpatient visits were 179,516 in 2014 and 176,165 in 2013. As a percent, the largest increase in outpatient visits was seen in laboratory, imaging and day surgeries.

The net patient revenue of the Rural Health Clinics (RHC's) and other Provider Based RHC's comprised about 13.8% of the total net patient revenue of the Healthcare System for 2014 and 2013. The revenue growth was 11.4% in 2014 and 30.3% in 2013 as a result of converting the remaining free standing clinics to either RHC's or Provider Based RHC's. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute losses on operations. There are two facilities in northeast Wisconsin and twelve off-campus practices in Michigan in addition to eleven practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from health care services, and nonoperating revenue, which is principally from investment income.

Operating Revenue

Total gross revenues for all patient services performed by the Healthcare System were \$259 million in 2014 and \$225 million in 2013. The overall increase reflects the year-to-year difference in patient volumes, service mix changes and annual price increases. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care and other free care services measured as unpaid gross revenues of 1.3% in 2014 and 1.2% in 2013 to patients who documented their inability to pay. Bad debt provisions were 2.3% of gross revenue in 2014 and 3.0% in 2013. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 63.0% in 2014 and 61.2% in 2013.

The resulting net patient services revenue was 33.5% of gross revenue in 2014 and 34.6% in 2013. Net patient service revenue increased \$8.868 million or 11.4% in 2014 as a result of an increase in patient volumes and case mix index as well as a more favorable payer mix. Net patient services revenue was flat in 2013.

Other operating revenue decreased \$2.9 million or 24.5% from 2013 to 2014 as a result of a reduction in Electronic Health Record incentive payments in year two of implementation as well as some reduction in 340B retail pharmacy program revenue. Other operating revenue increased \$5.4 million or 83.5% from 2012 to 2013. Accounting for \$3.7 million of that total were new revenues generated as a result of the 340B retail pharmacy program implemented at the beginning of 2012. In addition, the Healthcare System met criteria to record \$2.2 million in Medicare and Medicaid incentive payments for Electronic Health Records.

Nonoperating Revenue

Investment income remained flat at \$340 thousand for 2014 and \$386 thousand for 2013 due to weak interest rates. The change in unrealized gains and losses on investments was \$40 thousand in 2014 and (\$192) thousand in 2013.

Capital Contributions

There were \$40 thousand in capital contributions in 2014 for pediatric room renovations, infusion chairs and equipment for the mock code blue program and \$25 thousand in capital contributions in 2013 for OB/GYN equipment.

Forward Purchase Agreement

There has been a change in Generally Accepted Accounting Principles over time as it relates to the recording of these types of transactions. While the Financial Accounting Standards Board (FASB) has required that Forward Purchase Agreements be recorded at fair market value, the Governmental Accounting Standards Board (GASB) has just recently issued codification clarifying that FASB must be followed for governmental units as well. Therefore, at December 31, 2012 an adjustment of \$1.657 million was made to reflect the net increase in the market value from inception through December 31, 2011. The decrease in market value of \$13 thousand for 2012 was recorded as a nonoperating expense and is included in the loss before capital contributions. An additional decrease in market value of \$627 thousand was recorded in 2013 and an increase in market value of \$252 thousand was recorded in 2014.

Expenditure of Funds

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2014 and 2013 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2014 and 2013 (in Thousands)

	2014	2013	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 52,985	\$ 52,561	\$ 424	0.8%
Supplies and pharmaceuticals	13,316	12,732	584	4.6%
Professional fees and other purchased services	19,584	19,400	184	0.9%
Depreciation and amortization	4,923	5,038	(115)	-2.3%
Total	<u>\$ 90,808</u>	<u>\$ 89,731</u>	<u>\$ 1,077</u>	<u>1.2%</u>

Employee compensation and benefits increased \$424 thousand or 0.8%. The annual average total paid full-time equivalent (FTE) positions of 671.3 for 2014 increased by 0.6% from the 2013 amount of 667.0. Pension expense increased by \$157 thousand or 3.9% but health insurance expense decreased by \$1.074 million or 19.4% due to changes in plan design.

The cost of supplies and pharmaceuticals increased \$584 thousand or 4.6%, related to an increase in operating room cases of 162 or 5.7%. Specifically, orthopedic cases increased by 83 or 9.4% from 2013 to 2014 which resulted in increased orthopedic supply costs.

Professional fees, purchased services and other expenses for 2014 increased \$184 thousand or 0.9%. This was mainly the result of higher fees for hardware maintenance contracts, dues and subscriptions, repairs and minor equipment. Depreciation and amortization expense for 2014 decreased \$115 thousand or 2.3%, principally due to several assets reaching the end of their useful life.

The components of operating expenses for the Healthcare System for the years ended December 31, 2013 and 2012 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2013 and 2012 (in Thousands)

	2013	2012	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 52,561	\$ 49,782	\$ 2,779	5.6%
Supplies and pharmaceuticals	12,732	11,434	1,298	11.4%
Professional fees and other purchased services	19,400	17,518	1,882	10.7%
Depreciation and amortization	5,038	4,671	367	7.9%
Total	<u>\$ 89,731</u>	<u>\$ 83,405</u>	<u>\$ 6,326</u>	<u>7.6%</u>

Employee compensation and benefits increased \$2.779 million or 5.6%. The annual average total paid full-time equivalent (FTE) positions of 667.0 for 2013 increased by 1.9% from the 2012 amount of 654.7. The cost of supplies and pharmaceuticals increased \$1.298 million or 11.4%, related to 340B retail pharmacy activity. As well, orthopedic cases increased by 97 or 12.4% from 2012 to 2013 which resulted in increased orthopedic supply costs.

Professional fees, purchased services and other expenses for 2013 increased \$1.882 million or 10.7%. This was mainly the result of higher fees for hospitalist services, a new ENT practice and 340B retail pharmacy dispensing fees. Depreciation and amortization expense for 2013 increased \$367 thousand or 7.9%, principally due to the full year effect of the prior year's capital purchases.

Nonoperating Expense Items

Interest expense was \$1.6 million in 2014 and \$1.7 million in 2013. The Healthcare System capitalized interest expense amounts of \$54 thousand in 2014 and \$76 thousand in 2013.

Capital Expenditures

Fiscal Year 2014

Total capital spending increased slightly in 2014 from 2013 levels. Major projects included the following: Meaningful use and other information technology initiatives - \$1.329 million, real estate - \$537 thousand, x ray system - \$355 thousand, various remodel projects - \$104 thousand, vehicles - \$82 thousand.

Fiscal Year 2013

Total capital spending decreased in 2013 from 2012 levels. Major projects included the following: Purchase of two suites in the Dickinson Medical Building - \$1.278 million; T System electronic medical record in the Emergency Department and After Hours Clinic - \$451 thousand; additional HVAC system in computer room - \$134 thousand; Quality eMeasures and other meaningful use initiatives - \$231 thousand.

Fiscal Year 2012

Total capital spending increased significantly in 2012 after several years of limited spending. Major projects included the following: CT Scanner & renovations - \$2.1 million; MRT Rapid Arc Upgrade - \$913 thousand; Wound Care / DOC Building - \$575 thousand (\$601 thousand spent in 2011 for total spending of \$1.2 million); Pediatric Clinic Renovation - \$316 thousand; purchase of Dickinson Medical Building suite - \$266 thousand; Diagnostic Lab & Imaging Equipment for Bellin Clinic - \$306 thousand; Dietary Conversion to Room Service - \$236 thousand; X-ray Suite 100 - \$210 thousand; Portable X-ray Machine - \$185 thousand; Purchase of regular & portable C-Arm - \$172 thousand; new Home Health Building - \$154 thousand; and Urology Practice equipment & furnishings - \$108 thousand.

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The Current Budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Management's Discussion and Analysis

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2014 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 89,321	\$ 6,416	7.2%
Total operating expenses	(89,509)	(1,299)	-1.5%
Operating income	(188)	5,117	-2721.8%
Net nonoperating revenue and gains, (expenses and losses)	(336)	203	60.4%
Income before capital contributions	(524)	5,320	-1015.3%
Capital contributions	26	14	53.8%
Increase in net position	\$ (498)	\$ 5,334	-1071.1%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were unfavorable by approximately 9.5%, while total hospital outpatient visits were favorable by approximately 0.3%. However, the total visit variance was net of favorable variances of 5.6% in outpatient surgeries, 4.7% in observation patients and 1.9% for all other outpatient visits and unfavorable variances of 21% for radiation therapy services, 2.5% for emergency department visits and 1.7% in physical therapy and other recurring series visits. Expenses were unfavorable to budget by \$1.299 million or 1.5% mainly as a result of increased salary and wage expense. FTE's were 3.3% over budget partly as a result of the start up of two new employed physician practices. The variance in other net nonoperating items was caused principally by a significant unbudgeted unrealized gain on investments.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2014, 2013, and 2012 (in Thousands)

	2014	2013	2012
Budget	\$ 4,211	\$ 8,425	\$ 8,277
Actual	3,014	2,817	5,484
Variance	\$ 1,197	\$ 5,608	\$ 2,793
Variance %	28.4%	66.6%	33.7%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. The variance in 2012 and 2013 was due to management's actions to limit capital spending by eliminating or deferring several budgeted projects including a new medical office building on the east side of campus and phase 2 of an energy project. However, in 2014 as a result of operations, projects that could be justified with a return on investment were again initiated. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

Service volumes and payor mix rebounded in 2014 after being adversely affected by economic conditions in 2013. Uncompensated care with bad debt and charity write-offs totaled 3.5% of gross charges in 2014 while uncompensated care with bad debt and charity write-offs totaled 4.2% of gross charges in 2013. In February 2015, the most recent data available, the unemployment rate in Dickinson County was 5.9% compared to 7.7% over the entire Upper Peninsula and 5.9% for the State of Michigan. The same statistics for February 2014 were 8.5%, 10.6% and 7.8%, respectively.

Not unlike other areas of the country, the Upper Peninsula saw several healthcare system acquisitions in 2012. Marquette General Healthcare System was acquired by Duke LifePoint while Bell Memorial Hospital signed a letter of intent to be acquired by LifePoint Hospitals and Portage Health signed a letter of intent to form a joint venture with LifePoint Hospitals. Both the Bell Memorial Hospital and Portage Health transactions were completed in 2013. In 2014, Northstar Health System in Iron River, MI became part of the Aspirus Health System. Also, in 2014, the Healthcare System engaged Newpoint Healthcare Advisors to assist in determining what strategic partnerships may be beneficial to our community. That engagement is ongoing.

(This page left blank intentionally.)

	<u>2014</u>	<u>2013</u>
Assets and Deferred Outflows of Resources		
Current Assets		
Cash and cash equivalents	\$ 9,734,000	\$ 3,874,909
Short-term investments	517,121	632,017
Current portion of restricted assets	1,737,268	1,656,043
Receivables		
Patient, net of estimated uncollectibles of		
\$4,026,000 in 2014 and \$3,192,000 in 2013	13,474,346	12,757,177
Estimated third-party settlements	2,208,385	-
Other	3,048,002	3,490,297
Supplies and other current assets	3,580,520	2,328,505
	<u>34,299,642</u>	<u>24,738,948</u>
Total current assets		
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	1,726,034	1,806,026
Other long-term investments	3,508,320	5,228,202
	<u>5,234,354</u>	<u>7,034,228</u>
Total noncurrent cash and investments		
Capital Assets		
Capital assets not being depreciated	2,497,634	2,402,976
Depreciable capital assets, net of accumulated depreciation	34,846,349	36,811,539
	<u>37,343,983</u>	<u>39,214,515</u>
Total capital assets		
Total assets	<u>76,877,979</u>	<u>70,987,691</u>
Deferred Outflows of Resources on Refunding	<u>897,777</u>	<u>1,062,201</u>
Total assets and deferred outflows	<u>\$ 77,775,756</u>	<u>\$ 72,049,892</u>

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Net Position
December 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Liabilities and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 2,079,304	\$ 2,620,474
Accounts payable		
Trade	6,126,690	2,973,575
Estimated third-party payor settlements	-	543,284
Accrued expenses		
Salaries, wages, and related liabilities	1,569,334	1,271,393
Compensated absences	4,494,387	3,838,981
Other accrued liabilities	451,702	555,431
Interest	192,268	209,194
	<u>14,913,685</u>	<u>12,012,332</u>
Total current liabilities		
	<u>14,913,685</u>	<u>12,012,332</u>
Long-Term Liabilities		
Long-term debt, less current maturities	22,866,558	24,931,624
Reserve for loss on general and professional liabilities claims	708,000	654,000
	<u>23,574,558</u>	<u>25,585,624</u>
Total long-term liabilities		
	<u>23,574,558</u>	<u>25,585,624</u>
Total liabilities	<u>38,488,243</u>	<u>37,597,956</u>
	<u>38,488,243</u>	<u>37,597,956</u>
Net Position		
Invested in capital assets, net of related debt	13,295,898	12,724,618
Restricted - expendable for debt service	3,463,302	3,462,069
Unrestricted	22,528,313	18,265,249
	<u>39,287,513</u>	<u>34,451,936</u>
Total net position		
	<u>39,287,513</u>	<u>34,451,936</u>
Total liabilities and net position	<u>\$ 77,775,756</u>	<u>\$ 72,049,892</u>
	<u>\$ 77,775,756</u>	<u>\$ 72,049,892</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$5,818,017 in 2014 and \$6,768,497 in 2013	\$ 86,772,084	\$ 77,903,888
Supplies and 340b program revenue	5,378,057	7,411,568
Electronic health record incentive revenue	1,330,083	2,158,332
Other revenue	<u>2,257,116</u>	<u>2,298,159</u>
Total operating revenues	<u>95,737,340</u>	<u>89,771,947</u>
Operating Expenses		
Salaries and wages	40,445,741	39,644,298
Employee benefits	12,539,508	12,916,847
Supplies and pharmaceuticals	13,315,544	12,732,302
Medical and other professional fees	6,954,706	7,170,851
Purchased services and other	12,629,618	12,228,682
Depreciation	<u>4,922,810</u>	<u>5,037,963</u>
Total operating expenses	<u>90,807,927</u>	<u>89,730,943</u>
Operating Income	<u>4,929,413</u>	<u>41,004</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	859,658	568,439
Interest and amortization expense	(1,622,856)	(1,697,190)
Loss on disposal of capital assets	(2,778)	(5,031)
Investment income	340,006	385,584
Change in fair market value of forward purchase agreement	251,980	(627,234)
Change in unrealized gains and losses on investments	<u>40,336</u>	<u>(191,747)</u>
Nonoperating revenues (expenses), net	<u>(133,654)</u>	<u>(1,567,179)</u>
Revenues in Excess of (Less Than) Expenses Before Capital Contributions	4,795,759	(1,526,175)
Capital Contributions	<u>39,818</u>	<u>25,000</u>
Increase (Decrease) in Net Position	4,835,577	(1,501,175)
Net Position, Beginning of Year	<u>34,451,936</u>	<u>35,953,111</u>
Net Position, End of Year	<u><u>\$ 39,287,513</u></u>	<u><u>\$ 34,451,936</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 83,303,246	\$ 75,400,596
Payments from suppliers and contractors	(31,048,497)	(33,329,441)
Payments to employees	(52,031,902)	(52,226,964)
Other receipts	<u>9,407,551</u>	<u>11,120,445</u>
Net Cash From Operating Activities	<u>9,630,398</u>	<u>964,636</u>
Noncapital Financing Activity		
Unrestricted general contributions	<u>859,658</u>	<u>568,439</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(3,014,258)	(2,817,399)
Repayment of long-term debt	(2,620,473)	(2,561,133)
Interest paid, including capitalized interest	(1,512,919)	(1,598,717)
Capital contributions	39,818	25,000
Proceeds from the sale of capital assets	11,000	9,200
Proceeds from the issuance of long term debt	<u>-</u>	<u>819,902</u>
Net Capital Related Financing Activities	<u>(7,096,832)</u>	<u>(6,123,147)</u>
Investing Activities		
Purchases of investments	(13,452,724)	(6,423,935)
Proceeds from sales and maturities of investments	15,578,357	11,673,716
Investment income	<u>340,006</u>	<u>385,584</u>
Net Cash From Investing Activities	<u>2,465,639</u>	<u>5,635,365</u>
Net Increase in Cash and Cash Equivalents	5,858,863	1,045,293
Cash and Cash Equivalents, Beginning of Year	<u>4,102,224</u>	<u>3,056,931</u>
Cash and Cash Equivalents, End of Year	<u>\$ 9,961,087</u>	<u>\$ 4,102,224</u>
Reconciliation of Cash and Cash Equivalents		
to Cash and cash equivalents in current assets	\$ 9,734,000	\$ 3,874,909
Cash and cash equivalents in noncurrent cash and investments	<u>227,087</u>	<u>227,315</u>
Total cash and cash equivalents	<u>\$ 9,961,087</u>	<u>\$ 4,102,224</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income	\$ 4,929,413	\$ 41,004
Adjustments to reconcile operating income to net cash flows from operating activities		
Depreciation	4,922,810	5,037,963
Provision for bad debts	5,818,017	6,768,497
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(6,535,186)	(8,600,961)
Other receivables	442,295	(747,614)
Supplies and other current assets	(1,252,015)	(384,207)
Accounts payable - trade	3,153,115	(688,127)
Estimated third-party payor settlements	(2,751,669)	(670,828)
Accrued expenses	849,618	154,909
Reserve for loss on general and professional liabilities claims, net	54,000	54,000
Net Cash From Operating Activities	<u>\$ 9,630,398</u>	<u>\$ 964,636</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$51,798 and \$76,181 during 2014 and 2013.

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

The financial statements of the Dickinson County Healthcare System (Healthcare System) have been prepared in accordance with generally accepted accounting principles in the United States of America. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used by the Healthcare System are described below.

Reporting Entity

Dickinson County Healthcare System (Healthcare System) was formed as a county public Healthcare System in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public Healthcare System was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public Healthcare System. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

Basis of Presentation

The statement of net position displays the Healthcare System's assets, deferred outflows, and liabilities, with the difference reported as net position. Net position is reported in the following categories/components:

Net investment in capital assets, net of related debt consists of net capital assets reduced by the outstanding balances of any related debt obligations and deferred inflows of resources attributable to the acquisition, construction or improvement of those assets or the related debt obligations and increased by balances of deferred outflows of resources related to those assets or debt obligations.

Restricted - expendable for debt service results when constraints placed on net position use are externally imposed by the issuers of debt held by the Healthcare System.

Unrestricted net position consists of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the Healthcare System's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired. For purposes of the statement of cash flows, the Healthcare System considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Short-term Investments

Short-term investments include investments with an average maturity of three to twelve months, excluding internally designated and restricted cash and investments. Short-term investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Noncurrent Cash and Investments

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available or estimated fair value using quoted market prices for similar securities. Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and principal and interest funds and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when earned.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation in the financial statements. Contributed capital assets are reported at their estimated fair value at the time of their donation. The estimated useful lives of capital assets are as follows.

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position, and are excluded from revenues in excess of (less than) expenses. 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 net position.

Deferred Outflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The Healthcare System has only one item that qualifies for reporting in this category, which is the loss on defeasance of bonds. The loss on defeasance of bonds results from the retirement of the Hospital Revenue and Refunding Bonds, Series 1999. The loss on defeasance of bonds amount is systematically and rationally amortized over the remaining life of the old obligation or the life of the new obligation, whichever is shorter.

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Bond Discounts

Bonds payable are reported net of the applicable bond discount. Bond discounts are amortized over the life of the debt using the effective interest method. Amortization is included in interest expense.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Self-Funded Health Insurance

Beginning January 1, 2011, the Healthcare System self-funded health benefits for eligible employees and their dependents. Health insurance expense is recorded on an accrual basis. Beginning January 1, 2014, the Healthcare System switched to a high-deductible indemnity plan where they fund a portion of the deductible. A payable totaling \$96,246 and \$571,881 (included in accounts payable) is recorded which estimates the incurred but not paid claims for health insurance at December 31, 2014 and 2013. The Healthcare System has separate stop loss insurance coverage for health insurance of catastrophic claims.

Operating Revenues and Expenses

The Healthcare System's statement of revenues, expenses, and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues and expenses of the Healthcare System result from exchange transactions associated with providing health care services - the Healthcare System's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as nonoperating.

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Charity Care

The Healthcare System provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Healthcare System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was \$1,025,000 and \$957,000 for the years ended December 31, 2014 and 2013, calculated by multiplying the ratio of cost to gross charges for the Healthcare System by the gross uncompensated charges associated with providing charity care to its patients.

Grants and Contributions

The Healthcare System may receive grants as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after revenues in excess of (less than) expenses.

Electronic Health Record Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified Electronic Health Records (EHR) technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year.

The Healthcare System recognizes EHR incentive payments as revenue when there is reasonable assurance that the Hospital will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

The Healthcare System recognized revenue of \$1,330,083 and \$2,158,332 for the years ended December 31, 2014 and 2013 related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements.

Reclassifications

Reclassifications have been made to the December 31, 2013 financial information to make it conform to the current year presentation. The reclassifications had no effect on previously reported operating results or changes in net position.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2012. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on a cost reimbursement methodology for inpatient services. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System’s Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2011. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System’s Blue Cross cost reports have been settled by Blue Cross through December 31, 2013. Clinical services are reimbursed based on a fixed fee schedule.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Concentration of gross revenues by major payor accounted for the following percentages of the Healthcare System’s patient service revenues for the years ended December 31, 2014 and 2013:

	2014	2013
Medicare	47%	46%
Medicaid	11%	10%
Blue Cross	25%	26%
Self-pay and other	17%	18%
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2014 and 2013 increased approximately \$1,460,000 and \$908,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations.

RAC

The Centers for Medicare and Medicaid Services (CMS) has implemented a Recovery Audit Contractor (RAC) program under which claims are reviewed by contractors for validity, accuracy, and proper documentation. A demonstration project completed in several other states resulted in the identification of potential overpayments, some being significant. The potential exists that the Healthcare System may incur a liability for a claims overpayment at a future date. The Healthcare System is unable to determine the extent of the liability of overpayments, if any. As the outcome of such potential reviews is unknown and cannot be reasonably estimated, it is the Healthcare System's policy to adjust revenue for deductions from overpayment amounts or additions from underpayment amounts determined under the RAC audits at the time a change in reimbursement is agreed upon between the Healthcare System and CMS.

340B Program

Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

In order to qualify for the program, the hospital needs to have a large percentage of indigent volume, which is defined by the program to include Medicaid patients, Medicaid-eligible patients, and Medicare SSI patients. While indigent volumes are the qualifying factor, this program covers all payers for qualifying services. The program provides for reduced pharmaceutical costs for hospital outpatients. It also allows for contracts with retail pharmacies.

The financial statements include an estimated reserve of \$2,781,342 in accordance with generally accepted accounting principles related to this program. This amount is included in accounts payable on the statement of net position as of December 31, 2014. Actual results could differ from those estimates.

Note 3 - Deposits, Investments, and Investment Income

The carrying amounts of the Healthcare System's deposits and investments as of December 31, 2014 and 2013 are as follows:

	2014	2013
Carrying amount		
Deposits	\$ 9,961,087	\$ 4,102,224
Investments	5,992,795	8,078,091
Forward purchase contract (1)	1,268,861	1,016,882
Total	<u>\$ 17,222,743</u>	<u>\$ 13,197,197</u>

Deposits and investments are reported in the following statement of net position captions:

	2014	2013
Cash and cash equivalents	\$ 9,734,000	\$ 3,874,909
Temporary investments	517,121	632,017
Restricted assets - current portion (Note 6)	1,737,268	1,656,043
Restricted under indenture agreement for debt service (1) (Note 6)	1,726,034	1,806,026
Other long-term investments	<u>3,508,320</u>	<u>5,228,202</u>
Total	<u>\$ 17,222,743</u>	<u>\$ 13,197,197</u>

- (1) A forward purchase contract was entered into in 1999 by the Healthcare System relating to certain trustee held funds associated with the Series 1999 bonds. The contract provides a fixed rate of return of 5.775% on the Debt Service Fund and the Reserve Fund investments. The contract has a maturity date of November 2024, a notional value of approximately \$2,823,000 as of December 31, 2014 and 2013 and an estimated fair value of approximately \$1,269,000 and \$1,017,000 at December 31, 2014 and 2013. The forward purchase contract is included in other long-term investments in the accompanying financial statements. The forward purchase contract was subsequently liquidated on March 31, 2015.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2014 and 2013

Deposits

The Healthcare System had bank balances at December 31, 2014 and 2013 as follows:

	2014	2013
Insured (FDIC)	\$ 6,996,706	\$ 1,306,394
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	1,000,000	1,000,000
Uncollateralized	2,056,416	1,963,619
Total	<u>\$ 10,053,122</u>	<u>\$ 4,270,013</u>
Carrying value	<u>\$ 9,961,087</u>	<u>\$ 4,102,224</u>

Investments

The Healthcare System's investments are reported at fair value. The Healthcare System had the following investments and maturities at December 31, 2014 and 2013:

December 31, 2014

Investment Type	Carrying Amount	Rating	Investment Maturities (in Years)		
			Less Than 1	1-5	6-10
Certificates of deposit (1)	\$ 500,000		\$ 500,000	\$ -	\$ -
Commercial paper	3,236,215		3,236,215	-	-
Forward Purchase Agreement	1,268,861		1,268,861	-	-
Federal National Mortgage Association	199,886	Aaa	199,886	-	-
Federal Home Loan Mortgage Corporation	524,213	Aaa	-	524,213	-
Federal Home Loan Bank	763,561	Aaa	-	541,235	222,326
Federal Farm Credit Bank	283,655	Aaa	-	-	283,655
U.S. Treasuries	301,077	Aaa-mf	301,077	-	-
Freddie Mac	167,067	Aaa	-	167,067	-
Accrued interest	17,121		17,121	-	-
Total	<u>\$ 7,261,656</u>		<u>\$ 5,523,160</u>	<u>\$ 1,232,515</u>	<u>\$ 505,981</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2014 and 2013

December 31, 2013

Investment Type	Carrying Amount	Rating	<i>Investment Maturities (in Years)</i>		
			Less Than 1	1-5	6-10
Certificates of deposit (1)	\$ 600,092		\$ 600,092	\$ -	\$ -
Commercial paper	3,234,753		3,234,753	-	-
Forward Purchase Agreement	1,016,882		-	-	1,016,882
Federal National Mortgage Association	706,408	Aaa	507,500	198,908	-
Federal Home Loan Mortgage Corporation	528,615	Aaa	-	528,615	-
Federal Home Loan Bank	820,405	Aaa	-	547,982	272,423
Federal Farm Credit Bank	534,020	Aaa	255,065	-	278,955
U.S. Treasuries	1,450,093	Aaa-mf	-	510,418	939,675
Freddie Mac	171,780	Aaa	-	171,780	-
Accrued interest	31,925		31,925	-	-
	<u>\$ 9,094,973</u>		<u>\$ 4,629,335</u>	<u>\$ 1,957,703</u>	<u>\$ 2,507,935</u>

- (1) The certificates of deposit were purchased through the Certificate of Deposit Account Registry Service (CDARS) program. They are reported at fair value and have been included in investments. The entire amount above is insured by the FDIC.

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk.

Concentration of Credit Risk

The Healthcare System will limit credit risk, the risk of loss due to the failure of the security issuer or backer, by diversifying in the investment portfolio so that potential losses on individual securities will be minimized. The Healthcare System does not have a formally adopted investment policy for managing concentration of credit risk. However, more than 5% of the Healthcare System's investments are invested in the following securities:

	2014	2013
Certificates of Deposit	44.0%	7.2%
Fortis Funding LLC - Commercial paper	31.7%	39.0%
Federal Home Loan Bank	7.5%	9.9%
Federal Home Loan Mortgage Corporation	5.1%	6.4%
US Treasuries		17.5%
Federal National Mortgage Association		8.5%
Federal Farm Credit Bank		6.4%

Custodial Credit Risk

Custodial credit risk is the risk that in the event of a bank or investment company failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. At December 31, 2014 and 2013, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in other than the Healthcare System's name.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2014 and 2013:

	2014	2013
Interest income and realized gains and losses	\$ 117,571	\$ 165,007
Interest income on proceeds of borrowed funds	222,435	220,577
Total investment income	<u>\$ 340,006</u>	<u>\$ 385,584</u>
Change in unrealized gains and losses on investments	<u>\$ 40,336</u>	<u>\$ (191,747)</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2014 and 2013

Note 4 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2014 are as follows:

	Balance December 31, 2013	Additions	Transfers and Retirements	Balance December 31, 2014
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ -	\$ 1,623,212
Construction in progress	779,764	1,430,143	(1,335,485)	874,422
	<u>2,402,976</u>	<u>1,430,143</u>	<u>(1,335,485)</u>	<u>2,497,634</u>
Total capital assets, not being depreciated	<u>\$ 2,402,976</u>	<u>\$ 1,430,143</u>	<u>\$ (1,335,485)</u>	<u>\$ 2,497,634</u>
Capital assets being depreciated				
Land improvements	\$ 1,012,585	\$ -	\$ -	\$ 1,012,585
Buildings and improvements	44,985,456	490,805	176,137	45,652,398
Equipment	48,408,407	1,343,749	866,396	50,618,552
	<u>94,406,448</u>	<u>1,834,554</u>	<u>1,042,533</u>	<u>97,283,535</u>
Total capital assets being depreciated	<u>94,406,448</u>	<u>1,834,554</u>	<u>1,042,533</u>	<u>97,283,535</u>
Less accumulated depreciation for				
Land improvements	(625,491)	(47,048)	-	(672,539)
Buildings and improvements	(20,478,148)	(1,262,206)	-	(21,740,354)
Equipment	(36,491,270)	(3,613,556)	80,533	(40,024,293)
	<u>(57,594,909)</u>	<u>(4,922,810)</u>	<u>80,533</u>	<u>(62,437,186)</u>
Total accumulated depreciation	<u>(57,594,909)</u>	<u>(4,922,810)</u>	<u>80,533</u>	<u>(62,437,186)</u>
Net capital assets being depreciated	<u>\$ 36,811,539</u>	<u>\$ (3,088,256)</u>	<u>\$ 1,123,066</u>	<u>\$ 34,846,349</u>
Capital assets, net	<u>\$ 39,214,515</u>			<u>\$ 37,343,983</u>

Construction in progress at December 31, 2014, represents costs related to information technology. The total estimated cost to complete the projects is \$292,000, which will be funded from working capital.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2014 and 2013

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2013 are as follows:

	Balance December 31, 2012	Additions	Transfers and Retirements	Balance December 31, 2013
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ -	\$ 1,623,212
Construction in progress	2,241,250	1,894,303	(3,355,789)	779,764
Total capital assets, not being depreciated	<u>\$ 3,864,462</u>	<u>\$ 1,894,303</u>	<u>\$ (3,355,789)</u>	<u>\$ 2,402,976</u>
Capital assets being depreciated				
Land improvements	\$ 1,012,585	\$ -	\$ -	\$ 1,012,585
Buildings and improvements	42,852,062	161,721	1,971,673	44,985,456
Equipment	46,854,640	935,856	617,911	48,408,407
Total capital assets being depreciated	<u>90,719,287</u>	<u>1,097,577</u>	<u>2,589,584</u>	<u>94,406,448</u>
Less accumulated depreciation for				
Land improvements	(569,289)	(56,202)	-	(625,491)
Buildings and improvements	(19,248,295)	(1,229,853)	-	(20,478,148)
Equipment	(33,393,036)	(3,751,908)	653,674	(36,491,270)
Total accumulated depreciation	<u>(53,210,620)</u>	<u>(5,037,963)</u>	<u>653,674</u>	<u>(57,594,909)</u>
Net capital assets being depreciated	<u>\$ 37,508,667</u>	<u>\$ (3,940,386)</u>	<u>\$ 3,243,258</u>	<u>\$ 36,811,539</u>
Capital assets, net	<u>\$ 41,373,129</u>			<u>\$ 39,214,515</u>

Note 5 - Lease Obligations

The Healthcare System leases certain medical and other equipment and office space under noncancelable long-term lease agreements. Total lease expense for the years ended December 31, 2014 and 2013 for all operating leases was \$866,808 and \$711,779. The capitalized leased assets consist of:

	<u>2014</u>	<u>2013</u>
Major movable equipment	\$ 901,220	\$ 2,878,576
Less accumulated amortization	<u>(195,270)</u>	<u>(764,113)</u>
	<u><u>\$ 705,950</u></u>	<u><u>\$ 2,114,463</u></u>

Minimum future lease payments for the capital and operating leases are as follows:

<u>Years Ending December 31,</u>	<u>Capital Leases</u>	<u>Operating Leases</u>
2015	\$ 225,252	\$ 461,488
2016	225,252	189,933
2017	<u>44,478</u>	<u>13,500</u>
Total minimum lease payments	494,982	\$ 664,921
Less interest	<u>(17,622)</u>	
Present value of minimum lease payments - Note 6	<u><u>\$ 477,360</u></u>	

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2014 and 2013

Note 6 - Long-Term Debt

A schedule of changes in the Healthcare System's long-term debt for 2014 and 2013 is as follows:

	Balance December 31, 2013	Additions	Reductions	Balance December 31, 2014	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 3,880,314	\$ -	\$ (158,784)	\$ 3,721,530	\$ 168,007
Hospital Revenue and Refunding Bonds, Series 1999	21,455,000	-	(1,450,000)	20,005,000	1,545,000
Original issue discount	(91,972)	-	14,237	(77,735)	-
Batti land contract	286,752	-	(65,393)	221,359	68,397
Cameron land contract	679,439	-	(81,091)	598,348	84,816
Total bonds and notes	26,209,533	-	(1,741,031)	24,468,502	1,866,220
Capital Leases (Note 5)	1,342,565	-	(865,205)	477,360	213,084
Total long-term debt	<u>\$ 27,552,098</u>	<u>\$ -</u>	<u>\$ (2,606,236)</u>	<u>\$ 24,945,862</u>	<u>\$ 2,079,304</u>
	Balance December 31, 2012	Additions	Reductions	Balance December 31, 2013	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 4,030,380	\$ -	\$ (150,066)	\$ 3,880,314	\$ 158,784
Hospital Revenue and Refunding Bonds, Series 1999	22,815,000	-	(1,360,000)	21,455,000	1,450,000
Original issue discount	(107,148)	-	15,176	(91,972)	-
Batti land contract	344,000	-	(57,248)	286,752	65,393
Cameron land contract	-	819,902	(140,463)	679,439	81,091
Total bonds and notes	27,082,232	819,902	(1,692,601)	26,209,533	1,755,268
Capital Leases (Note 5)	2,195,921	-	(853,356)	1,342,565	865,206
Total long-term debt	<u>\$ 29,278,153</u>	<u>\$ 819,902</u>	<u>\$ (2,545,957)</u>	<u>\$ 27,552,098</u>	<u>\$ 2,620,474</u>

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2014 and 2013 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
 - 5.70% to 5.80% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999 (Series 1999 Bonds) - Due in varying annual installments to November 2024, secured by a pledge of net revenues, investment income, and bond funds held under the indenture agreement (Note 3). (1)
 - Original Issue Discount - Associated with the Series 1999 Bonds issuance.
 - Capital Leases
 - o MRT Equipment Note Payable – During 2012, the Healthcare System placed in service certain equipment financed by Wells Fargo Equipment Finance, Inc. and recorded a corresponding liability. On November 15, 2012, the Healthcare System entered into a 3.2%, 52 month note payable with Wells Fargo Equipment Finance, Inc. The note payable is due in monthly installments of \$18,771 to March 2017, and is secured by certain equipment.
 - o Seimens Note Payable – During 2012, the Healthcare System placed in service certain equipment provided by Seimens and recorded a corresponding liability. On May 14, 2012, the Healthcare System entered into a 0.8%, 3 year note payable with Seimens. The note payable was due in yearly installments of \$664,227 to May 2014, and was secured by certain equipment.
 - Batti land contract – On December 28, 2012, the Healthcare System entered into a 4.5%, 60 month note payable. The note payable is due in monthly installments of \$6,413 to December 2017, and is secured by certain equipment.
 - Cameron land contract – On March 6, 2013, the Healthcare System entered into a 4.5%, 97 month note payable. The note payable is due in monthly installments of \$9,167 to March 2021, and is secured by certain equipment.
- (1) The Series 2004 Bonds and Series 1999 Bonds loan agreements place limits on the incurrence of additional borrowings and requires the Healthcare System satisfy certain measures of financial performance. The Series 1999 Bonds loan agreement also requires the Healthcare System maintain certain deposits with a trustee. Such deposits are shown as restricted for this purpose in the statements of net position (Note 3).

Scheduled principal and interest payments on long-term debt are as follows:

Year Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2015	\$ 2,079,304	\$ 1,405,851	\$ 3,485,155
2016	2,188,023	1,294,068	3,482,091
2017	2,121,578	1,178,447	3,300,025
2018	2,091,072	1,063,142	3,154,214
2019	2,232,093	944,807	3,176,900
2020-2024	12,784,725	2,679,386	15,464,111
2025-2029	1,526,802	213,234	1,740,036
	<u>25,023,597</u>	<u>\$ 8,778,935</u>	<u>\$ 33,802,532</u>
Less unamortized bond discount	(77,735)		
Total	<u>\$ 24,945,862</u>		

Note 7 - Defined Benefit Pension Plan

Plan Description and Funding Policy

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year. The plan was closed to all new entrants effective February 22, 2013.

The most recent actuarial valuation was made as of January 1, 2015. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2014 and 2013 was approximately \$23,979,000 and \$24,274,000. The Healthcare System's total actual payroll for the years ended December 31, 2014 and 2013 was approximately \$40,445,741 and \$39,644,298.

Current membership in the Plan consists of the following at December 31:

	2014	2013
Retirees and beneficiaries currently receiving benefits	305	299
Vested terminated members	167	161
Active and inactive employees		
Fully vested	432	450
Nonvested	<u>6</u>	<u>10</u>
	<u>910</u>	<u>920</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. 50% of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2014 and 2013 were 15.58% and 15.22%, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2014 and 2013 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2013 and 2012, respectively.

Funding Progress

The funded status of the Plan based on the actuarial valuations as of the January 1, 2011, 2012, 2013, 2014, and 2015 is as follows:

Actuarial Valuation Date January 1,	Actuarial Value of Assets (A)	Actuarial Accrued Liability (AAL) Entity Age (B)	Unfunded (Over funded) AAL (UAAL) (B - A)	Funded Ratio (A/B)	Covered Payroll (C)	UAAL as a Percentage of Covered Payroll ((B-A)/C)
2011	30,455,817	43,178,949	12,723,132	70.5%	31,447,854	40.5%
2012	32,811,379	47,643,705	14,832,326	68.9%	32,382,406	45.8%
2013	35,047,767	52,404,010	17,356,243	66.9%	28,723,689	60.4%
2014	39,593,016	56,580,893	16,987,877	70.0%	24,274,184	70.0%
2015	42,983,742	59,975,265	16,991,523	71.7%	23,979,247	70.9%

The funded status disclosed above was actuarially determined using methods prescribed for governmental defined benefit pension plans.

Annual Pension Cost

For 2014, 2013, 2012, 2011, and 2010, the Healthcare System's annual pension cost was equal to the Healthcare System's required and actual contributions. The required contribution was determined as part of the January 1, 2014, 2013, 2012, 2011, and 2010, actuarial valuations using the projected unit credit cost actuarial funding method. The actuarial assumptions for fiscal 2014 and 2013 included (a) 7.5% investment rate of return and (b) salary increases including merit and seniority increases ranging from 5.3% to 0.2% per year, plus wage inflation of 3.5%. The assumptions regarding benefits are that no changes will occur on a postretirement basis.

The Healthcare System's annual pension cost, and required and actual contributions for the years ended December 31, 2014, 2013, 2012, 2011, and 2010 were approximately \$3,736,000, \$3,699,000, \$2,993,000, \$3,062,000 and \$2,822,000. The net pension obligation for the years ended December 31, 2014, 2013, 2012, 2011, and 2010 was zero.

A separately issued financial report of the Dickinson County Healthcare System Retirement Plan is available which includes financial statements and required supplementary information for the Plan.

Note 8 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Lincoln Financial Group Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

The DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 9 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees who were not currently vested in the DB pension plan were transitioned to the new DC plan design. Non-vested MNA (nursing staff) transitioned effective May 1, 2011 and non-vested, non-union staff transitioned effective September 4, 2011. Concurrently, all MNA and non-union new hires became members of the new DC plan. Lastly, non-vested AFSCME staff were transitioned effective February 23, 2013 and concurrently, all AFSCME new hires became DC plan members.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1-3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 8), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$419,128 and \$298,904 for the years ended December 31, 2014 and 2013.

Note 10 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$3 million. The policies end July 31, 2015.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis.

The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2014 and 2013. Amounts included as expense for general and professional liability for the years ended December 31, 2014 and 2013, which include claims and premiums paid, were approximately \$364,658 and \$416,186.

The reserve for loss on professional liability claims at December 31, 2014 and 2013 and activity for the years then ended is as follows:

Balance December 31, 2012	Additions	Reductions	Balance December 31, 2013	Additions	Reductions	Balance December 31, 2014
\$ 600,000	\$ 54,000	\$ -	\$ 654,000	\$ 54,000	\$ -	\$ 708,000

Note 11 - Contingencies

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Litigations, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 12 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2014 and 2013 was as follows:

	2014	2013
Medicare	38%	32%
Blue Cross	22%	21%
Medicaid	10%	9%
Commercial insurance and other	21%	23%
Self pay	9%	15%
	<u>100%</u>	<u>100%</u>

The Healthcare System is subject to collective bargaining agreements for approximately 60.5% of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in February of 2019. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2015.

Note 13 - Dickinson County Hospital Foundation

Dickinson County Hospital Foundation (Foundation) is organized to raise funds for the benefit of the Healthcare System and the community. The Foundation is deemed not to be a component unit of the Healthcare System as defined in GASB 39, *Determining Whether Certain Organizations Are Component Units*, as the economic resources received or held by the Foundation is not considered significant to the Healthcare System. As the Foundation is not considered a component unit, the Foundation's financial statements are not included in these financial statements. At December 31, 2014 and 2013, the Foundation's assets consisted primarily of cash and short-term investments and totaled \$384,835 and \$381,668.

Note 14 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$37,788 and \$60,104 for the years ended December 31, 2014 and 2013. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2014 was approximately \$14,490,000.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 15 - New Accounting Pronouncements

In June 2012, the GASB issued Statement No. 68, *Accounting and Financial Reporting for Pensions*, which revises and establishes new financial reporting requirements for most governments that provide their employees with pension benefits. Among other provisions, Statement No. 68 requires governments providing defined benefit pensions to recognize their long-term obligation for pension benefits as a liability for the first time, and to more comprehensively and comparably measure the annual costs of pension benefits. The Statement also enhances accountability and transparency through revised and new note disclosures and required supplementary information (RSI). This Statement calls for immediate recognition of more pension expense than is currently required. In November 2013, the GASB issued Statement No. 71, *Pension Transition for Contributions made Subsequent to the Measurement Date*, which addresses an issue regarding application of the transition provisions of Statement No. 68. Statement No. 71 amends paragraph 137 of Statement No. 68 to require that, at transition, a government recognizes a beginning deferred outflow of resources for its pension contributions, if any, made subsequent to the measurement date of the beginning of net pension liability. The provisions in Statement No. 68 are effective for fiscal years beginning after June 15, 2014, with the option to implement early, with the provisions related to Statement No. 71 to be applied simultaneously. The Healthcare System elected not to implement Statement No. 68 and 71 early and has not yet evaluated the impact of these pronouncements on the financial statements.

In February 2015, the GASB issued Statement No. 72, *Fair Value Measurement and Application*, which requires that the governmental entity may only invest in external investment pools. This statement enhances transparency and comparability of fair value measurements and disclosures in state and local governments' financial statements. The provisions in Statement No. 72 are effective for fiscal years beginning after June 15, 2015. The Healthcare System has not yet evaluated the impact of this pronouncement on the financial statements when implemented.

Note 16 - Subsequent Events

Effective March 30, 2015 Dickinson County Healthcare System entered into a \$10,000,000 term loan agreement with Fifth Third Bank. The loan is to be paid in monthly installments of stated principal plus interest at a fixed rate of 3.59%, beginning April 15, 2015 and continuing until the balloon payment due on March 30, 2020.

Effective March 31, 2015 Dickinson County Healthcare System entered into a \$10,000,000 term loan agreement with Fifth Third Bank. The loan is to be paid in monthly installments of stated principal plus interest at a fixed rate of 3.59%, beginning April 15, 2015 and continuing until the balloon payment due on March 30, 2020.

A Debt Service Reserve account has been established with Fifth Third Bank in the amount of \$2,000,000. The loans are subject to various ratio and covenant requirements and they are subject to prepayment premiums.

Effective March 31, 2015 an escrow account was funded to pay off the Revenue and Refunding Bonds, Series 1999 on May 1, 2015.



Management Discussion and Analysis and
Financial Statements

December 31, 2013 and 2012

Dickinson County Healthcare System

(A Component Unit of Dickinson County)

Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2013 and 2012

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	3
Financial Statements	
Balance Sheets.....	18
Revenues, Expenses, and Changes in Net Position	19
Cash Flows	20
Notes to Financial Statements	22



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County), which comprise the balance sheets as of December 31, 2013 and 2012, and the related statements of revenues, expenses, and changes in net position 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's 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.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2013 and 2012, and the results of its operations, changes in net position, and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Change in Accounting Principle

As described in Note 16 to the financial statements, the Healthcare System adopted the provisions of GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*. As discussed in Note 16 to the financial statements, the Healthcare System has retroactively restated the previously reported net position to account for deferred financing costs in accordance with this Statement. Our opinions are not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 15 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated April 23, 2014 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

A handwritten signature in black ink that reads "Eide Bailly LLP". The signature is written in a cursive, flowing style.

Fargo, North Dakota
April 23, 2014

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2013 and 2012. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2013

The Healthcare System's net position decreased in 2013 by \$1.501 million or 4.2% with losses before capital contributions and deferred financing cost adjustment of \$1.526 million, comprised of an operating income of \$41 thousand and nonoperating expenses in excess of nonoperating revenue of \$1.567 million. There were \$25 thousand contributions for capital purposes in 2013. During 2013, the Healthcare System's total operating revenues of \$89.8 million was 6.5% higher than the amount in 2012. The resulting operating income for 2013 of \$41 thousand was 0.05% of total operating revenue compared to an operating income of \$865 thousand for 2012 which was 1.0% of operating revenue.

The following major projects and service enhancements were completed in 2013:

- The Healthcare System expanded participation in the 340B program by entering into retail pharmacy agreements with two local retail pharmacies.
- Providers added included: Dr. Cameron – Ears, Nose and Throat, Dr. Venditti – Orthopedics and Dr. Cook – Gynecology.
- Offered an early retirement window, along with implementing volume related staffing changes and completing successful contract negotiations with both the Michigan Nurses Association and American Federation of State, County and Municipal Employee union.
- Became an affiliate member of St. Joseph's Hospital Med Assets purchasing network along with the renegotiation of several stand alone purchasing contracts.
- Began outsourcing laundry services as well as transitioning the lifeline program to Phillips Lifeline.
- New electronic medical record (EMR) technology was implemented in the Emergency Department (ED) and After Hours Clinic. Triage renovations were also completed to give those patients entering the ED a better understanding of the triage process and flow. The expanded triage area also allows those who are wheelchair bound a more comfortable process.
- In order to prepare for electronic results reporting and EMR interface, Cardiac Diagnostics purchased new equipment including electrocardiographs and treadmills for stress tests. This allows a more efficient ordering process and will eventually be 100% electronic.

- Completed Meaningful Use Stage 1, year 1 reporting period successfully and received 1st incentive payment for hospital and a number of our providers. Also implemented Physician Documentation system for inpatients, live in January 2014. This is necessary to meet the requirements of future stages of meaningful use.
- The separate central nurse stations in the medical and surgical units were combined into one central location as a response to declining inpatient volumes. Processes were implemented to assure this change had no detrimental effect on patient care.
- Purchased a Visera Pro Laryngoscope which allows physicians to have better clarity when assessing patients. The equipment also has video and picture taking capabilities to easily compare pre and post procedure analysis, and is smaller in size making it much easier for physicians to use.
- The Dickinson Ear, Nose & Throat Clinic introduced **Real-Ear technology** to its audiology services. *Real-Ear* technology is currently the most accurate measurement equipment in the field of hearing aids. It allows for a recording of the hearing aid output directly at the patient's ear drum. When the exact output of the hearing in the patient's ear is known, corrections can be made in the manufacturer's software to ensure that the hearing aid prescription exactly matches the hearing loss. With *Real-Ear* measurement, each patient's specific individual ear canal resonance and physical properties are taken into account rather than relying on average calculated data. Patient satisfaction with hearing aids increases, and the incidence of returned hearing aids has reduced dramatically.
- Dickinson Home Health began a **Hospital to Home program** in collaboration with Dickinson Memorial Hospital's nursing units. The new program provides one free follow-up home visit to at-risk, non-homebound patients in order to provide a successful transition from hospital to home. A home health nurse focuses on medication reconciliation, home safety and community referrals as needed.
- Attained an "A" rating from the Leapfrog Group - Again
The Leapfrog Group, an independent national nonprofit organization, again awarded Dickinson Memorial Hospital a grade of A and congratulated hospital staff for their "commitment to patient safety and for making critical safety information available to healthcare consumers through participation in national performance measurement and public-reporting programs." The Leapfrog Group calculates a single safety score, based upon 26 measures of publicly available hospital safety data, which represents a hospital's overall capacity to keep patients safe from infections, injuries, and medical and medication errors.
- The **Radiation Oncology Center at Dickinson Memorial Hospital received national accreditation**, an accomplishment that places it in an elite group of only 11 centers in the state of Michigan to do so. There are only 12 accredited centers in Wisconsin; Appleton being the closest one. National accreditation assures patients that the radiation treatments they receive locally meet the most stringent of national standards for safety and quality.
- The September 2013 issue of Consumer Reports magazine rated Dickinson Memorial Hospital as one of the better hospitals to choose when surgery was needed. Dickinson was one of 17 hospitals in the State of Michigan to receive an above average rating. The study was based upon a review of Medicare claims and clinical data for nearly 2,500 hospitals across the country for 27 kinds of surgeries combined – large and small hospitals in each state were compared.

Year Ended December 31, 2012

The Healthcare System's net position increased in 2012 by \$1.689 million or 4.9% with losses before capital contributions and forward purchase agreement adjustment of (\$153) thousand, comprised of an operating income of \$865 thousand and nonoperating expenses in excess of nonoperating revenue of \$1.018 million. There were \$186 thousand contributions for capital purposes in 2012. As a result of a change in the method of recording the forward purchase agreement, an unrealized gain of \$1.657 million was recorded in 2012 for prior years. During 2012, the Healthcare System's total operating revenues of \$84.3 million was 10.1% higher than the amount in 2011. The resulting operating income for 2012 of \$865 thousand was 1.0% of total operating revenue compared to an operating loss of \$1.034 million for 2011 which was (1.4%) of operating revenue.

The following major projects and service enhancements were completed in 2012:

- The Healthcare System expanded participation in the 340B program by entering into retail pharmacy agreements with three local retail pharmacies. In addition, 2012 was the first full year of hospital outpatient drug cost savings.
- Providers added included: Dr. Shaker – Cardiology and Dr. Scott – Urology.
- New medical record technology was implemented throughout the patient care units in Dickinson Memorial Hospital. These included Medication Administration and Computerized Physician Order Entry which are necessary to meet Stage 1 Meaningful Use requirements.
- Installed the Practice Partner Electronic Health Record at Dickinson Cardiology Services, UP Sleep Disorders Center, Dickinson Internal Medicine Clinic, Dickinson Podiatry Services, Dickinson OB/GYN Clinic.
- Installed the following systems/modules; OB Fetal Monitoring, Dietary Room Service, Wound Care, EEG system, Public Wireless Network, and OR Tracking Board
- Upgraded the following systems; Paragon (4 times), Practice Partner, Lawson LBI, Lawson Applications, McKesson Document Interface, Single Sign On, Cactus – Physician Credentialing, Intellicode, eMail Encryption, Misys/Tiger (2 times), EC2000, Pathways Compliance Advisor, and Pathways Contract Management.
- Networked the following new clinics; Wound Care, Urology, Bellin, Cardiology – Marquette, Cardiology – Iron River, UP Sleep Disorder, and Dickinson Medical Services at Bayside
- Interfaces developed include results to MGHS Practice Partner, results to Michigan-Wisconsin Family Practice Associates PC eMDs, radiology billing, dietary system orders/ADT's, and Misys/Tiger financial interface.
- A new CT scanner was installed that contains a flash CT mode which allows split second scanning with a 60% dose reduction. The dual source CT enables early detection of calcification in cardiac arteries and the dual energy CT determines the chemical composition of kidney stones. It also contains an industry leading bariatric option for patients up to 660 pounds.

- Radiation Oncology Technology was upgraded to Rapid Arc which provides greater treatment accuracy and greater patient comfort. The hardware upgrade to the linear accelerator enables finer shaping of the radiation beam for more precise treatment of cancer cells while preserving healthy tissue.
- The Dickinson Pediatric Clinic added concussion management, providing ImPACT testing. Baseline tests were provided to children in grades 5-8 thanks to a donation from Dickinson Memorial Hospital Foundation. Pediatric Neurology services were also added through telehealth appointments with Dr. Arndt of Helen DeVos Children's Hospital in Grand Rapids. He is a noted specialist in children's seizure disorders. Pediatric Nephrology services were also added through quarterly visits by Dr. Haws from the Marshfield Clinic.
- Services were expanded into Delta County, at Cedar Hill-Bayside Clinic in Gladstone. These services include Podiatry and Dermatology.
- A surgical tracking system was developed and implemented whereby patients undergoing a surgical procedure are assigned a number that is shared with family members. The number is displayed on computer screens located in the Surgical Lounge and Cafeteria showing the different stages of the surgical process for each patient. This enables family members to track their loved one's progress.
- The Healthcare System's Laboratory and Imaging services were added to the Bellin Clinic on Woodward Avenue.
- The following Physician Practices attained designation as provider based clinics: Dickinson Cardiology Services, Dickinson Podiatry Services, Dickinson Dermatology Services and Barry D. Johnson, MD Neurology Clinic.
- The Dietary department became Food and Nutrition Services and launched the new Room Service program. The kitchen was revamped from its emphasis on bulk cooking to short order meal preparation. The patient can eat whatever they like whenever they like by ordering their meals from a designated anytime within a 12 hour time frame. Patient satisfaction scores climbed from the 30th to the 98th percentile with temperature and quality of food ranked in the 99th percentile.
- The Healthcare System attained an "A" rating from the Leapfrog Group, an independent national non profit organization. They calculate a single safety score, based upon 26 measures of publicly available hospital safety data, which represents a hospital's overall capacity to keep patients safe from infections, injuries, and medical and medication errors.
- Construction was completed on the new medical office building on the west side of the hospital campus for the relocation of the Dickinson Occupational Clinic and the expansion of the wound care program to become The Center for Wound Healing and Hyperbaric Medicine. The Dickinson Pediatric Clinic was also expanded to twice its former size to add a telehealth room and an ImPACT testing room.

Year Ended December 31, 2011

The Healthcare System's net position decreased in 2011 by \$1.628 million or 4.6% with losses before capital contributions of \$1.652 million, comprised of an operating loss of \$1.034 million and non operating expenses in excess of non operating revenue of \$607 thousand. There were \$13 thousand contributions for capital purposes in 2011. During 2011, the Healthcare System's total operating revenues of \$76.5 million was 3.8% higher than the amount in 2010. The resulting operating loss for 2011 of \$1.034 million was (1.4%) of total operating revenue compared to operating income of \$403 thousand for 2010 which was 0.5% of operating revenue.

The following major projects and service enhancements were completed in 2011:

- Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.
- Providers added included: Dr. Hartfiel – OBGYN, Dr. Anderson – Podiatry; Dr. Kaur – Internal Medicine/Nephrology; Dr. Rayel – Cardiology; Dr. Downs – Emergency Medicine; and Dr. Tuladhar – Pediatrics.
- Contracted with Hospitalists of Northern Michigan to provide hospitalist services to inpatients. This new group of hospitalists have gained widespread acceptance from the medical staff, most of who have handed over their inpatients to the care of the hospitalists. They also work with many hospital committees to improve care and compliance. Due to their ability to treat more complex cases and their consistent and accurate coding, the Healthcare System has experienced an increase in the case mix index and a related increase in reimbursement.
- Installed the Practice Partner Electronic Health Record at the Pediatric Clinic and Florence Medical Center and well as a new budget and management reporting system and a dietary Point of Sale system. In addition a compellent storage area network and Relay Clearance Pro (insurance eligibility system) were installed.
- Upgrades to nine systems were completed which included Horizon Patient Folder, Paragon (necessary for meeting Meaningful Use criteria), the Tera Recon and PACS radiology imaging systems, Lawson Requisition Self Serve for Purchasing, Misys Tiger professional billing system, EC2000, and Pathways Compliance Advisor and Contract Management.
- Interfaces were developed for reporting to Marquette General Health System and Cedar Hill Clinic as well as reporting to/from Practice Partner.
- Other major IT projects included implementation of a pharmacy repackaging system for barcoding drugs, replacement of 70 user workstations in preparation for the Horizon Patient Folder and Paragon upgrades.

- Relocation of the OB/GYN Clinic, redesign of the hospital website and installation of Green Bay Oncology equipment in the Ambulatory Care Unit infusion area for accessing their electronic health record.
- Construction began in the fall on a 5,896 square foot medical office building on the west side of the hospital campus to house an expanded wound care program to include hyperbaric medicine. In addition, the Dickinson Occupational Clinic was relocated to the new building from its current location in the Dickinson Medical Building to allow for the expansion of the Pediatrics Clinic which houses a full complement of providers including three physicians and two mid-level providers.
- The Healthcare System's Defined Benefit Pension Plan was closed to new hires effective May 1 for Michigan Nurses Association members and September 4 for non-union members. A new Defined Contribution Pension Plan was created for these new hires as well as non-vested employees in the two groups.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Balance Sheet includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all nonoperating revenue and expense items, capital contributions and the net increase in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2013, 2012, and 2011

Financial Analysis of the System

The condensed Balance Sheets of the Healthcare System as of December 31, 2013, 2012, and 2011 are summarized in the following table.

Condensed Balance Sheets
December 31, 2013, 2012, and 2011 (in Thousands)

	2013	2012	2011
Total current assets (includes the current portion of restricted assets)	\$ 24,738	\$ 23,530	\$ 23,339
Cash and investments internally designated for other purposes	5,228	8,424	7,925
Cash and investments restricted by bond indentures	1,806	1,878	1,989
Other Assets	450	736	702
Capital assets, net	39,215	41,373	37,776
 Total Assets	 71,437	 75,941	 71,731
 Total Deferred Outflows of Resources	 1,063	 1,237	 1,423
 Total Assets and Deferred Outflows	 <u>\$ 72,500</u>	 <u>\$ 77,178</u>	 <u>\$ 73,154</u>
 Total current liabilities	 \$ 12,012	 \$ 13,032	 \$ 10,803
Long-term debt, net of current portion	24,932	26,857	26,722
Other long-term liabilities	1,104	1,336	1,365
 Total Liabilities	 38,048	 41,225	 38,890
 Total Net Position	 34,452	 35,953	 34,264
 Total Liabilities and Net Position	 <u>\$ 72,500</u>	 <u>\$ 77,178</u>	 <u>\$ 73,154</u>

Current Assets and Liabilities

Net patient accounts receivable increased to 55 days' of net revenue at December 31, 2013 compared to 47 days' of net revenue at December 31, 2012 and compared to 51 at December 31, 2011. The 2013 increase was the result of a delay in certification of a new Independent Diagnostic Testing Facility and an Independent Laboratory as well as the start up of several new specialty physician practices and the inability to maintain a full complement of billing staff. 5010 processing issues experienced by National Government Services in 2011 were resolved in 2012, resulting in the decrease of 4 days.

Total current assets increased 5.1% in 2013 and increased 1.0% in 2012 compared to each prior year. The 2013 increase is primarily due to an increase in patient accounts receivable while the 2012 increase is a result of an increase in other accounts receivable and cash offset by a decrease in short term investments and patient accounts receivable.

Current liabilities decreased 7.8% in 2013 as a result of the reduction of trade accounts payable and estimated third-party payor settlements while current liabilities increased 21% in 2012 as a result of an increase in trade accounts payable and current maturity of debt and capital lease obligations. The Healthcare System's current ratio (current assets divided by current liabilities) was 2.06 at December 31, 2013 and 1.81 at December 31, 2012.

Total Cash and Investments

The number of days of total cash and investments was 44.6 at December 31, 2013 and 68.4 at December 31, 2012. Excluding the restricted amounts, the ratios for 2013 and 2012 were 38.1 days and 61.8 days, respectively.

The total cash and investments at December 31, 2013 were \$13.2 million including restricted funds of \$3.5 million. Total cash and investments at December 31, 2012 were \$18.2 million including restricted funds of \$3.5 million.

Long-Term Debt

The Healthcare System had long-term debt of \$24.9 million at December 31, 2013 and \$26.9 million at December 31, 2012 (net of current maturities of \$2.6 million in 2013 and \$2.4 million in 2012). In 2013 a land contract was entered into to purchase a physician office suite in the Dickinson Medical Building. In 2012 capital leases were issued for a CT Scanner and a MRT upgrade. Long-term debt at December 31, 2013 represents 95.8% of total long-term liabilities and 65.5% of total liabilities as compared to 95.3% of total long-term liabilities and 65.1% of total liabilities at December 31, 2012. The debt service coverage ratio for the years ended December 31, 2013 and 2012 was 1.45 and 1.76 respectively.

Net Position

Total net position decreased in 2013 and increased in 2012 while unrestricted net position decreased from 2012 to 2013 and from 2011 to 2012. The decrease in the unrestricted component for 2013 was due to the unfavorable financial results of the healthcare system while the decrease in the unrestricted component for 2012 was due to increased investment in capital assets. The amount invested in capital assets, net of related debt increased in 2012 as a result of the need to replace outdated equipment that had been forgone in the last few years of decreased capital spending. However, in 2013 the healthcare system once again made capital purchases only for those items required by HITECH and for equipment that was no longer usable. The restricted amount for debt service represents the funds held by the trustee for the Series 1999 bonds. This amount increased slightly in 2013 and decreased in 2012 related to debt service requirements. These components are presented in the following table.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2013, 2012, and 2011

Components of Net Position (in thousands)

	December 31,		
	2013	2012	2011
Invested in capital assets, net of related debt Restricted by revenue bond indentures, expendable for debt service	\$ 12,725	\$ 13,332	\$ 11,021
Unrestricted	3,462	3,456	3,540
	<u>18,265</u>	<u>19,165</u>	<u>19,703</u>
Total net position	<u>\$ 34,452</u>	<u>\$ 35,953</u>	<u>\$ 34,264</u>

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2013, 2012, and 2011 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2013, 2012, and 2011 (in Thousands)

	2013		2012		2011	
Revenue and (expenses):						
Net patient service revenue	\$ 77,904	86.8%	\$ 77,801	92.3%	\$ 74,456	97.3%
Other revenue	11,868	13.2%	6,469	7.7%	2,079	2.7%
Total operating revenue	<u>89,772</u>	100.0%	<u>84,270</u>	100.0%	<u>76,535</u>	100.0%
Total operating expenses	<u>89,731</u>	100.0%	<u>83,405</u>	99.0%	<u>77,569</u>	101.4%
Operating income	<u>41</u>	0.0%	<u>865</u>	1.0%	<u>(1,034)</u>	-1.4%
Investment income	386	0.4%	681	0.8%	1,135	1.5%
Change in unrealized gains and losses on investments	(192)	-0.2%	7	0.0%	119	0.2%
Change in fair market value of forward purchase agreement	(627)	-0.7%	(13)	0.0%	-	0.0%
Interest and amortization expense	(1,697)	-1.9%	(1,719)	-2.0%	(1,827)	-2.4%
Other non-operating revenue and expenses (net)	<u>563</u>	0.6%	<u>25</u>	0.0%	<u>(34)</u>	0.0%
Non-operating expenses in excess of revenue	<u>(1,567)</u>	-1.7%	<u>(1,019)</u>	-1.2%	<u>(607)</u>	-0.8%
Income (loss) before capital contributions	<u>(1,526)</u>	<u>-1.7%</u>	<u>(154)</u>	<u>-0.2%</u>	<u>(1,641)</u>	<u>-2.1%</u>
Forward purchase agreement adjust:	-		1,657		-	
Capital contributions	<u>25</u>		<u>186</u>		<u>13</u>	
Increase (decrease) in net position	<u>(1,501)</u>		<u>1,689</u>		<u>(1,628)</u>	
Net position - beginning of year	<u>35,953</u>		<u>34,264</u>		<u>35,892</u>	
Net position - end of year	<u>\$ 34,452</u>		<u>\$ 35,953</u>		<u>\$ 34,264</u>	

Results of Operations

Overall results of operations of \$41 thousand or 0.0% of revenue for 2013 decreased from \$865 thousand or 1.0% of revenue for 2012. The net nonoperating expenses in excess of nonoperating revenue for 2013 increased to \$1.567 million from \$1.018 million in 2012. The net increase in 2013 is due to the change in unrealized gains and losses on investments and the change in fair market value of the forward purchase agreement. The net increase in 2012 was due to lower investment income. The net result for 2013 was a loss of (\$1.526) million or (1.7%) of total operating revenue before capital contributions. The net result for 2012 was a loss of (\$153) thousand or (0.2%) of total operating revenue before capital contributions.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2013 comprised 31.4% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2012 was 33.7%. The operating performance of DCMH was affected by inpatient discharges decreasing by 4.7% to 3,069 from 3,219 in 2012, while acute adult and pediatric inpatient days decreased by 9.8% to 10,624 from 11,777 in 2012. Net patient revenue decreased 6.7% and the all-payer case mix index decreased to 1.153 from 1.232 in 2012. Discharges decreased 3.6% in 2012 while net inpatient revenue increased 4.4% due to the higher case mix index.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 54.8% of total Healthcare System net patient revenue and its operating activities for 2013. The comparable percentage for 2012 was 55.7%. Net outpatient revenue decreased 1.5% in 2013 and increased 2.5% in 2012. Total outpatient visits were 176,165 in 2013 and 169,863 in 2012. As a percent, the largest increase in outpatient visits was seen in laboratory, imaging and observation status.

The net patient revenue of the Rural Health Clinics (RHC's) and other Provider Based RHC's comprised about 13.8% of the total net patient revenue of the Healthcare System for 2013 and 10.6% for 2012. The revenue growth was 30.3% in 2013 and 17.0% in 2012 as a result of converting the remaining free standing clinics to either RHC's or Provider Based RHC's. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute losses on operations. There are two facilities in Northeast Wisconsin and eleven off-campus practices in Michigan in addition to practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from healthcare services, and nonoperating revenue, which is principally from investment income.

Operating Revenue

Total gross revenues for all patient services performed by the Healthcare System were \$225 million in 2013 and \$211 million in 2012. The overall increase reflects the year-to-year difference in patient volumes, service mix changes and annual price increases. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care services measured as unpaid gross revenues of 1.1% in 2013 and 2012 to patients who documented their inability to pay. Bad debt provisions were 3.0% of gross revenue in 2013 and 3.3% in 2012. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 61% in 2013 and 59% in 2012.

The resulting net patient services revenue was 35% of gross revenue in 2013 and 37% in 2012. Net patient services revenue remained flat in 2013 and increased \$3.3 million or 4.5% in 2012 due to the net effects of patient volumes, price increases, third-party payment rates, bad debt provisions and charity and other adjustments.

Other operating revenue increased \$5.4 million or 83.5% from 2012 to 2013. Accounting for \$3.7 million of that total were new revenues generated as a result of the 340B retail pharmacy program implemented at the beginning of 2012. In addition, the Healthcare System met criteria to record \$2.2 million in Medicare and Medicaid incentive payments for Electronic Health Records. Other operating revenue increased \$4.4 million or 211.2% from 2011 to 2012 mainly due to the 340B retail pharmacy program.

Nonoperating Revenue

Investment income was \$386 thousand for 2013 and \$681 thousand for 2012. The decrease for both years was the result of declining cash and investment balances. The change in unrealized gains and losses on investments was (\$192) thousand in 2013 and \$7 thousand for 2012.

Capital Contributions

There were \$25 thousand in capital contributions in 2013 for OBYN equipment. There were \$186 thousand in capital contributions in 2012 for the new CT Scanner and Radiology upgrades.

Forward Purchase Agreement

There has been a change in Generally Accepted Accounting Principles over time as it relates to the recording of these types of transactions. While FASB has required that Forward Purchase Agreements be recorded at fair market value, GASB has just recently issued codification clarifying that FASB must be followed for governmental units as well. Therefore, at 12/31/12 an adjustment of \$1.657 million was made to reflect the net increase in the market value from inception through 12/31/11. The decrease in market value of \$13 thousand for 2012 was recorded as a nonoperating expense and is included in the loss before capital contributions. An additional decrease in market value of \$627 thousand was recorded in 2013.

Expenditure of Funds

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2013 and 2012 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2013 and 2012 (in Thousands)

	2013	2012	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 52,561	\$ 49,782	\$ 2,779	5.6%
Supplies and pharmaceuticals	12,732	11,434	1,298	11.4%
Professional fees and other purchased services	19,400	17,518	1,882	10.7%
Depreciation and amortization	5,038	4,671	367	7.9%
Total	<u>\$ 89,731</u>	<u>\$ 83,405</u>	<u>\$ 6,326</u>	<u>7.6%</u>

Employee compensation and benefits increased \$2.779 million or 5.6%. The annual average total paid full-time equivalent (FTE) positions of 667.0 for 2013 increased by 1.9% from the 2012 amount of 654.7. Pension expense increased by \$855 thousand or 27.2% and health insurance expense increased by \$820 thousand or 17.4%.

The cost of supplies and pharmaceuticals increased \$1.298 million or 11.4%, related to 340B retail pharmacy activity. As well, orthopedic cases increased by 97 or 12.4% from 2012 to 2013 which resulted in increased orthopedic supply costs.

Professional fees, purchased services and other expenses for 2013 increased \$1.882 million or 10.7%. This was mainly the result of higher fees for hospitalist services, a new ENT practice and 340B retail disbursement fees. Depreciation and amortization expense for 2013 increased \$367 thousand or 7.9%, principally due to the full year effect of the prior year's capital purchases.

The components of operating expenses for the Healthcare System for the years ended December 31, 2012 and 2011 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2012 and 2011 (in Thousands)

	2012	2011	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 49,782	\$ 48,208	\$ 1,574	3.3%
Supplies and pharmaceuticals	11,434	9,717	1,717	17.7%
Professional fees and other purchased services	17,518	15,263	2,255	14.8%
Depreciation and amortization	4,671	4,381	290	6.6%
Total	<u>\$ 83,405</u>	<u>\$ 77,569</u>	<u>\$ 5,836</u>	<u>7.5%</u>

Employee compensation and benefits increased \$1.574 million or 3.3%. The annual average total paid full-time equivalent (FTE) positions of 654.7 for 2012 increased by 4.0% from the 2011 amount of 629.6.

The cost of supplies and pharmaceuticals increased \$1.717 million or 17.7%, related to 340B retail pharmacy activity.

Professional fees, purchased services and other expenses for 2012 increased \$2.255 million or 14.8%. This was mainly the result of higher fees for emergency department coverage, hospitalist services and bad debt collections. Depreciation and amortization expense for 2012 increased \$290 thousand or 6.6%, principally due to increased capital spending.

Nonoperating Expense Items

Interest expense was \$1.7 million in 2013 and 2012. The Healthcare System capitalized interest expense amounts of \$76 thousand in 2013 and \$106 thousand in 2012.

Capital Expenditures

Fiscal Year 2013

Total capital spending decreased in 2013 from 2012 levels. Major projects included the following: Purchase of two suites in the Dickinson Medical Building - \$1.278 million; T System electronic medical record in the Emergency Department and After Hours Clinic - \$451 thousand; additional HVAC system in computer room - \$134 thousand; Quality eMeasures and other meaningful use initiatives - \$231 thousand.

Fiscal Year 2012

Total capital spending increased significantly in 2012 after several years of limited spending. Major projects included the following: CT Scanner & renovations - \$2.1 million; MRT Rapid Arc Upgrade - \$913 thousand; Wound Care / DOC Building - \$575 thousand (\$601 thousand spent in 2011 for total spending of \$1.2 million); Pediatric Clinic Renovation - \$316 thousand; purchase of Dickinson Medical Building suite - \$266 thousand; Diagnostic Lab & Imaging Equipment for Bellin Clinic - \$306 thousand; Dietary Conversion to Room Service - \$236 thousand; X-ray Suite 100 - \$210 thousand; Portable X-ray Machine - \$185 thousand; Purchase of regular & portable C-Arm - \$172 thousand; new Home Health Building - \$154 thousand; and Urology Practice equipment & furnishings - \$108 thousand.

Fiscal Year 2011

Total capital spending increased modestly in 2011 after several years of limited spending. Major projects included the following: upgrade to hospital heating and cooling system - \$973 thousand; purchase of a suite in the Dickinson Medical Building - \$405 thousand; purchase of land and building to house the OBGYN Clinic - \$261 thousand; Horizon Patient Folder upgrade - \$229 thousand; X-ray equipment for the Bayside Clinic - \$105 thousand; Dell minitower - \$82 thousand; SAN upgrade - \$68 thousand; and an autostainer - \$53 thousand.

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The Current Budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2013, 2012, and 2011

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2013 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 89,566	\$ 206	0.2%
Total operating expenses	(88,390)	(1,341)	-1.5%
Operating income	1,176	(1,135)	-96.5%
Net nonoperating revenue and gains, (expenses and losses)	(1,139)	(428)	-37.6%
Income before capital contributions	37	(1,563)	-4224.3%
Capital contributions	25	-	0.0%
Increase in net position	\$ 62	\$ (1,563)	-2521.0%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were unfavorable by approximately 7%, while total outpatient visits were favorable by approximately 2.6%. However, the total visit variance was net of favorable variances of 9.5% in outpatient observation patients and 7.9% for all other outpatient visits and unfavorable variances of 7.6% for radiation therapy services, 9.6% for Emergency Department visits, 3.6% in physical therapy and other recurring series visits and 0.9% in outpatient surgeries. Expenses were unfavorable to budget by \$1.341 million or 1.5% mainly as a result of increased 340B retail activity and increased fees for emergency department physicians. The variance in other net nonoperating items was caused principally by a significant unbudgeted unrealized loss on investments offset by a significant unbudgeted unrestricted donation.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2013, 2012, and 2011 (in Thousands)

	2013	2012	2011
Budget	\$ 8,425	\$ 8,277	\$ 6,186
Actual	2,817	5,484	4,330
Variance	\$ 5,608	\$ 2,793	\$ 1,856
Variance %	66.6%	33.7%	30.0%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. The variance in 2011 was due to management's actions to limit capital spending by eliminating or deferring several budgeted projects while in 2012 it became necessary to purchase or upgrade several pieces of diagnostic equipment and several real estate locations. However, in 2013 as a result of operations, projects were again delayed or eliminated. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

Management believes that service volumes and payor mix were adversely affected by economic conditions in 2013 and 2012. Uncompensated care with bad debt and charity write-offs totaled 4.2% of gross charges in 2013 while uncompensated care with bad debt and charity write-offs totaled 4.5% of gross charges in 2012. In February 2014, the most recent data available, the unemployment rate in Dickinson County was 8.6% compared to 10.6% over the entire Upper Peninsula and 8.5% for the State of Michigan. The same statistics for February 2013 were 8.4%, 10.5% and 9.3%, respectively.

Not unlike other areas of the country, the Upper Peninsula saw several healthcare system acquisitions in 2012. Marquette General Healthcare System was acquired by Duke LifePoint while Bell Memorial Hospital signed a letter of intent to be acquired by LifePoint Hospitals and Portage Health signed a letter of intent to form a joint venture with LifePoint Hospitals. Both the Bell Memorial Hospital and Portage Health transactions were completed in 2013.

(This page left blank intentionally.)

	<u>2013</u>	<u>2012</u> (Restated)
Assets		
Current Assets		
Cash and cash equivalents	\$ 3,874,909	\$ 2,831,615
Temporary investments	632,017	3,508,965
Current portion of restricted assets	1,656,043	1,578,510
Receivables		
Patient, net of estimated uncollectibles of		
\$3,192,000 in 2013 and \$2,817,000 in 2012	12,757,177	10,924,713
Other	3,490,297	2,742,683
Supplies and other current assets	<u>2,328,505</u>	<u>1,944,298</u>
Total current assets	<u>24,738,948</u>	<u>23,530,784</u>
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	1,806,026	1,877,956
Other long-term investments	<u>5,228,202</u>	<u>8,423,620</u>
Total noncurrent cash and investments	<u>7,034,228</u>	<u>10,301,576</u>
Capital assets not being depreciated	2,402,976	3,864,462
Depreciable capital assets, net of accumulated depreciation	<u>36,811,539</u>	<u>37,508,667</u>
Total capital assets	<u>39,214,515</u>	<u>41,373,129</u>
Professional Liabilities Insurance Receivable	<u>450,000</u>	<u>736,400</u>
Total assets	<u>71,437,691</u>	<u>75,941,889</u>
Deferred Outflows of Resources		
Loss on defeasance of bonds	<u>1,062,201</u>	<u>1,237,272</u>
Total assets and deferred outflows	<u>\$ 72,499,892</u>	<u>\$ 77,179,161</u>

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Balance Sheets
December 31, 2013 and 2012

	<u>2013</u>	<u>2012</u> (Restated)
Liabilities and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 2,620,474	\$ 2,420,670
Accounts payable	2,973,575	3,661,702
Estimated third-party payor settlements	543,284	1,214,112
Accrued expenses		
Salaries, wages, and related liabilities	1,271,393	1,144,419
Compensated absences	3,838,981	3,631,774
Other accrued liabilities	555,431	734,703
Interest	209,194	224,787
Total current liabilities	<u>12,012,332</u>	<u>13,032,167</u>
Long-Term Liabilities		
Long-term debt, less current maturities	24,931,624	26,857,483
Reserve for loss on general and professional liabilities claims	<u>1,104,000</u>	<u>1,336,400</u>
Total long-term liabilities	<u>26,035,624</u>	<u>28,193,883</u>
Total liabilities	<u>38,047,956</u>	<u>41,226,050</u>
Net Position		
Invested in capital assets, net of related debt	12,724,618	13,332,248
Restricted - expendable for debt service	3,462,069	3,456,466
Unrestricted	<u>18,265,249</u>	<u>19,164,397</u>
Total net position	<u>34,451,936</u>	<u>35,953,111</u>
Total liabilities and net position	<u><u>\$ 72,499,892</u></u>	<u><u>\$ 77,179,161</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2013 and 2012

	<u>2013</u>	<u>2012</u> (Restated)
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$6,768,497 in 2013 and \$7,031,067 in 2012	\$ 77,903,888	\$ 77,800,690
Supplies and 340b program revenue	7,411,568	3,750,504
Electronic health record incentive revenue	2,158,332	505,913
Other revenue	<u>2,298,159</u>	<u>2,212,409</u>
Total operating revenues	<u>89,771,947</u>	<u>84,269,516</u>
Operating Expenses		
Salaries and wages	39,644,298	37,859,846
Employee benefits	12,916,847	11,922,102
Supplies and pharmaceuticals	12,732,302	11,434,271
Medical and other professional fees	7,170,851	6,473,366
Purchased services and other	12,228,682	11,044,797
Depreciation	<u>5,037,963</u>	<u>4,670,535</u>
Total operating expenses	<u>89,730,943</u>	<u>83,404,917</u>
Operating Income	<u>41,004</u>	<u>864,599</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	568,439	50,334
Interest and amortization expense	(1,697,190)	(1,718,080)
Loss on disposal of capital assets	(5,031)	(25,706)
Investment income	385,584	681,425
Change in fair market value of forward purchase agreement	(627,234)	(13,006)
Change in unrealized gains and losses on investments	<u>(191,747)</u>	<u>7,006</u>
Total nonoperating revenues (expenses), net	<u>(1,567,179)</u>	<u>(1,018,027)</u>
Expenses in Excess of Revenues Before Capital Contributions	(1,526,175)	(153,428)
Forward Purchase Agreement Adjustment	-	1,657,121
Capital Contributions	<u>25,000</u>	<u>185,541</u>
Increase (Decrease) in Net Position	(1,501,175)	1,689,234
Net Position, Beginning of Year (Restated)	<u>35,953,111</u>	<u>34,263,877</u>
Net Position, End of Year	<u><u>\$ 34,451,936</u></u>	<u><u>\$ 35,953,111</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2013 and 2012

	<u>2013</u>	<u>2012</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 76,071,424	\$ 78,175,373
Receipts with third-party payors for settlements	(670,828)	(1,011,801)
Payments to suppliers and contractors	(33,122,234)	(27,063,832)
Payments to employees	(52,434,171)	(49,516,924)
Other receipts	11,120,445	4,532,187
	<u>964,636</u>	<u>5,115,003</u>
Net Cash From Operating Activities		
Noncapital Financing Activity		
Unrestricted general contributions	568,439	50,334
	<u>568,439</u>	<u>50,334</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(2,817,399)	(5,483,942)
Repayment of long-term debt	(2,561,133)	(2,228,427)
Proceeds from the issuance of long term debt	819,902	430,000
Interest paid, including capitalized interest	(1,598,717)	(1,621,475)
Capital contributions	25,000	185,541
Proceeds from the sale of capital assets	9,200	101,321
	<u>(6,123,147)</u>	<u>(8,616,982)</u>
Net Cash Used For Capital and Capital Related Financing Activities		
Investing Activities		
Purchases of investments	(6,423,935)	(10,461,358)
Proceeds from sales and maturities of investments	11,673,716	14,260,798
Investment income	385,584	681,425
	<u>5,635,365</u>	<u>4,480,865</u>
Net Cash From Investing Activities		
Net Increase in Cash and Cash Equivalents	1,045,293	1,029,220
Cash and Cash Equivalents, Beginning of Year	3,056,931	2,027,711
	<u>3,056,931</u>	<u>2,027,711</u>
Cash and Cash Equivalents, End of Year	<u>\$ 4,102,224</u>	<u>\$ 3,056,931</u>
Reconciliation of Cash and Cash Equivalents to the Balance Sheets		
Cash and cash equivalents in current assets	\$ 3,874,909	\$ 2,831,615
Cash and cash equivalents in noncurrent cash and investments	227,315	225,316
	<u>227,315</u>	<u>225,316</u>
Total cash and cash equivalents	<u>\$ 4,102,224</u>	<u>\$ 3,056,931</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2013 and 2012

	<u>2013</u>	<u>2012</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income (loss)	\$ 41,004	\$ 864,599
Adjustments to reconcile operating income (loss) to net cash flows from operating activities		
Depreciation	5,037,963	4,670,535
Provision for bad debts	6,768,497	7,031,067
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(8,600,961)	(6,656,384)
Other receivables	(747,614)	(1,936,639)
Supplies and other current assets	(384,207)	(136,105)
Accounts payable - trade	(688,127)	1,185,505
Estimated third-party payor settlements	(670,828)	(1,011,801)
Accrued expenses	154,909	1,174,226
Reserve for loss on general and professional liabilities claims, net	<u>54,000</u>	<u>(70,000)</u>
Net Cash From Operating Activities	<u>\$ 964,636</u>	<u>\$ 5,115,003</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$76,181 and \$105,992 during 2013 and 2012.

The Healthcare System entered into capital lease agreements totaling \$2,876,519 during 2012.

Note 1 - Organization and Significant Accounting Policies

Organization

Dickinson County Healthcare System (Healthcare System) was formed as a county public Healthcare System in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public Healthcare System was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public Healthcare System. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Enterprise Fund Accounting

The Healthcare System uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

The financial statements have been presented in conformity with generally accepted accounting principles as promulgated by GASB and as recommended in the Audit and Accounting Guide for Health Care Organizations published by the American Institute of Certified Public Accountants.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired.

Temporary Investments

Temporary investments include investments with an average maturity of three to twelve months, excluding internally designated and restricted cash and investments. Temporary investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Investments and Investment Income

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available or estimated fair value using quoted market prices for similar securities. Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when incurred.

Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and principal and interest funds and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. All capital assets other than land and construction in progress are depreciated or amortized (in the case of capital leases) using the straight-line method of depreciation using these asset lives:

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Original Issue Discount and Unamortized Loss on Defeasance

Original issue discount is amortized over the period the related obligation is outstanding using the bonds-outstanding method. Unamortized loss on defeasance is amortized using the bonds outstanding method over the remaining life of the old obligation or the life of the new obligation, whichever is shorter. Amortization of original issue discount and unamortized loss on defeasance is included in interest and amortization expense in the financial statements.

Self-Funded Health Insurance

Beginning January 1, 2011, the Healthcare System self-funded health benefits for eligible employees and their dependents. Health insurance expense is recorded on an accrual basis. A payable totaling \$571,811 and \$720,353 (included in accounts payable) is recorded which estimates the incurred but not paid claims for health insurance at December 31, 2013 and 2012. The Healthcare System has separate stop loss insurance coverage for health insurance of catastrophic claims.

The Healthcare System retained Blue Cross Blue Shield of Michigan as the third-party administrator to the plan.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Professional Liability Claims

The Healthcare System evaluates its exposure to losses arising from claims and recognizes a liability and at the same time it recognizes an insurance receivable for anticipated insurance recoveries, measured on the same basis as the related liability.

Grants and Contributions

From time to time, the Healthcare System receives grants and contributions. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after expenses in excess of revenues.

Restricted Resources

When the Healthcare System has both restricted and unrestricted resources available to finance a particular program, it is the Healthcare System's policy to use restricted resources before unrestricted resources.

Net Position

Net position is presented in the following three components:

Net Position Invested in Capital Assets, Net of Related Debt - Invested in capital assets net of related debt consists of capital assets, including restricted capital assets, net of accumulated depreciation, and reduced by any outstanding borrowings used to finance the purchase or construction of those assets.

Restricted Expendable Net Position - Restricted expendable net position is non-capital net position that must be used for a particular purpose, as specified by creditor, grantors, or contributors external to the Healthcare System, including amounts deposited with trustees as required by bond indenture agreements.

Unrestricted Net Position - Unrestricted net position is the remaining net position that does not meet the definition of "Invested in Capital Assets, Net of Related Debt," or "Restricted."

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Operating Revenues and Expenses

The Healthcare System's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services - the Healthcare System's principal activity. Nonexchange revenues, including grants and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Charity Care

The Healthcare System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Healthcare System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of charges foregone for services provided under the Hospital's charity care policy were \$2,765,831 and \$2,523,471 for the years ended December 31, 2013 and 2012. Total direct and indirect costs related to these foregone charges were approximately \$957,000 and \$920,000 at December 31, 2013 and 2012, based on an average ratio of cost to gross charges.

Advertising Costs

The Healthcare System expenses advertising costs as incurred.

Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that meaningfully use certified Electronic Health Records (EHR) technology.

These incentive payments will be paid out over six years on a transitional schedule. To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the State of Michigan. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year.

The Hospital recognizes EHR incentive payments as revenue when there is reasonable assurance that the Hospital will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2009.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on a cost reimbursement methodology for inpatient services. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System’s Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2010.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System’s Blue Cross cost reports have been settled by Blue Cross through December 31, 2012.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2013 and 2012 increased approximately \$908,000 and decreased approximately \$167,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations.

A summary of patient service revenue, contractual adjustments, and provision for bad debts for the years ended December 31, 2013 and 2012 is as follows:

	2013	2012
Patient service revenue		
Gross patient service revenue	\$ 225,117,832	\$ 211,037,292
Less: charity care	(2,765,831)	(2,523,471)
Total patient service revenue	<u>222,352,001</u>	<u>208,513,821</u>
Contractual adjustments		
Medicare	(71,390,673)	(64,614,486)
Medicaid	(18,697,363)	(16,285,734)
Blue Cross	(35,224,522)	(31,103,822)
Other	(12,367,058)	(11,678,022)
	<u>(137,679,616)</u>	<u>(123,682,064)</u>
Provision for bad debts	<u>(6,768,497)</u>	<u>(7,031,067)</u>
Total contractual adjustments and provision for bad debts	<u>(144,448,113)</u>	<u>(130,713,131)</u>
Net patient service revenue	<u>\$ 77,903,888</u>	<u>\$ 77,800,690</u>

Note 3 - Deposits, Investments, and Investment Income

Deposits

Custodial credit risk is the risk that in the event of a bank failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. The Healthcare System had bank balances at December 31, 2013 and 2012 as follows:

	2013	2012
Insured (FDIC)	\$ 1,306,394	\$ 1,343,047
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	1,000,000	1,000,000
Uncollateralized	1,963,619	955,218
Total	<u>\$ 4,270,013</u>	<u>\$ 3,298,265</u>
Carrying value	<u>\$ 4,102,224</u>	<u>\$ 3,056,931</u>

Investments

The Healthcare System's investments are reported at fair value. At December 31, 2013 and 2012, the Healthcare System's investments consisted of the following:

December 31, 2013

Investment Type	Carrying Amount	Investment Maturities (in Years)			
		Less Than 1	1-5	6-10	More Than 10
Certificates of deposit (1)	\$ 600,092	\$ 600,092	\$ -	\$ -	\$ -
Commercial paper	3,234,753	3,234,753	-	-	-
Federal National Mortgage Association	706,408	507,500	198,908	-	-
Federal Home Loan Mortgage Corporation	528,615	-	528,615	-	-
Federal Home Loan Bank	820,405	-	547,982	272,423	-
Federal Farm Credit Bank	534,020	255,065	-	278,955	-
U.S. Treasuries	1,450,093	-	510,418	939,675	-
Freddie Mac	171,780	-	171,780	-	-
Accrued interest	31,925	31,925	-	-	-
Total	<u>\$ 8,078,091</u>	<u>\$ 4,629,335</u>	<u>\$ 1,957,703</u>	<u>\$ 1,491,053</u>	<u>\$ -</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2013 and 2012

December 31, 2012

Investment Type	Carrying Amount	Investment Maturities (in Years)			
		Less Than 1	1-5	6-10	More Than 10
Certificates of deposit (1)	\$ 4,675,321	\$ 3,465,061	\$ 1,210,260	\$ -	\$ -
Commercial paper	3,231,151	3,231,151	-	-	-
Federal National Mortgage Association	971,425	256,150	715,275	-	-
Federal Home Loan Mortgage Corporation	610,381	49,450	271,618	289,313	-
Federal Home Loan Bank	1,625,958	502,835	278,935	844,188	-
Federal Farm Credit Bank	643,510	77,239	261,833	304,438	-
U.S. Treasuries	1,537,273	-	520,992	1,016,281	-
Freddie Mac	180,699	-	180,699	-	-
Accrued interest	43,902	43,902	-	-	-
	<u>\$ 13,519,620</u>	<u>\$ 7,625,788</u>	<u>\$ 3,439,612</u>	<u>\$ 2,454,220</u>	<u>\$ -</u>

- (1) The certificates of deposit were purchased through the Certificate of Deposit Account Registry Service (CDARS) program. They are reported at fair value and have been included in investments. The entire amount above is insured by the FDIC.

Interest Rate Risk

The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk. As of December 31, 2013, the Healthcare System's investment in Federal Home Loan Bank, Federal Home Loan Mortgage Corporation, Federal National Mortgage Association, Federal Farm Credit Bank, and U.S. Treasuries are rated AAA by Moody's Investors Service and AA+ by Standards and Poors.

Concentration of Credit Risk

The Healthcare System currently does not place a limit on the amount it may invest with any one issuer. More than 5 percent of the Healthcare System's investments are in the following investments as of December 31, 2013:

	<u>Percentage</u>
Fortis Funding LLC - Commercial paper	39.0%
U.S. Treasuries	17.5%
Federal Home Loan Bank	9.9%
Federal National Mortgage Association	8.5%
Certificates of Deposit	7.2%
Federal Farm Credit Bank	6.4%
Federal Home Loan Mortgage Corporation	6.4%

Custodial Credit Risk

For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Healthcare System will not be able to recover the value of its investment or collateral securities that are in the possession of an outside party. At December 31, 2013 and 2012, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in other than the Healthcare System's name.

Summary of Carrying Amounts

The carrying amounts of the Healthcare System's deposits and investments shown above are included in the balance sheets at December 31, 2013 and 2012 as follows:

	<u>2013</u>	<u>2012</u>
Carrying amount		
Deposits	\$ 4,102,224	\$ 3,056,931
Investments	8,078,091	13,519,620
Forward purchase contract (1)	1,016,882	1,644,115
Total	<u>\$ 13,197,197</u>	<u>\$ 18,220,666</u>
Included in the following balance sheet captions		
Cash and cash equivalents	\$ 3,874,909	\$ 2,831,615
Temporary investments	632,017	3,508,965
Restricted assets - current portion (Note 6)	1,656,043	1,578,510
Other long-term investments	5,228,202	8,423,620
Restricted under indenture agreement for debt service (1)(Note 6)	1,806,026	1,877,956
Total	<u>\$ 13,197,197</u>	<u>\$ 18,220,666</u>

- (1) A forward purchase contract was entered into in 1999 by the Healthcare System relating to certain trustee held funds associated with the Series 1999 bonds. The contract provides a fixed rate of return of 5.775% on the Debt Service Fund and the Reserve Fund investments. The contract has a maturity date of November 2024, a notional value of approximately \$2,823,000 as of December 31, 2013 and 2012, respectively, and an estimated fair value of approximately \$1,017,000 and \$1,644,000 at December 31, 2013 and 2012, respectively. The forward purchase contract is included in other long-term investments in the accompanying financial statements.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2013 and 2012:

	2013	2012
Interest income and realized gains and losses	\$ 165,007	\$ 332,100
Interest income on proceeds of borrowed funds	220,577	349,325
Total investment income	<u>\$ 385,584</u>	<u>\$ 681,425</u>
Change in unrealized gains and losses on investments	<u>\$ (191,747)</u>	<u>\$ 7,006</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2013 and 2012

Note 4 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2013 are as follows:

	Balance December 31, 2012	Additions	Transfers and Retirements	Balance December 31, 2013
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ -	\$ 1,623,212
Construction in progress	2,241,250	1,894,303	(3,355,789)	779,764
Total capital assets, not being depreciated	<u>\$ 3,864,462</u>	<u>\$ 1,894,303</u>	<u>\$ (3,355,789)</u>	<u>\$ 2,402,976</u>
Capital assets being depreciated				
Land improvements	\$ 1,012,585	\$ -	\$ -	\$ 1,012,585
Buildings and improvements	42,852,062	161,721	1,971,673	44,985,456
Equipment	46,854,640	935,856	617,911	48,408,407
Total capital assets being depreciated	<u>90,719,287</u>	<u>1,097,577</u>	<u>2,589,584</u>	<u>94,406,448</u>
Less accumulated depreciation for				
Land improvements	(569,289)	(56,202)	-	(625,491)
Buildings and improvements	(19,248,295)	(1,229,853)	-	(20,478,148)
Equipment	(33,393,036)	(3,751,908)	653,674	(36,491,270)
Total accumulated depreciation	<u>(53,210,620)</u>	<u>(5,037,963)</u>	<u>653,674</u>	<u>(57,594,909)</u>
Net capital assets being depreciated	<u>\$ 37,508,667</u>	<u>\$ (3,940,386)</u>	<u>\$ 3,243,258</u>	<u>\$ 36,811,539</u>
Capital assets, net	<u>\$ 41,373,129</u>			<u>\$ 39,214,515</u>

Construction in progress at December 31, 2013, represents costs related to information technology. The total estimated cost to complete the projects is \$145,000, which will be funded from working capital.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2013 and 2012

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2012 are as follows:

	Balance December 31, 2011	Additions	Transfers and Retirements	Balance December 31, 2012
Capital assets not being depreciated				
Land	\$ 1,675,542	\$ -	\$ (52,330)	\$ 1,623,212
Construction in progress	1,887,130	3,768,092	(3,413,972)	2,241,250
Total capital assets, not being depreciated	<u>\$ 3,562,672</u>	<u>\$ 3,768,092</u>	<u>\$ (3,466,302)</u>	<u>\$ 3,864,462</u>
Capital assets being depreciated				
Land improvements	\$ 1,011,580	\$ 1,005	\$ -	\$ 1,012,585
Buildings and improvements	41,238,335	1,552,258	61,469	42,852,062
Equipment	41,217,380	3,021,300	2,615,960	46,854,640
Total capital assets being depreciated	<u>83,467,295</u>	<u>\$ 4,574,563</u>	<u>\$ 2,677,429</u>	<u>90,719,287</u>
Less accumulated depreciation for				
Land improvements	(512,800)	(56,489)	-	(569,289)
Buildings and improvements	(18,068,800)	(1,179,495)	-	(19,248,295)
Equipment	(30,672,659)	(3,434,551)	714,174	(33,393,036)
Total accumulated depreciation	<u>(49,254,259)</u>	<u>(4,670,535)</u>	<u>714,174</u>	<u>(53,210,620)</u>
Net capital assets being depreciated	<u>\$ 34,213,036</u>	<u>\$ (95,972)</u>	<u>\$ 3,391,603</u>	<u>\$ 37,508,667</u>
Capital assets, net	<u>\$ 37,775,708</u>			<u>\$ 41,373,129</u>

Construction in progress at December 31, 2012, represents costs related to information technology and planning for the construction of a medical office building.

Note 5 - Operating Leases

The Healthcare System leases certain medical and other equipment and office space under operating leases having terms of more than one year. Total operating lease expense for the years ended December 31, 2013 and 2012 for all operating leases was \$711,779 and \$693,308. Minimum future lease payments for these operating leases are as follows:

<u>Year Ending December 31,</u>	<u>Amount</u>
2014	\$ 204,343
2015	71,289
2016	56,196
2017	<u>13,200</u>
Total minimum lease payments	<u><u>\$ 345,028</u></u>

Note 6 - Long-Term Debt

Long-term debt activity for the year ended December 31, 2013 follows:

	<u>Balance December 31, 2012</u>	<u>Additions</u>	<u>Reductions</u>	<u>Balance December 31, 2013</u>	<u>Amounts Due Within One Year</u>
Hospital Revenue Bonds, Series 2004	\$ 4,030,380	\$ -	\$ (150,066)	\$ 3,880,314	\$ 158,784
Hospital Revenue and Refunding Bonds, Series 1999	22,815,000	-	(1,360,000)	21,455,000	1,450,000
Original issue discount	(107,148)	-	15,176	(91,972)	-
Equipment leases	2,195,921	-	(853,356)	1,342,565	865,206
Batti land contract	344,000	-	(57,248)	286,752	65,393
Cameron land contract	<u>-</u>	<u>819,902</u>	<u>(140,463)</u>	<u>679,439</u>	<u>81,091</u>
	<u><u>\$ 29,278,153</u></u>	<u><u>\$ 819,902</u></u>	<u><u>\$ (2,545,957)</u></u>	<u><u>\$ 27,552,098</u></u>	<u><u>\$ 2,620,474</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2013 and 2012

Long-term debt activity for the year ended December 31, 2012 follows:

	Balance December 31, 2011	Additions	Reductions	Balance December 31, 2012	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 4,172,208	\$ -	\$ (141,828)	\$ 4,030,380	\$ 150,066
Hospital Revenue and Refunding Bonds, Series 1999	24,135,000	-	(1,320,000)	22,815,000	1,360,000
Original issue discount	(123,198)	-	16,050	(107,148)	-
Equipment leases	-	2,876,519	(680,598)	2,195,921	853,356
Batti land contract	-	430,000	(86,000)	344,000	57,248
	<u>\$ 28,184,010</u>	<u>\$ 3,306,519</u>	<u>\$ (2,212,376)</u>	<u>\$ 29,278,153</u>	<u>\$ 2,420,670</u>

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2013 and 2012 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
- 5.70% to 5.80% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999 (Series 1999 Bonds) - Due in varying annual installments to November 2024, secured by a pledge of net revenues, investment income, and bond funds held under the indenture agreement (Note 3). (1)
- Original Issue Discount - Associated with the Series 1999 Bonds issuance.
- Equipment Notes Payable
 - o MRT Equipment Note Payable – During 2012, the Healthcare System placed in service certain equipment financed by Wells Fargo Equipment Finance, Inc. and recorded a corresponding liability. On November 15, 2012, the Healthcare System entered into a 3.2%, 52 month note payable with Wells Fargo Equipment Finance, Inc. The note payable is due in monthly installments of \$18,771 to March 2017, and is secured by certain equipment.
 - o Seimens Note Payable – During 2012, the Healthcare System place in service certain equipment provided by Seimens and recorded a corresponding liability. On May 14, 2012, the Healthcare System entered into a 0.8%, 3 year note payable with Seimens. The note payable is due in yearly installments of \$664,227 to May 2014, and is secured by certain equipment.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2013 and 2012

- Batti land contract – On December 28, 2012, the Healthcare System entered into a 4.5%, 60 month note payable. The note payable is due in monthly installments of \$6,413 to December 2017, and is secured by certain equipment.
 - Cameron land contract – On March 6, 2013, the Healthcare System entered into a 4.5%, 97 month note payable. The note payable is due in monthly installments of \$9,167 to March 2021, and is secured by certain equipment.
- (1) The Series 2004 Bonds and Series 1999 Bonds loan agreements places limits on the incurrence of additional borrowings and requires the Healthcare System satisfy certain measures of financial performance. The Series 1999 Bonds loan agreement also requires the Healthcare System maintain certain deposits with a trustee. Such deposits are shown as restricted for this purpose in the balance sheets (Note 3).

Scheduled principal and interest payments on long-term debt are as follows:

<u>Year Ending December 31,</u>	<u>Long-Term Debt</u>		<u>Total</u>
	<u>Principal</u>	<u>Interest</u>	
2014	\$ 2,620,474	\$ 1,516,559	\$ 4,137,033
2015	2,079,303	1,405,851	3,485,154
2016	2,188,023	1,294,068	3,482,091
2017	2,121,578	1,178,447	3,300,025
2018	2,091,072	1,063,142	3,154,214
2019-2023	12,192,539	3,381,529	15,574,068
2024-2028	4,113,337	450,937	4,564,274
Thereafter	237,744	4,961	242,705
	<u>27,644,070</u>	<u>\$ 10,295,494</u>	<u>\$ 37,939,564</u>
Less unamortized bond discount	<u>(91,972)</u>		
Total	<u>\$ 27,552,098</u>		

Note 7 - Defined Benefit Pension Plan

A. Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year.

The most recent actuarial valuation was made as of January 1, 2014. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2013 and 2012 was approximately \$24,274,000 and \$28,724,000. The Healthcare System's total actual payroll for the years ended December 31, 2013 and 2012 was approximately \$39,644,298 and \$37,859,846.

Current membership in the Plan consists of the following at December 31:

	2013	2012
Retirees and beneficiaries currently receiving benefits	299	260
Vested terminated members	161	159
Active and inactive employees		
Fully vested	450	505
Nonvested	10	76
	920	1,000

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. Fifty percent of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2013 and 2012 were 15.22% and 10.42%, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2013 and 2012 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2012 and 2011, respectively.

Funding Progress

The funded status of the Plan based on the actuarial valuations as of the January 1, 2010, 2011, 2012, 2013, and 2014 is as follows:

Actuarial Valuation Date January 1,	Actuarial Value of Assets (A)	Actuarial Accrued Liability (AAL) Entity Age (B)	Unfunded (Over funded) AAL (UAAL) (B - A)	Funded Ratio (A/B)	Covered Payroll (C)	UAAL as a Percentage of Covered Payroll ((B-A)/C)
2010	27,576,575	41,656,118	14,079,543	66.2%	32,389,391	43.5%
2011	30,455,817	43,178,949	12,723,132	70.5%	31,447,854	40.5%
2012	32,811,379	47,643,705	14,832,326	68.9%	32,382,406	45.8%
2013	35,047,767	52,404,010	17,356,243	66.9%	28,723,689	60.4%
2014	39,593,016	56,580,893	16,987,877	70.0%	24,274,184	70.0%

The funded status disclosed above was actuarially determined using methods prescribed for governmental defined benefit pension plans.

Annual Pension Cost

For 2013, 2012, 2011, 2010, and 2009, the Healthcare System's annual pension cost was equal to the Healthcare System's required and actual contributions. The required contribution was determined as part of the January 1, 2013, 2012, 2011, 2010, and 2009, actuarial valuations using the projected unit credit cost actuarial funding method. The actuarial assumptions for fiscal 2013 and 2012 included (a) 7.5% investment rate of return and (b) salary increases including merit and seniority increases ranging from 5.3% to 0.2% per year, plus wage inflation of 3.5%. The assumptions regarding benefits are that no changes will occur on a postretirement basis.

The Healthcare System's annual pension cost, and required and actual contributions for the years ended December 31, 2013, 2012, 2011, 2010, and 2009 were approximately \$3,699,000, \$2,993,000, \$3,062,000, \$2,822,000 and \$2,363,000. The net pension obligation for the years ended December 31, 2013, 2012, 2011, 2010, and 2009 was zero.

A separately issued financial report of the Dickinson County Healthcare System Retirement Plan is available which includes financial statements and required supplementary information for the Plan.

Note 8 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Wilmington Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

In accordance with the provisions of GASB Statement No. 32, the DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 9 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees (with the exception of AFSCME employees and contracted physicians) who were not currently vested in the defined benefit pension plan were transitioned to the new plan design. Effective February 22, 2013, all AFSCME employees who were not vested were transferred to the new plan design.

MNA nursing staff transitioned effective May 1, 2011 per the MNA collective bargaining agreement and non-union staff transitioned effective September 4, 2011. In addition, all new hires as of September 4, 2011 are members of the new plan. Effective February 22, 2013, all new AFSCME new hires are members of the new plan.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1-3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 8), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$298,904 and \$149,828 for the years ended December 31, 2013 and 2012.

Note 10 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$3 million. The policies end in July 31, 2014.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis.

The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2013 and 2012. Amounts included as expense for general and professional liability for the years ended December 31, 2013 and 2012, which include claims and premiums paid, were approximately \$416,186 and \$426,554.

The reserve for loss on professional liability claims at December 31, 2013 and 2012 and activity for the years then ended is as follows:

Balance December 31, 2011	Additions	Reductions	Balance December 31, 2012	Additions	Reductions	Balance December 31, 2013
\$ 1,365,000	\$ -	\$ (28,600)	\$ 1,336,400	\$ -	\$ (232,400)	\$ 1,104,000

Note 11 - Litigation, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 12 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2013 and 2012 was as follows:

	2013	2012
Medicare	32%	29%
Blue Cross	21%	20%
Medicaid	9%	8%
Commercial insurance and other	23%	27%
Self pay	15%	16%
	<u>100%</u>	<u>100%</u>

The Healthcare System is subject to collective bargaining agreements for approximately 60.3 percent of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in February of 2019. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2015.

Note 13 - Dickinson County Hospital Foundation

Dickinson County Hospital Foundation (Foundation) is organized to raise funds for the benefit of the Healthcare System and the community. The Foundation is deemed not to be a component unit of the Healthcare System as defined in GASB 39, *Determining Whether Certain Organizations Are Component Units*, as the economic resources received or held by the Foundation is not considered significant to the Healthcare System. As the Foundation is not considered a component unit, the Foundation's financial statements are not included in these financial statements. At December 31, 2013 and 2012, the Foundation's assets consisted primarily of cash and short-term investments and totaled approximately \$381,668 and \$406,854.

Note 14 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$60,104 and \$31,302 for the years ended December 31, 2013 and 2012. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2013 was approximately \$13,440,000.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 15 - Electronic Health Record Incentive Payments

The Healthcare System recognized revenue of \$2,158,332 and \$505,913 for the years ended December 31, 2013 and 2012 related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements

Note 16 - Changes in Account Principals

As of January 1, 2013 and for the year ended December 31, 2013, the Healthcare System adopted Governmental Accounting Standards Board (GASB) Statement No. 65: *Items Previously Reported as Assets and Liabilities*. As a result of adopting GASB 65, the Healthcare System had an increase in noncurrent cash and investments restricted under indenture agreement for debt service of \$103,569, a decrease in deferred financing costs, net of accumulated amortization of \$148,065 as of December 31, 2012, and a decrease in interest and amortization expense of \$19,163 and investment income of \$8,750 for the years ended December 31, 2012. The effect on December 31, 2012 net position was to decrease net position by \$44,496.

The following shows the effect of the change on beginning net position:

	<u>2012</u>
Beginning net position	\$ 34,318,786
Effect of restatement	<u>(54,909)</u>
Restated beginning net position	<u><u>\$ 34,263,877</u></u>

Note 17 - Subsequent Events

The Healthcare System has evaluated subsequent events through April 23, 2014, the date which the financial statements were available to be issued.



Management Discussion and Analysis and
Financial Statements

December 31, 2012 and 2011

Dickinson County Healthcare System

(A Component Unit of Dickinson County)

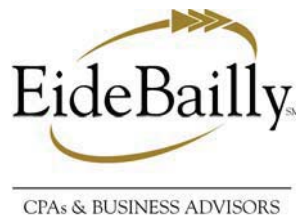
Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2012 and 2011

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	3
Financial Statements	
Balance Sheets.....	17
Statements of Revenues, Expenses, and Changes in Net Position	18
Statements of Cash Flows	19
Notes to Financial Statements	21



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

Report on the Financial Statements

We have audited the accompanying financial statements of Dickinson County Healthcare System (a component unit of Dickinson County), which comprise the balance sheets as of December 31, 2012 and 2011, and the related statements of revenues, expenses, and changes in net position 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.

Auditor's 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. 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 auditor's 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.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2012 and 2011, and the results of its operations, changes in net position, and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 15 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 1, 2013 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

A handwritten signature in black ink that reads "Eide Bailly LLP". The signature is written in a cursive, flowing style.

Fargo, North Dakota
May 1, 2013

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2012 and 2011. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2012

The Healthcare System's net position increased in 2012 by \$1.679 million or 4.8% with losses before capital contributions and forward purchase agreement adjustment of \$164 thousand, comprised of an operating income of \$865 thousand and nonoperating expenses in excess of nonoperating revenue of \$1.029 million. There were \$186 thousand contributions for capital purposes in 2012. As a result of a change in the method of recording the forward purchase agreement, an unrealized gain of \$1.657 million was recorded in 2012 for prior years. During 2012, the Healthcare System's total operating revenues of \$84.3 million was 10.2% higher than the amount in 2011. The resulting operating income for 2012 of \$865 thousand was 1.0% of total operating revenue compared to an operating loss of \$1.034 million for 2011 which was (1.4%) of operating revenue.

The following major projects and service enhancements were completed in 2012:

- The Healthcare System expanded participation in the 340B program by entering into retail pharmacy agreements with three local retail pharmacies. In addition, 2012 was the first full year of hospital outpatient drug cost savings.
- Providers added included: Dr. Shaker – Cardiology and Dr. Scott – Urology.
- New medical record technology was implemented throughout the patient care units in Dickinson Memorial Hospital. These included Medication Administration and Computerized Physician Order Entry which are necessary to meet Stage 1 Meaningful Use requirements.
- Installed the Practice Partner Electronic Health Record at Dickinson Cardiology Services, UP Sleep Disorders Center, Dickinson Internal Medicine Clinic, Dickinson Podiatry Services, Dickinson OB/GYN Clinic.
- Installed the following systems/modules; OB Fetal Monitoring, Dietary Room Service, Wound Care, EEG system, Public Wireless Network, and OR Tracking Board
- Upgraded the following systems; Paragon (4 times), Practice Partner, Lawson LBI, Lawson Applications, McKesson Document Interface, Single Sign On, Cactus – Physician Credentialing, Intellicode, eMail Encryption, Misys/Tiger (2 times), EC2000, Pathways Compliance Advisor, and Pathways Contract Management.

- Networked the following new clinics; Wound Care, Urology, Bellin, Cardiology – Marquette, Cardiology – Iron River, UP Sleep Disorder, and Dickinson Medical Services at Bayside
- Interfaces developed include results to MGHS Practice Partner, results to Michigan-Wisconsin Family Practice Associates PC eMDs, radiology billing, dietary system orders/ADT's, and Misys/Tiger financial interface.
- A new CT scanner was installed that contains a flash CT mode which allows split second scanning with a 60% dose reduction. The dual source CT enables early detection of calcification in cardiac arteries and the dual energy CT determines the chemical composition of kidney stones. It also contains an industry leading bariatric option for patients up to 660 pounds.
- Radiation Oncology Technology was upgraded to Rapid Arc which provides greater treatment accuracy and greater patient comfort. The hardware upgrade to the linear accelerator enables finer shaping of the radiation beam for more precise treatment of cancer cells while preserving healthy tissue.
- The Dickinson Pediatric Clinic added concussion management, providing ImPACT testing. Baseline tests were provided to children in grades 5-8 thanks to a donation from Dickinson Memorial Hospital Foundation. Pediatric Neurology services were also added through telehealth appointments with Dr. Arndt of Helen DeVos Children's Hospital in Grand Rapids. He is a noted specialist in children's seizure disorders. Pediatric Nephrology services were also added through quarterly visits by Dr. Haws from the Marshfield Clinic.
- Services were expanded into Delta County, at Cedar Hill-Bayside Clinic in Gladstone. These services include Podiatry and Dermatology.
- A surgical tracking system was developed and implemented whereby patients undergoing a surgical procedure are assigned a number that is shared with family members. The number is displayed on computer screens located in the Surgical Lounge and Cafeteria showing the different stages of the surgical process for each patient. This enables family members to track their loved one's progress.
- The Healthcare System's Laboratory and Imaging services were added to the Bellin Clinic on Woodward Avenue.
- The following Physician Practices attained designation as provider based clinics: Dickinson Cardiology Services, Dickinson Podiatry Services, Dickinson Dermatology Services and Barry D. Johnson, MD Neurology Clinic.
- The Dietary department became Food and Nutrition Services and launched the new Room Service program. The kitchen was revamped from its emphasis on bulk cooking to short order meal preparation. The patient can eat whatever they like whenever they like by ordering their meals from a designated anytime within a 12 hour time frame. Patient satisfaction scores climbed from the 30th to the 98th percentile with temperature and quality of food ranked in the 99th percentile.
- The Healthcare System attained an "A" rating from the Leapfrog Group, an independent national non profit organization. They calculate a single safety score, based upon 26 measures of publicly available hospital safety data, which represents a hospital's overall capacity to keep patients safe from infections, injuries, and medical and medication errors.

- Construction was completed on the new medical office building on the west side of the hospital campus for the relocation of the Dickinson Occupational Clinic and the expansion of the wound care program to become The Center for Wound Healing and Hyperbaric Medicine. The Dickinson Pediatric Clinic was also expanded to twice its former size to add a telehealth room and an ImPACT testing room.

Year Ended December 31, 2011

The Healthcare System's net position decreased in 2011 by \$1.639 million or 4.6% with losses before capital contributions of \$1.652 million, comprised of an operating loss of \$1.034 million and nonoperating expenses in excess of nonoperating revenue of \$618 thousand. There were \$13 thousand contributions for capital purposes in 2011. During 2011, the Healthcare System's total operating revenues of \$76.5 million was 3.8% higher than the amount in 2010. The resulting operating loss for 2011 of \$1.034 million was (1.4%) of total operating revenue compared to operating income of \$403 thousand for 2010 which was 0.5% of operating revenue.

The following major projects and service enhancements were completed in 2011:

- Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.
- Providers added included: Dr. Hartfiel – OBGYN, Dr. Anderson – Podiatry; Dr. Kaur – Internal Medicine/Nephrology; Dr. Rayel – Cardiology; Dr. Downs – Emergency Medicine; and Dr. Tuladhar – Pediatrics.
- Contracted with Hospitalists of Northern Michigan to provide hospitalist services to inpatients. This new group of hospitalists have gained widespread acceptance from the medical staff, most of who have handed over their inpatients to the care of the hospitalists. They also work with many hospital committees to improve care and compliance. Due to their ability to treat more complex cases and their consistent and accurate coding, the Healthcare System has experienced an increase in the case mix index and a related increase in reimbursement.
- Installed the Practice Partner Electronic Health Record at the Pediatric Clinic and Florence Medical Center and well as a new budget and management reporting system and a dietary Point of Sale system. In addition a compellent storage area network and Relay Clearance Pro (insurance eligibility system) were installed.
- Upgrades to nine systems were completed which included Horizon Patient Folder, Paragon (necessary for meeting Meaningful Use criteria), the Tera Recon and PACS radiology imaging systems, Lawson Requisition Self Serve for Purchasing, Misys Tiger professional billing system, EC2000, and Pathways Compliance Advisor and Contract Management.
- Interfaces were developed for reporting to Marquette General Health System and Cedar Hill Clinic as well as reporting to/from Practice Partner.

- Other major IT projects included implementation of a pharmacy repackaging system for barcoding drugs, replacement of 70 user workstations in preparation for the Horizon Patient Folder and Paragon upgrades.
- relocation of the OB/GYN Clinic, redesign of the hospital website and installation of Green Bay Oncology equipment in the Ambulatory Care Unit infusion area for accessing their electronic health record.
- Construction began in the fall on a 5,896 square foot medical office building on the west side of the hospital campus to house an expanded wound care program to include hyperbaric medicine. In addition, the Dickinson Occupational Clinic was relocated to the new building from its current location in the Dickinson Medical Building to allow for the expansion of the Pediatrics Clinic which houses a full complement of providers including three physicians and two mid-level providers.
- The Healthcare System's Defined Benefit Pension Plan was closed to new hires effective May 1 for Michigan Nurses Association members and September 4 for non-union members. A new Defined Contribution Pension Plan was created for these new hires as well as non vested employees in the two groups.

Year Ended December 31, 2010

The Healthcare System's net position decreased in 2010 by \$705 thousand, or 1.9% with losses before capital contributions of \$708 thousand, comprised of operating income of \$403 thousand less nonoperating expenses in excess of nonoperating revenue of \$1.1 million. There were \$3 thousand contributions for capital purposes in 2010. During 2010, the Healthcare System's total operating revenues of \$73.7 million was 0.7% higher than the amount in 2009. The resulting operating income for 2010 of \$403 thousand was 0.5% of total operating revenue compared to operating income of \$90 thousand for 2009 which was 0.1% of operating revenue.

The following major projects and service enhancements were completed in 2010:

- Rehabilitation Services began providing on-site care at Northland International University during the last quarter of 2010. This expansion of care provides necessary services on campus for the students of NIU who have only limited time off campus, as well as for the patients within that community.
- Two family practice physicians were added during the year; Dr. Knauf-Jorasz is located in the Cedar Hill Clinic and Dr. Jakel practices in Norway. The family practice clinic at Cedar Hill was subsequently discontinued in the fall of 2011.
- A Stereotactic Breast Biopsy unit was installed to enhance our digital mammography unit by providing a full circle of care in diagnosing and treating breast cancer.
- Through collaboration with Marquette General Health System and Dr. Coccia, the Healthcare System enhanced their ability to provide Neurology surgical services.
- The Emergency Department began a large process improvement project in 2010 using Lean tools and techniques. This was done in conjunction with the MHA Keystone Initiative. Several other smaller scale projects have taken place that affect areas such as Imaging, Rehabilitation Services and various storage locations. The Healthcare System began applying the Lean methodology to various projects in 2009 with the ED initiative helping to spread the efforts further into the organization.

- Completed our image migration from the legacy A4/MSA enVista Document Imaging system to the McKesson Horizon Patient Folder system. This allows clinicians to access a single system for patient results.
- Upgraded the Paragon system to the 9.4 major release which provided improvements for clinicians who utilize Physicians Webstation. This was also a necessary step before we can upgrade to the next major release (10.x) that is required to become meaningful users.
- Upgraded our McKesson interface engine to the version required for becoming meaningful users.
- Installed a results interface for the Rehabilitation Documentation System to send results directly to Horizon Patient Folder eliminating the need to scan the records on the back end in Medical records. The only records being scanned on the back end now are those that require signatures.
- Upgraded our Storage Area Network (SAN) to the next model to correct system failures that could not be fixed in the current model. We experienced multiple 8-10 hour total system outages throughout the year until this upgrade was completed. We have experienced zero unplanned outages for our SAN since the upgrade.
- Installed a new patient discharge instruction system for the emergency department that provides much improved functionality and ease of use for the providers than the previous system used.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Balance Sheet includes all assets, liabilities and net position. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Position measures the annual financial performance of operations and reports all nonoperating revenue and expense items, capital contributions and the net increase in Net Position. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Financial Analysis of the System

The condensed Balance Sheets of the Healthcare System as of December 31, 2012, 2011, and 2010 are summarized in the following table.

Condensed Balance Sheets

December 31, 2012, 2011, and 2010 (in Thousands)

	2012	2011	2010
Total current assets (includes the current portion of restricted assets)	\$ 23,530	\$ 23,339	\$ 24,202
Cash and investments internally designated for other purposes	8,424	7,925	9,374
Cash and investments restricted by bond indentures	1,774	1,877	1,868
Other Assets	884	869	201
Capital assets, net	41,373	37,776	37,788
Total Assets	\$ 75,985	\$ 71,786	\$ 73,433
Total current liabilities	\$ 13,032	\$ 10,803	\$ 10,275
Long-term debt, net of current portion	25,619	25,299	26,550
Other long-term liabilities	1,336	1,365	650
Total Liabilities	39,987	37,467	37,475
Total Net Position	35,998	34,319	35,958
Total Liabilities and Net Position	\$ 75,985	\$ 71,786	\$ 73,433

Current Assets and Liabilities

Net patient accounts receivable decreased to 51.3 days' of net revenue at December 31, 2012 compared to 55.4 days' of net revenue at December 31, 2011 and compared to 48.7 at December 31, 2010. The 2011 increase was a result of 5010 processing issues experienced by National Government Services which resulted in a backlog of claims to be processed. The processing issues were resolved in 2012, resulting in the decrease of 4.1 days.

Total current assets increased 1.0% in 2012 and decreased 3.6% in 2011 compared to each prior year. The 2012 increase is a result of an increase in other accounts receivable and cash offset by a decrease in short term investments and patient accounts receivable while the 2011 decrease is the net result of an increase in accounts receivable offset by a decrease in cash and temporary investments.

Current liabilities increased 21% in 2012 as a result of an increase in trade accounts payable and current maturity of debt and capital lease obligations while current liabilities increased 5% in 2011 as a result of an increase in trade accounts payable compared to the prior year-end. The Healthcare System's current ratio (current assets divided by current liabilities) was 1.81 at December 31, 2012 and 2.16 at December 31, 2011.

Total Cash and Investments

The number of days of total cash and investments was 82.2 at December 31, 2012 and 93.5 at December 31, 2011. Excluding the restricted amounts, the ratios for 2012 and 2011 were 67.0 days and 76.9 days, respectively.

The total cash and investments at December 31, 2012 were \$18.1 million including restricted funds of \$3.4 million. Total cash and investments at December 31, 2011 were \$19.2 million including restricted funds of \$3.4 million.

Long-Term Debt

The Healthcare System had long-term debt of \$25.6 million at December 31, 2012 and \$25.3 million at December 31, 2011 (net of current maturities of \$2.4 million in 2012 and \$1.5 million in 2011). In 2012 capital leases were issued for a CT Scanner, MRT upgrade and the purchase of a physician office suite in the Dickinson Medical Building. No new debt or capital leases were issued in 2011. Long-term debt at December 31, 2012 represents 95.0% of total long-term liabilities and 64.1% of total liabilities as compared 94.9% of total long-term liabilities and 67.5% of total liabilities at December 31, 2011. The debt service coverage ratio for the years ended December 31, 2012 and 2011 was 1.62 and 1.44 respectively.

Net Position

Total net position increased in 2012 and decreased in 2011 while unrestricted net position decreased from 2011 to 2012 and from 2010 to 2011. The decrease in the unrestricted component for 2012 was due to increased investment in capital assets. The decrease in the unrestricted component for 2011 was due to increased investment in capital assets and declines in operating income. The amount invested in capital assets, net of related debt increased in 2012 and 2011 as a result of the need to replace outdated equipment that had been forgone in the last few years of decreased capital spending. The restricted amount for debt service represents the funds held by the trustee for the Series 1999 bonds. This amount decreased slightly in 2012 and increased in 2011 related to debt service requirements. These components are presented in the following table.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2012, 2011, and 2010

Components of Net Position (in thousands)

	December 31,		
	2012	2011	2010
Invested in capital assets, net of related debt Restricted by revenue bond indentures, expendable for debt service	\$ 13,480	\$ 11,189	\$ 10,049
Unrestricted	3,353	3,427	3,334
	<u>19,165</u>	<u>19,703</u>	<u>22,575</u>
Total net position	<u>\$ 35,998</u>	<u>\$ 34,319</u>	<u>\$ 35,958</u>

Statements of Revenues, Expenses, and Changes in Net Position

The condensed statements of revenues, expenses, and changes in net position of the Healthcare System for the years ended December 31, 2012, 2011, and 2010 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Position
Years Ended December 31, 2012, 2011, and 2010 (in Thousands)

	2012		2011		2010	
Revenue and (expenses):						
Net patient service revenue	\$ 77,801	92.3%	\$ 74,456	97.3%	\$ 71,858	97.5%
Other revenue	6,469	7.7%	2,079	2.7%	1,851	2.5%
Total operating revenue	<u>84,270</u>	100.0%	<u>76,535</u>	100.0%	<u>73,709</u>	100.0%
Total operating expenses	<u>83,405</u>	99.0%	<u>77,569</u>	101.4%	<u>73,306</u>	99.5%
Operating income	<u>865</u>	1.0%	<u>(1,034)</u>	-1.4%	<u>403</u>	0.5%
Investment income	690	0.8%	1,144	1.5%	888	1.2%
Change in unrealized gains and losses on investments	7	0.0%	119	0.2%	55	0.1%
Change in fair market value of forward purchase agreement	(13)	0.0%	-	0.0%	-	0.0%
Interest and amortization expense	(1,738)	-2.1%	(1,847)	-2.4%	(1,994)	-2.7%
Other non-operating revenue and expenses (net)	<u>25</u>	0.0%	<u>(34)</u>	0.0%	<u>(60)</u>	-0.1%
Non-operating expenses in excess of revenue	<u>(1,029)</u>	-1.2%	<u>(618)</u>	-0.8%	<u>(1,111)</u>	-1.5%
Income (loss) before capital contributions	<u>(164)</u>	<u>-0.2%</u>	<u>(1,652)</u>	<u>-2.2%</u>	<u>(708)</u>	<u>-1.0%</u>
Forward purchase agreement adjust:	1,657		-		-	
Capital contributions	<u>186</u>		<u>13</u>		<u>3</u>	
Increase (decrease) in net position	1,679		(1,639)		(705)	
Net position - beginning of year	<u>34,319</u>		<u>35,958</u>		<u>36,663</u>	
Net position - end of year	<u>\$ 35,998</u>		<u>\$ 34,319</u>		<u>\$ 35,958</u>	

Results of Operations

Overall results of operations of \$865 thousand or 1.0% of revenue for 2012 increased from (\$1,034) thousand or (1.4%) of revenue for 2011. The net nonoperating expenses in excess of nonoperating revenue for 2012 increased to \$1.029 million from \$618 thousand in 2011. The net increase in 2012 is due to lower investment income. The net decrease in 2011 was due to higher investment income, higher change in unrealized gains on investments and lower interest expense. The net result for 2012 was a loss of (\$164) thousand or (0.2%) of total operating revenue before capital contributions. The net result for 2011 was a loss of (\$1.652) million or (2.2%) of total operating revenue before capital contributions.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2012 comprised 33.7% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2011 was also 33.7%. The operating performance of DCMH was affected by inpatient discharges decreasing by 3.6% to 3,219 from 3,338 in 2011, while acute adult and pediatric inpatient days increased by 1% to 11,777 from 11,681 in 2011. Net patient revenue increased 4.4% and the all-payer case mix index increased to 1.232 from 1.175 in 2011. Patients have higher deductibles and co pays and therefore are delaying treatment until they are sicker, resulting in the decreased discharges but increased patient days and case mix index that was experienced by DCMH in 2012. Discharges increased 5.9% in 2011 while net inpatient revenue increased 11.8% due in large to the new hospitalist program that was implemented in June of 2011.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 55.7% of total Healthcare System net patient revenue and its operating activities for 2012. The comparable percentage for 2011 was 56.8%. Net outpatient revenue increased 2.5% in 2012 and decreased 1.2% in 2011. Total outpatient visits were 169,863 in 2012 and 166,515 in 2011. As a percent, the largest increase in outpatient visits was seen in Radiation Oncology due in large part to the employment of a new Radiation Oncologist.

The net patient revenue of the Rural Health Clinics and other physician practices comprised about 10.6% of the total net patient revenue of the Healthcare System for 2012 and 9.5% for 2011. The revenue growth was 17.0% in 2012 and 7.3% in 2011 reflecting increases in the number of employed physicians and mid-level providers of 10% and 7%, respectively. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute losses on operations. There are two facilities in Northeast Wisconsin and twelve off-campus practices in Michigan in addition to practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from healthcare services, and nonoperating revenue, which is principally from investment income.

Operating Revenue

Total gross revenues for all patient services performed by the Healthcare System were \$211 million in 2012 and \$196 million in 2011. The overall increase reflects the year-to-year difference in patient volumes, service mix changes and annual price increases. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care services measured as unpaid gross revenues of 1.1% in 2012 and 2011 to patients who documented their inability to pay. Bad debt provisions were 3.3% of gross revenue in 2012 and 3.2% in 2011. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 59% in 2012 and 58% in 2011.

The resulting net patient services revenue was 37% of gross revenue in 2012 and 38% in 2011. Net patient services revenue increased \$3.3 million or 4.5% in 2012 and \$2.6 million or 3.6% in 2011 due to the net effects of patient volumes, price increases, third-party payment rates, bad debt provisions and charity and other adjustments.

Other operating revenue increased \$4.4 million or 211.2% from 2011 to 2012. Accounting for \$3.7 million of that total were new revenues generated as a result of the 340B retail pharmacy program implemented at the beginning of 2012. In addition, the Healthcare System met criteria to record \$0.5 million in Medicaid incentive payments for Electronic Health Records. Other operating revenue increased \$228 thousand or 12.3% from 2010 to 2011.

Nonoperating Revenue

Investment income was \$690 thousand for 2012 and \$1.144 million for 2011. The 2012 decrease was the result of declining cash and investment balances. The 2011 increase was a result of a further reduction by the Upper Peninsula Health Plan of their Risk Based Capital position. The positive change in unrealized gains and losses on investments was \$7 thousand in 2012 and \$119 thousand for 2011.

Capital Contributions

There were \$186 thousand in capital contributions in 2012 for the new CT Scanner and Radiology upgrades. There were \$13 thousand in capital contributions in 2011 for telemedicine equipment and a breast pump. +

Forward Purchase Agreement

There has been a change in Generally Accepted Accounting Principles over time as it relates to the recording of these types of transactions. While FASB has required that Forward Purchase Agreements be recorded at fair market value, GASB has just recently issued codification clarifying that FASB must be followed for governmental units as well. Therefore, at 12/31/12 an adjustment of \$1.657 million was made to reflect the net increase in the market value from inception through 12/31/11. The decrease in market value of \$13 thousand for 2012 was recorded as a nonoperating expense and is included in the loss before capital contributions.

Expenditure of Funds

Operating Expenses

The components of operating expenses for the Healthcare System for the years ended December 31, 2012 and 2011 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2012 and 2011 (in Thousands)

	2012	2011	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 49,782	\$ 48,208	\$ 1,574	3.3%
Supplies and pharmaceuticals	11,434	9,717	1,717	17.7%
Professional fees and other purchased services	17,518	15,263	2,255	14.8%
Depreciation and amortization	4,671	4,381	290	6.6%
Total	<u>\$ 83,405</u>	<u>\$ 77,569</u>	<u>\$ 5,836</u>	<u>7.5%</u>

Employee compensation and benefits increased \$1.574 million or 3.3%. The annual average total paid full-time equivalent (FTE) positions of 654.7 for 2012 increased by 4.0% from the 2011 amount of 629.6.

The cost of supplies and pharmaceuticals increased \$1.717 million or 17.7%, related to 340B retail pharmacy activity.

Professional fees, purchased services and other expenses for 2012 increased \$2.255 million or 14.8%. This was mainly the result of higher fees for emergency department coverage, hospitalist services and bad debt collections. Depreciation and amortization expense for 2012 increased \$290 thousand or 6.6%, principally due to increased capital spending.

The components of operating expenses for the Healthcare System for the years ended December 31, 2011 and 2010 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2010 and 2009 (in Thousands)

	2011	2010	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 48,208	\$ 47,170	\$ 1,038	2.2%
Supplies and pharmaceuticals	9,717	8,870	847	9.5%
Professional fees and other purchased services	15,263	12,458	2,805	22.5%
Depreciation and amortization	4,381	4,808	(427)	-8.9%
Total	<u>\$ 77,569</u>	<u>\$ 73,306</u>	<u>\$ 4,263</u>	<u>5.8%</u>

Employee compensation and benefits increased \$1.038 million or 2.2%. The annual average total paid full-time equivalent (FTE) positions of 629.6 for 2011 increased by 0.8% from the 2010 amount of 624.9. This was the net result of a decrease in FTE's in hospital operations of (3.3) and an increase in FTE's in the physician practices of 8.0.

The cost of supplies and pharmaceuticals increased \$847 thousand or 9.5%, related to increased patient volumes.

Professional fees, purchased services and other expenses for 2011 increased \$2.805 million or 22.5%. This was mainly the result of the contract with Hospitalists of Northern Michigan to provide inpatient hospitalist services on a 24/7 basis of \$1.8 million. Depreciation and amortization expense for 2011 decreased \$427 thousand or 8.9%, principally due to the aging of assets currently in service.

Nonoperating Expense Items

Interest expense was \$1.7 million in 2012 and \$1.8 million in 2011. The Healthcare System capitalized interest expense amounts of \$106 thousand in 2012 and \$75 thousand in 2011.

Capital Expenditures

Fiscal Year 2012

Total capital spending increased significantly in 2012 after several years of limited spending. Major projects included the following: CT Scanner & renovations - \$2.1 million; MRT Rapid Arc Upgrade - \$913 thousand; Wound Care / DOC Building - \$575 thousand (\$601 thousand spent in 2011 for total spending of \$1.2 million); Pediatric Clinic Renovation - \$316 thousand; purchase of Dickinson Medical Building suite - \$266 thousand; Diagnostic Lab & Imaging Equipment for Bellin Clinic - \$306 thousand; Dietary Conversion to Room Service - \$236 thousand; X-ray Suite 100 - \$210 thousand; Portable X-ray Machine - \$185 thousand; Purchase of regular & portable C-Arm - \$172 thousand; new Home Health Building - \$154 thousand; and Urology Practice equipment & furnishings - \$108 thousand.

Fiscal Year 2011

Total capital spending increased modestly in 2011 after several years of limited spending. Major projects included the following: upgrade to hospital heating and cooling system - \$973 thousand; purchase of a suite in the Dickinson Medical Building - \$405 thousand; purchase of land and building to house the OBGYN Clinic - \$261 thousand; Horizon Patient Folder upgrade - \$229 thousand; X-ray equipment for the Bayside Clinic - \$105 thousand; Dell minitower - \$82 thousand; SAN upgrade - \$68 thousand; and an autostainer - \$53 thousand.

Fiscal Year 2010

Total capital spending was limited by management because of the need to conserve cash in light of the revenue challenges in 2010. Capital project costs totaled \$1.7 million, including \$252 thousand for the Laboratory Anatomic Pathology and Blood Bank systems, \$165 thousand to complete the PACS Deep Image Archive system, \$113 thousand for the Stereotactic Breast Biopsy unit, \$79 thousand for the Paragon Pharmacy upgrade, and \$69 thousand for the SAN upgrade.

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The Current Budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2012, 2011, and 2010

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2012 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 82,490	\$ 1,780	2.2%
Total operating expenses	(81,164)	(2,241)	-2.8%
Operating income	1,326	(461)	-34.8%
Net nonoperating revenue and gains, (expenses and losses)	(1,298)	269	20.7%
Income before capital contributions	28	(192)	-685.7%
Forward purchase agreement adjustment	-	1,657	100.0%
Capital contributions	66	120	181.8%
Increase in net position	\$ 94	\$ 1,585	1686.2%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were unfavorable by approximately 5%, while outpatient volumes in total were favorable by approximately 0.3%, but the total visit variance was net of favorable variances of 14.2% for radiation therapy services, 1.6% for Emergency Department visits, and 2.9% in physical therapy and other recurring series visits and unfavorable variances of 14.0% in outpatient observation patients, 0.4% in outpatient surgeries and 1.3% for all other outpatient visits. Expenses were unfavorable to budget by \$2.2 million or 2.8% mainly as a result of increased staffing costs related to new physician practices and services. The variance in other net nonoperating items was caused principally by investment returns higher than anticipated in the budget and interest expense that was less than anticipated.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2012, 2011, and 2010 (in Thousands)

	2012	2011	2010
Budget	\$ 8,277	\$ 6,186	\$ 4,654
Actual	5,481	4,330	1,653
Variance	\$ 2,796	\$ 1,856	\$ 3,001
Variance %	33.8%	30.0%	64.5%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. The variance in 2011 and 2010 is due to management's actions to limit capital spending by eliminating or deferring several budgeted projects. However, in 2012 it became necessary to purchase or upgrade several pieces of diagnostic equipment and several real estate locations. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

Management believes that service volumes and payor mix were adversely affected by economic conditions in 2012 and 2011. Uncompensated care with bad debt and charity write-offs increased in 2012 to 4.5% of gross charges while the Healthcare System saw an increase in uncompensated care with bad debt and charity write-offs totaling 4.4% of gross charges in 2011. In February 2013, the most recent data available, the unemployment rate in Dickinson County was 8.4% compared to 10.5% over the entire Upper Peninsula and 9.3% for the State of Michigan. The same statistics for February 2012 were 8.4%, 10.5% and 9.4%, respectively.

BellinHealth from Green Bay, Wisconsin, continues to have a strong presence in the community with the employment of several primary care physician practices in Iron Mountain. In the fall of 2011, BellinHealth commenced construction on an 18,000 square foot medical office building on the property where the former County Hospital was located. The clinic became operational in the fall of 2012. The Healthcare System operates and staffs a diagnostics suite in the new building. Diagnostics include a full scale laboratory capable of providing up to 95% of requested laboratory services and a full service radiography suite capable of most radiography services.

In July 2011, the Healthcare System entered into a Support Services agreement with Superior Health Partners (SHP) to explore the possibility of developing an Accountable Care Organization as well as to promote positive provider/payor relations with Blue Cross Blue Shield of Michigan and certain other third party payors. Other affiliate members of SHP include Marquette General, a Duke Lifepoint Hospital, Portage Health, Baraga County Memorial Hospital, Schoolcraft Memorial Hospital, Bell Memorial Hospital, Helen Newberry Joy Hospital and Munising Memorial Hospital as well as Blue Cross Blue Shield of Michigan (BCBS). SHP affiliate members continue to work with BCBS to reduce outmigration of Michigan patients to Wisconsin providers.

The Healthcare System is a member of the Upper Peninsula Healthcare Network (UPHCN) along with other Upper Peninsula hospitals whose interests are aligned to help retain primary care in their local communities and to meet the tertiary care needs of those markets within Michigan. The Upper Peninsula Health Plan (UPHP) is owned by UPHCN members and has developed an alliance with Blue Cross Blue Shield of Michigan to provide a network of Michigan providers. The Healthcare System currently uses that network for its employee health plan.

The Healthcare System leases part of a clinic facility in Bark River, Michigan, from a primary care physician practice to the east of the Healthcare System's primary market. The Healthcare System has established basic radiography, mammography, densitometry, ultra sound and phlebotomy services at the facility, and rents out examining rooms to its specialists to see patients in this adjacent service area for possible services to be performed at DCMH. Presently, urologic, orthopedic and podiatry clinics are conducted by Healthcare System associated physicians in Bark River, and the Healthcare System operates a remote sleep center and pulmonary medicine practice, adjunct to its hospital-based sleep center at the Bark River location. The Healthcare System also provides basic radiography, phlebotomy, podiatry and dermatology services at Bayside Clinic in Gladstone, Michigan.

Not unlike other areas of the country, the Upper Peninsula saw several healthcare system acquisitions in 2012. Marquette General Healthcare System was acquired by Duke LifePoint while Bell Memorial Hospital signed a letter of intent to be acquired by LifePoint Hospitals and Portage Health signed a letter of intent to form a joint venture with LifePoint Hospitals.

(This page left blank intentionally.)

	<u>2012</u>	<u>2011</u>
Assets		
Current Assets		
Cash and cash equivalents	\$ 2,831,615	\$ 1,948,178
Temporary investments	3,508,965	5,927,246
Current portion of restricted assets	1,578,510	1,550,610
Receivables		
Patient, net of estimated uncollectibles of		
\$2,817,000 in 2012 and \$3,038,000 in 2011	10,924,713	11,299,396
Other	2,742,683	806,044
Supplies and other current assets	1,944,298	1,808,193
Total current assets	<u>23,530,784</u>	<u>23,339,667</u>
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	1,774,387	1,876,744
Other long-term investments	8,423,620	7,924,668
Total noncurrent cash and investments	<u>10,198,007</u>	<u>9,801,412</u>
Capital Assets		
Capital assets not being depreciated	3,864,462	3,562,672
Depreciable capital assets, net of accumulated depreciation	37,508,667	34,213,036
Total capital assets	<u>41,373,129</u>	<u>37,775,708</u>
Other Assets		
Deferred Financing Costs, Net Accumulated		
Amortization of \$297,382 in 2012 and \$310,398 in 2011	148,065	174,234
Professional liabilities receivable	736,400	695,000
Total other assets	<u>884,465</u>	<u>869,234</u>
Total assets	<u>\$ 75,986,385</u>	<u>\$ 71,786,021</u>

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Balance Sheets
December 31, 2012 and 2011

	<u>2012</u>	<u>2011</u>
Liabilities and Net Position		
Current Liabilities		
Current maturities of long-term debt	\$ 2,420,670	\$ 1,461,827
Accounts payable		
Trade	3,661,702	2,476,197
Construction and capital assets	-	71,470
Estimated third-party payor settlements	1,214,112	2,225,913
Accrued expenses		
Salaries, wages, and related liabilities	1,144,419	879,395
Compensated absences	3,631,774	2,846,898
Other accrued liabilities	734,703	610,377
Interest	224,787	230,613
Total current liabilities	<u>13,032,167</u>	<u>10,802,690</u>
Long-Term Liabilities		
Long-term debt, less current maturities	25,620,211	25,299,545
Reserve for loss on general and professional liabilities claims	<u>1,336,400</u>	<u>1,365,000</u>
Total long-term liabilities	<u>26,956,611</u>	<u>26,664,545</u>
Total liabilities	<u>39,988,778</u>	<u>37,467,235</u>
Net Position		
Invested in capital assets, net of related debt	13,480,313	11,188,570
Restricted - expendable for debt service	3,352,897	3,427,354
Unrestricted	<u>19,164,397</u>	<u>19,702,862</u>
Total net position	<u>35,997,607</u>	<u>34,318,786</u>
Total liabilities and net position	<u>\$ 75,986,385</u>	<u>\$ 71,786,021</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2012 and 2011

	<u>2012</u>	<u>2011</u>
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$7,031,067 in 2012 and \$6,259,740 in 2011	\$ 77,800,690	\$ 74,456,458
Other revenue	<u>6,468,826</u>	<u>2,078,968</u>
Total operating revenues	<u>84,269,516</u>	<u>76,535,426</u>
Operating Expenses		
Salaries and wages	37,859,846	36,815,186
Employee benefits	11,922,102	11,393,256
Supplies and pharmaceuticals	11,434,271	9,717,282
Medical and other professional fees	6,473,366	5,143,760
Purchased services and other	11,044,797	10,118,746
Depreciation	<u>4,670,535</u>	<u>4,380,792</u>
Total operating expenses	<u>83,404,917</u>	<u>77,569,022</u>
Operating Income (Loss)	<u>864,599</u>	<u>(1,033,596)</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	50,334	54,025
Interest and amortization expense	(1,737,243)	(1,846,713)
Loss on disposal of capital assets	(25,706)	(88,170)
Investment income	690,175	1,144,106
Change in fair market value of forward purchase agreement	(13,006)	-
Change in unrealized gains and losses on investments	<u>7,006</u>	<u>118,496</u>
Total nonoperating revenues (expenses), net	<u>(1,028,440)</u>	<u>(618,256)</u>
Expenses in Excess of Revenues Before Capital Contributions	(163,841)	(1,651,852)
Forward Purchase Agreement Adjustment	1,657,121	-
Capital Contributions	<u>185,541</u>	<u>12,618</u>
Decrease in Net Position	1,678,821	(1,639,234)
Net Position, Beginning of Year	<u>34,318,786</u>	<u>35,958,020</u>
Net Position, End of Year	<u><u>\$ 35,997,607</u></u>	<u><u>\$ 34,318,786</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2012 and 2011

	<u>2012</u>	<u>2011</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 78,175,373	\$ 72,739,371
Receipts with third-party payors for settlements	(1,011,801)	(490,227)
Payments to suppliers and contractors	(38,985,934)	(34,999,831)
Payments to employees	(37,594,822)	(36,788,614)
Other receipts and payments	4,532,187	1,629,298
Net Cash From Operating Activities	<u>5,115,003</u>	<u>2,089,997</u>
Noncapital Financing Activity		
Unrestricted general contributions and other	<u>50,334</u>	<u>54,025</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(5,483,942)	(4,331,454)
Repayment of long-term debt	(2,228,427)	(1,390,954)
Proceeds from the issuance of long term debt	430,000	-
Interest paid, including capitalized interest	(1,621,475)	(1,694,096)
Capital contributions	185,541	12,618
Proceeds from the sale of capital assets	<u>101,321</u>	<u>15,700</u>
Net Cash Used For Capital and Capital Related Financing Activities	<u>(8,616,982)</u>	<u>(7,388,186)</u>
Investing Activities		
Purchases of investments	(10,461,358)	(19,737,326)
Proceeds from sales and maturities of investments	14,260,798	23,832,327
Investment income	<u>681,425</u>	<u>1,135,356</u>
Net Cash From (Used For) Investing Activities	<u>4,480,865</u>	<u>5,230,357</u>
Net Decrease in Cash and Cash Equivalents	1,029,220	(13,807)
Cash and Cash Equivalents, Beginning of Year	<u>2,027,711</u>	<u>2,041,518</u>
Cash and Cash Equivalents, End of Year	<u><u>\$ 3,056,931</u></u>	<u><u>\$ 2,027,711</u></u>
Reconciliation of Cash and Cash Equivalents to the Balance Sheets		
Cash and cash equivalents in current assets	\$ 2,831,615	\$ 1,948,178
Cash and cash equivalents in noncurrent cash and investments	<u>225,316</u>	<u>79,533</u>
Total cash and cash equivalents	<u><u>\$ 3,056,931</u></u>	<u><u>\$ 2,027,711</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2012 and 2011

	<u>2012</u>	<u>2011</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income (loss)	\$ 864,599	\$ (1,033,596)
Adjustments to reconcile operating income (loss) to net cash flows from operating activities		
Depreciation	4,670,535	4,380,792
Provision for bad debts	7,031,067	6,259,740
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(6,656,384)	(7,976,827)
Other receivables	(1,936,639)	(449,670)
Supplies and other current assets	(136,105)	487,751
Accounts payable - trade	1,185,505	1,028,711
Estimated third-party payor settlements	(1,011,801)	(490,227)
Accrued expenses	1,174,226	(136,677)
Reserve for loss on general and professional liabilities claims	<u>(70,000)</u>	<u>20,000</u>
Net Cash From Operating Activities	<u>\$ 5,115,003</u>	<u>\$ 2,089,997</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$105,992 and \$75,064 during 2012 and 2011.

The Healthcare System recognized \$8,750 of the deferred gain associated with the forward purchase contract (Note 4) during 2012 and 2011. These amounts are included in investment income in the accompanying financial statements.

The Healthcare System recorded amortization of deferred financing costs of \$13,016 and \$27,043 during 2012 and 2011 and amortization of loss on defeasance and original issue discount of \$201,417 and \$211,868 during 2012 and 2011.

The Healthcare System entered into capital lease agreements totaling \$2,876,519 during 2012.

Note 1 - Organization and Significant Accounting Policies

Organization

Dickinson County Healthcare System (Healthcare System) was formed as a county public Healthcare System in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public Healthcare System was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public Healthcare System. The Healthcare System provides acute, ambulatory, home health and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Enterprise Fund Accounting

The Healthcare System uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

The financial statements have been presented in conformity with generally accepted accounting principles as promulgated by GASB and as recommended in the Audit and Accounting Guide for Health Care Organizations published by the American Institute of Certified Public Accountants.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired.

Temporary Investments

Temporary investments include investments with an average maturity of three to twelve months, excluding internally designated and restricted cash and investments. Temporary investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Investments and Investment Income

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available or estimated fair value using quoted market prices for similar securities. Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when incurred.

Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and principal and interest funds and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Capital Assets

Capital asset acquisitions in excess of \$1,000 are capitalized and recorded at cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. All capital assets other than land and construction in progress are depreciated or amortized (in the case of capital leases) using the straight-line method of depreciation using these asset lives:

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The Healthcare System capitalized \$105,992 and \$75,064 of interest cost in 2012 and 2011.

Deferred Financing Costs, Original Issue Discount, and Unamortized Loss on Defeasance

Deferred financing costs and original issue discount are amortized over the period the related obligation is outstanding using the bonds-outstanding method. Unamortized loss on defeasance is amortized using the bonds outstanding method over the remaining life of the old obligation or the life of the new obligation, whichever is shorter (Note 6). Amortization of deferred financing costs, original issue discount, and unamortized loss on defeasance is included in interest and amortization expense in the financial statements.

Self-Funded Health Insurance

Beginning January 1, 2011, the Healthcare System self-funded health benefits for eligible employees and their dependents. Health insurance expense is recorded on an accrual basis. A payable totaling \$720,353 and \$402,456 (included in accounts payable) is recorded which estimates the incurred but not paid claims for health insurance at December 31, 2012 and 2011. The Healthcare System has separate stop loss insurance coverage for health insurance of catastrophic claims.

The Healthcare System retained Blue Cross Blue Shield of Michigan as the third-party administrator to the plan.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Professional Liability Claims

The Healthcare System has adopted the Financial Accounting Standards Board ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*, as of January 1, 2011. ASU 2010-24 requires the Healthcare System to evaluate its exposure to losses arising from claims and recognize a liability and at the same time recognize an insurance receivable for anticipated insurance recoveries, measured on the same basis as the related liability.

Grants and Contributions

From time to time, the Healthcare System receives grants and contributions. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after expenses in excess of revenues.

Restricted Resources

When the Healthcare System has both restricted and unrestricted resources available to finance a particular program, it is the Healthcare System's policy to use restricted resources before unrestricted resources.

Net Position

Net position is presented in the following three components:

Net Position Invested in Capital Assets, Net of Related Debt - Invested in capital assets net of related debt consists of capital assets, including restricted capital assets, net of accumulated depreciation, plus the balance of deferred financing costs, and reduced by any outstanding borrowings used to finance the purchase or construction of those assets.

Restricted Expendable Net Position - Restricted expendable net position is non-capital net position that must be used for a particular purpose, as specified by creditor, grantors, or contributors external to the Healthcare System, including amounts deposited with trustees as required by bond indenture agreements.

Unrestricted Net Position - Unrestricted net position is the remaining net position that does not meet the definition of "Invested in Capital Assets, Net of Related Debt," or "Restricted."

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Operating Revenues and Expenses

The Healthcare System's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services - the Healthcare System's principal activity. Nonexchange revenues, including grants and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Charity Care

The Healthcare System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Healthcare System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of charges foregone for services provided under the Hospital's charity care policy were \$2,523,471 and \$2,430,045 for the years ended December 31, 2012 and 2011. Total direct and indirect costs related to these foregone charges were approximately \$920,000 and \$934,000 at December 31, 2012 and 2011, based on an average ratio of cost to gross charges.

Advertising Costs

The Healthcare System expenses advertising costs as incurred.

Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that meaningfully use certified Electronic Health Records (EHR) technology.

These incentive payments will be paid out over six years on a transitional schedule. To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the State of Michigan. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) an initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year.

The Hospital recognizes EHR incentive payments as revenue when there is reasonable assurance that the Hospital will comply with the conditions attached to the incentive payments. EHR incentive payments are included in other operating revenue in the accompanying financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur.

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2010.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on a cost reimbursement methodology for inpatient services. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System’s Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2010.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System’s Blue Cross cost reports have been settled by Blue Cross through December 31, 2010.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2012 and 2011 decreased approximately \$167,000 and increased approximately \$531,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations.

A summary of patient service revenue, contractual adjustments, and provision for bad debts for the years ended December 31, 2012 and 2011 is as follows:

	2012	2011
Patient service revenue		
Gross patient service revenue	\$ 211,037,292	\$ 196,361,439
Less: charity care	(2,523,471)	(2,430,045)
Total patient service revenue	<u>208,513,821</u>	<u>193,931,394</u>
Contractual adjustments		
Medicare	(64,614,486)	(57,994,285)
Medicaid	(16,285,734)	(15,603,730)
Blue Cross	(31,103,822)	(28,356,872)
Other	(11,678,022)	(11,260,309)
	<u>(123,682,064)</u>	<u>(113,215,196)</u>
Provision for bad debts	<u>(7,031,067)</u>	<u>(6,259,740)</u>
Total contractual adjustments and provision for bad debts	<u>(130,713,131)</u>	<u>(119,474,936)</u>
Net patient service revenue	<u>\$ 77,800,690</u>	<u>\$ 74,456,458</u>

Note 3 - Deposits, Investments, and Investment Income

Deposits

Custodial credit risk is the risk that in the event of a bank failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. The Healthcare System had bank balances at December 31, 2012 and 2011 as follows:

	2012	2011
Insured (FDIC)	\$ 1,343,047	\$ 798,741
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	1,000,000	1,000,000
Uncollateralized	955,218	1,115,913
Total	<u>\$ 3,298,265</u>	<u>\$ 2,914,654</u>
Carrying value	<u>\$ 2,831,615</u>	<u>\$ 1,948,178</u>

Investments

The Healthcare System's investments are reported at fair value. At December 31, 2012 and 2011, the Healthcare System's investments consisted of the following:

December 31, 2012

Investment Type	Carrying Amount	Investment Maturities (in Years)			
		Less Than 1	1-5	6-10	More Than 10
Certificates of deposit (1)	\$ 4,675,321	\$ 3,465,061	\$ 1,210,260	\$ -	\$ -
Commercial paper	3,231,151	3,231,151	-	-	-
Federal National Mortgage Association	971,425	256,150	715,275	-	-
Federal Home Loan Mortgage Corporation	610,381	49,450	271,618	289,313	-
Federal Home Loan Bank	1,625,958	502,835	278,935	844,188	-
Federal Farm Credit Bank	643,510	77,239	261,833	304,438	-
U.S. Treasuries	1,537,273	-	520,992	1,016,281	-
Freddie Mac	180,699	-	180,699	-	-
Accrued interest	43,902	43,902	-	-	-
Total	<u>\$ 13,519,620</u>	<u>\$ 7,625,788</u>	<u>\$ 3,439,612</u>	<u>\$ 2,454,220</u>	<u>\$ -</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2012 and 2011

Investment Type	Carrying Amount	Investment Maturities (in Years)			
		Less Than 1	1-5	6-10	More Than 10
Certificates of deposit (1)	\$ 5,869,109	\$ 5,869,109	\$ -	\$ -	\$ -
Commercial paper	3,460,140	3,460,140	-	-	-
Federal National Mortgage Association	1,340,853	251,522	787,972	301,359	-
Federal Home Loan Mortgage Corporation	1,069,657	330,662	-	738,995	-
Federal Home Loan Bank	2,843,769	509,135	1,241,439	1,093,195	-
Federal Farm Credit Bank	1,145,074	252,345	346,726	546,003	-
U.S. Treasuries	1,525,314	-	530,125	995,189	-
Accrued interest	58,138	58,138	-	-	-
	<u>\$ 17,312,054</u>	<u>\$ 10,731,051</u>	<u>\$ 2,906,262</u>	<u>\$ 3,674,741</u>	<u>\$ -</u>

- (1) The certificates of deposit were purchased through the Certificate of Deposit Account Registry Service (CDARS) program. They are reported at fair value and have been included in investments. The entire amount above is insured by the FDIC.

Interest Rate Risk

The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk. As of December 31, 2012, the Healthcare System's investment in Federal Home Loan Bank, Federal Home Loan Mortgage Corporation, Federal National Mortgage Association, Federal Farm Credit Bank, and U.S. Treasuries are rated AAA by Moody's Investors Service and AA+ by Standards and Poors.

Concentration of Credit Risk

The Healthcare System currently does not place a limit on the amount it may invest with any one issuer. More than 5 percent of the Healthcare System's investments are in the following investments as of December 31, 2012:

	<u>Percentage</u>
Fortis Funding LLC - Commercial paper	23.5%
Federal Home Loan Bank	11.8%
U.S. Treasuries	11.2%
Federal National Mortgage Association	7.1%

Custodial Credit Risk

For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Healthcare System will not be able to recover the value of its investment or collateral securities that are in the possession of an outside party. At December 31, 2012 and 2011, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in other than the Healthcare System's name.

Summary of Carrying Amounts

The carrying amounts of the Healthcare System's deposits and investments shown above are included in the balance sheets at December 31, 2012 and 2011 as follows:

	<u>2012</u>	<u>2011</u>
Carrying amount		
Deposits	\$ 2,831,615	\$ 1,948,178
Investments	13,519,620	17,312,054
Forward purchase contract/deferred gain (1)	<u>1,540,546</u>	<u>(112,319)</u>
Total	<u>\$ 17,891,781</u>	<u>\$ 19,147,913</u>
Included in the following balance sheet captions		
Cash and cash equivalents	\$ 2,831,615	\$ 1,948,178
Temporary investments	3,508,965	5,927,246
Restricted assets - current portion (Note 6)	1,578,510	1,550,610
Other long-term investments	8,423,620	7,924,668
Restricted under indenture agreement for debt service (1)(Note 6)	<u>1,774,387</u>	<u>1,876,744</u>
Total	<u>\$ 18,117,097</u>	<u>\$ 19,227,446</u>

- (1) A forward purchase contract was entered into in 1999 by the Healthcare System relating to certain trustee held funds associated with the Series 1999 bonds. The contract provides a fixed rate of return of 5.775% on the Debt Service Fund and the Reserve Fund investments. The contract has a maturity date of November 2024, a notional value of approximately \$2,823,000 as of December 31, 2012 and 2011, respectively, and an estimated fair value of approximately \$1,644,000 and \$1,657,000 at December 31, 2012 and 2011, respectively. Upon inception of the agreement, the Healthcare System received a premium of \$220,000 from the counter party, which is being amortized over the life of the debt, and is recorded as a deferred gain. The unamortized balance of the deferred gain at December 31, 2012 and 2011 was \$103,569 and \$112,319 and is included with noncurrent cash and investments restricted under indenture agreement for debt service. The Healthcare System believes its credit risk is minimal on the transaction.

The Healthcare System adopted Governmental Accounting Standards Board (GASB) Statement No. 62: *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, as of January 1, 2011. The adoption of GASB 62 had no effect on previously reported operating results or changes in net assets. As a result of adopting GASB 62, the Healthcare System began recording the forward purchase contract discussed above at fair market value, which resulted in a \$1,657,000 increase in net position at January 1, 2012, with a fair market value of \$1,644,000 at December 31, 2012. In addition, the Healthcare System recorded the change in value during 2012 as a nonoperating loss of approximately \$13,000.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2012 and 2011:

	2012	2011
Interest income and realized gains and losses	\$ 340,850	\$ 916,841
Interest income on proceeds of borrowed funds	349,325	227,265
Total investment income	<u>\$ 690,175</u>	<u>\$ 1,144,106</u>
Change in unrealized gains and losses on investments	<u>\$ 7,006</u>	<u>\$ 118,496</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2012 and 2011

Note 4 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2012 are as follows:

	Balance December 31, 2011	Additions	Transfers and Retirements	Balance December 31, 2012
Capital assets not being depreciated				
Land	\$ 1,675,542	\$ -	\$ (52,330)	\$ 1,623,212
Construction in progress	1,887,130	3,768,092	(3,413,972)	2,241,250
	<u>3,562,672</u>	<u>3,768,092</u>	<u>(3,466,302)</u>	<u>3,864,462</u>
Total capital assets, not being depreciated	<u>\$ 3,562,672</u>	<u>\$ 3,768,092</u>	<u>\$ (3,466,302)</u>	<u>\$ 3,864,462</u>
Capital assets being depreciated				
Land improvements	\$ 1,011,580	\$ 1,005	\$ -	\$ 1,012,585
Buildings and improvements	41,238,335	1,552,258	61,469	42,852,062
Equipment	41,217,380	3,021,300	2,615,960	46,854,640
	<u>83,467,295</u>	<u>4,574,563</u>	<u>2,677,429</u>	<u>90,719,287</u>
Total capital assets being depreciated	<u>83,467,295</u>	<u>4,574,563</u>	<u>2,677,429</u>	<u>90,719,287</u>
Less accumulated depreciation for				
Land improvements	(512,800)	(56,489)	-	(569,289)
Buildings and improvements	(18,068,800)	(1,179,495)	-	(19,248,295)
Equipment	(30,672,659)	(3,434,551)	714,174	(33,393,036)
	<u>(49,254,259)</u>	<u>(4,670,535)</u>	<u>714,174</u>	<u>(53,210,620)</u>
Total accumulated depreciation	<u>(49,254,259)</u>	<u>(4,670,535)</u>	<u>714,174</u>	<u>(53,210,620)</u>
Net capital assets being depreciated	<u>\$ 34,213,036</u>	<u>\$ (95,972)</u>	<u>\$ 3,391,603</u>	<u>\$ 37,508,667</u>
Capital assets, net	<u>\$ 37,775,708</u>			<u>\$ 41,373,129</u>

Construction in progress at December 31, 2012, represents costs related to information technology and planning for the construction of a medical office building. The total estimated cost to complete the projects is \$10,853,000, which will be funded from working capital and additional borrowing.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2012 and 2011

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2011 are as follows:

	Balance December 31, 2010	Additions	Transfers and Retirements	Balance December 31, 2011
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ 52,330	\$ 1,675,542
Construction in progress	397,273	3,414,208	(1,924,351)	1,887,130
Total capital assets, not being depreciated	<u>\$ 2,020,485</u>	<u>\$ 3,414,208</u>	<u>\$ (1,872,021)</u>	<u>\$ 3,562,672</u>
Capital assets being depreciated				
Land improvements	\$ 1,011,580	\$ -	\$ -	\$ 1,011,580
Buildings and improvements	40,611,872	12,595	613,868	41,238,335
Equipment	39,300,198	1,058,362	858,820	41,217,380
Total capital assets being depreciated	<u>80,923,650</u>	<u>\$ 1,070,957</u>	<u>\$ 1,472,688</u>	<u>83,467,295</u>
Less accumulated depreciation for				
Land improvements	(456,348)	(56,452)	-	(512,800)
Buildings and improvements	(16,855,566)	(1,213,234)	-	(18,068,800)
Equipment	(27,844,395)	(3,111,106)	282,842	(30,672,659)
Total accumulated depreciation	<u>(45,156,309)</u>	<u>(4,380,792)</u>	<u>282,842</u>	<u>(49,254,259)</u>
Net capital assets being depreciated	<u>\$ 35,767,341</u>	<u>\$ (3,309,835)</u>	<u>\$ 1,755,530</u>	<u>\$ 34,213,036</u>
Capital assets, net	<u>\$ 37,787,826</u>			<u>\$ 37,775,708</u>

Construction in progress at December 31, 2011, represents costs related to information technology and planning for the construction of a medical office building.

Note 5 - Operating Leases

The Healthcare System leases certain medical and other equipment and office space under operating leases having terms of more than one year. Total operating lease expense for the years ended December 31, 2012 and 2011 for all operating leases was \$693,308 and \$755,687. Minimum future lease payments for these operating leases are as follows:

<u>Year Ending December 31,</u>	<u>Amount</u>
2013	\$ 325,419
2014	68,267
2015	59,267
2016	59,267
2017	46,067
	<u>46,067</u>
Total minimum lease payments	<u><u>\$ 558,287</u></u>

Note 6 - Long-Term Debt

Long-term debt activity for the year ended December 31, 2012 follows:

	<u>Balance December 31, 2011</u>	<u>Additions</u>	<u>Reductions</u>	<u>Balance December 31, 2012</u>	<u>Amounts Due Within One Year</u>
Hospital Revenue Bonds, Series 2004	\$ 4,172,208	\$ -	\$ (141,829)	\$ 4,030,379	\$ 150,066
Hospital Revenue and Refunding Bonds, Series 1999	24,135,000	-	(1,320,000)	22,815,000	1,360,000
Original issue discount	(123,198)	-	16,050	(107,148)	-
Equipment leases	-	2,876,519	(680,598)	2,195,921	853,356
Batti land contract	-	430,000	(86,000)	344,000	57,248
Unamortized loss on defeasance of Series 1994 Bonds	(1,422,638)	-	185,367	(1,237,271)	-
	<u><u>\$ 26,761,372</u></u>	<u><u>\$ 3,306,519</u></u>	<u><u>\$ (2,027,010)</u></u>	<u><u>\$ 28,040,881</u></u>	<u><u>\$ 2,420,670</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2012 and 2011

Long-term debt activity for the year ended December 31, 2011 follows:

	Balance December 31, 2010	Additions	Reductions	Balance December 31, 2011	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 4,306,249	\$ -	\$ (134,041)	\$ 4,172,208	\$ 141,827
Hospital Revenue and Refunding Bonds, Series 1999	25,360,000	-	(1,225,000)	24,135,000	1,320,000
Original issue discount	(140,078)	-	16,880	(123,198)	-
Equipment leases	31,913	-	(31,913)	-	-
Unamortized loss on defeasance of Series 1994 Bonds	(1,617,626)	-	194,988	(1,422,638)	-
	<u>\$ 27,940,458</u>	<u>\$ -</u>	<u>\$ (1,179,086)</u>	<u>\$ 26,761,372</u>	<u>\$ 1,461,827</u>

On December 1, 2011, the Healthcare System was approved for a United States Department of Agriculture Rural Development Loan in an amount not to exceed \$9,000,000 – a direct loan not to exceed \$6,900,000 (interest rate of 3.75%) and a guaranteed loan not to exceed \$2,100,000 (interest rate to be determined). The repayment period on the direct portion would be 40 years, and 20 years for the guaranteed portion. The proceeds will be used to construct a medical office building on the Healthcare System's campus.

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2012 and 2011 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
- 5.50% to 5.80% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999 (Series 1999 Bonds) - Due in varying annual installments to November 2024, secured by a pledge of net revenues, investment income, and bond funds held under the indenture agreement (Note 3). (1)
- Original Issue Discount - Associated with the Series 1999 Bonds issuance.
- Equipment Notes Payable
 - Megavoltage Radiation Therapy (MRT) Equipment Note Payable #1 – During 2000, the Healthcare System entered into a 6%, 10-year note payable with Marquette General Hospital (Marquette), an unrelated organization, for the purchase of MRT equipment. The note payable was due in monthly installments of \$20,700 to January 2011, and was secured by certain MRT equipment.
 - MRT Equipment Note Payable #2 – During 2007, the Healthcare System placed in service certain equipment provided by Marquette and recorded a corresponding liability. On February 8, 2008, the Healthcare System entered into a 6%, 35 month note payable with Marquette. The note payable was due in monthly installments of \$11,373 to January 2011, and was secured by certain equipment.

- o MRT Equipment Note Payable #3 – During 2012, the Healthcare System placed in service certain equipment provided by Marquette and recorded a corresponding liability. On November 15, 2012, the Healthcare System entered into a 3.2%, 52 month note payable with Marquette. The note payable was due in monthly installments of \$18,771 to March 2017, and was secured by certain equipment.
 - o Seimens Note Payable – During 2012, the Healthcare System placed in service certain equipment provided by Seimens and recorded a corresponding liability. On May 14, 2012, the Healthcare System entered into a 0.8%, 3 year note payable with Seimens. The note payable was due in yearly installments of \$664,227 to May 2014, and was secured by certain equipment.
 - Batti land contract – On December 28, 2012, the Healthcare System entered into a 4.5%, 60 month note payable. The note payable was due in monthly installments of \$6,413 to December 2017, and was secured by certain equipment.
 - Unamortized Loss on Defeasance of Series 1994 Bonds – During 1999, the Healthcare System defeased the Series 1994 Revenue Bonds (Series 1994 Bonds) by issuing the Series 1999 Bonds. A portion of the Series 1999 Bond proceeds totaling \$32,810,599 was placed in an irrevocable trust to provide for all future debt service payments on the Series 1994 Bonds. The Series 1994 Bonds were subsequently redeemed in 2004. The resulting loss on defeasance of approximately \$4,480,000 is being amortized using the bonds outstanding method, over the life of the Series 1999 Bonds.
- (1) The Series 2004 Bonds and Series 1999 Bonds loan agreements places limits on the incurrence of additional borrowings and requires the Healthcare System satisfy certain measures of financial performance. The Series 1999 Bonds loan agreement also requires the Healthcare System maintain certain deposits with a trustee. Such deposits are shown as restricted for this purpose in the balance sheets (Note 3).

Scheduled principal and interest payments on long-term debt are as follows:

Year Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2013	\$ 2,420,670	\$ 1,584,743	\$ 4,005,413
2014	2,539,383	1,487,643	4,027,026
2015	1,994,487	1,380,660	3,375,147
2016	2,099,310	1,272,774	3,372,084
2017	2,028,790	1,161,228	3,190,018
2018-2022	11,307,634	4,023,143	15,330,777
2023-2027	6,407,231	822,692	7,229,923
Thereafter	587,795	29,242	617,037
	<u>29,385,300</u>	<u>\$ 11,762,125</u>	<u>\$ 41,147,425</u>
Less unamortized bond discount	(107,148)		
Less unamortized loss on defeasance	<u>(1,237,271)</u>		
Total	<u>\$ 28,040,881</u>		

Note 7 - Defined Benefit Pension Plan

A. Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year.

The most recent actuarial valuation was made as of January 1, 2013. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2012 and 2011 was approximately \$28,724,000 and \$32,382,000. The Healthcare System's total actual payroll for the years ended December 31, 2012 and 2011 was approximately \$37,859,846 and \$36,815,186.

Current membership in the Plan consists of the following at December 31:

	2012	2011
Retirees and beneficiaries currently receiving benefits	260	250
Vested terminated members	159	148
Active and inactive employees		
Fully vested	505	538
Nonvested	76	127
	<u>1,000</u>	<u>1,063</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. Fifty percent of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2012 and 2011 were 10.42% and 9.45%, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2012 and 2011 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2011 and 2010, respectively.

Funding Progress

The funded status of the Plan based on the actuarial valuations as of the January 1, 2009, 2010, 2011, 2012, and 2013 is as follows:

Actuarial Valuation Date January 1,	Actuarial Value of Assets (A)	Actuarial Accrued Liability (AAL) Entity Age (B)	Unfunded (Over funded) AAL (UAAL) (B - A)	Funded Ratio (A/B)	Covered Payroll (C)	UAAL as a Percentage of Covered Payroll ((B-A)/C)
2009	25,008,465	37,762,525	12,754,060	66.2%	33,455,267	38.1%
2010	27,576,575	41,656,118	14,079,543	66.2%	32,389,391	43.5%
2011	30,455,817	43,178,949	12,723,132	70.5%	31,447,854	40.5%
2012	32,811,379	47,643,705	14,832,326	68.9%	32,382,406	45.8%
2013	35,047,767	52,404,010	17,356,243	66.9%	28,723,689	60.4%

The funded status disclosed above was actuarially determined using methods prescribed for governmental defined benefit pension plans.

Annual Pension Cost

For 2012, 2011, 2010, 2009, and 2008, the Healthcare System's annual pension cost was equal to the Healthcare System's required and actual contributions. The required contribution was determined as part of the January 1, 2012, 2011, 2010, 2009, and 2008, actuarial valuations using the projected unit credit cost actuarial funding method. The actuarial assumptions for fiscal 2012 and 2011 included (a) 7.5% investment rate of return and (b) salary increases including merit and seniority increases ranging from 5.3% to 0.2% per year, plus wage inflation of 3.5%. The assumptions regarding benefits are that no changes will occur on a postretirement basis.

The Healthcare System's annual pension cost, and required and actual contributions for the years ended December 31, 2012, 2011, 2010, 2009, and 2008 were approximately \$2,993,000, \$3,062,000, \$2,822,000, \$2,363,000 and \$2,276,000. The net pension obligation for the years ended December 31, 2012, 2011, 2010, 2009, and 2008 was zero.

A separately issued financial report of the Dickinson County Healthcare System Retirement Plan is available which includes financial statements and required supplementary information for the Plan.

Note 8 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Wilmington Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

In accordance with the provisions of GASB Statement No. 32, the DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 9 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees (with the exception of AFSCME employees and contracted physicians) who were not currently vested in the defined benefit pension plan were transitioned to the new plan design. Effective February 22, 2013, all AFSCME employees who were not vested were transferred to the new plan design.

MNA nursing staff transitioned effective May 1, 2011 per the MNA collective bargaining agreement and non-union staff transitioned effective September 4, 2011. In addition, all new hires as of September 4, 2011 are members of the new plan. Effective February 22, 2013, all new AFSCME new hires are members of the new plan.

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1-3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 8), up to maximum of 4% of employee compensation. Defined contribution plan expenses were \$149,828 and \$56,607 for the years ended December 31, 2012 and 2011.

Note 10 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$3 million. The policies end in July 31, 2013.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis.

The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 3% for 2012 and 2011. Amounts included as expense for general and professional liability for the years ended December 31, 2012 and 2011, which include claims and premiums paid, were approximately \$371,242 and \$560,000.

The reserve for loss on professional liability claims at December 31, 2012 and 2011 and activity for the years then ended is as follows:

Balance December 31, 2010	Additions	Reductions	Balance December 31, 2011	Additions	Reductions	Balance December 31, 2012
\$ 650,000	\$ 715,000	\$ -	\$ 1,365,000	\$ -	\$ (28,600)	\$ 1,336,400

Note 11 - Litigation, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 12 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2012 and 2011 was as follows:

	2012	2011
Medicare	29%	34%
Blue Cross	20%	19%
Medicaid	8%	10%
Commercial insurance and other	27%	23%
Self pay	16%	14%
	<u>100%</u>	<u>100%</u>

The Healthcare System is subject to collective bargaining agreements for approximately 62 percent of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in February of 2019. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2015.

Note 13 - Dickinson County Hospital Foundation

Dickinson County Hospital Foundation (Foundation) is organized to raise funds for the benefit of the Healthcare System and the community. The Foundation is deemed not to be a component unit of the Healthcare System as defined in GASB 39, *Determining Whether Certain Organizations Are Component Units*, as the economic resources received or held by the Foundation is not considered significant to the Healthcare System. As the Foundation is not considered a component unit, the Foundation's financial statements are not included in these financial statements. At December 31, 2012 and 2011, the Foundation's assets consisted primarily of cash and short-term investments and totaled approximately \$406,854 and \$716,000.

Note 14 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$31,302 and \$40,846 for the years ended December 31, 2012 and 2011. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2012 was approximately \$11,624,000.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 15 - Electronic Health Record Incentive Payments

The Healthcare System recognized revenue of \$505,913 for the year ended December 31, 2012 related to EHR incentive payments. These incentive payments are included in other revenue in the accompanying financial statements.

Note 16 - Subsequent Events

The Healthcare System has evaluated subsequent events through May 1, 2013, the date which the financial statements were available to be issued.



Management Discussion and Analysis and
Financial Statements
December 31, 2011 and 2010

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

Dickinson County Healthcare System

Table of Contents

December 31, 2011 and 2010

Independent Auditor's Report.....	1
Management's Discussion and Analysis.....	3
Financial Statements	
Balance Sheets.....	16
Statements of Revenues, Expenses, and Changes in Net Assets	17
Statements of Cash Flows	18
Notes to Financial Statements	20



Independent Auditor's Report

The Board of Trustees
Dickinson County Healthcare System
Iron Mountain, Michigan

We have audited the accompanying balance sheets of Dickinson County Healthcare System (a component unit of Dickinson County) as of December 31, 2011 and 2010, and the related statements of revenues, expenses, and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Healthcare System's management. 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 and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 1, the financial statements present only Dickinson County Healthcare System and are not intended to present fairly the financial position of Dickinson County, Michigan, and do not reflect the results of its operations and cash flows of its proprietary funds in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Dickinson County Healthcare System as of December 31, 2011 and 2010, and the results of its operations, changes in net assets, and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Management's discussion and analysis on pages 3 through 15 is not a required part of the basic financial statements but is supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on management's discussion and analysis.

In accordance with *Government Auditing Standards*, we have also issued our report dated April 27, 2012 on our consideration of Dickinson County Healthcare System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

A handwritten signature in black ink that reads "Erik Sully LLP". The signature is written in a cursive, flowing style.

Fargo, North Dakota
April 27, 2012

Management's Discussion and Analysis

Our discussion and analysis of Dickinson County Healthcare System's (Healthcare System's) financial performance provides an overview of financial activities for the fiscal years that ended on December 31, 2011 and 2010. This financial report is designed to provide our local citizens, customers, and creditors with a general overview of the Healthcare System's finances and to demonstrate the Healthcare System's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Healthcare System's Financial Offices, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, 49801.

Financial Highlights

Year Ended December 31, 2011

The Healthcare System's net assets decreased in 2011 by \$1.639 million or 4.6% with losses before capital contributions of \$1.652 million, comprised of an operating loss of \$1.034 million and non-operating expenses in excess of non-operating revenue of \$618 thousand. There were \$13 thousand contributions for capital purposes in 2011. During 2011, the Healthcare System's total operating revenues of \$76.5 million was 3.8% higher than the amount in 2010. The resulting operating loss for 2011 of \$1.034 million was (1.4%) of total operating revenue compared to operating income of \$403 thousand for 2010 which was 0.5% of operating revenue.

The following major projects and service enhancements were completed in 2011:

- Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.
- Providers added included: Dr. Hartfiel – OBGYN; Dr. Anderson – Podiatry; Dr. Kaur – Internal Medicine/Nephrology; Dr. Rayel – Cardiology; Dr. Downs – Emergency Medicine; and Dr. Tuladhar – Pediatrics.
- Contracted with Hospitalists of Northern Michigan to provide hospitalist services to inpatients. This new group of hospitalists have gained widespread acceptance from the medical staff, most of who have handed over their inpatients to the care of the hospitalists. They also work with many hospital committees to improve care and compliance. Due to their ability to treat more complex cases and their consistent and accurate coding, the Healthcare System has experienced an increase in the case mix index and a related increase in reimbursement.
- Installed the Practice Partner Electronic Health Record at the Pediatric Clinic and Florence Medical Center and well as a new budget and management reporting system and a dietary Point of Sale system. In addition a compellent storage area network and Relay Clearance Pro (insurance eligibility system) were installed.

- Upgrades to nine systems were completed which included Horizon Patient Folder, Paragon (necessary for meeting Meaningful Use criteria), the Tera Recon and PACS radiology imaging systems, Lawson Requisition Self Serve for Purchasing, Misys Tiger professional billing system, EC2000, and Pathways Compliance Advisor and Contract Management.
- Interfaces were developed for reporting to Marquette General Health System and Cedar Hill Clinic as well as reporting to/from Practice Partner.
- Other major IT projects included implementation of a pharmacy repackaging system for barcoding drugs, replacement of 70 user workstations in preparation for the Horizon Patient Folder and Paragon upgrades, relocation of the OB/GYN Clinic, redesign of the hospital website and installation of Green Bay Oncology equipment in the Ambulatory Care Unit infusion area for accessing their electronic health record.
- Construction began in the fall on a 5,896 square foot medical office building on the west side of the hospital campus to house an expanded wound care program to include hyperbaric medicine. In addition, the Dickinson Occupational Clinic was relocated to the new building from its current location in the Dickinson Medical Building to allow for the expansion of the Pediatrics Clinic which houses a full complement of providers including three physicians and two mid level providers.
- The Healthcare System's Defined Benefit Pension Plan was closed to new hires effective May 1 for Michigan Nurses Association members and September 4 for non union members. A new Defined Contribution Pension Plan was created for these new hires as well as non vested employees in the two groups.

Year Ended December 31, 2010

The Healthcare System's net assets decreased in 2010 by \$705 thousand, or 1.9% with losses before capital contributions of \$708 thousand, comprised of operating income of \$403 thousand less non-operating expenses in excess of non-operating revenue of \$1.1 million. There were \$3 thousand contributions for capital purposes in 2010. During 2010, the Healthcare System's total operating revenues of \$73.7 million was 0.7% higher than the amount in 2009. The resulting operating income for 2010 of \$403 thousand was 0.5% of total operating revenue compared to operating income of \$90 thousand for 2009 which was 0.1% of operating revenue.

The following major projects and service enhancements were completed in 2010:

- Rehabilitation Services began providing on-site care at Northland International University during the last quarter of 2010. This expansion of care provides necessary services on campus for the students of NIU who have only limited time off campus, as well as for the patients within that community.
- Two family practice physicians were added during the year; Dr. Knauf-Jorasz is located in the Cedar Hill Clinic and Dr. Jakel practices in Norway. The family practice clinic at Cedar Hill was subsequently discontinued in the fall of 2011.
- A Stereotactic Breast Biopsy unit was installed to enhance our digital mammography unit by providing a full circle of care in diagnosing and treating breast cancer.

- Through collaboration with Marquette General Health System and Dr. Coccia, the Healthcare System enhanced their ability to provide Neurology surgical services.
- The Emergency Department began a large process improvement project in 2010 using Lean tools and techniques. This was done in conjunction with the MHA Keystone Initiative. Several other smaller scale projects have taken place that affect areas such as Imaging, Rehabilitation Services and various storage locations. The Healthcare System began applying the Lean methodology to various projects in 2009 with the ED initiative helping to spread the efforts further into the organization.
- Completed our image migration from the legacy A4/MSA enVista Document Imaging system to the McKesson Horizon Patient Folder system. This allows clinicians to access a single system for patient results.
- Upgraded the Paragon system to the 9.4 major release which provided improvements for clinicians who utilize Physicians Webstation. This was also a necessary step before we can upgrade to the next major release (10.x) that is required to become meaningful users.
- Upgraded our McKesson interface engine to the version required for becoming meaningful users.
- Installed a results interface for the Rehabilitation Documentation System to send results directly to Horizon Patient Folder eliminating the need to scan the records on the back end in Medical records. The only records being scanned on the back end now are those that require signatures.
- Upgraded our Storage Area Network (SAN) to the next model to correct system failures that could not be fixed in the current model. We experienced multiple 8-10 hour total system outages throughout the year until this upgrade was completed. We have experienced zero unplanned outages for our SAN since the upgrade.
- Installed a new patient discharge instruction system for the emergency department that provides much improved functionality and ease of use for the providers than the previous system used.

Year Ended December 31, 2009

The Healthcare System's net assets decreased in 2009 by \$1,463 thousand, or 3.8% with losses before capital contributions of \$1.5 million, comprised of operating income of \$90 thousand less non-operating expenses in excess of revenue of \$1.6 million. There were no contributions for capital purposes in 2009. During 2009, the Healthcare System's total operating revenues of \$73.2 million was flat compared to the amount in 2008. The resulting operating income for 2009 of \$90 thousand was 0.1% of total operating revenue compared to operating income of \$1.5 million for 2008 which was 2.1% of operating revenue.

The following major projects and service enhancements were completed in 2009:

- The Healthcare System employed four physicians to care for inpatients and created a Hospitalist Program that began in June 2009. Office-based Family Practice physicians who choose to use the program to maintain their office schedule, delegate care to the Hospitalist for inpatient services. The Healthcare System has seen a favorable effect in improved documentation, lengths of stay, costs and reimbursement.
- Two employed Obstetric-gynecologist physicians who were in separate practice locations moved into a building in Iron Mountain that was acquired to accommodate the newly combined and growing practices.
- Radiology Imaging updated another room to provide the same testing capabilities and procedures as other rooms previously updated.
- The Fusion Sinus System was installed to provide an image of the sinus area during surgery as well as to reduce the need to refer patients for sinus revision surgery. This is the new standard of care.
- The Hematology Analyzers were replaced due to aging equipment, breakdowns, and the manufacturer's plan to sunset the current systems in 2010 at which time they will also discontinue to manufacture the reagents.
- Other physician practices recruited and established during the year were Dermatology in Iron Mountain and a satellite Sleep Medicine Center at the Cedar Hill Clinic in Bark River, Michigan.
- Began sharing clinical information with Cardiology Associates of Green Bay and Green Bay Oncology who treat patients at the Healthcare System's Newburg Clinic through newly configured remote connections.
- Began a project to install the first Anatomical Pathology & Blood Bank systems in the laboratory as well as an upgrade to the recently installed Pharmacy System as a necessary step toward Physician Order Entry.
- Upgraded the Lawson enterprise resource procurement systems used by management, finance materials management and human resource professionals to the most current released product including the Microsoft-based technology environment and Installed Lawson Business Intelligence module for improved analytics.
- Upgraded the Radiology Imaging picture archiving computer system (PACS) to provide an improved solution for deep archiving and retrieving these strategically important digital clinical images.

The source of funding for capital projects in all years came from current and prior years' operations and capital contributions from the public through the Dickinson County Hospital Foundation. There was no new borrowing in the three-year period ended December 31, 2011 and no government funding from taxes or any other source was used for capital or operating purposes.

Required Financial Statements

The Basic Financial Statements of the Healthcare System report financial activities and financial status. The Balance Sheet includes all assets, liabilities and net assets. It provides information about the nature and amounts of cash, receivables, and investments in resources (assets) and the obligations to creditors (liabilities) at the end of each year presented. A summary table of this statement is presented later in this discussion and analysis. The Statement of Revenues, Expenses, and Changes in Net Assets measures the annual financial performance of operations and reports all non-operating revenue and expense items, capital contributions and the net increase in Net Assets. A summary table of this statement is presented later in this discussion and analysis. The Statement of Cash Flows shows the cash provided by or used in operating, financing, and investing activities in each of the last two years, and accounts for the change in the cash on hand at the beginning and end of the two preceding annual periods.

Financial Analysis of the System

The condensed Balance Sheets of the Healthcare System as of December 31, 2011, 2010, and 2009 are summarized in the following table.

Condensed Balance Sheets
December 31, 2011, 2010, and 2009 (in Thousands)

	2011	2010	2009
Total current assets (includes the current portion of restricted assets)	\$ 23,339	\$ 24,202	\$ 23,496
Cash and investments internally designated for other purposes	7,925	9,374	8,087
Cash and investments restricted by bond indentures	1,877	1,868	2,129
Other Assets	869	201	229
Capital assets, net	37,776	37,788	41,262
Total Assets	\$ 71,786	\$ 73,433	\$ 75,203
Total current liabilities	\$ 10,803	\$ 10,275	\$ 10,171
Long-term debt, net of current portion	25,299	26,550	27,719
Other long-term liabilities	1,365	650	650
Total Liabilities	37,467	37,475	38,540
Total Net Assets	34,319	35,958	36,663
Total Liabilities and Net Assets	\$ 71,786	\$ 73,433	\$ 75,203

Current Assets and Liabilities:

Net patient accounts receivable increased to 55.4 days' of net revenue at December 31, 2011 compared to 48.7 days' of net revenue at December 31, 2010 and 50.8 at December 31, 2009. The 2011 increase was a result of 5010 processing issues experienced by National Government Services which resulted in a backlog of claims to be processed. The 2010 decrease was a result of increased self pay collections.

Total current assets decreased 3.6% in 2011 and increased 3.0% in 2010 compared to each prior year. The 2011 decrease is the net result of an increase in accounts receivable offset by a decrease in cash and temporary investments while the 2010 increase was primarily due to the change in cash.

Current liabilities increased 5% in 2011 as a result of an increase in trade accounts payable while current liabilities were flat at December 31, 2010 compared to the prior year-end. The Healthcare System's current ratio (current assets divided by current liabilities) was 2.16 at December 31, 2011 and 2.36 at December 31, 2010.

Total Cash and Investments:

The number of days of total cash and investments was 93.5 at December 31, 2011 and 120.2 at December 31, 2010. Excluding the restricted amounts, the ratios for 2011 and 2010 were 76.9 days and 102.9 days, respectively.

The total cash and investments at December 31, 2011 were \$19.2 million including restricted funds of \$3.4 million. Total cash and investments at December 31, 2010 were \$23.2 million including restricted funds of \$3.3 million.

Long-Term Debt:

The Healthcare System had long-term debt of \$25.3 million at December 31, 2011 and \$26.6 million at December 31, 2010 (net of current maturities of \$1.5 million in 2011 and \$1.4 million in 2010). No new debt or capital leases were issued in 2011 or 2010. Long-term debt at December 31, 2011 represents 94.9% of total long-term liabilities and 67.5% of total liabilities as compared 97.6% of total long-term liabilities and 70.8% of total liabilities at December 31, 2010. The debt service coverage ratio for the years ended December 31, 2011 and 2010 was 1.44 and 1.75, respectively.

Net Assets:

Total net assets decreased in 2011 and 2010 while unrestricted net assets decreased from 2010 to 2011 but increased from 2009 to 2010. The decrease in the unrestricted component for 2011 was due to increased investment in capital assets and declines in operating income. The increase in the unrestricted component of net assets for 2010 was due to decreased investment in capital assets related to decreased capital spending and annual depreciation of capital assets partly offset by declines in operating income and capital contributions. The amount invested in capital assets, net of related debt increased in 2011 as a result of the need to replace outdated equipment that had been forgone in the last few years of decreased capital spending while the amount invested in capital assets in 2010 decreased due to the net effects of capital expenditures, the annual depreciation, and the payment of debt principal. The restricted amount for debt service represents the funds held by the trustee for the Series 1999 bonds. This amount increased slightly in 2011 and decreased in 2010 related to debt service requirements. These components are presented in the following table.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2011, 2010, and 2009

Components of Net Assets (in thousands):

	December 31,		
	2011	2010	2009
Invested in capital assets, net of related debt Restricted by revenue bond indentures, expendable for debt service	\$ 11,189	\$ 10,049	\$ 12,100
Unrestricted	3,427	3,334	3,556
	<u>19,703</u>	<u>22,575</u>	<u>21,007</u>
Total net assets	<u>\$ 34,319</u>	<u>\$ 35,958</u>	<u>\$ 36,663</u>

Statements of Revenues, Expenses, and Changes in Net Assets

The condensed statements of revenues, expenses, and changes in net assets of the Healthcare System for the years ended December 31, 2011, 2010, and 2009 is summarized in the following table.

Condensed Statements of Revenue, Expenses, and Changes in Net Assets
Years Ended December 31, 2011, 2010, and 2009 (in Thousands)

	2011		2010		2009	
Revenue and (expenses):						
Net patient service revenue	\$ 74,456	97.3%	\$ 71,858	97.5%	\$ 71,412	97.6%
Other revenue	2,079	2.7%	1,851	2.5%	1,761	2.4%
Total operating revenue	<u>76,535</u>	100.0%	<u>73,709</u>	100.0%	<u>73,173</u>	100.0%
Total operating expenses	<u>77,569</u>	101.4%	<u>73,306</u>	99.5%	<u>73,083</u>	99.9%
Operating income	<u>(1,034)</u>	-1.4%	<u>403</u>	0.5%	<u>90</u>	0.1%
Investment income	1,144	1.5%	888	1.2%	632	0.9%
Change in unrealized gains and losses on investments	119	0.2%	55	0.1%	(100)	-0.1%
Interest and amortization expense	(1,847)	-2.4%	(1,994)	-2.7%	(2,081)	-2.8%
Other non-operating revenue and expenses (net)	<u>(34)</u>	0.0%	<u>(60)</u>	-0.1%	<u>(4)</u>	0.0%
Non-operating expenses in excess of revenue	<u>(618)</u>	-0.8%	<u>(1,111)</u>	-1.5%	<u>(1,553)</u>	-2.1%
Income (loss) before capital contributions	(1,652)	<u>-2.2%</u>	(708)	<u>-1.0%</u>	(1,463)	<u>-2.0%</u>
Capital contributions	<u>13</u>		<u>3</u>		<u>-</u>	
Increase (decrease) in net assets	(1,639)		(705)		(1,463)	
Net assets - beginning of year	<u>35,958</u>		<u>36,663</u>		<u>38,126</u>	
Net assets - end of year	<u>\$ 34,319</u>		<u>\$ 35,958</u>		<u>\$ 36,663</u>	

Results of Operations

Overall results of operations of (\$1,034) thousand or (1.4%) of revenue for 2011 decreased from \$403 thousand or 0.5% of revenue for 2010. The net non-operating expenses in excess of non-operating revenue for 2011 decreased to \$618 thousand from \$1.111 million in 2010. The net decrease in 2011 is due to higher investment income, higher change in unrealized gains on investments and lower interest expense. The net decrease in 2010 of \$442 thousand was due mainly to \$256 thousand higher investment income and the positive change in unrealized gains in 2010 of \$55 thousand compared to a loss of \$100 thousand in the prior year. The net result for 2011 was a loss of (\$1.652) million or (2.2%) of total operating revenue before capital contributions. The net result for 2010 was a loss of (\$708) thousand or (1.0%) of total operating revenue before capital contributions.

The net inpatient revenue of the Dickinson County Memorial Hospital (DCMH) facility for 2011 comprised 33.7% of the total net patient revenue and the activities of the Healthcare System. The comparable percentage for 2010 was 31.2%. The operating performance of DCMH was affected by the inpatient activity increasing significantly, with the 2011 acute adult and pediatric inpatient days of 11,681 and discharges of 3,338 compared to 10,474 and 3,152 for 2010. Discharges increased 5.9% in 2011 while net patient revenue increased 11.8% and the all-payer case mix index increased to 1.175 from 1.137 in 2010. This improvement is largely due to the new hospitalist program that was implemented in June of 2011. Discharges decreased 9.9% in 2010 while net inpatient revenue decreased 13.3% due in part to the unfavorable economic conditions including the increase in the underinsured and uninsured population.

The net patient revenue from outpatient services and other business units, including Dickinson Home Health, Upper Peninsula Sleep Center and other programs comprised 56.8% of total Healthcare System net patient revenue and its operating activities for 2011. The comparable percentage for 2010 was 59.6%. Net outpatient revenue decreased 1.2% in 2011 and increased 6.0% in 2010. Total outpatient visits were 166,515 in 2011 and 165,125 in 2010. Although total outpatient visits between the two years were flat, the mix of visits was less acute which contributed to the revenue decrease.

The net patient revenue of the Rural Health Clinics and other physician practices comprised about 9.5% of the total net patient revenue of the Healthcare System for 2011 and 9.1% for 2010. The revenue growth was 7.3% in 2011 and 28.2% in 2010 reflecting increases in the number of employed physicians and mid level providers of 0% and 19.0%, respectively. While page 3 noted six new providers in 2011, three were replacements for providers who left the Healthcare System in 2011 and the other three were offset by the replacement of employed hospitalists with contracted hospitalists. Overall, these strategically important clinics and other practices provide the communities in Dickinson County and adjacent Michigan and Wisconsin counties access to physician services that would otherwise not be available, but contribute losses on operations. There are two facilities in Northeast Wisconsin and eleven off-campus practices in Michigan in addition to practices which operate on our campus. The employed and contracted physicians who staff these clinics provide a significant percentage of admissions and outpatient referrals to the Healthcare System. The clinic operating in Goodman, Wisconsin was closed August 1, 2009 and operations were combined with the Wausaukee, Wisconsin location.

Sources of Financial Support

The Healthcare System relies upon its revenues and public contributions received directly or through the Dickinson County Hospital Foundation for 100% of its financial support. No tax revenue is received either directly from local taxpayers or through fund transfers from Dickinson County or other governments. Revenue is comprised of operating revenue, which is principally from healthcare services, and non-operating revenue, which is principally from investment income.

Operating Revenue:

Total gross revenues for all patient services performed by the Healthcare System were \$196 million in 2011 and \$184 million in 2010. The overall increase reflects the year-to-year difference in patient volumes, service mix changes and annual price increases. Gross revenue is based upon services provided at established rates before reductions for contractual and administrative allowances, charity care and provision for bad debts.

The Healthcare System provided charity care services measured as unpaid gross revenues of 1.1% in 2011 and 1.2% in 2010 to patients who documented their inability to pay. Bad debt provisions were 3.2% of gross revenue in 2011 and 3.1% in 2010. Provisions for contractual allowances for Medicare, Medicaid, Blue Cross, and other payers as a percentage of total gross charges were 58% in 2011 and 57% in 2010.

The resulting net patient services revenue was 38% of gross revenue in 2011 and 39.0% in 2010. Net patient services revenue increased \$2.6 million or 3.6% in 2011 and \$446 thousand or 0.6% in 2010 due to the net effects of patient volumes, price increases, third-party payment rates, bad debt provisions and charity and other adjustments.

Nonoperating Revenue:

Investment income was \$1.144 million for 2011 and \$888 thousand for 2010. The 2011 increase was a result of a further reduction by the Upper Peninsula Health Plan of their Risk Based Capital position. The 2010 increase was a result of distributions from the Upper Peninsula Health Plan of excess surplus, dividend payments and the reduction of their Risk Based Capital position. The positive change in unrealized gains and losses on investments was \$118 thousand in 2011 and \$55 thousand for 2010.

Capital Contributions:

There were \$13 thousand in capital contributions in 2011 for telemedicine equipment and a breast pump. There was \$3 thousand in capital contributions received in 2010 from a physician for a copier.

Dickinson County Healthcare System
Management's Discussion and Analysis
December 31, 2011, 2010, and 2009

Expenditure of Funds

Operating Expenses:

The components of operating expenses for the Healthcare System for the years ended December 31, 2011 and 2010 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2011 and 2010 (in Thousands)

	2011	2010	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 48,208	\$ 47,170	\$ 1,038	2.2%
Supplies and pharmaceuticals	9,717	8,870	847	9.5%
Professional fees and other purchased services	15,263	12,458	2,805	22.5%
Depreciation and amortization	4,381	4,808	(427)	-8.9%
Total	<u>\$ 77,569</u>	<u>\$ 73,306</u>	<u>\$ 4,263</u>	<u>5.8%</u>

Employee compensation and benefits increased \$1.038 million or 2.2%. The annual average total paid full-time equivalent (FTE) positions of 629.6 for 2011 increased by 0.8% from the 2010 amount of 624.9. This was the net result of a decrease in FTE's in hospital operations of (3.3) and an increase in FTE's in the physician practices of 8.0.

The cost of supplies and pharmaceuticals increased \$847 thousand or 9.5%, related to increased patient volumes.

Professional fees, purchased services and other expenses for 2011 increased \$2.805 million or 22.5%. This was mainly the result of the contract with Hospitalists of Northern Michigan to provide inpatient hospitalist services on a 24/7 basis of \$1.8 million. Depreciation and amortization expense for 2011 decreased \$427 thousand or 8.9%, principally due to the aging of assets currently in service.

The components of operating expenses for the Healthcare System for the years ended December 31, 2010 and 2009 is summarized in the following table:

Components of Operating Expenses
for the Years Ended December 31, 2010 and 2009 (in Thousands)

	2010	2009	Increase/(Decrease)	
Salaries, wages and employee benefits	\$ 47,170	\$ 47,011	\$ 159	0.3%
Supplies and pharmaceuticals	8,870	9,342	(472)	-5.1%
Professional fees and other purchased services	12,458	11,668	790	6.8%
Depreciation and amortization	4,808	5,062	(254)	-5.0%
Total	<u>\$ 73,306</u>	<u>\$ 73,083</u>	<u>\$ 223</u>	<u>0.3%</u>

Employee compensation and benefits increased \$159 thousand or 0.3%. The annual average total paid FTE positions of 624.9 for 2010 decreased by 3.0% from the 2009 amount of 644.3. This decrease in FTE positions included a 27% increase in physicians to 17.9 from 14.1, which caused a disproportionate increase in overall compensation and benefits.

The cost of supplies and pharmaceuticals decreased \$472 thousand or 5.1%, related to decreased patient volumes.

Professional fees, purchased services, and other expenses for 2010 increased \$790 thousand or 6.8% due to an increase in contracted services for Dermatology of \$415 thousand and Family Practice of \$120 thousand along with increases in repairs and utility expense of \$119 thousand each.

Depreciation and amortization expense for 2010 decreased \$254 thousand or 5.0%, principally due to the reduction in new capital spending along with the aging of assets currently in service.

Non-operating Expense Items:

Interest expense was \$1.8 million in 2011 and \$2.0 million in 2010. The Healthcare System capitalized interest expense amounts of \$75 thousand in 2011 and \$19 thousand in 2010.

Capital Expenditures:

Fiscal Year 2011

Total capital spending increased modestly in 2011 after several years of limited spending. Major projects included the following: upgrade to hospital heating and cooling system - \$973 thousand; purchase of a suite in the Dickinson Medical Building - \$405 thousand; purchase of land and building to house the OBGYN Clinic - \$261 thousand; Horizon Patient Folder upgrade - \$229 thousand; X-ray equipment for the Bayside Clinic - \$105 thousand; Dell minitower - \$82 thousand; SAN upgrade - \$68 thousand; and an autostainer - \$53 thousand.

Fiscal Year 2010

Total capital spending was limited by management because of the need to conserve cash in light of the revenue challenges in 2010. Capital project costs totaled \$1.7 million, including \$252 thousand for the Laboratory Anatomic Pathology and Blood Bank systems, \$165 thousand to complete the PACS Deep Image Archive system, \$113 thousand for the Stereotactic Breast Biopsy unit, \$79 thousand for the Paragon Pharmacy upgrade, and \$69 thousand for the SAN upgrade.

Fiscal Year 2009

Total capital spending was limited by management because of the need to conserve cash in light of the revenue challenges in 2009. Capital project costs totaled \$1.8 million, including \$378 thousand for the acquisition of an offsite medical building to house the two physician Obstetrics practice, \$211 thousand for a digital radiography room, \$167 thousand for two hematology analyzers for the laboratory, \$106 thousand for an image guided fusion sinus system for the operating room and \$120 thousand cost to complete the Radiology voice/text processing system component of the new information system.

Dickinson County Healthcare System

Management's Discussion and Analysis

December 31, 2011, 2010, and 2009

Budgets

As required by the Bylaws, Management prepares an annual budget for the approval of the Board of Trustees of the Healthcare System. The Current Budget as approved consists of an operating budget, a cash flow budget, and a three-year capital budget together with the capital plan that identifies the source of funds for capital financing. Operating statistics that serve as assumptions underlying the financial amounts in the budgets are also budgeted. On a monthly basis, actual financial and statistical amounts are compared to budgeted amounts and variances are monitored and controlled.

The revenue and expenses that were budgeted for the current year and the resultant variances were as follows:

Budget and Variances from Actual
Year Ended December 31, 2011 (in Thousands)

	Budgeted Amount	Variance* from Actual	% Variance
Total operating revenue	\$ 77,186	\$ (651)	-0.8%
Total operating expenses	(75,478)	(2,091)	-2.8%
Operating income	1,708	(2,742)	-160.5%
Net nonoperating revenue and gains, (expenses and losses)	(1,298)	680	52.4%
Income before capital contributions	410	(2,062)	-502.9%
Capital contributions	66	(53)	-80.3%
Increase in net assets	\$ 476	\$ (2,115)	-444.3%

*In the variance column of this table, a negative value (-) indicates an unfavorable variance to budget.

Budget variances in operating revenue and operating expenses relate to patient volumes and the mix of services. Inpatient volumes were favorable by approximately 5%, while outpatient volumes in total were favorable by approximately 1%, but the total visit variance was net of favorable variances of 7% for radiation therapy services, 5% for Emergency Department visits, and 1% for all other outpatient visits and unfavorable variances of 7% in outpatient observation patients, 2% in outpatient surgeries and 2% in physical therapy and other recurring series visits. Expenses were unfavorable to budget by \$2.1 million or 2.8% as a result of the contract with Hospitalists of Northern Michigan which was not anticipated in the budget as well as an unanticipated increase in operating room and pharmaceutical supply expense as a result of the increased inpatient volumes. The variance in other net non-operating items was caused principally by investment returns higher than anticipated in the budget.

Each year the Healthcare System prepares a three-year capital budget, with the two out-years subject to revision in each of the two next subsequent budget periods. The actual spending (in thousands) compared to the final budget amounts for each of the three preceding years is as follows:

Capital Budget
Years Ended December 31, 2011, 2010, and 2009 (in Thousands)

	2011	2010	2009
Budget	\$ 6,186	\$ 4,654	\$ 5,238
Actual	4,330	1,653	1,860
Variance	\$ 1,856	\$ 3,001	\$ 3,378
Variance %	30.0%	64.5%	64.5%

Management controls the actual spending on capital projects based upon cash flow variances, and delays projects until the following quarter or the following year as necessary. The variance in 2011 and 2010 is due to management's actions to limit capital spending by eliminating or deferring several budgeted projects. Actual capital spending is discussed further under the caption: **Capital Expenditures**.

Economic Conditions and Corporate Affiliation

Management believes that service volumes were adversely affected by economic conditions to a lesser degree in 2011 than 2010 but still believe payer mix has been adversely affected by economic conditions in 2011 and 2010. Uncompensated care with bad debt and charity write-offs increased in 2011 to 4.4% of gross charges while the Healthcare System saw an increase in uncompensated care with bad debt and charity write-offs totaling 4.3% of gross charges in 2010. In February 2012, the most recent data available, the unemployment rate in Dickinson County was 8.4% compared to 10.5% over the entire Upper Peninsula and 9.4% for the State of Michigan. The same statistics for February 2011 were 10.0%, 11.8% and 11.0%, respectively.

BellinHealth from Green Bay, Wisconsin, continues to have a strong presence in the community with the employment of several primary care physician practices in Iron Mountain. In the fall of 2011, BellinHealth commenced construction on an 18,000 square foot medical office building on the property where the former County Hospital was located. Occupancy is scheduled for the fall of 2012. The Healthcare System has been approached by BellinHealth to operate and staff a diagnostics suite in the new building. Diagnostics would include a full scale laboratory capable of providing up to 95% of requested laboratory services and a full service radiography suite capable of most radiography services. The details of the agreement are still being worked out.

In July 2011, the Healthcare System entered into a Support Services agreement with Superior Health Partners (SHP) to explore the possibility of developing an Accountable Care Organization as well as to promote positive provider/payor relations with Blue Cross Blue Shield of Michigan and certain other third party payors. Other affiliate members of SHP include Marquette General Health System, Portage Health, Baraga County Memorial Hospital, Schoolcraft Memorial Hospital and Munising Memorial Hospital as well as Blue Cross Blue Shield of Michigan (BCBS). SHP affiliate members continue to work with BCBS to reduce outmigration of Michigan patients to Wisconsin providers.

The Healthcare System is a member of the Upper Peninsula Healthcare Network (UPHCN) along with other Upper Peninsula hospitals whose interests are aligned to help retain primary care in their local communities and to meet the tertiary care needs of those markets within Michigan. The Upper Peninsula Health Plan (UPHP) is owned by UPHCN members and has developed an alliance with Blue Cross Blue Shield of Michigan to provide a network of Michigan providers. The Healthcare System currently uses that network for its employee health plan.

The Healthcare System leases part of a clinic facility in Bark River, Michigan, from a primary care physician practice to the east of the Healthcare System's primary market. The Healthcare System has established basic radiography, mammography, densitometry, ultra sound and phlebotomy services at the facility, and rents out examining rooms to its specialists to see patients in this adjacent service area for possible services to be performed at DCMH. Presently, obstetric, urologic, orthopedic and podiatry clinics are conducted by Healthcare System associated physicians in Bark River, and the Healthcare System operates a remote sleep center and pulmonary medicine practice, adjunct to its hospital-based sleep center at the Bark River location. In addition, during 2011 the Healthcare System began providing basic radiography, phlebotomy and podiatry services at Bayside Clinic in Gladstone, Michigan.

(This page left blank intentionally.)

	<u>2011</u>	<u>2010</u>
Assets		
Current Assets		
Cash and cash equivalents	\$ 1,948,178	\$ 2,038,818
Temporary investments	5,927,246	8,461,690
Current portion of restricted assets	1,550,610	1,466,838
Receivables		
Patient, net of estimated uncollectibles of		
\$3,038,000 in 2011 and \$2,939,000 in 2010	11,299,396	9,582,309
Other	806,044	356,374
Supplies and other current assets	1,808,193	2,295,944
Total current assets	<u>23,339,667</u>	<u>24,201,973</u>
Noncurrent Cash and Investments		
Restricted under indenture agreement for debt service	1,876,744	1,867,561
Other long-term investments	7,924,668	9,374,102
Total noncurrent cash and investments	<u>9,801,412</u>	<u>11,241,663</u>
Capital Assets		
Capital assets not being depreciated	3,562,672	2,020,485
Depreciable capital assets, net of accumulated depreciation	34,213,036	35,767,341
Total capital assets	<u>37,775,708</u>	<u>37,787,826</u>
Other Assets		
Deferred Financing Costs, Net Accumulated		
Amortization of \$310,398 in 2011 and \$283,355 in 2010	174,234	201,277
Professional liabilities receivable	695,000	-
Total other assets	<u>869,234</u>	<u>201,277</u>
Total assets	<u>\$ 71,786,021</u>	<u>\$ 73,432,739</u>

See Notes to Financial Statements

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Balance Sheets
December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Liabilities and Net Assets		
Current Liabilities		
Current maturities of long-term debt	\$ 1,461,827	\$ 1,390,954
Accounts payable		
Trade	2,476,197	1,447,486
Construction and capital assets	71,470	5,445
Estimated third-party payor settlements	2,225,913	2,716,140
Accrued expenses		
Salaries, wages, and related liabilities	879,395	852,823
Compensated absences	2,846,898	3,142,585
Other accrued liabilities	610,377	477,939
Interest	<u>230,613</u>	<u>241,843</u>
Total current liabilities	<u>10,802,690</u>	<u>10,275,215</u>
Long-Term Liabilities		
Long-term debt, less current maturities	25,299,545	26,549,504
Reserve for loss on general and professional liabilities claims	<u>1,365,000</u>	<u>650,000</u>
Total long-term liabilities	<u>26,664,545</u>	<u>27,199,504</u>
Total liabilities	<u>37,467,235</u>	<u>37,474,719</u>
Net Assets		
Invested in capital assets, net of related debt	11,188,570	10,048,645
Restricted - expendable for debt service	3,427,354	3,334,399
Unrestricted	<u>19,702,862</u>	<u>22,574,976</u>
Total net assets	<u>34,318,786</u>	<u>35,958,020</u>
Total liabilities and net assets	<u>\$ 71,786,021</u>	<u>\$ 73,432,739</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Revenues, Expenses, and Changes in Net Assets
Years Ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Operating Revenues		
Net patient service revenue, net of provision for bad debts of \$6,259,740 in 2011 and \$5,662,955 in 2010	\$ 74,456,458	\$ 71,858,202
Other revenue	<u>2,078,968</u>	<u>1,850,872</u>
Total operating revenues	<u>76,535,426</u>	<u>73,709,074</u>
Operating Expenses		
Salaries and wages	36,815,186	35,964,154
Employee benefits	11,393,256	11,205,425
Supplies and pharmaceuticals	9,717,282	8,870,035
Medical and other professional fees	5,143,760	2,751,054
Purchased services and other	10,118,746	9,708,104
Depreciation	<u>4,380,792</u>	<u>4,807,621</u>
Total operating expenses	<u>77,569,022</u>	<u>73,306,393</u>
Operating Income (Loss)	<u>(1,033,596)</u>	<u>402,681</u>
Nonoperating Revenues (Expenses)		
Unrestricted general contributions and other	54,025	70,121
Interest and amortization expense	(1,846,713)	(1,993,448)
Loss on disposal of capital assets	(88,170)	(130,176)
Investment income	1,144,106	887,791
Change in unrealized gains and losses on investments	<u>118,496</u>	<u>55,187</u>
Total nonoperating revenues (expenses), net	<u>(618,256)</u>	<u>(1,110,525)</u>
Expenses in Excess of Revenues Before Capital Contributions	(1,651,852)	(707,844)
Capital Contributions	<u>12,618</u>	<u>3,000</u>
Decrease in Net Assets	(1,639,234)	(704,844)
Net Assets, Beginning of Year	<u>35,958,020</u>	<u>36,662,864</u>
Net Assets, End of Year	<u>\$ 34,318,786</u>	<u>\$ 35,958,020</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Operating Activities		
Receipts from and on behalf of patients	\$ 72,739,371	\$ 72,209,932
Receipts with third-party payors for settlements	(490,227)	1,092,361
Payments to suppliers and contractors	(34,999,831)	(33,003,859)
Payments to employees	(36,788,614)	(35,897,950)
Other receipts and payments	<u>1,629,298</u>	<u>2,138,556</u>
Net Cash From Operating Activities	<u>2,089,997</u>	<u>6,539,040</u>
Noncapital Financing Activity		
Unrestricted general contributions and other	<u>54,025</u>	<u>70,121</u>
Capital and Capital Related Financing Activities		
Purchase of capital assets	(4,331,454)	(1,656,733)
Repayment of long-term debt	(1,390,954)	(1,672,483)
Interest paid, including capitalized interest	(1,694,096)	(1,773,117)
Capital contributions	12,618	3,000
Proceeds from the sale of capital assets	<u>15,700</u>	<u>9,820</u>
Net Cash Used For Capital and Capital Related Financing Activities	<u>(7,388,186)</u>	<u>(5,089,513)</u>
Investing Activities		
Purchases of investments	(19,737,326)	(24,936,585)
Proceeds from sales and maturities of investments	23,832,327	15,251,652
Investment income	<u>1,135,356</u>	<u>879,041</u>
Net Cash From (Used For) Investing Activities	<u>5,230,357</u>	<u>(8,805,892)</u>
Net Decrease in Cash and Cash Equivalents	(13,807)	(7,286,244)
Cash and Cash Equivalents, Beginning of Year	<u>2,041,518</u>	<u>9,327,762</u>
Cash and Cash Equivalents, End of Year	<u><u>\$ 2,027,711</u></u>	<u><u>\$ 2,041,518</u></u>
Reconciliation of Cash and Cash Equivalents to the Balance Sheets		
Cash and cash equivalents in current assets	\$ 1,948,178	\$ 2,038,818
Cash and cash equivalents in noncurrent cash and investments	<u>79,533</u>	<u>2,700</u>
Total cash and cash equivalents	<u><u>\$ 2,027,711</u></u>	<u><u>\$ 2,041,518</u></u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Statements of Cash Flows
Years Ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating income (loss)	\$ (1,033,596)	\$ 402,681
Adjustments to reconcile operating income (loss) to net cash flows from operating activities		
Depreciation	4,380,792	4,807,621
Provision for bad debts	6,259,740	5,662,955
Changes in assets and liabilities		
Patient receivables, net of provision for bad debts	(7,976,827)	(5,311,225)
Other receivables	(449,670)	287,684
Supplies and other current assets	487,751	92,097
Accounts payable - trade	1,028,711	(657,427)
Estimated third-party payor settlements	(490,227)	1,092,361
Accrued expenses	(136,677)	162,293
Reserve for loss on general and professional liabilities claims	<u>20,000</u>	<u>-</u>
Net Cash From Operating Activities	<u>\$ 2,089,997</u>	<u>\$ 6,539,040</u>

Supplemental Disclosure of Cash Flow Information

The Healthcare System capitalized interest expense totaling \$75,064 and \$18,618 during 2011 and 2010.

The Healthcare System recognized \$8,750 of the deferred gain associated with the forward purchase contract (Note 4) during 2011 and 2010. These amounts are included in investment income in the accompanying financial statements.

The Healthcare System recorded amortization of deferred financing costs of \$27,043 and \$27,888 during 2011 and 2010 and amortization of loss on defeasance and original issue discount of \$211,868 and \$221,828 during 2011 and 2010.

Note 1 - Organization and Significant Accounting Policies

Organization

Dickinson County Healthcare System (Healthcare System) was formed as a county public Healthcare System in 1947. It was created to operate, control, and manage all matters concerning Michigan's Dickinson County healthcare function. In 1990, the county public Healthcare System was reorganized as a Michigan Municipal Healthcare Facility, organized under PA230 of 1987, as amended, and assumed all rights, privileges, immunities and franchise of the predecessor county public Healthcare System. The Healthcare System provides acute, ambulatory, home health and certain physician services to the residents of its service area. The Board of County Commissioners approves the members of the Board of Trustees of the Healthcare System. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare System is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one hundred year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

These financial statements include only the activity of the Healthcare System.

Enterprise Fund Accounting

The Healthcare System uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on Governmental Accounting Standards Board (GASB) Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the Healthcare System has adopted the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

The financial statements have been presented in conformity with generally accepted accounting principles as promulgated by GASB and as recommended in the Audit and Accounting Guide for Health Care Organizations published by the American Institute of Certified Public Accountants.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired.

Temporary Investments

Temporary investments include investments with an average maturity of three to twelve months, excluding internally designated and restricted cash and investments. Temporary investments are recorded at fair value.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at average cost.

Investments and Investment Income

Investments in debt and equity securities are reported at fair value. Fair value is determined based on quoted market prices, if available or estimated fair value using quoted market prices for similar securities. Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in non-operating revenues when incurred.

Internally designated funds consist primarily of U.S. Treasury securities, mortgage-backed securities, and money market funds. Funds restricted under indenture agreements for debt service consists of a debt service reserve fund and principal and interest funds and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Other long-term investments consist primarily of mortgage-backed securities. Funds that are available for obligations classified as current liabilities are reported in current assets.

Capital Assets

Capital asset acquisitions in excess of \$1,000 are capitalized and recorded at cost. Contributed capital assets are reported at their estimated fair value at the time of their donation. All capital assets other than land and construction in progress are depreciated or amortized (in the case of capital leases) using the straight-line method of depreciation using these asset lives:

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The Healthcare System capitalized \$75,064 and \$18,618 of interest cost in 2011 and 2010.

Deferred Financing Costs, Original Issue Discount, and Unamortized Loss on Defeasance

Deferred financing costs and original issue discount are amortized over the period the related obligation is outstanding using the bonds-outstanding method. Unamortized loss on defeasance is amortized using the bonds outstanding method over the remaining life of the old obligation or the life of the new obligation, whichever is shorter (Note 6). Amortization of deferred financing costs, original issue discount, and unamortized loss on defeasance is included in interest and amortization expense in the financial statements.

Self-funded Health Insurance

Beginning January 1, 2011, the Healthcare System self funds health benefits for eligible employees and their dependents. Health insurance expense is recorded on an accrual basis. A payable totaling \$402,456 (included in accounts payable) is recorded which estimates the incurred but not paid claims for health insurance at December 31, 2011. The Healthcare System has separate stop loss insurance coverage for health insurance to cover catastrophic claims.

The Healthcare System retained Blue Cross Blue Shield of Michigan as the third-party administrator to the plan.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours. CAT days not paid out are applied to years of service for pension credit calculations.

Professional Liability Claims

The Healthcare System has adopted the Financial Accounting Standards Board ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*, as of January 1, 2011. ASU 2010-24 requires the Healthcare System to evaluate its exposure to losses arising from claims and recognize a liability and at the same time recognize an insurance receivable for anticipated insurance recoveries, measured on the same basis as the related liability.

Grants and Contributions

From time to time, the Healthcare System receives grants and contributions. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after expenses in excess of revenues.

Restricted Resources

When the Healthcare System has both restricted and unrestricted resources available to finance a particular program, it is the Healthcare System's policy to use restricted resources before unrestricted resources.

Net Assets

Net assets are presented in the following three components:

Net Assets Invested in Capital Assets, Net of Related Debt - Invested in capital assets net of related debt consists of capital assets, including restricted capital assets, net of accumulated depreciation, plus the balance of deferred financing costs, and reduced by any outstanding borrowings used to finance the purchase or construction of those assets.

Restricted Expendable Net Assets - Restricted expendable net assets are non-capital net assets that must be used for a particular purpose, as specified by creditor, grantors, or contributors external to the Healthcare System, including amounts deposited with trustees as required by bond indenture agreements.

Unrestricted Net Assets - Unrestricted net assets are remaining net assets that do not meet the definition of "Invested in Capital Assets, Net of Related Debt," or "Restricted."

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. 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.

Operating Revenues and Expenses

The Healthcare System's statements of revenues, expenses, and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services - the Healthcare System's principal activity. Nonexchange revenues, including grants and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Charity Care

The Healthcare System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Healthcare System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of charges foregone for services provided under the Hospital's charity care policy were \$2,430,045 and \$2,255,854 for the years ended December 31, 2011 and 2010. Total direct and indirect costs related to these foregone charges were approximately \$934,000 and \$875,000 at December 31, 2011 and 2010, based on an average ratio of cost to gross charges.

Advertising Costs

The Healthcare System expenses advertising costs as incurred.

Risk Management

The Healthcare System is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Note 2 - Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. The Healthcare System's Medicare cost reports have been settled by the Medicare fiscal intermediary through the year ended December 31, 2009.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on a cost reimbursement methodology for inpatient services. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. The Healthcare System's Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2005.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. The Healthcare System's Blue Cross cost reports have been settled by Blue Cross through December 31, 2008.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Laws and regulations governing the Medicare, Medicaid, and other 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 for the years ended December 31, 2011 and 2010 increased approximately \$531,000 and \$163,000 due to removal of allowances previously estimated that are no longer necessary as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

A summary of patient service revenue, contractual adjustments, and provision for bad debts for the years ended December 31, 2011 and 2010 is as follows:

	2011	2010
Patient service revenue		
Gross patient service revenue	\$ 196,361,439	\$ 184,274,655
Less: charity care	(2,430,045)	(2,255,854)
Total patient service revenue	<u>193,931,394</u>	<u>182,018,801</u>
Contractual adjustments		
Medicare	(57,994,285)	(51,767,580)
Medicaid	(15,603,730)	(15,489,415)
Blue Cross	(28,356,872)	(26,417,780)
Other	(11,260,309)	(10,822,869)
	<u>(113,215,196)</u>	<u>(104,497,644)</u>
Provision for bad debts	<u>(6,259,740)</u>	<u>(5,662,955)</u>
Total contractual adjustments and provision for bad debts	<u>(119,474,936)</u>	<u>(110,160,599)</u>
Net patient service revenue	<u>\$ 74,456,458</u>	<u>\$ 71,858,202</u>

Note 3 - Deposits, Investments, and Investment Income

Deposits

Custodial credit risk is the risk that in the event of a bank failure, the Healthcare System's deposits may not be returned to it. The Healthcare System has a general investment policy to minimize custodial credit risk. The Healthcare System had bank balances at December 31, 2011 and 2010 as follows:

	2011	2010
Insured (FDIC)	\$ 798,741	\$ 1,019,092
Collateralized by corporate securities held by the pledging institution in the Healthcare System's name	1,000,000	1,000,000
Uncollateralized	<u>1,115,913</u>	<u>846,046</u>
Total	<u>\$ 2,914,654</u>	<u>\$ 2,865,138</u>
Carrying value	<u>\$ 1,948,178</u>	<u>\$ 2,038,818</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

Investments

The Healthcare System's investments are reported at fair value. At December 31, 2011 and 2010, the Healthcare System's investments consisted of the following:

December 31, 2011

Investment Type	Carrying Amount	Investment Maturities (in Years)			
		Less Than 1	1-5	6-10	More Than 10
Money market funds	\$ 79,533	\$ 79,533	\$ -	\$ -	\$ -
Certificates of deposit (1)	5,869,109	5,869,109	-	-	-
Commercial paper	3,460,140	3,460,140	-	-	-
Federal National Mortgage Association	1,340,853	251,522	787,972	301,359	-
Federal Home Loan Mortgage Corporation	1,069,657	330,662	-	738,995	-
Federal Home Loan Bank	2,843,769	509,135	1,241,439	1,093,195	-
Federal Farm Credit Bank	1,145,074	252,345	346,726	546,003	-
U.S. Treasuries	1,525,314	-	530,125	995,189	-
Accrued interest	58,138	58,138	-	-	-
Total	<u>\$ 17,391,587</u>	<u>\$ 10,810,584</u>	<u>\$ 2,906,262</u>	<u>\$ 3,674,741</u>	<u>\$ -</u>

December 31, 2010

Investment Type	Carrying Amount	Investment Maturities (in Years)			
		Less Than 1	1-5	6-10	More Than 10
Money market funds	\$ 2,700	\$ 2,700	\$ -	\$ -	\$ -
Certificates of deposit (1)	8,210,333	8,210,333	-	-	-
Commercial paper	3,452,768	3,452,768	-	-	-
Federal National Mortgage Association	1,823,501	-	1,583,109	240,392	-
Federal Home Loan Mortgage Corporation	836,284	251,737	584,547	-	-
Federal Home Loan Bank	4,366,643	503,188	1,533,353	2,330,102	-
Federal Farm Credit Bank	2,599,031	-	851,673	1,747,358	-
Total	<u>\$ 21,291,260</u>	<u>\$ 12,420,726</u>	<u>\$ 4,552,682</u>	<u>\$ 4,317,852</u>	<u>\$ -</u>

- (1) The certificates of deposit were purchased through the Certificate of Deposit Account Registry Service (CDARS) program. They are reported at fair value and have been included in investments. The entire amount above is insured by the FDIC.

Interest Rate Risk

The Healthcare System's investment policy contains a provision that limits the investment maturities of commercial paper to 270 days as a means of managing its exposure to fair value losses arising from increasing interest rates. The investment policy does not contain a provision that limits other types of investment maturities.

Credit Risk

Michigan Compiled Laws, Section 129.91, authorizes the Healthcare System to deposit and invest in accounts of federally insured banks, credit unions, and savings and loan associations which have an office in Michigan. The Healthcare System is allowed to invest in bonds, securities and other direct obligations of the United States or any agency or instrumentality of the United States; United States government or federal agency obligations; repurchase agreements; banker's acceptance of United States banks; commercial paper rated within the two highest classifications which mature not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions which are rated as investment grade; and mutual funds composed of investment vehicles which are legal for direct investment by local units of government in Michigan. The Healthcare System complies with State Statutes with regard to credit risk. As of December 31, 2011, the Healthcare System's investment in Federal Home Loan Bank, Federal Home Loan Mortgage Corporation, Federal National Mortgage Association, Federal Farm Credit Bank, and U.S. Treasuries are rated AAA by Moody's Investors Service and AA+ by Standards and Poors.

Concentration of Credit Risk

The Healthcare System currently does not place a limit on the amount it may invest with any one issuer. More than 5 percent of the Healthcare System's investments are in the following investments as of December 31, 2011:

	<u>Percentage</u>
Abbey National LLC - Commercial paper	19.9%
Federal Home Loan Bank	16.4%
U.S. Treasuries	8.8%
Federal National Mortgage Association	7.7%
Federal Farm Credit Bank	6.6%
Federal Home Loan Mortgage Corporation	6.2%

Custodial Credit Risk

For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Healthcare System will not be able to recover the value of its investment or collateral securities that are in the possession of an outside party. At December 31, 2011 and 2010, all of the underlying securities for the Healthcare System's investments in mortgage-backed securities, repurchase agreements, and U.S. government securities are held by the counterparties in other than the Healthcare System's name.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

Summary of Carrying Amounts

The carrying amounts of the Healthcare System's deposits and investments shown above are included in the balance sheets at December 31, 2011 and 2010 as follows:

	2011	2010
Carrying amount		
Deposits	\$ 1,948,178	\$ 2,038,818
Investments	17,391,587	21,291,260
Forward purchase contract/deferred gain (1)	(112,319)	(121,069)
Total	<u>\$ 19,227,446</u>	<u>\$ 23,209,009</u>
Included in the following balance sheet captions		
Cash and cash equivalents	\$ 1,948,178	\$ 2,038,818
Temporary investments	5,927,246	8,461,690
Restricted assets - current portion (Note 6)	1,550,610	1,466,838
Other long-term investments	7,924,668	9,374,102
Restricted under indenture agreement for debt service (1)(Note 6)	<u>1,876,744</u>	<u>1,867,561</u>
Total	<u>\$ 19,227,446</u>	<u>\$ 23,209,009</u>

- (1) A forward purchase contract was entered into in 1999 by the Healthcare System relating to certain trustee held funds associated with the Series 1999 bonds. The contract provides a fixed rate of return of 5.775% on the Debt Service Fund and the Reserve Fund investments. The contract has a maturity date of November 2024, a notional value of approximately \$2,823,000 as of December 31, 2011 and 2010, respectively, and an estimated fair value of approximately \$1,657,000 and \$942,000 at December 31, 2011 and 2010, respectively. Upon inception of the agreement, the Healthcare System received a premium of \$220,000 from the counter party, which is being amortized over the life of the debt, and is recorded as a deferred gain. The unamortized balance of the deferred gain at December 31, 2011 and 2010 was \$112,319 and \$121,069 and is included with noncurrent cash and investments restricted under indenture agreement for debt service. The Healthcare System believes its credit risk is minimal on the transaction.

Investment Income

Investment income and gains and losses on cash equivalents and investments consist of the following for the years ended December 31, 2011 and 2010:

	2011	2010
Interest income and realized gains and losses	\$ 916,841	\$ 660,984
Interest income on proceeds of borrowed funds	<u>227,265</u>	<u>226,807</u>
Total investment income	<u>\$ 1,144,106</u>	<u>\$ 887,791</u>
Change in unrealized gains and losses on investments	<u>\$ 118,496</u>	<u>\$ 55,187</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

Note 4 - Capital Assets

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2011 are as follows:

	Balance December 31, 2010	Additions	Transfers and Retirements	Balance December 31, 2011
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ 52,330	\$ 1,675,542
Construction in progress	397,273	3,414,208	(1,924,351)	1,887,130
Total capital assets, not being depreciated	<u>\$ 2,020,485</u>	<u>\$ 3,414,208</u>	<u>\$ (1,872,021)</u>	<u>\$ 3,562,672</u>
Capital assets being depreciated				
Land improvements	\$ 1,011,580	\$ -	\$ -	\$ 1,011,580
Buildings and improvements	40,611,872	12,595	613,868	41,238,335
Equipment	39,300,198	1,058,362	858,820	41,217,380
Total capital assets being depreciated	<u>80,923,650</u>	<u>1,070,957</u>	<u>1,472,688</u>	<u>83,467,295</u>
Less accumulated depreciation for				
Land improvements	(456,348)	(56,452)	-	(512,800)
Buildings and improvements	(16,855,566)	(1,213,234)	-	(18,068,800)
Equipment	(27,844,395)	(3,111,106)	282,842	(30,672,659)
Total accumulated depreciation	<u>(45,156,309)</u>	<u>(4,380,792)</u>	<u>282,842</u>	<u>(49,254,259)</u>
Net capital assets being depreciated	<u>\$ 35,767,341</u>	<u>\$ (3,309,835)</u>	<u>\$ 1,755,530</u>	<u>\$ 34,213,036</u>
Capital assets, net	<u>\$ 37,787,826</u>			<u>\$ 37,775,708</u>

Construction in progress at December 31, 2011, represents costs related to information technology and planning for the construction of a medical office building. The total estimated cost to complete the projects is \$1,636,000, which will be funded from working capital.

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

Capital asset additions, transfers, retirements, and balances for the year ended December 31, 2010 are as follows:

	Balance December 31, 2009	Additions	Transfers and Retirements	Balance December 31, 2010
Capital assets not being depreciated				
Land	\$ 1,623,212	\$ -	\$ -	\$ 1,623,212
Construction in progress	733,598	508,416	(844,741)	397,273
	<u>2,356,810</u>	<u>508,416</u>	<u>(844,741)</u>	<u>2,020,485</u>
Total capital assets, not being depreciated				
Capital assets being depreciated				
Land improvements	\$ 1,011,580	\$ -	\$ -	\$ 1,011,580
Buildings and improvements	40,578,136	34,336	(600)	40,611,872
Equipment	38,671,537	981,738	(353,077)	39,300,198
	<u>80,261,253</u>	<u>1,016,074</u>	<u>(353,677)</u>	<u>80,923,650</u>
Total capital assets being depreciated				
Less accumulated depreciation for				
Land improvements	(399,896)	(56,452)	-	(456,348)
Buildings and improvements	(15,614,974)	(1,240,592)	-	(16,855,566)
Equipment	(25,341,493)	(3,510,577)	1,007,675	(27,844,395)
	<u>(41,356,363)</u>	<u>(4,807,621)</u>	<u>1,007,675</u>	<u>(45,156,309)</u>
Total accumulated depreciation				
Net capital assets being depreciated	<u>\$ 38,904,890</u>	<u>\$ (3,791,547)</u>	<u>\$ 653,998</u>	<u>\$ 35,767,341</u>
Capital assets, net	<u>\$ 41,261,700</u>			<u>\$ 37,787,826</u>

Construction in progress at December 31, 2010, represents costs related to information technology and planning for the construction of a medical office building.

Note 5 - Operating Leases

The Healthcare System leases certain medical and other equipment and office space under operating leases having terms of more than one year. Total operating lease expense for the years ended December 31, 2011 and 2010 for all operating leases was \$755,687 and \$665,850. Minimum future lease payments for these operating leases are as follows:

Year Ending December 31,	Amount
2012	\$ 329,677
2013	143,722
2014	68,267
2015	59,267
	<u>600,933</u>
Total minimum lease payments	<u>\$ 600,933</u>

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

Note 6 - Long-Term Debt

Long-term debt activity for the year ended December 31, 2011 follows:

	Balance December 31, 2010	Additions	Reductions	Balance December 31, 2011	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 4,306,249	\$ -	\$ (134,041)	\$ 4,172,208	\$ 141,827
Hospital Revenue and Refunding Bonds, Series 1999	25,360,000	-	(1,225,000)	24,135,000	1,320,000
Original issue discount	(140,078)	-	16,880	(123,198)	-
Equipment notes payable	31,913	-	(31,913)	-	-
Unamortized loss on defeasance of Series 1994 Bonds	(1,617,626)	-	194,988	(1,422,638)	-
	<u>\$ 27,940,458</u>	<u>\$ -</u>	<u>\$ (1,179,086)</u>	<u>\$ 26,761,372</u>	<u>\$ 1,461,827</u>

Long-term debt activity for the year ended December 31, 2010 follows:

	Balance December 31, 2009	Additions	Reductions	Balance December 31, 2010	Amounts Due Within One Year
Hospital Revenue Bonds, Series 2004	\$ 4,432,930	\$ -	\$ (126,681)	\$ 4,306,249	\$ 134,041
Hospital Revenue and Refunding Bonds, Series 1999	26,535,000	-	(1,175,000)	25,360,000	1,225,000
Original issue discount	(157,745)	-	17,667	(140,078)	-
Equipment notes payable	402,715	-	(370,802)	31,913	31,913
Unamortized loss on defeasance of Series 1994 Bonds	(1,821,787)	-	204,161	(1,617,626)	-
	<u>\$ 29,391,113</u>	<u>\$ -</u>	<u>\$ (1,450,655)</u>	<u>\$ 27,940,458</u>	<u>\$ 1,390,954</u>

On December 1, 2011, the Healthcare System was approved for a United States Department of Agriculture Rural Development Loan in an amount not to exceed \$9,000,000 – a direct loan not to exceed \$6,900,000 (interest rate of 3.75%) and a guaranteed loan not to exceed \$2,100,000 (interest rate to be determined). The repayment period on the direct portion would be 40 years, and 20 years for the guaranteed portion. The proceeds will be used to construct a medical office building on the Healthcare System's campus.

Long-Term Debt

The terms and due dates of the Healthcare System's long-term debt at December 31, 2011 and 2010 are as follows:

- 5.66% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue Bonds, Series 2004 (Series 2004 Bonds) - due in monthly installments of \$31,194 including interest, to August 2029, secured by certain equipment. (1)
 - 5.50% to 5.80% Dickinson County Healthcare System, County of Dickinson, State of Michigan, Hospital Revenue and Refunding Bonds, Series 1999 (Series 1999 Bonds) - Due in varying annual installments to November 2024, secured by a pledge of net revenues, investment income, and bond funds held under the indenture agreement (Note 3). (1)
 - Original Issue Discount - Associated with the Series 1999 Bonds issuance.
 - Equipment Notes Payable
 - Megavoltage Radiation Therapy (MRT) Equipment Note Payable #1 – During 2000, the Healthcare System entered into a 6%, 10-year note payable with Marquette General Hospital (Marquette), an unrelated organization, for the purchase of MRT equipment. The note payable was due in monthly installments of \$20,700 to January 2011, and was secured by certain MRT equipment.
 - MRT Equipment Note Payable #2 – During 2007, the Healthcare System placed in service certain equipment provided by Marquette and recorded a corresponding liability. On February 8, 2008, the Healthcare System entered into a 6%, 35 month note payable with Marquette. The note payable was due in monthly installments of \$11,373 to January 2011, and was secured by certain equipment.
 - Unamortized Loss on Defeasance of Series 1994 Bonds – During 1999, the Healthcare System defeased the Series 1994 Revenue Bonds (Series 1994 Bonds) by issuing the Series 1999 Bonds. A portion of the Series 1999 Bond proceeds totaling \$32,810,599 was placed in an irrevocable trust to provide for all future debt service payments on the Series 1994 Bonds. The Series 1994 Bonds were subsequently redeemed in 2004. The resulting loss on defeasance of approximately \$4,480,000 is being amortized using the bonds outstanding method, over the life of the Series 1999 Bonds.
- (1) The Series 2004 Bonds and Series 1999 Bonds loan agreements places limits on the incurrence of additional borrowings and requires the Healthcare System satisfy certain measures of financial performance. The Series 1999 Bonds loan agreement also requires the Healthcare System maintain certain deposits with a trustee. Such deposits are shown as restricted for this purpose in the balance sheets (Note 3).

Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Notes to Financial Statements
December 31, 2011 and 2010

Scheduled principal and interest payments on long-term debt are as follows:

Year Ending December 31,	Long-Term Debt		Total
	Principal	Interest	
2012	\$ 1,461,827	\$ 1,616,160	\$ 3,077,987
2013	1,510,066	1,535,321	3,045,387
2014	1,608,784	1,451,804	3,060,588
2015	1,713,007	1,359,929	3,072,936
2016	1,807,768	1,262,105	3,069,873
2017-2021	10,686,273	4,639,534	15,325,807
2022-2026	8,600,853	1,321,669	9,922,522
2027-2029	918,630	72,742	991,372
	<u>28,307,208</u>	<u>\$ 13,259,264</u>	<u>\$ 41,566,472</u>
Less unamortized bond discount	(123,198)		
Less unamortized loss on defeasance	<u>(1,422,638)</u>		
Total	<u>\$ 26,761,372</u>		

Note 7 - Defined Benefit Pension Plan

A. Plan Description

The Healthcare System is the administrator of a single-employer defined benefit noncontributory pension plan (Plan) which, prior to May 1, 2011, covered substantially all of its employees who met the Plan's eligibility requirements. The Plan was established in 1965. On May 1, 2011, the Plan was amended and closed to new entrants for many of the participating employee groups. Prior to May 1, 2011, all employees of the Healthcare System were eligible to participate in the Plan following the completion of at least one year of service and a minimum of 1,000 hours. Benefits vest after five years of service and a minimum of 1,000 hours per year.

The most recent actuarial valuation was made as of January 1, 2012. Based on actuarial information, the Healthcare System's estimated payroll for employees covered by the Plan for the years ended December 31, 2011 and 2010 was approximately \$32,382,000 and \$31,448,000. The Healthcare System's total actual payroll for the years ended December 31, 2011 and 2010 was approximately \$36,815,186 and \$35,964,154.

Current membership in the Plan consists of the following at December 31:

	2011	2010
Retirees and beneficiaries currently receiving benefits	250	224
Vested terminated members	148	155
Active and inactive employees		
Fully vested	538	539
Nonvested	<u>127</u>	<u>136</u>
	<u>1,063</u>	<u>1,054</u>

Normal retirement age is 65 with the completion of five or more years of service. Normal retirement pays a monthly pension for life, equal to 1.25% of average monthly compensation per year of credited service plus 0.65% of average monthly compensation in excess of covered compensation per year of service up to a maximum of 35 years, with a \$50 minimum. Participants may elect an early retirement on or after age 60 which pays a monthly pension for life computed in the same manner as a normal retirement pension, but based on service and earnings to date of retirement, and actuarially reduced to reflect the early commencement date. Early retirees receive \$200 per month for health insurance for up to 36 months which is included in taxable income. The stipend is paid directly from the Plan.

Active employees with 15 or more years of service and who have attained age 50, who become disabled are eligible for a disability pension, provided they qualify for Social Security disability. A disability pension is computed in the same manner as a normal retirement pension, but based on service and earnings to the date of disability.

If a vested employee dies, a death benefit is paid to the surviving spouse. Fifty percent of the deceased employee's benefit accrued to the date of death, is paid immediately or at the date the employee would have been age 60, whichever is later.

Funding Policy

The Plan's funding policy provides for periodic employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are designed to accumulate sufficient assets to pay benefits when due. The required contributions for the years ended December 31, 2011 and 2010 were 9.45% and 8.97%, of annual covered payroll. The annual contribution amounts are determined prior to the start of each year as part of the annual budget process. The 2011 and 2010 contribution amounts and percentages of covered payroll were determined by the Actuarial Valuation dated January 1, 2010 and 2009, respectively.

Funding Progress

The funded status of the Plan based on the actuarial valuations as of the January 1, 2008, 2009, 2010, 2011, and 2012 is as follows:

Actuarial Valuation Date January 1,	Actuarial Value of Assets (A)	Actuarial Accrued Liability (AAL) Entity Age (B)	Unfunded (Over funded) AAL (UAAL) (B - A)	Funded Ratio (A/B)	Covered Payroll (C)	UAAL as a Percentage of Covered Payroll ((B-A)/C)
2008	25,169,589	34,211,089	9,041,500	73.6%	31,172,369	29.0%
2009	25,008,465	37,762,525	12,754,060	66.2%	33,455,267	38.1%
2010	27,576,575	41,656,118	14,079,543	66.2%	32,389,391	43.5%
2011	30,455,817	43,178,949	12,723,132	70.5%	31,447,854	40.5%
2012	32,811,379	47,643,705	14,832,326	68.9%	32,382,406	45.8%

The funded status disclosed above was actuarially determined using methods prescribed for governmental defined benefit pension plans.

Annual Pension Cost

For 2011, 2010, 2009, 2008, and 2007, the Healthcare System's annual pension cost was equal to the Healthcare System's required and actual contributions. The required contribution was determined as part of the January 1, 2011, 2010, 2009, 2008, and 2007, actuarial valuations using the projected unit credit cost actuarial funding method. The actuarial assumptions for fiscal 2011 and 2010 included (a) 8.0% investment rate of return and (b) salary increases including merit and seniority increases ranging from 5.3% to 0.2% per year, plus wage inflation of 4%. The assumptions regarding benefits are that no changes will occur on a postretirement basis.

The Healthcare System's annual pension cost, and required and actual contributions for the years ended December 31, 2011, 2010, 2009, 2008, and 2007 were approximately \$3,062,000, \$2,822,000, \$2,363,000, \$2,276,000 and \$1,818,000. The net pension obligation for the years ended December 31, 2011, 2010, 2009, 2008, and 2007 was zero.

A separately issued financial report of the Dickinson County Healthcare System Retirement Plan is available which includes financial statements and required supplementary information for the Plan.

Note 8 - Deferred Compensation Plan

The Healthcare System offers its employees a deferred compensation plan (DC Plan) created in accordance with the Internal Revenue Code, Section 457 and administered by Lincoln Retirement Services Company, LLC (Lincoln). The DC Plan is available to all employees and permits them to defer a portion of their current earnings from income taxes until withdrawal in retirement, upon death, withdrawal upon termination at the employee's option, or withdrawal due to an unforeseeable emergency.

The assets of the DC Plan are held in trust for the exclusive benefit of participants and beneficiaries under the DC Plan, in accordance with Internal Revenue Code, Section 457 (g). Wilmington Trust Company, a Lincoln Affiliate, is the Trustee. Participants or surviving beneficiaries under the DC Plan may allocate their fund balances among independently managed mutual funds Lincoln's Alliance Program and a fixed annuity provided by Lincoln.

In accordance with the provisions of GASB Statement No. 32, the DC Plan assets and activities are not reflected in the financial statements of the Healthcare System.

Note 9 - Defined Contribution Plan

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program, administered by Lincoln Retirement Services Company, LLC (Lincoln). All Healthcare System employees (with the exception of AFSCME employees and contracted physicians) who were not currently vested in the defined benefit pension plan were transitioned to the new plan design.

MNA nursing staff transitioned effective May 1, 2011 per the MNA collective bargaining agreement and non-union staff transitioned effective September 4, 2011. In addition, all new hires as of September 4, 2011 are members of the new plan (with the exception of AFSCME new hires).

The Dickinson County Healthcare System 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. The base and match are only applicable to Healthcare System plan participants as discussed below. For base contributions, the Healthcare System contributes 3% of pay for each eligible employee who has 1-3 years of eligible service. This contribution is reduced to 0% after 3 years of service. Employer match contributions begin with service year 4 and the Healthcare System will match the employee's contributions up to 100% of the employee's salary deferral to the deferred compensation plan (Note 8), up to maximum of 4% of employee compensation. Defined contribution plan expense was \$56,607 for the year ended December 31, 2011.

Note 10 - General and Professional Liability Insurance

The Healthcare System carries general and professional liability insurance through ProAssurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. The Healthcare System also has excess layered coverage of \$3 million. The policies end in July 31, 2012.

The Healthcare System has exposure to deductibles for professional liability claims and a liability for such claims has been established based upon an actuarial determination of expected losses on an occurrence basis. The Healthcare System's estimate of general and professional liability includes a provision for known claims and for unreported claims and incidents. The Healthcare System's liability for unreported and known claims and incidents has been recorded at the total of anticipated future payments, and is discounted at a present value factor of 4% for 2011 and 2010. Amounts included as expense for general and professional liability for the years ended December 31, 2011 and 2010, which include claims and premiums paid, were approximately \$560,000 and \$519,000.

The reserve for loss on professional liability claims at December 31, 2011 and 2010 and activity for the years then ended is as follows:

Balance December 31, 2009	Additions	Reductions	Balance December 31, 2010	(A) Additions	Reductions	Balance December 31, 2011
\$ 650,000	\$ -	\$ -	\$ 650,000	\$ 715,000	\$ -	\$ 1,365,000

(A) As mentioned in Note 1, the Healthcare System adopted Financial Accounting Standards Board ASU No. 2010-24 (ASU 2010-24), *Presentation of Insurance Claims and Related Insurance Recoveries*, as of January 1, 2011. The adoption of ASU 2010-24 had no effect on previously reported operating results or changes in net assets. As a result of adopting ASU 2010-24, the Healthcare System increased the reserve for professional liability claims by \$695,000 at December 31, 2011. In addition, the Healthcare System recorded a receivable at December 31, 2011 for anticipated professional liability recoveries of \$695,000 (included in other assets in the accompanying financial statements) for estimated insurance proceeds on the outstanding claims for which a liability has been recorded.

The Healthcare System also increased its reserve for professional liability claims by \$20,000 during 2011.

Note 11 - Litigation, Claims, and Disputes

The Healthcare System is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. In the opinion of management, the ultimate settlement of any litigations, claims, and disputes in process will not be material to the financial position, operations, or cash flows of the Healthcare System.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 12 - Concentrations

The Healthcare System grants credit without collateral to its patients, most of who are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2011 and 2010 was as follows:

	2011	2010
Medicare	34%	29%
Blue Cross	19%	21%
Medicaid	10%	10%
Commercial insurance and other	23%	23%
Self pay	14%	17%
	<u>100%</u>	<u>100%</u>

The Healthcare System is subject to collective bargaining agreements for approximately 62 percent of its labor force. These agreements are negotiated on a tri-annual basis. The agreement for the Michigan Nurses Association will expire in April of 2013. The agreement for the American Federation of State, County, and Municipal Employees (AFSCME) will expire on December 31, 2012.

Note 13 - Dickinson County Hospital Foundation

Dickinson County Hospital Foundation (Foundation) is organized to raise funds for the benefit of the Healthcare System and the community. The Foundation is deemed not to be a component unit of the Healthcare System as defined in GASB 39, *Determining Whether Certain Organizations Are Component Units*, as the economic resources received or held by the Foundation is not considered significant to the Healthcare System. As the Foundation is not considered a component unit, the Foundation's financial statements are not included in these financial statements. At December 31, 2011 and 2010, the Foundation's assets consisted primarily of cash and short-term investments and totaled approximately \$716,000 and \$598,000.

Note 14 - Beneficiary of Trust

The Healthcare System has been named as a beneficiary in a charitable trust (Trust). The Trust agreement provides for the Healthcare System to receive 15% of the net income of the Trust on an annual basis. The Healthcare System received distributions from the Trust, which is included with donations, totaling \$40,846 and \$40,189 for the years ended December 31, 2011 and 2010. The Healthcare System will also receive 15% of the assets of the Trust upon termination of the Trust. The market value of the Trust at December 31, 2011 was approximately \$10,925,000.

The assets of the Trust are held by a trustee. The trustee shall, at their discretion, have the right to distribute trust principal to or for the benefit of the beneficiaries. The Trust's assets shall be distributed no later than 21 years after the death of the last beneficiary. As the trustee holds variance power over the timing of the distributions of the Trust's assets, the Healthcare System has not recorded a beneficial interest in the Trust in the accompanying financial statements.

Note 15 - Subsequent Events

The Healthcare System has evaluated subsequent events through April 27, 2012, the date which the financial statements were available to be issued.



Forecasted Financial Statements
Five Years Ending December 31, 2023
Dickinson County Healthcare System
(A Component Unit of Dickinson County)
Iron Mountain, Michigan

19.19

Dickinson County Healthcare System

Table of Contents

Five Years Ending December 31, 2023

Independent Accountant's Report	1
Forecasted Financial Statements	3
Statements of Net Position	3
Statements of Revenues, Expenses, and Changes in Net Position	5
Statements of Cash Flows	6
Forecasted Debt Service Coverage	8
Forecasted Schedule of Debt Service	9
Forecasted Financial Ratios	10
Summary of Significant Forecast Assumptions and Accounting Policies	12
Summary of Significant Forecast Demand Assumptions	41
Sensitivity Analysis	58
Historical Financial Statements	61
Statements of Net Position	62
Statements of Revenues, Expenses, and Changes in Net Position	63
Statements of Cash Flows	64



Independent Accountant's Report

Board of Directors
Dickinson County Healthcare System
Iron Mountain, Michigan

We have examined the accompanying forecast of Dickinson County Healthcare System (a component unit of Dickinson County) (Healthcare System), which comprises the forecasted statements of net position as of December 31, 2019, 2020, 2021, 2022, and 2023, and the related forecasted statements of revenues, expenses, and changes in net position, and cash flows for the five years then ending, based on guidelines for the presentation of a forecast established by the American Institute of Certified Public Accountants (AICPA). The Healthcare System's management is responsible for preparing and presenting the forecast in accordance with the guidelines for presentation of a forecast established by the AICPA. Our responsibility is to express an opinion on the forecast based on our examination.

Our examination was conducted in accordance with attestation standards established by the AICPA. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the forecast is presented in accordance with the guidelines for the presentation of a forecast established by the AICPA, in all material respects. An examination involves performing procedures to obtain evidence about the forecast. The nature, timing, and extent of the procedures selected depend upon our judgment, including an assessment of the risks of material misstatement of the forecast, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

Our examination of the financial forecast was made for the purpose of forming an opinion on whether the financial forecast is presented in conformity with AICPA guidelines for presentation of a forecast and the underlying assumptions provide a reasonable basis for the forecast. The historical information as of and for the years ended December 31, 2014 through 2018 is presented for purposes of additional analysis and is not a required part of the financial forecast. Such information is required to be presented in accordance with Guidelines for Preparation of Financial Feasibility Studies – Healthcare Type Facilities issued by the U. S. Department of Agriculture – Rural Development. Such information has not been subjected to the procedures applied in the examination of the forecast, and accordingly, we express no opinion or other form of assurance on it. The historical information was extracted from the Healthcare System's audited financial statements during the years ended December 31, 2014 through December 31, 2018. Those audited financial statements should be read in conjunction with this examined forecast.

The accompanying forecasted financial statements depart from the AICPA guidelines as they do not include implementation of Governmental Accounting Standards Board (GASB) 87, *Leases*, which is effective for the Healthcare System for the year beginning January 1, 2020. Management has not determined the financial impact of not implementing the GASB during the forecast period.

In our opinion, except for the departure noted above, the accompanying forecast is presented, in all material respects, in accordance with the guidelines for presentation of a forecast established by the AICPA, and the underlying assumptions are suitably supported and provide a reasonable basis for management's forecast.

Fargo, North Dakota

DATE

Draft_07.19.19

Dickinson County Healthcare System
Forecasted Statements of Net Position – Assets and Deferred Outflows of Resources
December 31, 2019, 2020, 2021, 2022, and 2023

	2019	2020	2021	2022	2023
Assets and Deferred Outflows of Resources					
Current Assets					
Cash and cash equivalents	\$ 6,264,000	\$ 6,022,000	\$ 8,566,000	\$ 10,319,000	\$ 10,854,000
Receivables					
Patient, net of uncollectibles	14,057,000	14,207,000	13,656,000	13,600,000	13,393,000
Estimated third-party payor settlements	532,000	532,000	532,000	532,000	532,000
Other	1,927,000	1,927,000	1,927,000	1,927,000	1,927,000
Supplies and other current assets	2,587,000	2,587,000	2,587,000	2,587,000	2,587,000
Total current assets	25,367,000	25,275,000	27,268,000	28,965,000	29,293,000
Noncurrent Cash and Investments					
Restricted under indenture agreement for debt service	-	148,000	296,000	444,000	592,000
Capital Assets					
Capital assets not being depreciated	2,465,000	2,465,000	2,465,000	2,465,000	2,465,000
Depreciable capital assets, net of accumulated depreciation	27,500,000	40,196,000	37,782,000	35,367,000	32,916,000
Total capital assets	29,965,000	42,661,000	40,247,000	37,832,000	35,381,000
Other Assets					
Investments in joint ventures	625,000	625,000	625,000	625,000	625,000
Total assets	55,957,000	68,709,000	68,436,000	67,866,000	65,891,000
Deferred Outflows of Resources					
Refunding costs	41,000	-	-	-	-
Pension related deferred outflows	2,755,000	1,041,000	518,000	-	-
Total deferred outflows of resources	2,796,000	1,041,000	518,000	-	-
Total assets and deferred outflows of resources	\$ 58,753,000	\$ 69,750,000	\$ 68,954,000	\$ 67,866,000	\$ 65,891,000

Dickinson County Healthcare System

Forecasted Statements of Net Position – Liabilities, Deferred Inflows of Resources, and Net Position
December 31, 2019, 2020, 2021, 2022, and 2023

	2019	2020	2021	2022	2023
Liabilities, Deferred Inflows of Resources, and Net Position					
Current Liabilities					
Current maturities of long-term-debt	\$ 1,883,000	\$ 994,000	\$ 1,006,000	\$ 1,046,000	\$ 366,000
Accounts payable	4,123,000	4,204,000	4,274,000	4,395,000	4,515,000
Accrued expenses					
Salaries, wages, and related liabilities	1,923,000	1,904,000	1,942,000	1,968,000	1,995,000
Compensated absences	3,708,000	3,672,000	3,744,000	3,796,000	3,847,000
Other accrued liabilities	961,000	952,000	971,000	984,000	997,000
Total current liabilities	<u>12,598,000</u>	<u>11,726,000</u>	<u>11,937,000</u>	<u>12,189,000</u>	<u>11,720,000</u>
Long-Term Liabilities					
Long-term debt, less current maturities	14,211,000	26,731,000	25,726,000	24,679,000	24,313,000
Reserve for loss on general and professional liabilities claims	450,000	450,000	450,000	450,000	450,000
Net pension liability	20,306,000	20,306,000	20,306,000	20,306,000	20,306,000
Total long-term liabilities	<u>34,967,000</u>	<u>47,487,000</u>	<u>46,482,000</u>	<u>45,435,000</u>	<u>45,069,000</u>
Total liabilities	<u>47,565,000</u>	<u>59,213,000</u>	<u>58,419,000</u>	<u>57,624,000</u>	<u>56,789,000</u>
Deferred Inflows of Resources					
Pension related deferred inflows	<u>2,434,000</u>	<u>714,000</u>	-	-	-
Net Position					
Invested in capital assets, net of related debt	13,871,000	14,936,000	13,515,000	12,107,000	10,702,000
Restricted - expendable for debt service	-	148,000	296,000	444,000	592,000
Unrestricted	<u>(5,117,000)</u>	<u>(5,261,000)</u>	<u>(3,276,000)</u>	<u>(2,309,000)</u>	<u>(2,192,000)</u>
Total net position	<u>8,754,000</u>	<u>9,823,000</u>	<u>10,535,000</u>	<u>10,242,000</u>	<u>9,102,000</u>
Total liabilities, deferred inflows of resources, and net position	<u>\$ 58,753,000</u>	<u>\$ 69,750,000</u>	<u>\$ 68,954,000</u>	<u>\$ 67,866,000</u>	<u>\$ 65,891,000</u>

Dickinson County Healthcare System
Forecasted Statements of Revenues, Expenses, and Changes in Net Position
Five Years Ending December 31, 2023

	2019	2020	2021	2022	2023
Operating Revenues					
Net patient service revenue	\$ 93,287,000	\$ 94,538,000	\$ 95,856,000	\$ 97,332,000	\$ 97,769,000
Supplies and 340B program revenue	2,620,000	2,400,000	2,448,000	2,497,000	2,547,000
Other revenue	2,428,000	2,452,000	2,477,000	2,502,000	2,527,000
Total operating revenues	98,335,000	99,390,000	100,781,000	102,331,000	102,843,000
Operating Expenses					
Salaries and wages	37,699,000	37,422,000	38,051,000	38,568,000	39,091,000
Employee benefits	14,174,000	14,510,000	14,533,000	15,418,000	15,076,000
Professional fees and other	10,081,000	10,258,000	10,000,000	10,247,000	10,489,000
Purchased services	8,296,000	8,455,000	8,652,000	8,858,000	9,058,000
Supplies	18,479,000	18,973,000	19,538,000	20,194,000	20,853,000
Utilities	1,254,000	1,288,000	1,324,000	1,360,000	1,397,000
Repairs and maintenance	232,000	236,000	241,000	246,000	251,000
Insurance	436,000	442,000	449,000	456,000	462,000
Lease and rentals	675,000	689,000	702,000	716,000	731,000
Depreciation	3,114,000	3,677,000	4,413,000	4,415,000	4,451,000
Other	1,221,000	1,240,000	1,258,000	1,277,000	1,296,000
Total Operating Expenses	95,661,000	97,190,000	99,161,000	101,755,000	103,155,000
Operating Income (Loss)	2,674,000	2,200,000	1,620,000	576,000	(312,000)
Nonoperating Revenue (Expenses)					
Unrestricted contributions	55,000	55,000	55,000	55,000	55,000
Interest and amortization expense	(1,114,000)	(1,221,000)	(998,000)	(959,000)	(918,000)
Issuance and financing fees	(402,000)	-	-	-	-
Investment income	35,000	35,000	35,000	35,000	35,000
Nonoperating Revenues (Expenses), net	(1,426,000)	(1,131,000)	(908,000)	(869,000)	(828,000)
Revenues in Excess of (Less Than) Expenses	1,248,000	1,069,000	712,000	(293,000)	(1,140,000)
Net Position, Beginning of Year	7,506,000	8,754,000	9,823,000	10,535,000	10,242,000
Net Position, End of Year	\$ 8,754,000	\$ 9,823,000	\$ 10,535,000	\$ 10,242,000	\$ 9,102,000

Dickinson County Healthcare System

Forecasted Statements of Cash Flows

Five Years Ending December 31, 2023

	2019	2020	2021	2022	2023
Operating Activities					
Receipts from and on behalf of patients	\$ 94,941,000	\$ 94,388,000	\$ 96,407,000	\$ 97,388,000	\$ 97,976,000
Payments from supplies and contractors	(41,411,000)	(41,509,000)	(42,075,000)	(43,220,000)	(44,404,000)
Payments to employees	(53,073,000)	(51,993,000)	(52,665,000)	(53,390,000)	(54,089,000)
Other receipts	5,047,000	4,852,000	4,927,000	4,998,000	5,074,000
Net Cash from Operating Activities	5,504,000	5,738,000	6,594,000	5,776,000	4,557,000
Noncapital Financing Activity					
Unrestricted general contributions	55,000	55,000	55,000	55,000	55,000
Capital and Capital Related Financing Activities					
Purchase of capital assets	(2,000,000)	(16,373,000)	(2,000,000)	(2,000,000)	(2,000,000)
Repayment of long-term debt	(14,746,000)	(2,742,000)	(994,000)	(1,006,000)	(1,046,000)
Interest paid on long-term debt	(945,000)	(1,180,000)	(998,000)	(959,000)	(918,000)
Payment of debt issuance costs	(402,000)	-	-	-	-
Proceeds from the issuance of long-term debt	10,277,000	14,373,000	-	-	-
Net Cash used for Capital and Capital Related Financing Activities	(7,816,000)	(5,922,000)	(3,992,000)	(3,965,000)	(3,964,000)
Investing Activities					
Proceeds from sales and maturities of investments	2,332,000	-	-	-	-
Investment income	35,000	35,000	35,000	35,000	35,000
Net Cash from (used for) Investing Activities	2,367,000	35,000	35,000	35,000	35,000
Net Increase in Cash and Cash Equivalents	110,000	(94,000)	2,692,000	1,901,000	683,000
Cash and Cash Equivalents, Beginning of Year	6,154,000	6,264,000	6,170,000	8,862,000	10,763,000
Cash and Cash Equivalents, End of Year	\$ 6,264,000	\$ 6,170,000	\$ 8,862,000	\$ 10,763,000	\$ 11,446,000
Reconciliation of Cash and Cash Equivalents to the Balance Sheets					
Cash and cash equivalents in current assets	\$ 6,264,000	\$ 6,022,000	\$ 8,566,000	\$ 10,319,000	\$ 10,854,000
Cash and cash equivalents in noncurrent cash and investments	-	148,000	296,000	444,000	592,000
Total cash and cash equivalents	\$ 6,264,000	\$ 6,170,000	\$ 8,862,000	\$ 10,763,000	\$ 11,446,000

Dickinson County Healthcare System

Forecasted Statements of Cash Flows

Five Years Ending December 31, 2023

	2019	2020	2021	2022	2023
Reconciliation of Operating Income to Net Cash from Operating Activities					
Operating Income (loss)	\$ 2,674,000	\$ 2,200,000	\$ 1,620,000	\$ 576,000	\$ (312,000)
Adjustments to reconcile operating income (loss) to net cash flows operating activities					
Depreciation	3,114,000	3,677,000	4,413,000	4,415,000	4,451,000
Provision for bad debts	3,851,000	3,874,000	3,933,000	3,999,000	4,057,000
Changes in assets and liabilities					
Patient receivables	(2,197,000)	(4,024,000)	(3,382,000)	(3,943,000)	(3,850,000)
Deferred outflows of resources	3,245,000	1,714,000	523,000	518,000	-
Accounts payable	(553,000)	81,000	70,000	121,000	120,000
Accrued expenses	(968,000)	(64,000)	131,000	90,000	91,000
Deferred inflows of resources	(3,662,000)	(1,720,000)	(714,000)	-	-
Net Cash from Operating Activities	<u>\$ 5,504,000</u>	<u>\$ 5,738,000</u>	<u>\$ 6,594,000</u>	<u>\$ 5,776,000</u>	<u>\$ 4,557,000</u>
Supplemental Disclosure of Cash Flow Information					
Issuance of long-term debt	\$ 10,277,000	\$ 14,373,000	\$ -	\$ -	\$ -
Debt issuance costs	(402,000)	-	-	-	-
Refinance long-term debt	(9,875,000)	-	-	-	-
Building and equipment upgrades	-	(14,373,000)	-	-	-
Net Proceeds from Issuance of Long-Term Debt	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

Dickinson County Healthcare System

Forecasted Debt Service Coverage
Five Years Ending December 31, 2023

Forecasted Debt Service Coverage

The debt service coverage reflects the results of the forecasted financial statements for the years ending December 31, 2019 through 2023 and should not be used as a forecast of coverage for later years. Financial operations for the years after 2023 may provide higher or lower debt service coverage.

	2019	2020	2021	2022	2023
Income Available For Debt Service					
Change in Net Position	\$ 1,248,000	\$ 1,069,000	\$ 712,000	\$ (293,000)	\$ (1,140,000)
Add back:					
Depreciation	3,114,000	3,677,000	4,413,000	4,415,000	4,451,000
Interest and amortization	1,114,000	1,221,000	998,000	959,000	918,000
Pension amortization	(417,000)	(5,000)	(192,000)	518,000	-
Issuance and financing fees	402,000	-	-	-	-
Total Income Available for Debt Service	<u>\$ 5,461,000</u>	<u>\$ 5,962,000</u>	<u>\$ 5,931,000</u>	<u>\$ 5,599,000</u>	<u>\$ 4,229,000</u>
Debt Service:					
Principal payments	\$ 14,746,000	\$ 2,742,000	\$ 994,000	\$ 1,006,000	\$ 1,046,000
Refinanced debt	(9,875,000)	-	-	-	-
Non-recurring debt payment (A)	(1,750,000)	-	-	-	-
Debt payment advance of maturity (B)	-	(859,000)	-	-	-
Interest payments	945,000	1,180,000	998,000	959,000	918,000
Total Debt Service	<u>\$ 4,066,000</u>	<u>\$ 3,063,000</u>	<u>\$ 1,992,000</u>	<u>\$ 1,965,000</u>	<u>\$ 1,964,000</u>
Debt Service Coverage Ratio (Times)	<u>1.34</u>	<u>1.95</u>	<u>2.98</u>	<u>2.85</u>	<u>2.15</u>

(A) – represents amounts paid on Bellin revolving note. This is a lump sum payment due at payoff of the Healthcare System's note payable to Fifth Third Bank.

(B) – represents amounts paid on Wisconsin Physician Services Insurance Corporation note. Original maturity date is January 2022.

Dickinson County Healthcare System

Forecasted Schedule of Debt Service

Forecasted Schedule of Debt Service

	Existing Debt		USDA Direct Loan		Total		
	Principal	Interest	Principal	Interest	Principal	Interest	Total
2019	\$ 14,746,000	\$ 945,000	\$ -	\$ -	\$ 14,746,000	\$ 945,000	\$ 15,691,000
2020	2,114,000	317,000	628,000	863,000	2,742,000	1,180,000	3,922,000
2021	344,000	167,000	650,000	831,000	994,000	998,000	1,992,000
2022	332,000	151,000	674,000	808,000	1,006,000	959,000	1,965,000
2023	349,000	135,000	697,000	783,000	1,046,000	918,000	1,964,000
2024	366,000	117,000	722,000	758,000	1,088,000	875,000	1,963,000
2025	385,000	98,000	748,000	733,000	1,133,000	831,000	1,964,000
2026	404,000	79,000	775,000	706,000	1,179,000	785,000	1,964,000
2027	425,000	58,000	802,000	679,000	1,227,000	737,000	1,964,000
2028	447,000	37,000	831,000	650,000	1,278,000	687,000	1,965,000
2029	337,000	15,000	860,000	621,000	1,197,000	636,000	1,833,000
2030	102,000	7,000	891,000	590,000	993,000	597,000	1,590,000
2031	105,000	4,000	923,000	558,000	1,028,000	562,000	1,590,000
2032	107,000	2,000	955,000	525,000	1,062,000	527,000	1,589,000
2033	-	-	989,000	491,000	989,000	491,000	1,480,000
2034	-	-	1,025,000	456,000	1,025,000	456,000	1,481,000
2035	-	-	1,061,000	420,000	1,061,000	420,000	1,481,000
2036	-	-	1,099,000	382,000	1,099,000	382,000	1,481,000
2037	-	-	1,138,000	343,000	1,138,000	343,000	1,481,000
2038	-	-	1,178,000	303,000	1,178,000	303,000	1,481,000
2039	-	-	1,220,000	261,000	1,220,000	261,000	1,481,000
2040	-	-	1,264,000	217,000	1,264,000	217,000	1,481,000
2041	-	-	1,309,000	172,000	1,309,000	172,000	1,481,000
2042	-	-	1,355,000	126,000	1,355,000	126,000	1,481,000
2043	-	-	1,403,000	78,000	1,403,000	78,000	1,481,000
2044	-	-	1,453,000	28,000	1,453,000	28,000	1,481,000
	\$ 20,563,000	\$ 2,132,000	\$ 24,650,000	\$ 12,382,000	\$ 45,213,000	\$ 14,514,000	\$ 59,727,000

For Project related terms, refer to: *Note 3 - Forecasted Construction and Financing Plan.*

Dickinson County Healthcare System
Forecasted Financial Ratios
Five Years Ending December 31, 2023

Forecasted Financial Ratios

	2019	2020	2021	2022	2023	Flex Monitoring Program * 2016 Median Indicator Values	
						MI	US
Profitability Indicators							
Total margin	1.29%	1.09%	0.71%	(0.29%)	(1.12%)	2.04%	2.74%
Cash flow margin	5.89%	5.91%	5.99%	4.88%	4.02%	7.45%	6.99%
Operating margin	2.72%	2.21%	1.61%	0.56%	(0.30%)	6.48%	5.32%
Return on equity	14.26%	10.88%	6.76%	(2.86%)	(12.52%)	3.25%	0.93%
Liquidity Indicators							
Current ratio	2.01	2.16	2.28	2.38	2.50	1.91	2.48
Days cash on hand (operating)	25	24	33	39	40	N/A	N/A
Total days cash on hand	25	24	33	39	40	47	78
Net days in accounts receivable	55	55	52	51	50	43	51
Capital Structure Indicators							
Equity financing	14.90%	14.08%	15.28%	15.09%	13.81%	65.25%	59.78%
Debt service coverage (times)	1.34	1.95	2.98	2.85	2.15	1.79	3.35
Long-term debt to capitalization	61.88%	73.13%	70.95%	70.67%	72.76%	17.56%	27.20%
Revenue Indicators							
Outpatient revenues to total revenues (1)	72.38%	72.64%	72.93%	73.25%	73.50%	85.56%	77.74%
Patient deductions (2)	68.51%	68.28%	68.32%	68.36%	68.67%	46.48%	43.46%
Medicare inpatient payor mix	61.39%	61.64%	61.89%	62.14%	62.39%	61.52%	72.70%
Medicare outpatient payor mix	45.18%	45.18%	45.18%	45.18%	45.17%	34.20%	37.10%
Cost Indicators							
Salaries to net patient service revenue (3)	40.41%	39.58%	39.70%	39.63%	39.98%	41.87%	44.90%
Supplies to net patient service revenue	19.81%	20.07%	20.38%	20.75%	21.33%	N/A	N/A
Average age of plant	24.86	22.05	19.37	20.36	21.20	11.35	10.48
FTE's per adjusted occupied bed	5.13	4.98	4.87	4.76	4.66	N/A	N/A
FTE's per adjusted occupied bed (4)	5.45	5.30	5.19	5.07	4.96	5.80	5.61
Average Salary per FTE	\$ 64,305	\$ 65,508	\$ 66,843	\$ 68,231	\$ 69,649	\$ 60,809	\$ 56,197
Utilization Indicators							
Average daily census	19.60	19.25	19.21	19.11	19.02	3.59	2.70

Notes:

- (1) - Total outpatient revenue (including clinic revenue) divided by total patient revenue.
- (2) - Excludes charity care and provision for bad debts.
- (3) - Includes hospital and clinic revenues.
- (4) - Hospital Only (excludes Clinic)

* -- Flex Monitoring Team consists of Rural Health Research Centers at the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine awarded by the Federal Office of Rural Health Policy to monitor and evaluate the Medicare Rural Hospital Flexibility Grant Program.

Note 1- Nature of Forecast

This financial forecast presents, to the best of management's knowledge and belief, Dickinson County Healthcare System (Healthcare System), expected financial position, results of operations, changes in net position, cash flows, debt service coverage, and schedule of debt service during the forecast period. Accordingly, the forecast reflects management's judgment, based on present circumstances, of expected conditions and its expected course of action. The assumptions disclosed herein, while not all inclusive, are those that management of the Healthcare System believes are significant to the forecast. There will usually be differences between forecasted and actual results, because events and circumstances frequently do not occur as expected, and those differences may be material.

This forecast, dated July XX, 2019, was prepared in connection with the issuance of a \$24,650,000 from the United States Department of Agriculture (USDA) Direct Loan (Direct Loan). The proceeds of the Direct Loan will be used to finance upgrades to the Healthcare System's radiological equipment, information technology equipment, and various other equipment upgrades, along with refinancing the Healthcare System's existing 2015 note payable and pay issuance costs of the transaction. The USDA Direct Loan is forecasted to carry an interest rate of 3.50%, with a term of 25 years.

The assumed project costs, interest rates, principal payments, financing assumptions and assumptions pertaining to forecasted revenues, expenses, and cash flows are described in the section titled *Summary of Significant Forecast Assumptions and Accounting Policies*. If the actual costs, interest rates, principal payments, funding requirements, and other assumptions are different from those assumed, the amount of debt and associated debt service requirements would need to be adjusted accordingly from those indicated in the forecast. If such costs, interest rates, principal payments, funding requirements, or other assumptions are different than those assumed, then such adjustments could adversely affect the forecast.

The forecasted financial statements have been presented in a format consistent with the presentation of the Healthcare System's historical financial statements. The accompanying forecasted financial statements depart from the American Institute of Certified Public Accountants guidelines as they do not include implementation of Governmental Accounting Standards Board (GASB) 87, *Leases*, which is effective for the Healthcare System for the year beginning January 1, 2020. Management has not determined the financial impact of not implementing this standard during the forecast period.

Legislation and regulations at all levels of government have affected and may continue to affect the revenues and expenses of healthcare facilities. This financial forecast is based upon legislation and regulations currently in effect. Many regulations of the Health Care Reform law continue to be under review and scrutiny. If future legislation or regulations related to the Healthcare System's operations are subsequently enacted, such legislation and regulations could have a material effect on future operations. The Healthcare System receives significant financial benefit from participation in the 340B drug program. Continued eligibility in this program is a sensitive assumption.

Some assumptions inevitably will not materialize, and unanticipated events and circumstances may occur subsequent to July XX, 2019, the date of this forecast. Therefore, the actual results achieved during the forecast period will vary from the forecast, and the variations may be material. Management has no intention to update this forecast at a future date to reflect changes in present circumstances or the occurrence of unanticipated events. Accordingly, there are risks inherent in using this forecast in the future as it becomes outdated. These forecasted financial statements have been computer generated which could result in rounding differences.

The forecasted financial statements are based on the historical operations of the Healthcare System for the years ended December 31, 2014 through 2018 and adjusted for management's knowledge and belief of the Healthcare System's expected financial position, results of operations, changes in net position, and cash flows during the forecast period. Management's knowledge, beliefs, expected course of action have been reviewed and appear reasonable based on historical performance, industry standards, and verification of major assumptions. The forecasted financial statements have been presented in a format consistent with the expected presentation of the Healthcare System's audited financial statements.

Note 2 - Summary of Significant Accounting Policies

The financial forecast has been prepared in accordance with the generally accepted accounting principles expected to be used in the financial statements covering the forecast period. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. The significant accounting and reporting policies and practices used in the Healthcare System's forecasted financial statements are described below.

Organization

Dickinson County Hospital, a Michigan public county hospital, was formed by a vote of the electorate of Dickinson County, Michigan, on July 29, 1947, under the provisions of 1913 PA 350. On October 10, 1990, the Dickinson County Board of Commissioners reorganized Dickinson County Hospital under 1987 PA 230, becoming Dickinson County Memorial Hospital System, a Michigan county health facilities public corporation. The Dickinson County Healthcare System Board of Trustees, with approval of the county board of commissioners, filed conversion Articles of Incorporation on June 27, 2017. Under Sec. 103 (d) of 1987 PA 230, the restructured corporation under Sec. 305a of 1987 PA 230 remains a municipal health facilities corporation. The Healthcare System provides acute, ambulatory, home health, and certain physician services to the residents of its service area. Members of the board of trustees are chosen with the advice and consent of the county board of commissioners. The Healthcare System may not issue long-term debt without the County's approval. The Healthcare system is considered to be a component unit of Dickinson County.

The current Healthcare System facility was completed in 1996 on land leased from Dickinson County (County) under a one-hundred-year lease. Under provisions of the lease, title and ownership of all buildings and improvements constructed on the site are in the name of the County. The lease places certain requirements and restrictions on the Healthcare System.

The Healthcare System is accounted for as an enterprise fund of the County. The Healthcare System is exempt from federal and state income taxes under Section 115 of the Internal Revenue Code.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

These forecasted financial statements include only the activity of the Healthcare System.

Board of Directors

There are 10 Board of Directors who serve 3-year terms. The Board of Directors consists of the following members:

Board Member	Occupation	Term Ends
Margaret Minerick, Chair	Owner, Minerick Logging	2021
Dave Brisson, Vice Chair	Owner, Loadmaster	2020
Sally Blom, Secretary	Broker/Owner, Stephens	2021
Bill Edberg	Retired	2019
Jeffery Campbell	CFO, MJ Electric	2020
Dave Holmes	Principal, Kingsford Middle School	2022
Kim Van Osdol	Market President, Great North Bank	2022
Dan Wender	Owner, DJW Services Property Mgmt	2022
Dr. John To	DCHS Radiology	2019
Dr. Donald Kube, Ex-Officio	Chief of Staff, DCHS	N/A

Senior Management

The following is a list of key management personnel of the Healthcare System:

Name	Title	Years in Current Position
Jeanne Goche	Chief Executive Officer	1
Dennis Smith	Interim Chief Restructuring Officer	1
Marie Debs	Interim Vice President Physician Network Operations and Human Resources	1
Jerry Worden	Interim Vice President of Finance	1
Susan Hadley	Vice President Clinical Services and Population Health	20
Meghan Rossato	Performance Improvement, Operations, and Analytics Director	8
Dean DeCremer	Director of Information Systems	25
Joe Rizzo	Public Relations Business Development Director/Occupational Clinic Director/Health Risk Assessments	3

Jeanne Goche, Interim Chief Executive Officer Jeanne has provided financial and operational improvement services in the management of health care organizations nationwide since 2008. She has experience in roles including CEO, COO, and CFO, often working in dual C-suite capacities. Her background includes 20+ years in a wide range of health care provider settings, from academic centers to physician groups, critical access and “tweener” hospitals, and nursing homes.

Jeanne has prepared a hospital for health system affiliation, conducted buy-side due diligence and transactional support for acquisitions, and stabilized a health system’s newly acquired medical center. She has effectively lead health care organizations to avoid closure and become leaders in their regions.

Her health finance background is enhanced by her work with client employers as Director of Business Development at Blue Cross and Blue Shield of Iowa where she was involved in PPO, TPA, and HMO advancements. At the University of Iowa during significant managed care growth, Jeanne built the revenue cycle system and achieved excellent rates for all the hospitals and clinical specialties. This revenue cycle system received perfect scores by outside auditors.

Jeanne specializes in effectively making needed improvements with health care organizations in ways that recognize their special leadership, economic, and employment roles in their communities. She has won the *Health Resources and Services Administration Award* (HRSA, U.S. Department of Health and Human Services) for meeting *Organ Donation Breakthrough Collaborative* goals ahead of schedule. This success involved collaboration with many regional health care organizations.

Jeanne holds an MA in health administration and a JD, both from the University of Iowa. She is a frequent speaker and visiting educator regarding health care management topics.

Dennis Smith, Interim Chief Restructuring Officer. Dennis has over 47 years of healthcare related experience starting at St. Joseph Mercy Hospital in 1971 managing the Operating Room and Surgical Floors. From 1977-1987, Dennis managed the 24/7 operation of Imaging Services at Saint Mary's Hospital. In 1988, he spent a year as the Director of Marketing Core Caretrac Rehabilitative Services. Then from 1988-2003, he was the Senior Director of Insurance and Pension Services at Michigan Health & Hospital Association. From 2003-July 2018, Dennis was the CEO and President of Upper Peninsula Managed Care LLC & Upper Peninsula Health Plan when he retired, to then start his own Consulting Firm. Dennis joined the Healthcare System in December 2018 as the Interim Chief Restructuring Officer.

Marie Debs, Interim VP Physician Network Operations and HR. Marie has 25 years of experience, 7 months contracted at the Healthcare System. While at the Healthcare System she has developed a position control process for reviewing staffing needs, worked with the Healthcare System's board to develop a subcommittee of the pension board and hire a third-party administrator to handle pension issues going forward. She has worked with the Accounts Receivable team to help identify priorities and implement change that significantly impacted income/expense. For physician services she has developed a standardized template for provider contracts which includes incentives for productivity and quality. She provided input on the re-organization of the physician services structure and is currently focused on management development and increased revenue through improvements in access, productivity and collections.

Jerry Worden, Interim VP of Finance. Jerry has 44 years of experience and has been contracted by the Healthcare System since April 2019. He has an M.S. in Business Administration, Accounting Major, 39 years of experience in Hospital administration starting as a payroll supervisor, working into Chief Financial Officer. Over the years Jerry has worked as an Assistant Vice President of Finance, and Chief Financial Officer at St. Joseph Hospital. He was Vice President of Corporate Services / CFO at Northern Michigan Hospital, Vice President and CFO / St Luke's Hospital, and Chief Financial Officer/Chief Compliance Officer at Marquette General Health System.

Susuan Hadley, VP Clinical Services and Population Health. Susan has been an RN for 34 years and at the Healthcare System for 20 years. She graduated from Northern Michigan University with a Bachelor's degree in Nursing and received her Master of Science Degree in August of 2005 from NMU where she received the outstanding graduating Master's Degree Student in Psychology, Training and Development. In her time at the Healthcare System she has worked with nursing management, coordinating of clinical systems, the budget process, regulatory agencies and development of her staff.

Meghan Rossato, Performance Improvement, Operations, and Analytics Director. Meghan has 10 years' experience in the healthcare field, 8 years of which at the Healthcare System. She has a Bachelor's Degree in Healthcare Administration from Central Michigan University, is LEAN certified through University of Michigan, and is actively enrolled in Central Michigan University Masters in Business Administration. She has worked as a receptionist, a patient flow enhancer, cash poster, Revenue Cycle/ Process Improvement Coordinator, Budget and Decision Support Coordinator, Manager of Support Services (including Materials Management and Environmental Services) and the title as listed above. She has extensive Chargemaster experience and has been working on product conversion to save the Healthcare System in material amounts. Additionally, she is on the contract negotiation team for AFSCME, and responsible for all pro-formas and linking statistics.

Dean DeCremer, Director of Information Systems. Dean has 34 years of experience in information technology and has been employed by the Healthcare System for 25+ years. He earned an Associate's degree in Data Processing in 1985 from North Central Technical College in Wausau Wisconsin. Dean began his career at a furniture factory, Khoury Inc. located in Iron Mountain, Michigan, as a Purchasing Assistant/Computer Programmer, after slightly less than a year moved on to work for a manufacturing/distribution company, Lake Shore, Inc. located in Kingsford, Michigan, as a Computer Operator. He worked for Lake Shore for a little over eight years finishing his career with them as a Programmer/Systems Analyst. Dean left Lake Shore to work for the Healthcare System in April 1994 as a Computer Operator/Programmer, where he was promoted to Interim Manager of Information Systems 6 months after being hired and was promoted to Manager in April 1995.

During his time with the Healthcare System he attended training and educational webinars for supervision, management, project management, HIPAA security, Meaningful Use, Microsoft office, and many other educational sessions related to the systems the Healthcare System supports. He is the acting HIPAA Security Officer, IT Project Manager, Network Operations/Security Staff Supervisor, Developers and Applications Support Staff Supervisor, Help Desk Manager and was recently promoted from Manager to Director of IT.

Joe Rizzo, Public Relations Business Development Director/Occupational Clinic Director/Health Risk Assessments. Joe, a resigned member of the PGA of America has been working in the Resort and Hospitality Industry for more than 30 years. His strengths are in customer service and public speaking and have been helpful during his three years at the Healthcare System. He has good marketing and sales instincts and is very cost conscious. His goal with the Healthcare System is to continue to nurture and grow the business relationships to increase Occupational Medicine and HRA programs as well as increase overall utilization.

Measurement Focus and Basis of Accounting

Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements. Basis of accounting relates to the timing of the measurements made, regardless of the measurement focus applied.

The accompanying forecasted financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Revenues are recognized when earned, and expenses are recorded when the liability is incurred.

Basis of Presentation

The statement of net position displays the Healthcare System's assets, deferred outflows, and liabilities, with the difference reported as net position. Net position is reported in the following categories/components:

Invested in capital assets, net of related debt consists of net capital assets reduced by the outstanding balances of any related debt obligations and deferred inflows of resources attributable to the acquisition, construction or improvement of those assets or the related debt obligations and increased by balances of deferred outflows of resources related to those assets or debt obligations.

Restricted - expendable for debt service results when constraints placed on net position use are externally imposed by the issuers of debt held by the Healthcare System.

Unrestricted net position consists of net position not meeting the definition of the preceding categories. Unrestricted net position often has constraints on resources imposed by management which can be removed or modified.

When an expense is incurred that can be paid using either restricted or unrestricted resources (net position), the Healthcare System's policy is to first apply the expense toward the most restrictive resources and then toward unrestricted resources.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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 highly liquid investments, unless otherwise designated or restricted, with an original maturity of three months or less when acquired. For purposes of the forecasted statements of cash flows, the Healthcare System considers all cash and investments with an original maturity of three months or less as cash and cash equivalents.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. Payments of patient receivables are allocated to the specific claims identified on the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

The carrying amount of patient receivables is reduced by a valuation allowance that reflects management's estimate of amounts that will not be collected from patients and third-party payors. Management reviews patient receivables by payor class and applies percentages to determine estimated amounts that will not be collected from third parties under contractual agreements and amounts that will not be collected from patients due to bad debts. Management considers historical write off and recovery information in determining the estimated bad debt provision.

Supplies

Supplies are stated at lower of cost (first in, first out) or net realizable value and are expensed when used.

Noncurrent Cash and Investments

Existing funds restricted under indenture agreements for debt service consists of a debt service reserve fund and are invested primarily in commercial paper with maturities that match planned expenditures and money market funds. Future USDA Direct Loan reserve funds are anticipated to be classified as cash and cash equivalents. Funds that are available for obligations classified as current liabilities are reported in current assets.

Investment Income

Interest, dividends, gains, and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenues when earned.

Capital Assets

Capital asset acquisitions in excess of \$5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Amortization is included in depreciation in the financial statements. Contributed capital assets are reported at their estimated fair value at the time of their donation.

The estimated useful lives of capital assets are as follows.

Land improvements	5-20 years
Buildings and improvements	5-40 years
Equipment	3-20 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net position and are excluded from expenses in excess of revenues. 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 net position.

Investment in Joint Ventures

Joint ventures in which the Healthcare System has an equity interest and either an ongoing financial interest or an ongoing financial responsibility are reported originally at cost and adjusted for changes in the equity interest in accordance with the joint venture agreement and for any other transactions, such as a return on capital. Equity earnings from joint ventures are included in nonoperating revenues (expenses).

Deferred Outflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The Healthcare System has two items that qualify for reporting in this category, which are the loss on defeasance of bonds and unrecognized items not yet charged to pension expense. The loss on defeasance of bonds results from the retirement of the Hospital Revenue and Refunding Bonds, Series 1999. The loss on defeasance of bonds amount is systematically and rationally amortized over the remaining life of the old obligation or the life of the new obligation, whichever is shorter and is included in interest and amortization expense.

Deferred Inflows of Resources

Deferred inflows of resources represent an increase in net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The deferred inflows of resources reported in the financial statements consist of the unamortized portion of the difference between expected and actual experience of pension plan assets.

Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions and pension expense, information about the fiduciary net position of the Dickinson County Healthcare System Pension Plan (Plan) and additions to/deductions from the Plan's net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value. On February 22, 2013, the plan was closed to all new entrants. On January 27, 2018, the plan was frozen (no additional benefits to accrue) for all non-Michigan Nurses Association (MNA) participants, and on February 10, 2018 the plan was frozen for all MNA participants.

Costs of Borrowing

Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Compensated Absences

The Healthcare System has a paid-time-off (PTO) program that allows employees to earn vacation and catastrophic leave (CAT) benefits based, in part, on length of service. Employees may accumulate PTO up to a specified maximum. Employees are paid for accumulated PTO if employment is terminated. The PTO program also allows for 25% of accumulated CAT days to be paid out at retirement up to a maximum of 120 hours.

Operating Revenues and Expenses

The Healthcare System's statement of revenues, expenses, and changes in net position distinguishes between operating and non-operating revenues and expenses. Operating revenues and expenses of the Healthcare System result from exchange transactions associated with providing health care services - the Healthcare System's principal activity, and the costs of providing those services, including depreciation and excluding interest cost. All other revenues and expenses are reported as non-operating.

Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. Payment arrangements include prospectively determined rates and discounted charges. 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.

Charity Care

The Healthcare System provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Healthcare System does not pursue collection of these amounts, they are not reported as patient service revenue.

Grants and Contributions

The Healthcare System may receive grants as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as non-operating revenues. Amounts restricted to capital acquisitions are reported after expenses in excess of revenues.

Note 3 - Project Overview and Financing Plan

Need for the Project

The Healthcare System owns and operates a 49-bed hospital, of which 39 beds are currently available for service. All inpatient care and certain outpatient services are delivered in the Hospital facility located in a commercial area on U.S. Highway 2 in Iron Mountain, Michigan (the City). Iron Mountain is the seat of Dickinson County (the County) and is situated in the central Upper Peninsula (the UP) of Michigan along the border with Wisconsin. The City is located approximately 225 miles north of Milwaukee, Wisconsin, and approximately 300 miles east of Minneapolis, Minnesota. In addition to the main campus, the Healthcare System owns or leases several properties used for various outpatient and ancillary services which are located in the City and in nearby communities. The Healthcare System draws most of its patients from the County and from adjacent counties in the UP and in Wisconsin (the Market Area).

The Healthcare System is a fixture in its community as it provides essential services to Market Area residents, as evidenced by its designation by Medicare as a Sole Community Hospital. In addition, the Healthcare System provides these services in a high-quality manner. The Healthcare System is one of the largest employers in the County, paying employees nearly \$45 million in salaries and wages during 2018. The Dickinson Area Economic Development Alliance relies heavily on the availability of healthcare in the community, the cornerstone of which is the Hospital, as a selling point for business recruitment and retention. The Healthcare System provides nearly \$15 million annually in community benefits, measured in accordance with Internal Revenue Service guidelines.

After years of exhibiting satisfactory financial performance, the Healthcare System began to incur significant monthly operating losses in late 2016 and into 2017. Some causes were those typically encountered by rural hospitals, including:

- declining population;
- difficulties recruiting and retaining physicians;
- payment rates that do not maintain pace with increasing expenses;
- the inefficiencies of operating a small hospital; and
- decreasing utilization of the Hospital services, partly due to increased competition from outpatient facilities and physician practices operated by Bellin Health (Bellin) which are located nearby.

The Healthcare System was also affected by certain more unique challenges:

- loss of eligibility to participate in the 340B drug reimbursement between July 2016 and June 2017 because the DSH percentage was slightly below the threshold for Sole Community Hospitals;
- discontinuation of Blue Cross Blue Shield of Michigan (BCBSM) additional payments (BCBSM is the Healthcare System most significant non-governmental payor);
- increases in the out-of-pocket cost differential for BCBSM subscribers between health care services delivered by the Healthcare System and other Michigan-based providers compared with the same services delivered by Wisconsin-based providers (an effect of being located on a state border);
- a sudden and sharp increase in premiums for employees' health insurance; and
- significant impact of Medicare's "two-midnight" rule which converted reimbursement for inpatient stays to that for observation cases.

In response, the Healthcare System began to take aggressive action, including the following:

- reduction in staffing levels, as measured by full-time equivalents (FTEs);
- decreasing operating expenses especially among non-clinical functions such as marketing;
- eliminating certain services provided by employed physicians and mid-level providers (MLPs) such as physician assistants and nurse practitioners; and
- curtailing capital expenditures, one reason for significant capital expenditures to be funded by the USDA Direct Loan.

In October 2018, the Healthcare System's long-standing Chief Executive Officer (CEO) retired effective at the end of 2018, and its Chief Financial Officer (CFO) resigned to take a CFO position with another local organization. The Hospital engaged the law firm Venable LLP, led by Honorable Bart T. Stupak, who had formerly represented the UP as its Congressman, to oversee a restructuring and formulation of a turnaround plan. Shortly thereafter, the Hospital named Jeanne M. Goche as the Interim CEO and Dennis H. Smith as the Interim Chief Restructuring Officer (CRO). Ms. Goche had previously served in similar capacities, leading financial turnarounds among several rural health care systems. Mr. Smith, a long-time resident of the UP, had formerly been the CEO of UPHP so is highly familiar with the reimbursement environment in which the Hospital operates.

These executives took immediate control over antiquated, duplicative and ineffective billing, revenue collection, expense payment and other revenue cycle systems to stabilize the Hospital's financial condition and gain a better understanding of financial challenges facing the Hospital. Venable LLP was able to negotiate a 36-month schedule over which to repay excess Medicare periodic interim payments (PIP Overpayments) that were caused by declining patient care volumes.

To round out the senior management team, DCHS engaged Jerry L. Worden as its Interim Chief Financial Officer (CFO) in April 2019. Mr. Worden is a resident of the UP and an experienced hospital CFO, having held that position with Marquette General Hospital from 2008 until its sale in 2012. Mr. Worden's current plan is to remain as Interim CFO until at least October 2019.

As a result of the improvement measures taken by management, the Healthcare System's financial performance has improved. Although patient service revenue has declined, management has offset the impact with expense reductions and other operational improvement.

The Healthcare System has a loan through Fifth Third Bank, N.A. with a current outstanding balance near \$10,650,000. The loan is reportedly in technical default as a result of the organization being out of compliance with certain covenants. Refinancing of this loan is imperative because it matures in March 2020, whereupon approximately \$9,395,000 would become due and payable. This amount far exceeds the Healthcare System's financial assets. Closing on the Direct Loan before then would avert a payment default.

The Healthcare System is also in dire need of upgrading various medical equipment throughout the facility that has been delayed for too long. These included significant upgrades to radiology equipment (estimated at \$5,902,000); upgrades to information technology equipment (estimated at \$6,814,000); and addressing various other equipment upgrade needs (estimated at \$1,657,000).

Information Technology

Information technology (IT) in the hospital setting is expensive. Over the last decade, the expense of acquiring and maintaining these systems is one of the principal reasons that smaller hospitals and health systems sought larger partners through acquisition, mergers, affiliations, etc.

The Healthcare System is reportedly well behind schedule for replacement of information technology systems. Management historically treated the IT capital budget too much as an elective area for spending rather than an area for consistent and necessary spending.

The Healthcare System has achieved Stage 1 and 2 Meaningful Use requirements to avoid reimbursement penalties from Medicare, but still needs to achieve Stage 3. The Healthcare System utilizes different electronic health record systems for the hospital, the emergency department, and the clinics. There is no interoperability between these systems. Disparate electronic health record systems add hardship for physicians, which can contribute to burnout and impact patient safety and quality of care.

The current Information System requires capital expenditure needs on a variety of systems, including electronic health records, supply chain management, nurse call system, phone system, time and attendance, HIPAA compliance, networking, etc. The needs include infrastructure costs, new software systems, and modules to update systems already in use. Upgrades and replacements are needed throughout the organization, including most if not all hospital departments and the clinics.

Other Equipment Needs

In addition to the IT/Information Systems that are behind schedule for upgrades and replacements, the Healthcare System has certain pieces of major equipment that are in need of replacement due to their age, life expectancy, and functionality. The Healthcare System management considers the near-term replacement of these items to be critical – needed as soon as possible.

- The MRI is roughly 12 years old, which is well beyond its life expectancy. Replacement parts are reported to be expensive. The expected replacement cost for a new MRI is \$1.9MM.
- The linear particle accelerator, used for cancer treatment, is at the end of its life expectancy. The expected replacement cost for a new machine \$4.0MM.
- The Healthcare System has two CT machines, one of which is modern and one of which is antiquated (16 slice) and in need of replacement. The expected replacement cost for a new CT is \$700,000.

Financing Plan

The financing plan consists of a \$24,650,000 USDA Direct Loan. The USDA Direct Loan is assumed to have an interest rate of 3.50% and a term of 25 years. The refinancing of the Healthcare System's existing debt is forecasted to take place in December 2019, and the equipment upgrades are forecasted to be made during 2020.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

The following is an estimated sources and uses of funds for the proposed Project:

Sources of Funds	
USDA Direct Loan	<u>\$ 24,650,000</u>
Uses of Funds	
Major Moveable Equipment	
Information Technology Upgrades	3,461,000
Information Technology Projects	3,353,000
Linear Accelerator	3,088,000
MRI Unit	1,546,000
SPECT CT Unit	658,000
CT Unit	610,000
Other Equipment Upgrades	910,000
Building and Improvements	747,000
Cost of Issuance	402,000
Refinancing of Long-Term Debt	<u>9,875,000</u>
Total Uses of Funds	<u>\$ 24,650,000</u>

Note 4 - Statement of Net Position Assumptions

Patient Receivables

The number of days of revenue outstanding in patient receivables has historically been between 56 and 60 days for the past five years. Patient receivables are forecasted to be 55 days in 2019 and 2020, and decrease to 52, 51, and 50 in 2021, 2022, and 2023. The slight decline in days in receivables is expected based on the information technology investments made to help streamline the Hospital's revenue cycle process.

Estimated Third-Party Payor Settlements

Estimated third-party payor settlement are forecasted to be \$532,000 receivable throughout the forecast and represent one year of Medicare and Medicaid settlements and is based on filed cost reports. The forecast assumes that interim rates will approximate costs.

Other Receivables

Other receivables include receivables for Michigan's Quality Assurance Assessment Program (QAAP), 340B programs and other miscellaneous items. Other receivables are forecasted to stay consistent with historical balances.

Inventories

Inventory is forecasted to be \$2,600,000 throughout the forecast, which is consistent with historical performance.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Assets Limited as to Use or Restricted

In 2020, when the Healthcare System pays their existing 2015 Note Payable, the existing reserve fund of \$2,331,000 will be eliminated. When the USDA Direct Loan is established, the Healthcare System will be required to establish a new debt service reserve fund, which is required to be funded on an annual basis at 1/10th of the maximum annual principal and interest payments over the following 10 years. Maximum annual debt service of the total USDA Direct Loan is approximately \$1,479,000.

Capital Assets

A summary of capital assets at December 31, 2019 through 2023 follows:

	2019	2020	2021	2022	2023
Capital assets not being depreciated					
Land	\$ 2,359,000	\$ 2,359,000	\$ 2,359,000	\$ 2,359,000	\$ 2,359,000
Construction in progress	106,000	106,000	106,000	106,000	106,000
Total capital assets not being depreciated	2,465,000	2,465,000	2,465,000	2,465,000	2,465,000
Capital assets being depreciated					
Land improvements	987,000	987,000	987,000	987,000	987,000
Buildings and improvements	48,489,000	49,236,000	49,236,000	49,236,000	49,236,000
Equipment	55,424,000	71,050,000	73,050,000	75,050,000	77,050,000
Total capital assets being depreciated	104,900,000	121,273,000	123,273,000	125,273,000	127,273,000
Accumulated depreciation and amortization	(77,400,000)	(81,077,000)	(85,491,000)	(89,906,000)	(94,357,000)
Net capital assets being depreciated	27,500,000	40,196,000	37,782,000	35,367,000	32,916,000
Capital assets, net	\$ 29,965,000	\$ 42,661,000	\$ 40,247,000	\$ 37,832,000	\$ 35,381,000

Capital Expenditures

Forecasted capital expenditures for the five years ending December 31, 2023 are as follows:

	2019	2020	2021	2022	2023
Routine					
Major moveable equipment	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000
Project					
Building and improvements	-	747,000	-	-	-
Major moveable equipment	-	13,626,000	-	-	-
	\$ 2,000,000	\$ 16,373,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Deferred Outflows of Resources

The Healthcare System is forecasted to amortize the deferred outflows of resources over the respective time period as required by accounting standards.

Accounts Payable

Accounts payable are forecasted to be 39 days of total operating expenses, excluding salaries and wages, employee benefits, and depreciation, based on historical experience.

Accrued Salaries, Wages, and Related Liabilities

Accrued compensation and related liabilities are forecasted to be 16 days of salaries, wages, and employee benefits at year end, based on historical experience.

Accrued Compensated Balances

Accrued compensated balances are forecasted to be 30 days of compensated balances at year end, based on historical experience.

Other Current Liabilities

Other current liabilities are forecasted to be 8 days of other current liabilities at year end, based on historical experience.

Long-Term Debt

Long-term debt consists of the following at December 31:

	2019	2020	2021	2022	2023
Revenue Bonds, Series 2004	\$ 2,778,000	\$ 2,555,000	\$ 2,321,000	\$ 2,069,000	\$ 1,806,000
Revenue Bonds, Series 2016	1,199,000	1,121,000	1,040,000	958,000	873,000
Wisconsin Physician Service Insurance Corporation Note	1,635,000	-	-	-	-
Other	205,000	27,000	-	-	-
USDA Direct Loan	10,277,000	24,022,000	23,371,000	22,698,000	22,000,000
Total Long-Term Debt	16,094,000	27,725,000	26,732,000	25,725,000	24,679,000
Less Current Maturities	(1,883,000)	(994,000)	(1,006,000)	(1,046,000)	(366,000)
Long-Term Debt, less current maturities	<u>\$ 14,211,000</u>	<u>\$ 26,731,000</u>	<u>\$ 25,726,000</u>	<u>\$ 24,679,000</u>	<u>\$ 24,313,000</u>

For Project related terms, refer to: *Note 3 - Forecasted Construction and Financing Plan*

Reserve for Loss on General and Professional Liabilities Claims

Reserve for loss on general and professional liabilities claims is forecasted to be \$450,000 throughout the forecast, which is consistent with historical performance.

Net Pension Liability

Net pension liability is forecasted to be \$20,306,000 throughout the forecast, based on the latest actuarial study performed.

Deferred Inflows of Resources

The Healthcare System is forecasted to amortize the deferred inflows of resources over the respective time period as required by accounting standards.

Note 5 – Forecasted Revenues

Gross and Net Patient Service Revenue

The Healthcare System has agreements with third-party payors that provide for payments to the Healthcare System at amounts different from its established rates. A summary of the payment arrangements with major thirdparty payors follows:

Medicare – Inpatient acute care and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per visit. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Medicaid – Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Defined capital costs are paid based on prospectively determined rates. Outpatient services related to Medicaid program beneficiaries are reimbursed on a fee for service basis. Clinical services are reimbursed based on a cost basis or fixed fee schedule.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are paid on a cost related methodology with final settlement determined after submission of annual cost reports by the Healthcare System and are subject to audits thereof by Blue Cross. Clinical services are reimbursed based on a fixed fee schedule.

The Healthcare System has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Healthcare System under these agreements includes prospectively determined rates per discharge and discounts from established charges.

Laws and regulations governing the Medicare, Medicaid, and other 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.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Historical and Forecasted Payor Mix – Revenues from Inpatient, Outpatient and Clinic Services

The forecasted payor mix reflects a trend similar to historical experience. The following tables show the historical and forecasted payor mix as a percentage of gross revenue:

	Historical Payor Mix (Percentage of Gross Patient Service Revenue)				
	2014	2015	2016	2017	2018
Medicare	46.72%	47.43%	47.74%	47.89%	47.79%
Medicaid	11.50%	12.23%	12.33%	12.23%	11.57%
Blue Cross	25.18%	20.15%	22.16%	22.07%	22.53%
Commercial and other	14.18%	18.67%	16.32%	16.40%	16.31%
Self Pay	2.41%	1.53%	1.45%	1.41%	1.79%
	100.00%	100.00%	100.00%	100.00%	100.00%
	Forecasted Payor Mix (Percentage of Gross Patient Service Revenue)				
	2019	2020	2021	2022	2023
Medicare	47.96%	47.94%	47.92%	47.91%	47.89%
Medicaid	11.20%	11.18%	11.17%	11.15%	11.13%
Blue Cross	22.61%	22.63%	22.65%	22.68%	22.70%
Commercial and other	16.71%	16.71%	16.72%	16.72%	16.73%
Self Pay	1.53%	1.53%	1.54%	1.55%	1.55%
	100.00%	100.00%	100.00%	100.00%	100.00%

Based on population growth estimates for the Healthcare System's primary service area, the total population is forecasted to decrease by 427 between 2019 and 2024 (1.3%), with the Healthcare System's Medicare population forecasted to increase by approximately 737 (9.4%). Given this greater increase in Medicare age-population, the Healthcare System is forecasted to see an increase in the Medicare payor mix throughout the forecast period. A majority of this increase is expected to occur in the inpatient setting, which represents only approximately 30% of the Healthcare System's total revenues. Therefore, the table above shows very little fluctuation in overall payor mix as the outpatient and clinical services, which have lower Medicare utilizations overall, account for approximately 70% of the Healthcare System's total revenues.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

The historical revenues by major payor for inpatient and outpatient hospital and clinic services as well as contractual adjustments by payor are detailed below:

	Historical Revenue by Payor and Classification				
	2014	2015	2016	2017	2018
Medicare					
Inpatient	\$ 44,170,000	\$ 39,245,000	\$ 37,516,000	\$ 37,684,000	\$ 32,621,000
Outpatient	76,801,000	83,707,000	91,827,000	96,598,000	100,723,000
Clinic	-	9,587,000	12,709,000	15,641,000	14,155,000
Total Medicare gross revenue	120,971,000	132,539,000	142,052,000	149,923,000	147,499,000
Total Medicare contractals	(84,721,000)	(92,598,000)	(99,633,000)	(106,787,000)	(105,809,000)
Total Medicare Net Revenue	36,250,000	39,941,000	42,419,000	43,136,000	41,690,000
Medicaid					
Inpatient	7,197,000	5,550,000	6,421,000	6,936,000	6,379,000
Outpatient	22,576,000	24,887,000	25,240,000	25,732,000	24,202,000
Clinic	-	3,725,000	5,029,000	5,629,000	5,119,000
Total Medicaid gross revenue	29,773,000	34,162,000	36,690,000	38,297,000	35,700,000
Total Medicaid contractals	(23,260,000)	(26,452,000)	(28,073,000)	(32,620,000)	(29,174,000)
Total Medicaid Net Revenue	6,513,000	7,710,000	8,617,000	5,677,000	6,526,000
Blue Cross					
Inpatient	10,405,000	6,890,000	7,286,000	7,484,000	6,611,000
Outpatient	54,800,000	43,403,000	49,775,000	51,545,000	52,544,000
Clinic	-	6,004,000	8,880,000	10,083,000	10,388,000
Total Blue Cross gross revenue	65,205,000	56,297,000	65,941,000	69,112,000	69,543,000
Total Blue Cross contractals	(40,464,000)	(34,556,000)	(40,777,000)	(43,475,000)	(44,349,000)
Total Blue Cross Net Revenue	24,741,000	21,741,000	25,164,000	25,637,000	25,194,000
Other					
Inpatient	6,717,000	7,523,000	7,005,000	6,911,000	6,921,000
Outpatient	30,004,000	39,175,000	35,566,000	37,396,000	36,644,000
Clinic	-	5,467,000	5,976,000	7,028,000	6,775,000
Total Other gross revenue	36,721,000	52,165,000	48,547,000	51,335,000	50,340,000
Total Other contractals	(14,642,000)	(19,039,000)	(20,094,000)	(22,686,000)	(22,504,000)
Total Other Net Revenue	22,079,000	33,126,000	28,453,000	28,649,000	27,836,000
Self Pay					
Inpatient	1,287,000	535,000	413,000	450,000	776,000
Outpatient	4,961,000	3,316,000	3,457,000	3,372,000	4,165,000
Clinic	-	422,000	441,000	597,000	584,000
Total Self Pay revenue	6,248,000	4,273,000	4,311,000	4,419,000	5,525,000
Subtotal	95,831,000	106,791,000	108,964,000	107,518,000	106,771,000
Provision for Bad Debts	(5,818,000)	(2,918,000)	(2,663,000)	(3,547,000)	(4,437,000)
Charity Care	(3,241,000)	(2,436,000)	(2,504,000)	(2,643,000)	(2,988,000)
Net Patient Service Revenue	\$ 86,772,000	\$ 101,437,000	\$ 103,797,000	\$ 101,328,000	\$ 99,346,000

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

The forecasted revenues by major payor for inpatient and outpatient and clinic services as well as contractual adjustments by payor are detailed below.

	Forecasted Revenue by Payor and Classification				
	2019	2020	2021	2022	2023
Medicare					
Inpatient	\$ 31,172,000	\$ 30,830,000	\$ 30,800,000	\$ 30,770,000	\$ 30,739,000
Outpatient	99,019,000	99,989,000	101,916,000	104,069,000	105,942,000
Clinic	11,866,000	12,044,000	12,286,000	12,533,000	12,784,000
Total Medicare gross revenue	142,057,000	142,863,000	145,002,000	147,372,000	149,465,000
Total Medicare contractuals	(101,907,000)	(101,738,000)	(103,323,000)	(105,076,000)	(107,473,000)
Total Medicare Net Revenue	40,150,000	41,125,000	41,679,000	42,296,000	41,992,000
Medicaid					
Inpatient	5,459,000	5,315,000	5,226,000	5,138,000	5,051,000
Outpatient	23,428,000	23,657,000	24,113,000	24,623,000	25,066,000
Clinic	4,292,000	4,356,000	4,443,000	4,533,000	4,624,000
Total Medicaid gross revenue	33,179,000	33,328,000	33,782,000	34,294,000	34,741,000
Total Medicaid contractuals	(28,540,000)	(28,686,000)	(29,094,000)	(29,552,000)	(29,955,000)
Total Medicaid Net Revenue	4,639,000	4,642,000	4,688,000	4,742,000	4,786,000
Blue Cross					
Inpatient	6,236,000	6,080,000	5,988,000	5,896,000	5,805,000
Outpatient	52,016,000	52,525,000	53,537,000	54,670,000	55,653,000
Clinic	8,709,000	8,839,000	9,017,000	9,198,000	9,382,000
Total Blue Cross gross revenue	66,961,000	67,444,000	68,542,000	69,764,000	70,840,000
Total Blue Cross contractuals	(43,539,000)	(43,888,000)	(44,637,000)	(45,469,000)	(46,207,000)
Total Blue Cross Net Revenue	23,422,000	23,556,000	23,905,000	24,295,000	24,633,000
Other					
Inpatient	7,865,000	7,747,000	7,708,000	7,669,000	7,631,000
Outpatient	35,939,000	36,291,000	36,990,000	37,773,000	38,452,000
Clinic	5,679,000	5,764,000	5,880,000	5,998,000	6,119,000
Total Other gross revenue	49,483,000	49,802,000	50,578,000	51,440,000	52,202,000
Total Other contractuals	(22,121,000)	(22,305,000)	(22,694,000)	(23,122,000)	(23,507,000)
Total Other Net Revenue	27,362,000	27,497,000	27,884,000	28,318,000	28,695,000
Self Pay					
Inpatient	49,000	48,000	48,000	48,000	47,000
Outpatient	3,988,000	4,027,000	4,104,000	4,191,000	4,266,000
Clinic	490,000	497,000	507,000	517,000	528,000
Total Self Pay revenue	4,527,000	4,572,000	4,659,000	4,756,000	4,841,000
Subtotal	100,100,000	101,392,000	102,815,000	104,407,000	104,947,000
Provision for Bad Debts	(3,851,000)	(3,874,000)	(3,933,000)	(3,999,000)	(4,057,000)
Charity Care	(2,962,000)	(2,980,000)	(3,026,000)	(3,076,000)	(3,121,000)
Net Patient Service Revenue	\$ 93,287,000	\$ 94,538,000	\$ 95,856,000	\$ 97,332,000	\$ 97,769,000

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

The Healthcare System's patient service revenues have been forecasted based upon historical patterns and 2019 year-to-date information and adjusted for expected changes in utilization and the effect of increases in charges. Starting on January 1, 2020, inpatient, outpatient, and clinical charges are forecasted to increase 1.50% annually. Annual charge increases are commonly implemented by healthcare facilities to capture increases in published fee schedule rates, which help offset the inflationary increases in healthcare expenses.

A schedule of historical and forecasted gross and net patient service revenue is summarized below:

	Historical Revenue by Classification				
	2014	2015	2016	2017	2018
Gross revenues					
Inpatient	\$ 69,776,000	\$ 59,743,000	\$ 58,641,000	\$ 59,465,000	\$ 53,308,000
Outpatient	189,142,000	194,488,000	205,865,000	214,643,000	218,278,000
Clinic	-	25,205,000	33,035,000	38,978,000	37,021,000
Total Gross Revenues	258,918,000	279,436,000	297,541,000	313,086,000	308,607,000
Contractual Adjustments	(163,087,000)	(172,645,000)	(188,577,000)	(205,568,000)	(201,836,000)
Charity Care	(3,241,000)	(2,436,000)	(2,504,000)	(2,643,000)	(2,988,000)
Provision for Bad Debts	(5,818,000)	(2,918,000)	(2,663,000)	(3,547,000)	(4,437,000)
Net Patient Service Revenue	<u>\$ 86,772,000</u>	<u>\$ 101,437,000</u>	<u>\$ 103,797,000</u>	<u>\$ 101,328,000</u>	<u>\$ 99,346,000</u>
	Forecasted Revenue by Classification				
	2019	2020	2021	2022	2023
Gross revenues					
Inpatient	\$ 50,781,000	\$ 50,020,000	\$ 49,770,000	\$ 49,521,000	\$ 49,273,000
Outpatient	214,390,000	216,489,000	220,660,000	225,326,000	229,379,000
Clinic	31,036,000	31,500,000	32,133,000	32,779,000	33,437,000
Total Gross Revenues	296,207,000	298,009,000	302,563,000	307,626,000	312,089,000
Contractual Adjustments	(196,107,000)	(196,617,000)	(199,748,000)	(203,219,000)	(207,142,000)
Charity Care	(2,962,000)	(2,980,000)	(3,026,000)	(3,076,000)	(3,121,000)
Provision for Bad Debts	(3,851,000)	(3,874,000)	(3,933,000)	(3,999,000)	(4,057,000)
Net Patient Service Revenue	<u>\$ 93,287,000</u>	<u>\$ 94,538,000</u>	<u>\$ 95,856,000</u>	<u>\$ 97,332,000</u>	<u>\$ 97,769,000</u>

Refer to *Summary of Significant Forecast Demand Assumptions; Note 10 – Historical and Forecasted Demand and Utilization* for related statistics and further service line analysis.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Contractual Adjustments, Charity Care, and Provision for Bad Debts

The following table shows the historical and forecasted contractual adjustments, charity care and provision for bad debts as a percentage of gross revenue:

	Historical Deductions from Revenue				
	2014	2015	2016	2017	2018
Deductions from Revenue					
Medicare	70.03%	69.86%	70.14%	71.23%	71.74%
Medicaid	78.12%	77.43%	76.51%	85.18%	81.72%
Blue Cross	62.06%	61.38%	61.84%	62.91%	63.77%
Commercial and Other	39.87%	36.50%	41.39%	44.19%	44.70%
Overall Contractual Adjustments	62.99%	61.78%	63.38%	65.66%	65.40%
Charity Care	1.25%	0.87%	0.84%	0.84%	0.97%
Provision for Bad Debts	2.25%	1.04%	0.90%	1.13%	1.44%
Total Deductions from Revenue	66.49%	63.70%	65.12%	67.64%	67.81%
	Forecasted Deductions from Revenue				
	2019	2020	2021	2022	2023
Deductions from Revenue					
Medicare	71.74%	71.21%	71.26%	71.30%	71.91%
Medicaid	86.02%	86.07%	86.12%	86.17%	86.22%
Blue Cross	65.02%	65.07%	65.12%	65.18%	65.23%
Commercial and Other	44.70%	44.79%	44.87%	44.95%	45.03%
Overall Contractual Adjustments	66.21%	65.98%	66.02%	66.06%	66.37%
Charity Care	1.00%	1.00%	1.00%	1.00%	1.00%
Provision for Bad Debts	1.30%	1.30%	1.30%	1.30%	1.30%
Total Deductions from Revenue	68.51%	68.28%	68.32%	68.36%	68.67%

Contractual adjustments are forecasted to change based on expected changes in reimbursement payor type. Medicare, Medicaid and Commercial payors reimbursed based on prospectively determined rates and percentage of charges; therefore, as charges increase, the Healthcare System will typically see an increase in contractual adjustments unless the charge increase is equal to the prospectively determined rate increases. Given the nominal price increases implemented by the Healthcare System, these contractual adjustments are forecasted to remain flat throughout the forecast period.

In April 2019, CMS released a proposed rule to update the Medicare fee-for-service (FFS) inpatient prospective payment system (IPPS) for fiscal year (FY) 2020. Before a rule can go into effect, a final rule must first be published in the Federal Register. The agency (CMS) may alter the rule in response to public comments received prior to it becoming a final rule. Michigan Health & Hospital Association (MHA) utilizes a third-party consultant, DataGen, to provide reimbursement impact analyses for its member hospitals. In May 2019 MHA supplied to its member hospitals the DataGen impact information pertaining to the proposed rule for FFY 2020.

This analysis concluded an additional reimbursement to the Healthcare System of approximately \$800,000. This new payment structure is scheduled to sunset in 2022. While, management of the Healthcare System believes that this payment methodology will be continued or replaced with similar payments, the forecast assumes that this add-on payment will be eliminated in 2023.

Management has forecasted the provision of bad debts and charity care as a percentage of gross patient service revenue based on review of historical and budgeted financials and review of current healthcare trends. Provision of bad debts and charity care are forecasted to remain flat throughout the forecast period at 1.30% and 1.00%, respectively, throughout the forecasted period.

Critical Access Hospital Designation

Management of the Healthcare System has considered conversion to Critical Access Hospital (CAH) designation. CAH hospitals are reimbursed by Medicare for both inpatient and outpatient services on the basis of their current Medicare-allowable costs. They are exempt from the inpatient, including swing bed, and outpatient prospective payment systems.

Because Medicare reimburses CAHs for both inpatient and outpatient services on the basis of reasonable cost, their opportunity to operate profitably is enhanced. As mentioned previously, the Healthcare System maintains Sole Community Hospital (SCH) status from CMS, which improves financial viability through certain payment enhancements and protections to the facility. The Medicare payment enhancements that SCHs receive are meant to protect against financial distress so that these institutions can continue to serve communities.

In order to qualify for a CAH designation, the Healthcare System would be limited to 25 beds. Currently, the Healthcare System runs an average daily census of approximately 19, and typically would exceed 25 patients a day throughout the year, which would cause the need to transfer patients to other facilities. Additionally, the Healthcare System's case mix index (acuity-level of the patient) is higher than peer facilities, primarily due to the extensive ICU volume. Based on these factors, it is currently more beneficial for the Healthcare System to maintain status as a SCH hospital. Healthcare System management will continue to review and evaluate this designation on an ongoing basis.

Supplies and 340B Revenue

Effective October 1, 2011, the Healthcare System qualified for the 340B drug pricing program. This program resulted from the enactment of Public Law 102-585, the Veterans Healthcare Act of 1992, and is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs. Participation in the 340B Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

In order to qualify for the program, the hospital needs to have a large percentage of indigent volume, which is defined by the program to include Medicaid patients, Medicaid-eligible patients, and Medicare SSI patients. While indigent volumes are the qualifying factor, this program covers all payers for qualifying services. The program provides for reduced pharmaceutical costs for hospital outpatients. It also allows for contracts with retail pharmacies. Effective July 2016, the Healthcare System was eliminated as a participant in the program. As of July 2017, the Healthcare System was readmitted to the program. The forecast assumes projected revenues for 2019 based on collections to date and approximately \$200,000 monthly collections for the rest of 2019. Starting in 2020, the Healthcare System will continue to receive \$200,000 in monthly collections and will increase 2% going forward throughout the remaining forecasted years. The forecast assumes the Healthcare System will maintain eligibility in this program, which is a particularly sensitive assumption in this forecast.

Other Operating Revenue

The Healthcare System current other operating revenue consists non-patient procedures, cafeteria revenue, ACO incentive revenues, rent revenues, grants, and other miscellaneous revenue. The forecast assumes that other operating revenues will increase by 1% throughout the forecast period, consistent with historical experience. A summary of other operating revenue amounts is as follows:

	2019	2020	2021	2022	2023
Other Operating Revenues					
Nonpatient procedures	\$ 1,526,000	\$ 1,541,000	\$ 1,557,000	\$ 1,572,000	\$ 1,589,000
Cafeteria	358,000	361,000	365,000	369,000	372,000
ACO Revenue	200,000	202,000	204,000	206,000	208,000
Rent Revenue	185,000	187,000	189,000	191,000	193,000
Restricted Grants	12,000	12,000	12,000	12,000	12,000
Other	147,000	149,000	150,000	152,000	153,000
	<u>\$ 2,428,000</u>	<u>\$ 2,452,000</u>	<u>\$ 2,477,000</u>	<u>\$ 2,502,000</u>	<u>\$ 2,527,000</u>

Note 6 - Forecasted Expenses

Operating expenses, by expense category, have been analyzed and inflated based on a review of historical experience, discussion with management of the Healthcare System, comparison to published Hospital Inflation Projections compiled by R-C Healthcare Management in November 2018, and current trends in the healthcare industry. In addition, a reasonable assumption is that various expenses will be affected by volume of services forecasted. Refer to *Summary of Significant Forecast Demand Assumptions; Note 10 – Historical and Forecasted Demand and Utilization* for related statistics. Operating expenses anticipated to be affected by these volume assumptions will be highlighted as applicable and volumes taken from the above referenced table will be utilized.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Salaries and Wages

Salaries and wage expense and full-time equivalents (FTEs) are forecasted based on providers, variable and non-variable staff. The average salary per each provider, variable and non-variable FTE was approximately \$204,100, \$66,900 and \$48,000 in 2018. The average salary per FTE has been adjusted in 2019 to eliminate one-time payout adjustments that occurred in 2018, and to also be reflective of current period staffing rates. The average salary per each provider, variable, and non-variable FTE is forecasted to be \$207,100, \$67,200, and \$47,600 in 2019 and is forecasted to increase 2.0% on an annual basis thereafter. During 2018, the Healthcare System started reducing FTEs to react to the decrease in patient volumes and to help improve financial operations. These reductions have continued through the first five months of 2019 and will continue through 2020. Based on the forecasted volumes and current staffing ratios, the Healthcare System will continue to slightly reduce FTEs throughout the forecast period.

The Healthcare System internally uses a cost allocation system for employees that work in multiple departments or that are reimbursed from other organizations when they work at other facilities. These internal allocations are shown on the Allocation line below. The 2019 figures are based upon year-to-date figures and expected salary and FTE changes throughout the rest of the year. Going forward, this amount is forecasted to increase by 2.0% consistent with the Healthcare Systems annual salary increase. It should be noted that these allocations cross all current Healthcare System FTEs, not just one class of employees.

The following table shows forecasted FTEs and salaries and wages for the forecasted years 2019 through 2023.

	Forecasted				
	2019	2020	2021	2022	2023
Provider	\$ 5,901,000	\$ 5,808,000	\$ 5,924,000	\$ 6,042,000	\$ 6,163,000
Variable	24,054,000	24,054,000	24,466,000	24,812,000	25,164,000
Non-variable	9,519,000	9,370,000	9,507,000	9,597,000	9,685,000
Salaries and Wages	39,474,000	39,232,000	39,897,000	40,451,000	41,012,000
Less: Allocation	(1,775,000)	(1,810,000)	(1,846,000)	(1,883,000)	(1,921,000)
Total salaries and wages	\$ 37,699,000	\$ 37,422,000	\$ 38,051,000	\$ 38,568,000	\$ 39,091,000
	2019	2020	2021	2022	2023
Provider	28.49	27.49	27.49	27.49	27.49
Variable	357.77	350.77	349.77	347.77	345.77
Non-variable	200.00	193.00	192.00	190.00	188.00
Total FTEs	586.26	571.26	569.26	565.26	561.26
FTE per Adjusted Occupied Bed (AOB)	5.13	4.98	4.87	4.76	4.66
FTE per AOB (Hospital Only)	5.45	5.30	5.19	5.07	4.96

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

The following table shows the actual FTEs and salaries and wages for the historical years 2014 through 2018 (note due to system limitations, salary expense for 2014 was not available to be split by FTE category).

	Historical				
	2014	2015	2016	2017	2018
Provider	\$ -	\$ 6,990,000	\$ 7,538,000	\$ 7,166,000	\$ 6,781,000
Variable	-	26,136,000	26,981,000	27,849,000	26,410,000
Non-variable	-	11,462,000	11,827,000	11,977,000	11,350,000
Salaries and Wages	-	44,588,000	46,346,000	46,992,000	44,541,000
Less: Allocation	-	(2,819,000)	(3,202,000)	(1,410,000)	(1,748,000)
Total salaries and wages	\$ 38,205,000	\$ 41,769,000	\$ 43,144,000	\$ 45,582,000	\$ 42,793,000
	2014	2015	2016	2017	2018
Provider	27.18	30.73	33.97	35.92	33.23
Variable	408.60	426.07	441.04	441.70	394.94
Non-variable	235.58	245.36	254.60	258.42	236.71
Total FTEs	671.36	702.16	729.61	736.04	664.88
FTE per Adjusted Occupied Bed (AOB)	5.61	5.59	5.81	5.37	5.51
FTE per AOB (Hospital Only)	5.39	5.89	6.24	5.83	5.94

Employee Benefits

Employee benefits include payroll taxes, health insurance, life and disability insurance, unemployment compensation, pension plan expenses, workers compensation, and other miscellaneous benefits. Non-pension employee benefits is forecasted to be 31.50% of salaries expense throughout the forecast period. Pension benefit expense is forecasted to be \$2,157,000 based on the 2018 required contribution figure; since the pension plan is currently frozen, the annual required contribution is forecasted to remain constant throughout the forecast period. The Healthcare System's amortization expense related to the Deferred Outflows and Inflows of Resources is based on the 2018 actuarial valuations. Employee benefits and the related percentage of salaries is forecasted as follows:

	2019	2020	2021	2022	2023
Non-Pension Benefit Expense	\$ 12,434,000	\$ 12,358,000	\$ 12,568,000	\$ 12,743,000	\$ 12,919,000
Pension Amortization Expense	(417,000)	(5,000)	(192,000)	518,000	-
Pension Benefit Expense	2,157,000	2,157,000	2,157,000	2,157,000	2,157,000
Employee Benefit Expense	\$ 14,174,000	\$ 14,510,000	\$ 14,533,000	\$ 15,418,000	\$ 15,076,000
Non-Pension Benefit as a % of Salaries	31.50%	31.50%	31.50%	31.50%	31.50%

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Professional Fees and Other

Professional fees and other expenses include physician fees and other contracted services provided to the Healthcare System. Variable fees and services include various medical professionals, which are impacted by volume assumptions, are forecasted based on an average cost per unit computed using inpatient, outpatient and clinic volumes. The average cost per unit is forecasted to increase 1.50% annually throughout the forecast period. This increase is based on a review of historical experience, discussions with management, and published inflationary increases.

Non-variable fees and services include collection fees, audit and accounting fees, legal, and other. All non-variable fees and services, are forecasted to increase 1.50% annually throughout the forecast period. This increase is reasonable based on review of historical information (last five years trial balances), discussions with management, and published inflationary increases. Legal fees are forecasted to have a one-time decrease in expense of approximately \$500,000 in 2021 after all elements of the USDA Direct Loan are completed during 2020. This will bring legal expenses more in-line with historical levels.

Professional fees and other expenses are forecasted as follows:

	2019	2020	2021	2022	2023
Variable					
Medical Professionals					
Hospitalists	\$ 3,096,000	\$ 3,160,000	\$ 3,259,000	\$ 3,362,000	\$ 3,461,000
Clinic	2,741,000	2,782,000	2,838,000	2,895,000	2,953,000
Waived Tests	807,000	824,000	849,000	877,000	903,000
Radiation Oncology	113,000	114,000	116,000	119,000	122,000
Emergency	166,000	168,000	172,000	176,000	180,000
Other	572,000	584,000	601,000	621,000	639,000
Non variable					
Collection Fees	1,177,000	1,194,000	1,212,000	1,230,000	1,249,000
Audit and accounting fees	63,000	64,000	65,000	66,000	67,000
Legal	817,000	830,000	342,000	347,000	352,000
Recruiting fees	99,000	101,000	103,000	104,000	106,000
Drug screening fees	430,000	437,000	443,000	450,000	457,000
	<u>\$ 10,081,000</u>	<u>\$ 10,258,000</u>	<u>\$ 10,000,000</u>	<u>\$ 10,247,000</u>	<u>\$ 10,489,000</u>

Refer to *Summary of Significant Forecast Demand Assumptions; Note 10 – Historical and Forecasted Demand and Utilization* for related statistics.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Purchased Services

Purchased services includes various variable and non-variable contracted services and maintenance contracts. Variable purchased services, which are impacted by volume assumptions, are forecasted based on an average cost per unit computed using inpatient, outpatient and clinic volumes. The average cost per unit is forecasted to increase 2.00% annually throughout the forecast period. This increase is based on a review of historical experience, discussions with management, and published inflationary increases.

Non-variable purchased services and maintenance contracts are forecasted to increase 1.50% annually throughout the forecast period. This increase is reasonable based on review of historical information (last five years trial balances), discussions with management, and published inflationary increases.

Purchased services are forecasted as follows:

	2019	2020	2021	2022	2023
Purchased services					
Anesthesia	\$ 1,259,000	\$ 1,278,000	\$ 1,317,000	\$ 1,356,000	\$ 1,390,000
Clinics	806,000	822,000	842,000	864,000	885,000
340b	472,000	479,000	486,000	496,000	506,000
Laboratory	397,000	403,000	416,000	428,000	439,000
Other variable	581,000	596,000	618,000	640,000	663,000
Non-variable	1,793,000	1,828,000	1,864,000	1,902,000	1,940,000
Maintenance contracts					
Information systems	1,828,000	1,865,000	1,902,000	1,940,000	1,979,000
Radiology	533,000	544,000	555,000	566,000	577,000
Radiation oncology	158,000	161,000	164,000	168,000	171,000
Other	469,000	479,000	488,000	498,000	508,000
	<u>\$ 8,296,000</u>	<u>\$ 8,455,000</u>	<u>\$ 8,652,000</u>	<u>\$ 8,858,000</u>	<u>\$ 9,058,000</u>

Refer to *Summary of Significant Forecast Demand Assumptions; Note 10 – Historical and Forecasted Demand and Utilization* for related statistics.

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Supplies

Variable departmental supply costs are impacted by volume assumptions and forecasted based on an average cost per departmental outpatient and overall patient volumes. The average cost per outpatient volume is forecasted to increase 2.75%, drugs are forecasted to increase 3.50%, and non-variable supplies are forecasted to increase 1.00% annually throughout the forecast period. These increases are considered reasonable based on review of historical information (last five years trial balances), discussions with management, and comparison to published inflationary increases.

Supplies expense is forecasted as follows:

	2019	2020	2021	2022	2023
Variable expenses					
Pharmaceuticals	\$ 12,144,000	\$ 12,506,000	\$ 12,881,000	\$ 13,332,000	\$ 13,796,000
Operating room	1,523,000	1,557,000	1,616,000	1,677,000	1,732,000
Laboratory	1,058,000	1,082,000	1,123,000	1,165,000	1,203,000
Home medical equipment	658,000	672,000	687,000	706,000	726,000
Wound heal & hyperbaric	335,000	342,000	350,000	359,000	369,000
Nuclear medicine	318,000	325,000	337,000	350,000	362,000
Blood supplies	298,000	305,000	316,000	328,000	339,000
Medical supplies	701,000	725,000	756,000	790,000	824,000
Non-variable expenses					
Admin supplies	327,000	330,000	334,000	337,000	340,000
Nonbillable	864,000	873,000	881,000	890,000	899,000
Other supplies	163,000	165,000	166,000	168,000	170,000
Minor equipment	90,000	91,000	91,000	92,000	93,000
	<u>\$ 18,479,000</u>	<u>\$ 18,973,000</u>	<u>\$ 19,538,000</u>	<u>\$ 20,194,000</u>	<u>\$ 20,853,000</u>

Refer to *Summary of Significant Forecast Demand Assumptions; Note 10 – Historical and Forecasted Demand and Utilization* for related statistics.

Utilities

Utilities expense is forecasted to increase 2.75% annually throughout the forecast period. Telephone and cable expense is forecasted to increase 2.75% annually throughout the forecast period. These increases are based on discussions with management, review of historical information, and comparison to published inflationary increases. Utilities are forecasted as follows:

	2019	2020	2021	2022	2023
Utilities	\$ 999,000	\$ 1,025,000	\$ 1,054,000	\$ 1,083,000	\$ 1,112,000
Telephone and cable	255,000	263,000	270,000	277,000	285,000
	<u>\$ 1,254,000</u>	<u>\$ 1,288,000</u>	<u>\$ 1,324,000</u>	<u>\$ 1,360,000</u>	<u>\$ 1,397,000</u>

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Repairs and Maintenance

Repairs and maintenance costs include general maintenance for the building and grounds and are forecasted to increase 2.00% annually throughout the forecast period. This increase is based on discussions with management, review of historical information, and comparison to published inflationary increases.

Insurance

Insurance expense includes professional liability, general, property, and auto insurances and are forecasted to increase 1.50% throughout the forecast period. This is based on discussions with management, review of historical information, and comparison to published inflationary increases. The Healthcare System reviews insurance coverage annually with its agent to determine adequacy of coverage.

Lease and Rentals

Rental and lease expenses is forecasted to increase 2.00% annually throughout the forecast period. This increase is based on discussions with management, review of historical information, and comparison to published inflationary increases.

Depreciation

Depreciation expense is forecasted using the straight-line method. Depreciation expense for the Project upgrades includes equipment with estimated useful lives of 7, 10, and 15 years, and building and improvements with estimated useful life of 15 years. The Healthcare System's routine capital additions for major moveable equipment will be depreciated using an average useful life of 7 years. These average useful lives are based on the American Hospital Association's Guide to Estimated Useful Lives for Healthcare Entities. The following table shows the Healthcare System's depreciation expense during the forecast period:

	2019	2020	2021	2022	2023
Existing - various	\$ 2,971,000	\$ 2,401,000	\$ 2,003,000	\$ 1,719,000	\$ 1,469,000
Routine					
Major movable equipment - 7	143,000	429,000	714,000	1,000,000	1,286,000
Project					
Building and improvements - 15	-	25,000	50,000	50,000	50,000
Major movable equipment - 7	-	642,000	1,285,000	1,285,000	1,285,000
Major movable equipment - 10	-	77,000	155,000	155,000	155,000
Major movable equipment - 15	-	103,000	206,000	206,000	206,000
	<u>\$ 3,114,000</u>	<u>\$ 3,677,000</u>	<u>\$ 4,413,000</u>	<u>\$ 4,415,000</u>	<u>\$ 4,451,000</u>

Dickinson County Healthcare System
Summary of Significant Forecast Assumptions and Accounting Policies
Five Years Ending December 31, 2023

Other

Other expenses include dues and subscriptions, advertising, travel and education, postage, vehicle and mileage costs, food, property taxes, and accounts payable discounts. Other expenses have been inflated 1.50% annually through the forecast period. This increase is based on discussions with management, review of historical information, and comparison to published inflationary increases.

	2019	2020	2021	2022	2023
Dues and subscriptions	\$ 361,000	\$ 366,000	\$ 370,000	\$ 378,000	\$ 383,000
Advertising	171,000	173,000	176,000	178,000	181,000
Travel and education	164,000	167,000	169,000	172,000	174,000
Postage	173,000	176,000	179,000	181,000	184,000
Vehicle and mileage	83,000	85,000	86,000	87,000	89,000
Food	382,000	388,000	394,000	399,000	405,000
Property taxes	60,000	61,000	62,000	63,000	64,000
Accounts payable discounts	(173,000)	(176,000)	(178,000)	(181,000)	(184,000)
	<u>\$ 1,221,000</u>	<u>\$ 1,240,000</u>	<u>\$ 1,258,000</u>	<u>\$ 1,277,000</u>	<u>\$ 1,296,000</u>

Note 7 - Forecasted Nonoperating Revenues (Expenses)

Nonoperating revenues (expenses) consist of interest expense, amortization expense, finance and issuance costs, unrestricted contributions, and investment income. The following table shows the forecasted breakdown of non-operating revenues (expenses) during the forecast period.

	2019	2020	2021	2022	2023
Nonoperating Revenues (Expenses)					
Interest expense	\$ (945,000)	\$ (1,180,000)	\$ (998,000)	\$ (959,000)	\$ (918,000)
Amortization expense	(169,000)	(41,000)	-	-	-
Finance and issuance costs	(402,000)	-	-	-	-
Unrestricted contributions	55,000	55,000	55,000	55,000	55,000
Investment income	35,000	35,000	35,000	35,000	35,000
Net Nonoperating Income (Expense)	<u>\$ (1,426,000)</u>	<u>\$ (1,131,000)</u>	<u>\$ (908,000)</u>	<u>\$ (869,000)</u>	<u>\$ (828,000)</u>

The Healthcare System expects to make the last principal and interest payments on existing debt in December 2019. Refer to *Note 3 – Project Overview, Construction Plan, and Financing Plan* for Project related terms and interest rates for the USDA Direct Loan. The following table summarizes interest and amortization expense during the forecast period.

	2019	2020	2021	2022	2023
Existing Debt	\$ 945,000	\$ 317,000	\$ 168,000	\$ 152,000	\$ 135,000
Loss on Refunding	169,000	41,000	-	-	-
USDA Direct Loan	-	863,000	830,000	807,000	783,000
Interest and Amortization Expense	<u>\$ 1,114,000</u>	<u>\$ 1,221,000</u>	<u>\$ 998,000</u>	<u>\$ 959,000</u>	<u>\$ 918,000</u>

Summary of Significant Forecast Demand Assumptions

General Methodology

The demand analysis performed for the forecast begins with the assumption that select outpatient and ancillary services at the Healthcare System will show slight growth after medical equipment upgrades are in place, but the majority, along with inpatient volumes, will show slight decline in the coming five years based on historical volume trends and projected population decline in the primary service area (PSA).

The following sections of the demand assumptions present data used by management in formulating the forecast of the demand for the Healthcare System:

- Factors impacting utilization
- Inpatient utilization
- Outpatient utilization
- Service area definition and patient origin
- Population of the service area
- Socioeconomic characteristics of the service area
- Market assessment of other healthcare providers within the service area
- Market share by service
- Inpatient use rates
- Historical and forecasted demand and utilization
- Medical staff

Note 1 – Factors Impacting Utilization

There are many factors affecting utilization (both inpatient and outpatient) within the healthcare industry on a national basis. On a national level, utilization/demand for healthcare services has had slower growth than what has been experienced in previous years. This slower growth rate has continued over the past few years as Americans are becoming more conscious of their healthcare spending. This slower growth rate is also being supplemented with wellness initiatives being promoted through employers and population health / value-based programs related to the Affordable Care Act and subsequent programs. There is a general consensus that emphasis will continue to be placed on preventative care and change from volume to value in healthcare, as these efforts are intended to improve overall population health while reducing costs.

Note 2 – Inpatient Utilization

The Healthcare System has a number of factors affecting inpatient activity in its market, including population changes, inpatient use rates and market share capture rates. To analyze use rates, data from the American Hospital Association (AHA) Hospital Statistics Reference Guide was utilized. The following table shows the use rates for inpatient services in the State of Michigan and the United States for years 2012 through 2016:

	2012	2013	2014	2015	2016
State of Michigan					
Admissions per 1,000	119.6	117.1	113.5	117.7	116.8
Inpatient days per 1,000	610.9	597.5	578.3	591.6	584.5
Average length of stay	4.8	4.9	4.8	4.8	4.8
United States:					
Admissions per 1,000	109.7	106.3	103.7	103.5	103.4
Inpatient days per 1,000	590.7	576.9	565.9	564.9	564.1
Average length of stay	5.0	5.0	5.1	5.1	5.1

Source: American Hospital Association Statistics Reference Guide

Both the State of Michigan and the United States saw downward trends with admissions per 1,000 population and inpatient days per 1,000 population from 2012 to 2016. The State of Michigan however saw increases in 2015 followed by decreases in 2016 to levels below year 2012. The trend for average length of stay in the State of Michigan was flat, while the United States saw a very slight increase from 5.0 days in 2012 to 5.1 days in 2016.

Note 3 – Outpatient Utilization

As noted above, the slight anticipated decline in outpatient activity (with exceptions in 2021 for lab, radiology, MRI, CT, operating room and recovery room) is based on historical volume trends and declining PSA population. The healthcare industry across the country has seen a significant shift in utilization from inpatient services to outpatient services as a result of advances in medical technology. Many procedures that were once performed solely as an inpatient service are now often done in an outpatient setting. The following table shows outpatient use rate trends (on a per 1,000 population basis) in the State of Michigan and the United States for years 2012 to 2016:

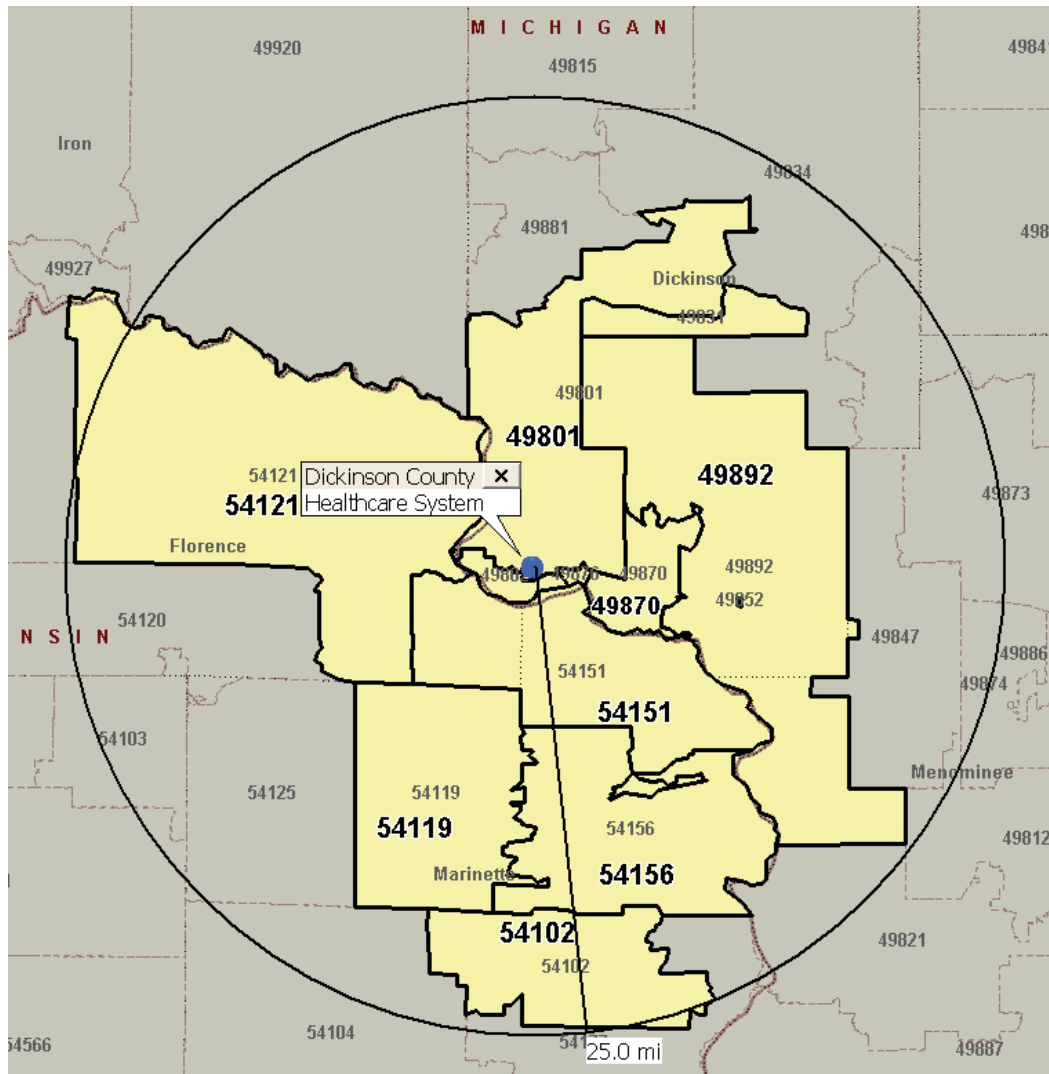
	2012	2013	2014	2015	2016
State of Michigan					
Outpatient (non-ER) visits	2,836.9	2,798.5	2,939.8	3,092.9	3,250.8
Emergency room visits	483.8	492.7	485.8	504.6	519.5
Outpatient surgeries	68.6	68.2	68.6	66.2	68.6
United States:					
Outpatient (non-ER) visits	1,725.8	1,721.9	1,746.2	1,806.4	1,870.9
Emergency room visits	424.4	422.6	427.6	440.3	441.2
Outpatient surgeries	55.1	55.1	54.5	54.7	56.5

Source: American Hospital Association Statistics Reference Guide

Outpatient Utilization in a per 1,000 population basis is significantly higher in the State of Michigan when compared to the United States, but the trends over time are similar. There were slight declines in 2013 followed by increases into 2016. Emergency room utilization for the State of Michigan and the United States trended upward from 2012 to 2016 but each saw temporary decreases (year 2014 for the State of Michigan and year 2013 for the United States). Outpatient surgery utilization in the State of Michigan stayed relatively flat during this time and rose slightly across the United States. The healthcare industry expects to see a continued increase in outpatient utilization due to the aging baby boomer population, continued advancement of medical technology, and demand for lower cost services.

Note 4 – Service Area Definition and Patient Origin

Iron Mountain is located in Dickinson County, Michigan (upper peninsula), approximately 4 miles (driving) north of the Wisconsin border. The factors taken into consideration to determine the service area were historical utilization, demographics, competition, and physical geography. The following is a map of the primary service area:



The primary service area includes the following zip codes: 49801, 49802, 49831, 49852, 49870, 49876, 49892, 54102, 54119, 54121, 54151, 54156, the first seven being Michigan zip codes and the last five being Wisconsin zip codes.

Dickinson County Healthcare System
Summary of Significant Demand Assumptions
Five Years Ending December 31, 2023

The following table shows patient origin by zip code for the Healthcare System's inpatient discharges and outpatient encounters for 2018 and partial 2019.

		2018				January through May 2019			
		Inpatient Discharges	%	Outpatient Encounters	%	Inpatient Discharges	%	Outpatient Encounters	%
<i>Primary Service Area (PSA)</i>									
49801	Iron Mountain, MI	651	23.8%	34,624	24.1%	234	21.9%	11,343	23.3%
49802	Kingsford, MI	536	19.6%	23,718	16.5%	169	15.8%	7,752	15.9%
49831	Felch, MI	31	1.1%	1,653	1.2%	7	0.7%	624	1.3%
49852	Loretto, MI	4	0.1%	358	0.2%	4	0.4%	140	0.3%
49870	Norway, MI	181	6.6%	10,824	7.5%	97	9.1%	3,922	8.0%
49876	Quinnesec, MI	62	2.3%	3,572	2.5%	42	3.9%	1,310	2.7%
49892	Vulcan, MI	93	3.4%	5,800	4.0%	31	2.9%	1,942	4.0%
54102	Amberg, WI	25	0.9%	1,241	0.9%	11	1.0%	367	0.8%
54119	Dunbar, WI	20	0.7%	1,212	0.8%	12	1.1%	362	0.7%
54121	Florence, WI	184	6.7%	9,004	6.3%	78	7.3%	2,908	6.0%
54151	Niagara, WI	182	6.7%	10,017	7.0%	65	6.1%	3,617	7.4%
54156	Pembine, WI	59	2.2%	3,807	2.7%	28	2.6%	1,289	2.6%
PSA Total		2,028	74.1%	105,830	73.8%	778	72.7%	35,576	73.0%
Total from outside PSA		707	25.9%	37,583	26.2%	292	27.3%	13,188	27.0%
Total		2,735	100.0%	143,413	100.0%	1,070	100.0%	48,764	100.0%

Source: Healthcare System records

As seen in the above table, residents of the PSA accounted for 73% to 74% of inpatient discharges and outpatient encounters during this time. In-migration, defined as patients coming in from outside the service area, was approximately 26% to 27%.

Note 5 – Population of the Service Area

The following tables summarize the primary service area populations, broken down by male, female, and age cohorts:

Zip Code	Town	2010 Census			2019 Estimate			2024 Projection					
		Male	Female	Total	%	Male	Female	Total	%	Male	Female	Total	%
Primary Service Area (PSA)													
49801	Iron Mountain, MI	5,721	5,845	11,566	32.9%	5,607	5,571	11,178	33.2%	5,541	5,495	11,036	33.2%
49802	Kingsford, MI	2,915	3,238	6,153	17.5%	2,822	3,018	5,840	17.4%	2,762	2,964	5,726	17.2%
49831	Felch, MI	344	330	674	1.9%	332	307	639	1.9%	325	303	628	1.9%
49852	Loretto, MI	65	63	128	0.4%	68	61	129	0.4%	65	64	129	0.4%
49870	Norway, MI	1,640	1,712	3,352	9.5%	1,570	1,610	3,180	9.5%	1,540	1,579	3,119	9.4%
49876	Quinnesec, MI	596	590	1,186	3.4%	567	557	1,124	3.3%	558	544	1,102	3.3%
49892	Vulcan, MI	1,035	1,013	2,048	5.8%	1,023	995	2,018	6.0%	1,022	981	2,003	6.0%
54102	Amberg, WI	417	384	801	2.3%	398	358	756	2.2%	387	354	741	2.2%
54119	Dunbar, WI	472	477	949	2.7%	401	385	786	2.3%	393	382	775	2.3%
54121	Florence, WI	1,519	1,450	2,969	8.5%	1,536	1,433	2,969	8.8%	1,550	1,454	3,004	9.0%
54151	Niagara, WI	1,787	1,790	3,577	10.2%	1,746	1,698	3,444	10.2%	1,727	1,673	3,400	10.2%
54156	Pembine, WI	879	832	1,711	4.9%	812	753	1,565	4.7%	797	741	1,538	4.6%
Total Service Area Population		17,390	17,724	35,114	100.0%	16,882	16,746	33,628	100.0%	16,667	16,534	33,201	100.0%

Source: Environics Analytics

The PSA population declined 4.2% from 2010 to 2019. Zip codes 49852 and 54121 were the only ones that didn't show decline. Looking ahead to 2024, 49852 is projected to have no population change and zip code 54121 is projected to grow 1.2%. The PSA is projected to decline 1.3%. Males and females are proportioned 50% to 50% in 2019 in the PSA.

Dickinson County Healthcare System
Summary of Significant Demand Assumptions
Five Years Ending December 31, 2023

Service Area Age Group	2010 Census				2019 Estimate				2024 Projection			
	Male	Female	Total	%PSA	Male	Female	Total	%PSA	Male	Female	Total	%PSA
Primary Service Area (PSA)												
Age 0-17	3,699	3,505	7,204	20.5%	3,159	2,966	6,125	18.2%	2,963	2,804	5,767	17.4%
Age 18-44	4,968	4,988	9,956	28.4%	4,843	4,628	9,471	28.2%	4,863	4,623	9,486	28.5%
Age 45-64	5,673	5,538	11,211	31.9%	5,139	5,044	10,183	30.3%	4,752	4,610	9,362	28.2%
Age 65-74	1,679	1,711	3,390	9.7%	2,213	2,178	4,391	13.0%	2,520	2,518	5,038	15.2%
Age 75-84	1,013	1,285	2,298	6.5%	1,092	1,232	2,324	6.9%	1,115	1,241	2,356	7.1%
Age 85+	358	697	1,055	3.0%	436	698	1,134	3.4%	454	738	1,192	3.6%
Total PSA Population	17,390	17,724	35,114	100.0%	16,882	16,746	33,628	100.0%	16,667	16,534	33,201	100.0%

Source: Enviroinformatics Analytics

Years 2010 to 2019 saw population decline in ages 0-64 and population growth in ages 65 and up. The cohort with the most rapid growth was the 65-74 age group (29.5% growth). Looking ahead to years 2019 to 2024, the 0-17 cohort is projected to decline 5.8% and the 45-64 cohort is projected to decline 8.1%. All other age group populations are projected to grow, with the 65-74 cohort projected to have the most rapid growth at 14.7%. The 65+ population of the PSA is projected to see 9% growth, which is slower than the 65+ population growths of the State of Michigan (14%) and the United States (17%). Older adult population cohorts are important to monitor as they impact senior living utilization and affect payer mix. As a percentage of gross patient revenue, Medicare makes up approximately 48% at the Healthcare Center.

PSA 65+ Cohorts	2019	2024	5yr		5yr %
			Change	Change	
65+	7,849	8,586	737	9.4%	9.4%
75+	3,458	3,548	90	2.6%	2.6%
85+	1,134	1,192	58	5.1%	5.1%

Source: Enviroinformatics Analytics

Note 6 – Socioeconomic Characteristics of the Service Area

The major employers in the Healthcare System's service area are as follows:

Employer	Industry	Approximate Number of Employees
Systems Control	Manufacturing	705
Department of Veterans Affairs Hospital	Health Care	686
Dickinson County Healthcare System	Health Care	600
Verso Paper	Paper	430
American Axle and Manufacturing	Manufacturing	400
CCI Systems Inc.	Communication Networks	400
Boss Snowplow / The Toro Co.	Machinery	325
MJ Electric, Inc.	Electrical Contractor	212
Breitung Township Schools	Education	200
Louisiana Pacific - Sagola	Manufacturing	175

Source: Dickinson Area Economic Development Alliance

Unemployment

The following table summarizes unemployment rates from 2014 through 2018. Dickinson County has had a higher unemployment rate than the United States since 2014 but the gap narrowed to 0.1% in 2018. The State of Michigan had the highest rate in 2014 when compared to the United States and Dickinson County but in 2015 its rate dropped significantly and from there it stayed on par with Dickinson County.

	Unemployment Statistics				
	2014	2015	2016	2017	2018
United States	5.4%	4.8%	4.5%	3.9%	3.7%
State of Michigan	7.2%	5.4%	5.0%	4.6%	4.1%
Dickinson County	6.8%	5.7%	5.2%	4.7%	3.8%

Source: Bureau of Labor Statistics - all rates are not seasonally adjusted

Household Income

The table below summarizes household income for the primary service area, the State of Michigan, and the United States. The median household income for the primary service area is estimated to be \$51,256 in 2019. PSA median household income is 11% lower than in the State of Michigan and 18% lower than across the United States.

	Primary Service Area		State of Michigan		United States	
Total Households						
Census 2000	17,418		3,785,645		105,480,131	
Estimated 2019	17,369		3,968,527		125,018,808	
Projected 2024	17,401		4,021,832		129,683,914	
Average Household Income						
Census 2000	\$ 44,952		\$ 57,535		\$ 56,644	
Estimated 2019	\$ 67,482		\$ 80,342		\$ 89,646	
Projected 2024	\$ 73,847		\$ 90,498		\$ 98,974	
Median Household Income						
Census 2000	\$ 36,825		\$ 44,835		\$ 42,339	
Estimated 2019	\$ 51,256		\$ 57,659		\$ 62,280	
Projected 2024	\$ 55,238		\$ 64,300		\$ 68,116	
Estimated 2019 Household Income						
< \$15,000	2,017	11.6%	436,845	11.0%	13,139,476	10.5%
\$15,000 - \$24,999	1,964	11.3%	384,841	9.7%	11,332,940	9.1%
\$25,000 - \$34,999	1,920	11.1%	377,358	9.5%	11,119,486	8.9%
\$35,000 - \$49,999	2,585	14.9%	543,907	13.7%	15,768,445	12.6%
\$50,000 - \$74,999	3,370	19.4%	705,520	17.8%	21,157,117	16.9%
\$75,000 - \$99,999	2,041	11.8%	490,035	12.3%	15,409,853	12.3%
\$100,000 +	3,472	19.9%	1,030,021	26.0%	37,091,491	29.7%
	17,369	100.0%	3,968,527	100.0%	125,018,808	100.0%

Source: Environics Analytics

Poverty

The following table shows poverty rates for Dickinson County, the State of Michigan, and the United States. Dickinson County, where the Healthcare System resides, has slightly lower individual and family poverty rates than the State of Michigan and the United States. The State of Michigan has a slightly higher individual poverty rate and a lower family poverty rate when compared to the United States.

	Percentage of Individuals below Poverty Rate	Percentage of Families below Poverty Rate
United States	15.5%	11.3%
State of Michigan	15.6%	10.9%
Dickinson County	15.2%	10.8%

Source: US Census Bureau American FactFinder

Note 7 – Market Assessment of Other Healthcare Providers within the Service Area

The Healthcare System is the only hospital in the PSA apart from Oscar G. Johnson VA Medical Center, which is one mile away in Iron Mountain, Michigan. There are two clinics in the PSA that could be thought of as competitors: Bellin Health Clinic in Iron Mountain, Michigan and Marquette Medical Clinic in Kingsford, Michigan. Expanding the view outward from the PSA, we look at a 50-mile radius from the Healthcare System. In this area are two hospitals (Aspirus Iron River and OSF St. Francis) and five clinics. While being within 50 miles, these are not considered competitors due to having no substantive PSA market share for inpatient services. The tables below illustrate competing hospital and clinics, identified as competitors due to having substantive PSA market share and/or by proximity to the Healthcare System.

Hospital Name	Town	Driving Distance from DCHS (miles)	Number of Acute Beds	Occupancy Rate	Average Daily Census
Dickinson County Healthcare System	Iron Mountain, MI	-	39	64%	24.98
UP Healthcare System Marquette	Marquette, MI	80	244	43%	103.97
Aurora BayCare Medical Center	Green Bay, WI	103	161	64%	102.66
Bellin Hospital	Green Bay, WI	104	161	44%	70.30
SHS St. Vincent	Green Bay, WI	104	223	55%	122.26

Source: American Hospital Directory, Google Maps

When applicable, nursery (newborn), psych, and rehab were omitted from ADC and occupancy rate

Occupancy rate and average daily census includes swing beds

Dickinson County Healthcare System

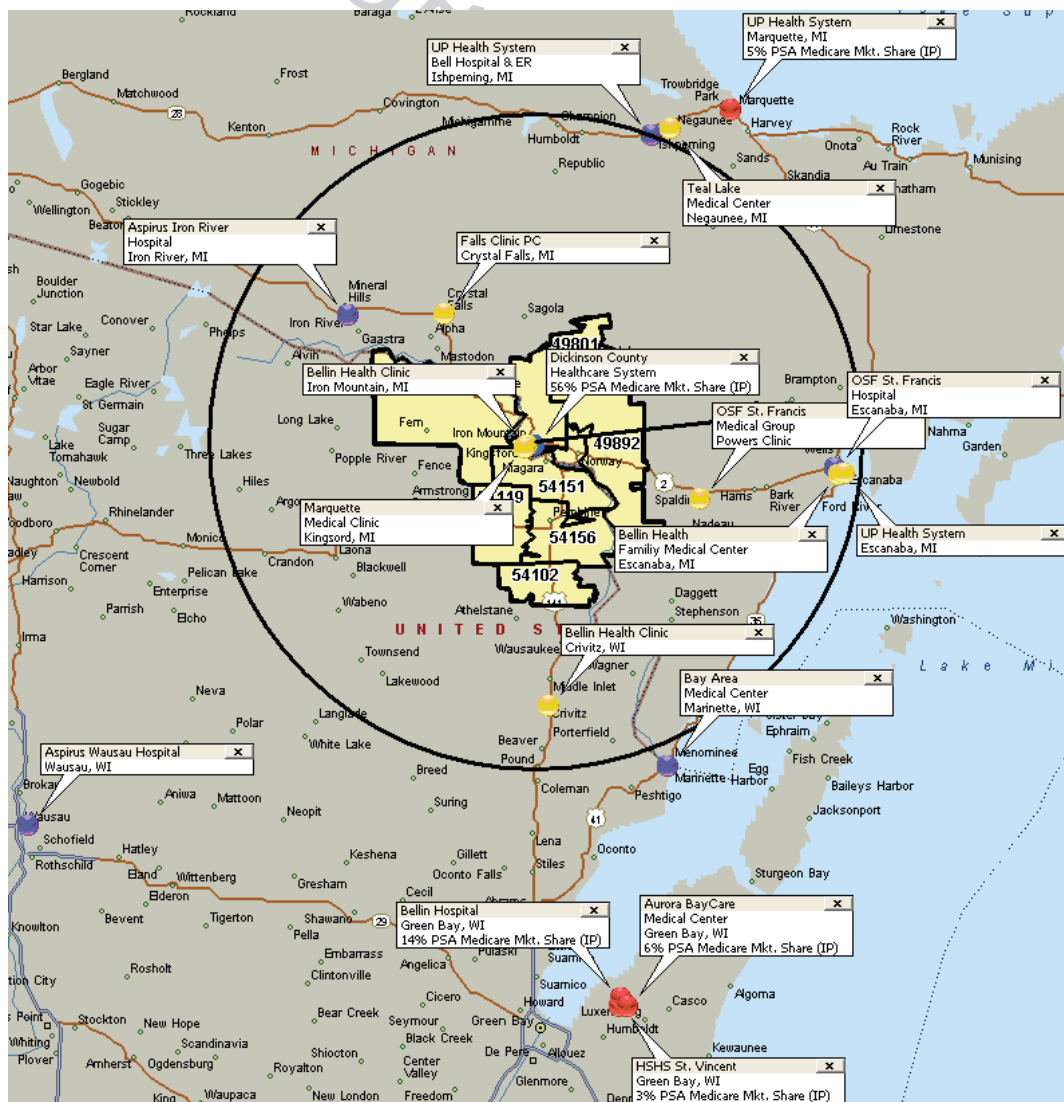
Summary of Significant Demand Assumptions

Five Years Ending December 31, 2023

Clinic Name	Town	Driving Distance from DCHS (miles)
Bellin Health Clinic	Iron Mountain, MI	2
Marquette Medical Clinic	Kingsford, MI	3
Falls Clinic PC	Crystal Falls, MI	30
OSF St. Francis Medical Group	Powers, MI	29
Bellin Health Clinic	Crivitz, MI	45
UP Healthcare System	Escanaba, MI	51
Teal Lake Medical Center	Negaunee, MI	70

Source: Healthcare System records, Google Maps

The map below features hospitals and clinics near the Healthcare System, some identified as competitors and some not. The Healthcare System is marked at the center with a blue dot. Competing clinics are identified with yellow dots. Hospitals with some PSA market share are marked with red dots, and those that don't carry substantive PSA market share are marked with purple dots.



Note 8 – Market Share

The following table shows years 2016 and 2017 PSA inpatient volumes and market shares (Medicare data) for the Healthcare System and four competing hospitals.

PSA Resident Inpatient Activity (Medicare)				
Facility	2016		2017	
	Discharges	Market Share	Discharges	Market Share
Dickinson County Healthcare System	1,165	57%	1,225	56%
Bellin Hospital, Green Bay, WI	266	13%	309	14%
Aurora BayCare Medical Center, Green Bay, WI	88	4%	134	6%
UPHS - Marquette, Marquette, MI	149	7%	109	5%
HSHS St. Vincent Hospital, Green Bay, WI	73	4%	59	3%
All Others	307	15%	346	16%
Total	2,048	100%	2,182	100%

Source: CMS Hospital Service Area File

As seen above, the Healthcare System carried the greatest PSA market share in 2016 and 2017. Three hospitals in Green Bay, Wisconsin and one in Marquette, Michigan each carried 3% or more PSA market share.

Note 9 – Inpatient Use Rates

The following table shows the number of inpatient beds per 1,000 population:

	PSA
Population (Estimated 2019):	<u>33,628</u>
Hospital Bed Count	
Dickinson County Healthcare System	<u>39</u>
Beds Per 1,000 population	<u>1.2</u>
State of Michigan Beds Per 1,000 (2016)	<u>2.5</u>
United States Beds Per 1,000 (2016)	<u>2.4</u>

Source: Environics Analytics, AHA Hospital Statistics Reference Guide

Current PSA population is estimated at 33,628. Inpatient beds (39 Healthcare System beds) per 1,000 population in the PSA calculates to 1.2. This is lower than the State of Michigan benchmark (2.5 beds per 1,000 population) and the United States benchmark (2.4 beds per 1,000 population).

Dickinson County Healthcare System
Summary of Significant Demand Assumptions
Five Years Ending December 31, 2023

Note 10 – Historical and Forecasted Demand and Utilization

The following table shows historical and forecasted inpatient and outpatient volumes for the Healthcare System:

	Historical					Forecasted					CAGR	
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2018-2023
Inpatient Volumes												
Acute patient days	11,764	9,806	9,028	9,506	7,614	7,154	7,047	7,011	6,976	6,942	(35.3%)	(8.8%)
Outpatient Volumes												
Emergency Svcs	14,103	14,997	14,638	14,111	13,378	12,226	12,165	12,287	12,409	12,471	(5.1%)	(6.8%)
Pharmacy	1,235,543	1,807,593	2,115,237	2,273,964	2,195,648	2,184,670	2,173,746	2,162,878	2,162,878	2,162,878	77.7%	(1.5%)
Lab	377,683	380,991	413,527	432,917	378,585	363,442	361,624	365,241	368,893	370,738	0.2%	(2.1%)
MRI	21,614	18,856	16,705	16,312	15,057	14,455	14,382	14,526	14,672	14,745	(30.3%)	(2.1%)
Radiology	61,284	42,991	41,527	44,425	38,925	37,368	37,181	37,553	37,929	38,118	(36.5%)	(2.1%)
CT Scanning	33,141	32,021	29,854	30,378	30,359	29,145	28,999	29,289	29,582	29,730	(8.4%)	(2.1%)
Ultrasound	10,297	13,657	16,133	17,127	15,419	14,802	14,728	14,655	14,655	14,655	49.7%	(5.0%)
Radiation Onc	16,514	18,441	21,537	17,420	24,980	24,855	24,731	24,978	25,228	25,354	51.3%	1.5%
Operating Room	3,869	3,819	3,860	3,840	3,405	3,388	3,371	3,405	3,439	3,456	(12.0%)	1.5%
Cardiac Diagnostics	10,282	10,629	10,771	11,475	10,745	10,691	10,638	10,585	10,585	10,585	4.5%	(1.5%)
Wound & Healing	11,194	8,651	13,189	14,767	16,255	16,174	16,093	16,012	16,012	16,012	45.2%	(1.5%)
Clinic visits	67,380	72,108	83,975	98,905	92,450	76,734	76,734	77,117	77,503	77,890	37.2%	(15.7%)
Adjusted Patient Days	43,653	45,866	45,807	50,049	44,078	41,729	41,983	42,624	43,338	43,966	1.0%	(0.3%)

Dickinson County Healthcare System
Summary of Significant Demand Assumptions
Five Years Ending December 31, 2023

Note 11 – Medical Staff

The composition of the Healthcare System’s medical staff includes the following providers:

Active Physician Provider	Specialty	Board Certified	Age	Year Privileges Granted
Adina-Maria Anderson, D.P.M.	Podiatry/Wound Care	Yes	48	2006
George E Bonefeld, D.O.	Anesthesiology	No	69	2008
Douglas P Calvin, M.D.	Radiation/Oncology	Yes	57	2017
Robyne D Camana, M.D.	Diagnostic/Interventional Radiology	Yes	45	2016
Waldo B Carlson, M.D.	Occupational Medicine/Wound Care	Yes	67	1984
Alexis A Cirilli Whaley, M.D.	Pediatrics/ Sleep Medicine	Yes	42	2006
Martin J Cristanelli, M.D.	Pathology	Yes	59	2010
Joseph T Donohue, M.D.	General Surgery	Yes	42	2007
Marjorie V Funtanilla, M.D.	Nephrology/Internal Med.	Yes	54	1998
John M Garrett, M.D.	Ophthalmology	Yes	70	1998
Charlene M Greene, D.O.	Family Medicine	Yes	62	2000
John R Groeneveld, M.D.	Family Medicine	Yes	59	1989
John T Hallfrisch, M.D.	Emergency Medicine	Yes	64	1992
Ryan N Hart, D.O.	Emergency Medicine	Yes	43	2016
Paul N Hayes, M.D.	Family Medicine	Yes	71	1977
Donald P Heilala, D.P.M.	Podiatry	Yes	67	1984
Steven J Hunt, M.D.	Dermatology	Yes	64	1995
Donald J Jacobs, M.D.	Family Medicine	No	88	1959
Victoria M Jakel, M.D.	Family Medicine	Yes	63	1993
Eric M Johnson, M.D.	Emergency Medicine	Yes	38	2017
Dan F Kreider, M.D.	Diagnostic/Interventional Radiology	Yes	58	2015
Jeffrey A Kreyer, M.D.	General Surgery	Yes	42	2014
Donald G Kube, Jr., D.O.	Anesthesiology	Yes	61	1996
Thomas H Lamirand, M.D.	Pediatrics	Yes	42	2008
Stephen R Leonard, M.D.	Internal Medicine	Yes	73	1976
John L Loewen, M.D.	Family Medicine	No	69	1977
Elizabeth A Mackey, D.O.	Emergency Medicine	Yes	49	2014
Louis J Mautone, D.O.	Diagnostic/Interventional Radiology	Yes	50	2003
Douglas A McDowell, M.D.	Emergency Medicine	Yes	62	2015
Daniel J McMahon, M.D.	Family Medicine	Yes	51	2000
James E Merrill, D.O.	Obstetrics/Gynecology	Yes	61	1994
Gustavo P Morel, M.D.	Hematology/Oncology	Yes	55	2001
Maria L Occhietti, M.D.	Anesthesiology	Yes	49	1999
Michael J Occhietti, M.D.	Orthopaedic Surgery	Yes	50	1999
Kristi Rae Olson, M.D.	Family Medicine /Hospitalist	Yes	42	2006
Charles A Papp, D.O.	Emergency Medicine	Yes	59	1989
Edward A Perez-Conde, M.D.	Emergency Medicine	Yes	50	2000
Gerald T Pruitt, D.O.	Hospitalist/Internal Medicine	Yes	57	2016
Adam P Ryan, M.D.	Obstetrics/Gynecology	Yes	47	2002
Terence D Ryan, M.D.	Family Medicine	Yes	60	1997
F Michael Saigh, M.D.	Family Medicine	Yes	66	1982
John A Sand, D.O.	Sleep Medicine	Yes	71	2011
Beth A Schroeder, M.D.	Family Medicine	Yes	43	2004
Kevin C Scott, M.D.	Urology	Yes	49	2005
Clayton M Shaker, M.D.	Cardiology	Yes	41	2012
Nilar Shein, M.D.	Neurology	Yes	55	2000
Vijay Singh, M.D.	Pain Medicine	Yes	64	1989
Igor Siniakov, M.D.	Dermatology	Yes	51	2009
Jeremy D Stayton, M.D.	General Surgery	Yes	38	2017
Breion M Tafoya, D.O.	Pulmonology	Yes	38	2014
Steven J Terrian, D.O.	General Surgery	Yes	51	2001
John S To, M.D.	Diagnostic/Interventional Radiology	Yes	56	1996
Anh Thu T Tran, M.D.	Diagnostic Neurology	No	39	2016
Ellen E VanLaanen, D.O.	Family Medicine	Yes	62	1982
Sarah E Venditti, M.D.	Orthopaedic Surgery	Yes	38	2013
Barbara A Washington, M.D.	Cardiology	Yes	60	2007

Source: Healthcare System Records

Dickinson County Healthcare System
Summary of Significant Demand Assumptions
Five Years Ending December 31, 2023

Non-Physician Provider	Specialty	Age
Isadora E Asman, P.A.	Neurosurgery	38
Deborah A Becker, N.P.	Family Medicine	60
Jeffrey M Bird, N.P.	Gerontology	49
Sherry L Bombardo, C.R.N.A.	Anesthesia	48
Christine A Borgstrom, N.P.	Family Medicine & Pediatrics	51
Brian L Brant, C.R.N.A.	Anesthesia	49
Katie L Brown, P.A.	Family Medicine	34
Shelly R Buch, N.P.	Family Medicine	52
Dorothea A Budek, N.P.	Family Medicine	46
Emma L Collins, P.A.	Hospitalist Medicine	26
Megan R Collins, P.A.	Cardiology	27
Paul Cunningham, P.A.	Hospitalist Medicine	45
Treavor J Eimers, C.R.N.A.	Nurse Anesthetist	43
Aaron M Fleming, N.P.	Family Medicine	35
Kelly R Floriano, P.A.	Internal Medicine	44
Donald W Gabbert, C.R.N.A.	Anesthesia	55
Andrew J Gearhart, D.N.P.	Family Medicine	29
Katie J Hampton, N.P.	Family Medicine	50
Heather L Hayes, P.A.	Family Medicine	37
Robert L Heinrich, C.R.N.A.	Anesthesia	54
Kelsey L House, N.P.	Gerontology	35
Korby J Howell, P.A.	Family Medicine	28
Shannon M Isaacson-Escobar, P.A.	Family Medicine	44
Mary Alice Johnson, C.R.N.A.	Anesthesia	66
Robyn L Kazianka, P.A.	Obstetrics/Gynecology	54
Robert M Kelly, C.R.N.A.	Anesthesia	65
Megan M Land, N.P.	Family Medicine	30
Andrij I Lawrin, P.A.	Hospitalist Medicine	34
Lane S Lindeman, P.A.	Orthopedics	33
Rebbekkah C Marasco, N.P.	Family Medicine	49
Melanie M Martin, D.N.P.	Family Medicine	48
Sadie S McGillviray, N.P.	Family Medicine	26
Jacilyn A Meinol, N.P.	Family Medicine	29
Mikayla K Meyer, P.A.	Neurosurgery	28
Joni A Meyers, C.R.N.A.	Anesthesia	63
Vanessa H Mitchell, P.A.	Family Medicine	33
Michelle R Morel, P.A.	Hematology/Oncology	47
Jennifer M Morrow, C.R.N.A.	Anesthesia	29
Nicole A Phillips, N.P.	Family Medicine	44
Rachel R Phillips, P.A.	Neurosurgery	37
Peggy C Pontti, C.R.N.A.	Anesthesia	59
Peter J Rittenhouse, P.A.	Urology	43
Derrick J Schinderle, N.P.	Family Medicine	34
Elena M Shinn, N.P.	Family Medicine	34
Alan G Smith, C.R.N.A.	Anesthesia	44
Carole L Spickerman, N.P.	Family Medicine	50
Brooke R Spigarelli, C.R.N.A.	Anesthesia	37
Karen M Steber, N.P.	Family Medicine	54
Cheryl A Vader, N.P.	Family Medicine	65
Susan A Willis, P.A.	Hospitalist Medicine	51
Jeffrey J Wisniewski, P.A.	Hospitalist Medicine	41
Nicole M Wisniewski, P.A.	Hospitalist Medicine	46
George P Wuensch, P.A.	Family Medicine	58

Source: Healthcare System Records

Dickinson County Healthcare System
Summary of Significant Demand Assumptions
Five Years Ending December 31, 2023

The following table shows admissions by provider for 2018 and partial year 2019 at the Healthcare System.

Provider	2018	Partial* 2019	Total	2018 %	Partial* 2019 %	Total %
Friar, Kenneth	329	158	487	12%	15%	13%
Woodbury, Richard	276	106	382	10%	10%	10%
Schroeder, Beth	204	95	299	7%	9%	8%
Ryan, Adam	199	75	274	7%	7%	7%
Olson, Kristi	157	99	256	6%	9%	7%
Merrill, James	158	65	223	6%	6%	6%
Brundavanam, Chaitanya	102	96	198	4%	9%	5%
Lamirand, Thomas	173	24	197	6%	2%	5%
Occhietti, Michael	124	34	158	5%	3%	4%
Whaley, Alexis	145	-	145	5%	0%	4%
Han, Robert	116	13	129	4%	1%	3%
Hayes, Paul	78	36	114	3%	3%	3%
Venditti, Sarah	82	24	106	3%	2%	3%
Jadoon, Adil	66	35	101	2%	3%	3%
Ahlstrom, Troy	94	3	97	3%	0%	3%
Loewen, John	66	19	85	2%	2%	2%
Salter, Joshua	75	-	75	3%	0%	2%
Mahadev, Vennaralagappan	50	23	73	2%	2%	2%
All Others	241	165	406	9%	15%	11%
Total	2,735	1,070	3,805			

Source: Healthcare System records

*partial 2019 is January 1 through May 31

Note 12 – Physician Questionnaire Results

Questionnaires were provided to several physicians of the Healthcare System to determine their attitude and perspective regarding the Project. The following is a summary of the questions and related responses.

Question 1 – Describe your knowledge of the proposed Project and are you supportive of the Project?

There are significant medical equipment and IT upgrades that are needed and have been put off for too long; The current debt structure/terms with the Pay back Fifth Third Bank Loan and Bellin have hindered the facility operationally.

Question 2 – How will the proposed Project impact your future practice?

Any process that bring more patients to the hospital will benefit any practice – there has been some lost market share recently, so these equipment upgrades are important to keep our facility relevant in the community. Additionally, freeing up cash flow by refinancing will allow the facility to make more long-term investments in the future.

The IT investment will also impact the practice – right now it is somewhat piecemealed together. Radiology and Radiation Oncology need investment upgrades to maintain quality – much of the capital has been placed on hold recently due to financial constraints.

Question 3 – What is the public's awareness of the proposed Project and what is the level of public support?

Patients want to see the hospital succeed because it is a vital service for the community.

Question 4 – What is the public's perception of the existing Organization and how will that change as a result of the proposed Project?

Patients are supportive of the hospital. Patients comment about wanting to use services – it is necessary for the community and area due to lack of other healthcare providers. Strong community understanding on services provided – if not local, nearest hospital is 90 miles away.

Question 5 – What medical staff needs or equipment needs do you see?

In addition to the above, anesthesia machines and sterilizers.

Question 6 – How do you rate the nursing care at the Healthcare System?

Nursing team is great, and the patient and quality scores have always been strong. We recently created a new position for Population Health to help with NextGen ACO and Clinically Integrated Network. This person will also help with Behavioral Health and Opioid addiction patients to address readmissions, unnecessary ED visits, and engage the patient population in their population health.

Draft_07.19.19

Sensitivity Analysis

Because forecasts are based on assumptions about circumstances and events that have not yet occurred, they are subject to unanticipated events and circumstances that may arise as future operations actually occur. Accordingly, the actual results achieved during the forecast period will vary from the forecast, and the variations may be material.

Some events or conditions may occur which would adversely affect the forecast results and affect the Healthcare System's ability to meet debt service requirements. Events may include, among others, changes in the assumptions concerning utilization, physician complement, project costs, and legislative changes, especially in the area of Medicare and Medicaid reimbursement.

The sensitivity of changes to critical variables is an important consideration in evaluating the forecasted financial statements. The following analyses contrasts the sensitivity of certain variables assuming that only the variable being considered will change, and all other assumptions or relationships will remain as originally forecasted. The extent of increases or decreases of other variables associated with the one being considered has not been determined.

Legislative Changes: Governmental legislation and regulation may affect revenues, contractual adjustments, and expenses of the Healthcare System. If future legislation or regulations are enacted relating to the Healthcare System's operations, especially as it relates to Critical Access Hospitals, such legislation or regulations could have a material effect on future operations.

The financial forecast is based on management's assumptions the Healthcare System will achieve the utilization levels discussed in this report. Forecasted utilization is subject to variation and the impact of such variation could be material.

In addition, the Medicare Program currently reimburses the Healthcare System for services to covered beneficiaries based on a cost reimbursement methodology. During the forecast period, this program represents approximately 48% of total inpatient, outpatient, and clinic revenues. A change in the reimbursement methodology used by Medicare, or a change in the mix of such patients, could impact forecasted revenues and the impact could be material.

Sensitivity A – Total Inpatient Days Reduced by 10%

Management has assumed that forecasted inpatient will decline slightly throughout the forecast period. However, if future total inpatient utilization were to be 10% lower for each forecast year, the impact of the decline would be as follows for the years ending December 31, 2021 through 2023:

TABLE

Sensitivity B – Total Outpatient Utilization Reduced by 10%

Management has assumed that forecasted outpatient utilization will remain relatively flat, with some specific growth areas after equipment upgrades. However, if future outpatient utilization (not including clinic utilization) were to be 10% lower for each forecast year, the impact of the decline would be as follows for the years ending December 31, 2021 through 2023:

TABLE

Sensitivity C – Total Medicare Reimbursement Reduced to 95%

Management has assumed that forecasted Medicare reimbursement will follow current regulations. However, if future Medicare reimbursement were to be 95% of current reimbursement, the impact of the decline would be as follows for the years ending December 31, 2021 through 2023:

TABLE

Draft_07.19.19

Dickinson County Healthcare System
Statements of Net Position – Assets
December 31, 2014, 2015, 2016, 2017 and 2018

Historical Financial Statements

	2014	2015	2016	2017	2018
Assets and Deferred Outflows of Resources					
Current Assets					
Cash and cash equivalents	\$ 9,735,000	\$ 12,282,000	\$ 14,622,000	\$ 3,997,000	\$ 6,154,000
Short-term investments	517,000	4,562,000	13,000	-	-
Current portion of restricted assets	1,737,000	-	-	-	-
Receivables					
Patient, net of uncollectibles	13,473,000	16,696,000	16,529,000	16,032,000	15,711,000
Estimated third-party payor settlements	2,208,000	-	1,136,000	904,000	532,000
Other	3,048,000	2,998,000	400,000	1,107,000	1,927,000
Supplies and other current assets	3,581,000	3,975,000	3,898,000	3,332,000	2,587,000
Total current assets	34,299,000	40,513,000	36,598,000	25,372,000	26,911,000
Noncurrent Cash and Investments					
Restricted under indenture agreement for debt service	1,726,000	2,000,000	2,000,000	2,000,000	2,332,000
Other long-term investments	3,508,000	2,291,000	1,899,000	-	-
Total noncurrent cash and investments	5,234,000	4,291,000	3,899,000	2,000,000	2,332,000
Capital Assets					
Capital assets not being depreciated	2,498,000	3,728,000	3,703,000	2,571,000	2,465,000
Depreciable capital assets, net of accumulated depreciation	34,846,000	32,607,000	30,920,000	31,637,000	28,613,000
Total capital assets	37,344,000	36,335,000	34,623,000	34,208,000	31,078,000
Other Assets					
Investments in joint ventures	-	-	2,558,000	3,241,000	625,000
Total assets	76,877,000	81,139,000	77,678,000	64,821,000	60,946,000
Deferred Outflows of Resources					
Refunding costs	898,000	715,000	547,000	379,000	210,000
Pension related deferred outflows	-	5,476,000	8,324,000	5,815,000	6,000,000
Total deferred outflows of resources	898,000	6,191,000	8,871,000	6,194,000	6,210,000
Total assets and deferred outflows of resources	\$ 77,775,000	\$ 87,330,000	\$ 86,549,000	\$ 71,015,000	\$ 67,156,000

Dickinson County Healthcare System
Statements of Net Position – Liabilities, Deferred Inflows of Resources, and Net Position
December 31, 2014, 2015, 2016, 2017 and 2018

	2014	2015	2016	2017	2018
Liabilities, Deferred Inflows of Resources, and Net Position					
Current Liabilities					
Current maturities of long-term-debt	\$ 2,079,000	\$ 2,167,000	\$ 2,056,000	\$ 16,044,000	\$ 14,669,000
Accounts payable					
Trade	6,127,000	6,879,000	3,811,000	3,921,000	4,676,000
Estimated third-party settlements	-	458,000	-	-	-
Accrued expenses					
Salaries, wages, and related liabilities	1,569,000	1,876,000	2,193,000	2,430,000	2,207,000
Compensated absences	4,494,000	4,932,000	5,068,000	5,234,000	4,207,000
Other accrued liabilities	452,000	403,000	540,000	653,000	1,145,000
Interest	192,000	-	-	-	-
Total current liabilities	<u>14,913,000</u>	<u>16,715,000</u>	<u>13,668,000</u>	<u>28,282,000</u>	<u>26,904,000</u>
Long-Term Liabilities					
Long-term debt, less current maturities	22,867,000	21,159,000	19,124,000	4,713,000	5,894,000
Reserve for loss on general and professional liabilities claims	708,000	500,000	500,000	600,000	450,000
Net pension liability	-	31,975,000	36,901,000	26,501,000	20,306,000
Total long-term liabilities	<u>23,575,000</u>	<u>53,634,000</u>	<u>56,525,000</u>	<u>31,814,000</u>	<u>26,650,000</u>
Total liabilities	<u>38,488,000</u>	<u>70,349,000</u>	<u>70,193,000</u>	<u>60,096,000</u>	<u>53,554,000</u>
Deferred Inflows of Resources					
Pension realted deferred inflows	-	25,000	459,000	8,162,000	6,096,000
Net Position					
Invested in capital assets, net of related debt	13,296,000	13,726,000	13,989,000	13,829,000	10,726,000
Restricted - expendable for debt service	3,463,000	2,000,000	2,000,000	2,000,000	2,332,000
Unrestricted	22,528,000	1,230,000	(92,000)	(13,072,000)	(5,552,000)
Total net position	<u>39,287,000</u>	<u>16,956,000</u>	<u>15,897,000</u>	<u>2,757,000</u>	<u>7,506,000</u>
Total liabilities, deferred inflows of resources, and net position	<u>\$ 77,775,000</u>	<u>\$ 87,330,000</u>	<u>\$ 86,549,000</u>	<u>\$ 71,015,000</u>	<u>\$ 67,156,000</u>

Dickinson County Healthcare System
Statements of Revenues, Expenses, and Changes in Net Position
Five Years Ended December 31, 2018

	2014	2015	2016	2017	2018
Operating Revenues					
Net patient service revenue	\$ 86,772,000	\$ 101,437,000	\$ 103,797,000	\$ 101,328,000	\$ 99,346,000
Supplies and 340B program revenue	5,378,000	6,874,000	3,721,000	386,000	2,277,000
Electronic health record incentive revenue	1,330,000	258,000	1,056,000	513,000	-
Other revenue	2,258,000	2,167,000	2,069,000	2,031,000	2,721,000
Total operating revenues	95,738,000	110,736,000	110,643,000	104,258,000	104,344,000
Operating Expenses		19.79%	19.84%	21.44%	21.19%
Salaries and wages	38,205,000	41,769,000	43,144,000	45,582,000	42,793,000
Employee benefits	12,540,000	15,639,000	18,597,000	18,578,000	7,011,000
Professional fees and other	6,955,000	8,348,000	10,673,000	12,090,000	11,642,000
Purchased services	9,241,000	10,452,000	10,526,000	9,551,000	8,843,000
Supplies	13,708,000	20,077,000	20,589,000	21,726,000	21,054,000
Utilities	1,191,000	1,228,000	1,160,000	1,208,000	1,220,000
Repairs and maintenance	545,000	644,000	556,000	527,000	227,000
Insurance	512,000	267,000	394,000	490,000	429,000
Lease and rentals	867,000	1,031,000	1,046,000	1,021,000	875,000
Depreciation	4,923,000	4,507,000	4,587,000	3,863,000	3,396,000
Other	2,121,000	2,296,000	2,177,000	1,946,000	1,354,000
Total Operating Expenses	90,808,000	106,258,000	113,449,000	116,582,000	98,844,000
Operating Income (Loss)	4,930,000	4,478,000	(2,806,000)	(12,324,000)	5,500,000
Nonoperating Revenue (Expenses)					
Unrestricted contributions	859,000	146,000	50,000	48,000	67,000
Interest and amortization expense	(1,623,000)	(1,392,000)	(994,000)	(945,000)	(1,017,000)
Issuance and financing fees					
Loss on disposal of capital assets	(3,000)	(178,000)	(28,000)	(734,000)	20,000
Gain on investment in joint ventures	-	-	495,000	683,000	165,000
Change in fair market value of forward purchase agreement	252,000	35,000	-	-	-
Change in unrealized gains and losses on investments	40,000	(85,000)	(31,000)	34,000	-
Investment income	340,000	193,000	92,000	(4,000)	14,000
Nonoperating Revenues (Expenses), net	(135,000)	(1,281,000)	(416,000)	(918,000)	(751,000)
Revenues in Excess of (Less Than) Expenses	4,795,000	3,197,000	(3,222,000)	(13,242,000)	4,749,000
Capital Contributions	40,000	49,000	41,000	102,000	-
Change in Net Position	4,835,000	3,246,000	(3,181,000)	(13,140,000)	4,749,000
Net Position, Beginning of Year	34,452,000	39,287,000	16,956,000	15,897,000	2,757,000
Restatement - Joint venture	-	-	2,122,000	-	-
Restatement - Net Pension Liability	-	(25,577,000)	-	-	-
Net Position, End of Year	39,287,000	16,956,000	15,897,000	2,757,000	7,506,000

Dickinson County Healthcare System

Statements of Cash Flows

Five Years Ended December 31, 2018

	2014	2015	2016	2017	2018
Operating Activities					
Receipts from and on behalf of patients	\$ 83,303,000	\$ 100,880,000	\$ 102,370,000	\$ 102,055,000	\$ 100,039,000
Payments from supplies and contractors	(31,048,000)	(41,422,000)	(46,605,000)	(46,091,000)	(43,634,000)
Payments to employees	(52,032,000)	(58,534,000)	(61,980,000)	(65,354,000)	(59,500,000)
Other receipts	9,408,000	9,348,000	9,444,000	2,223,000	4,178,000
Net Cash from Operating Activities	9,631,000	10,272,000	3,229,000	(7,167,000)	1,083,000
Noncapital Financing Activity					
Unrestricted general contributions	860,000	146,000	50,000	48,000	67,000
Capital and Capital Related Financing Activities					
Purchase of capital assets	(3,014,000)	(3,650,000)	(2,864,000)	(4,174,000)	(249,000)
Repayment of long-term debt	(2,620,000)	(21,698,000)	(2,211,000)	(2,122,000)	(4,493,000)
Interest paid, including capitalized interest	(1,513,000)	(1,356,000)	(1,067,000)	(1,008,000)	(1,033,000)
Capital contributions	40,000	49,000	41,000	102,000	-
Proceeds from the sale of capital assets	11,000	6,000	35,000	55,000	20,000
Proceeds from the issuance of long-term debt	-	20,000,000	66,000	1,699,000	4,299,000
Net Cash used for Capital and Capital Related Financing Activities	(7,096,000)	(6,649,000)	(6,000,000)	(5,448,000)	(1,456,000)
Investing Activities					
Purchases of investments	(13,453,000)	(59,356,000)	(97,543,000)	(30,792,000)	(2,332,000)
Proceeds from sales and maturities of investments	15,578,000	57,714,000	102,452,000	32,738,000	2,000,000
Proceeds from sale of joint ventures	-	-	-	-	2,781,000
Distributions from joint ventures	-	-	60,000	-	-
Investment income	340,000	193,000	92,000	(4,000)	14,000
Net Cash from (used for) Investing Activities	2,465,000	(1,449,000)	5,061,000	1,942,000	2,463,000
Net Increase in Cash and Cash Equivalents	5,860,000	2,320,000	2,340,000	(10,625,000)	2,157,000
Cash and Cash Equivalents, Beginning of Year	4,102,000	9,962,000	12,282,000	14,622,000	3,997,000
Cash and Cash Equivalents, End of Year	\$ 9,962,000	\$ 12,282,000	\$ 14,622,000	\$ 3,997,000	\$ 6,154,000

Dickinson County Healthcare System

Statements of Cash Flows

Five Years Ended December 31, 2018

	2014	2015	2016	2017	2018
Reconciliation of Cash and Cash Equivalents to the Balance Sheets					
Cash and cash equivalents in current assets	\$ 9,735,000	\$ 12,282,000	\$ 14,622,000	\$ 3,997,000	\$ 6,154,000
Cash and cash equivalents in noncurrent cash and investments	227,000	-	-	-	-
Total cash and cash equivalents	<u>\$ 9,962,000</u>	<u>\$ 12,282,000</u>	<u>\$ 14,622,000</u>	<u>\$ 3,997,000</u>	<u>\$ 6,154,000</u>
Reconciliation of Operating Income to Net Cash from Operating Activities					
Operating Income (loss)	\$ 4,930,000	\$ 4,478,000	\$ (2,806,000)	\$ (12,324,000)	\$ 5,500,000
Adjustments to reconcile operating income (loss) to net cash flows operating activities					
Depreciation	4,923,000	4,507,000	4,587,000	3,863,000	3,396,000
Provision for bad debts	5,818,000	2,918,000	2,663,000	3,547,000	4,437,000
Amortization of refunding costs	-	-	168,000	168,000	168,000
Changes in assets and liabilities					
Patient receivables	(6,535,000)	(6,141,000)	(2,496,000)	(3,053,000)	(4,116,000)
Other receivables	442,000	50,000	2,598,000	(707,000)	(820,000)
Supplies and other current assets	(1,252,000)	(394,000)	77,000	566,000	745,000
Deferred outflows of resources	-	(4,681,000)	(2,848,000)	2,509,000	(185,000)
Accounts payable	3,153,000	753,000	(3,068,000)	110,000	755,000
Estimated third-party payor settlements	(2,752,000)	2,666,000	(1,594,000)	233,000	372,000
Accrued expenses	850,000	695,000	589,000	517,000	(758,000)
Reserve for loss on general and professional liabilities claims, net	54,000	(208,000)	-	100,000	(150,000)
Net pension liability	-	5,638,000	4,925,000	(10,399,000)	(6,195,000)
Deferred inflows of resources	-	(9,000)	434,000	7,703,000	(2,066,000)
Net Cash from Operating Activities	<u>\$ 9,631,000</u>	<u>\$ 10,272,000</u>	<u>\$ 3,229,000</u>	<u>\$ (7,167,000)</u>	<u>\$ 1,083,000</u>

Position 3
OPERATING BUDGET

Schedule 1

Name Dickinson County Healthcare System			Address 1721 South Stephenson Ave. 		Iron Mountain
Applicant Fiscal Year From			County Dickinson		State (Including ZIP Code) Michigan 49801
	To				
	2019	2020	2021	2022	First Full Year
	(1)	(2)	(3)	(4)	(5)
OPERATING INCOME					
1. Net patient service rev	\$93,287,000.00	\$94,538,000.00	\$95,856,000.00	\$97,332,000.00	\$97,769,000.00
2. Supplies & 340B revenue	\$2,620,000.00	\$2,400,000.00	\$2,448,000.00	\$2,497,000.00	\$2,547,000.00
3. Other revenue	\$2,428,000.00	\$2,452,000.00	\$2,477,000.00	\$2,502,000.00	\$2,527,000.00
4.					
5. Miscellaneous					
6. Less: Allowances and Deductions	()	()	()	()	()
7. Total Operating Income (Add Lines 1 through 6)	\$98,335,000.00	\$99,390,000.00	\$100,781,000.00	\$102,331,000.00	\$102,843,000.00
OPERATING EXPENSES					
8. Salaries and wages	\$37,699,000.00	\$37,422,000.00	\$38,051,000.00	\$38,568,000.00	\$39,091,000.00
9. Employee benefits	\$14,174,000.00	\$14,510,000.00	\$14,533,000.00	\$15,418,000.00	\$15,076,000.00
10. Professional fees	\$10,081,000.00	\$10,258,000.00	\$10,000,000.00	\$10,247,000.00	\$10,489,000.00
11. Purchased services	\$8,296,000.00	\$8,455,000.00	\$8,652,000.00	\$8,858,000.00	\$9,058,000.00
12. Supplies	\$18,479,000.00	\$18,973,000.00	\$19,538,000.00	\$20,194,000.00	\$20,853,000.00
13. Utilities	\$1,254,000.00	\$1,288,000.00	\$1,324,000.00	\$1,360,000.00	\$1,397,000.00
14. Other	\$2,564,000.00	\$2,607,000.00	\$2,650,000.00	\$2,695,000.00	\$2,740,000.00
15. Interest (RD)	\$1,114,000.00	\$1,221,000.00	\$998,000.00	\$959,000.00	\$918,000.00
16. Depreciation	\$3,114,000.00	\$3,677,000.00	\$4,413,000.00	\$4,415,000.00	\$4,451,000.00
17. Total Operating Expense (Add lines 8 through 16)	\$96,775,000.00	\$98,411,000.00	\$100,159,000.00	\$102,714,000.00	\$104,073,000.00
18. NET OPERATING INCOME (LOSS) (Line 7 less 17)	\$1,560,000.00	\$979,000.00	\$622,000.00	(\$383,000.00)	(\$1,230,000.00)
NONOPERATING INCOME					
19. Contribs & investments	\$90,000.00	\$90,000.00	\$90,000.00	\$90,000.00	\$90,000.00
20. Financing fees	(\$402,000.00)	\$0.00	\$0.00	\$0.00	\$0.00
21. Total Nonoperating Income (Add Lines 19 and 20)	(\$312,000.00)	\$90,000.00	\$90,000.00	\$90,000.00	\$90,000.00
22. NET INCOME (LOSS) (Add Lines 18 and 21) (Transfer to Line A Schedule 2)	\$1,248,000.00	\$1,069,000.00	\$712,000.00	(\$293,000.00)	(\$1,140,000.00)

Budget and Projected Cash Flow Approved by Governing Body

Attest: _____ 07-25-2019
Secretary Date

Appropriate Official Date

PROJECTED CASH FLOW

	<u>20</u> <u>19</u>	<u>20</u> <u>20</u>	<u>20</u> <u>21</u>	<u>20</u> <u>22</u>	First Full Year
A. Line 22 from Schedule 1 Income (<i>Loss</i>)	\$1,248,000	\$1,069,000	\$712,000	(\$293,000)	(\$1,140,000)
<i>Add</i>					
B. Items in Operations not Requiring Cash:					
1. Depreciation (<i>Line 16, Schedule 1</i>)	\$3,114,000	\$3,677,000	\$4,413,000	\$4,415,000	\$4,451,000
2. Others: <u>Provision for bad debts & amortization</u>	\$4,021,000	\$3,915,000	\$3,933,000	\$3,999,000	\$4,057,000
C. Cash Provided from:					
1. Proceeds from RD loan/grant	\$10,277,000	\$14,373,000	\$0	\$0	\$0
2. Proceeds from others	\$2,331,000				
3. Increase (<i>Decrease</i>) in Accounts Payable, Accruals and other Current Liabilities	(\$5,183,000)	(\$1,703,000)	(\$513,000)	\$211,000	\$211,000
4. Decrease (<i>Increase</i>) in Accounts Receivable, inventories and Other Current Assets (<i>Exclude Cash</i>)	\$1,048,000	(\$2,310,000)	(\$2,859,000)	(\$3,425,000)	(\$3,850,000)
5. Other: _____					
6. _____					
D. Total all A, B and C Items	\$16,856,000	\$19,021,000	\$5,686,000	\$4,907,000	\$3,729,000
E. Less: Cash Expended for:					
1. All Construction, Equipment and New Capital Items (<i>Loan and grant funds</i>)	\$0	\$14,373,000	\$0	\$0	\$0
2. Replacement and Additions to Existing Property, Plant and Equipment	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
3. Principal Payment RD Loan	\$0	\$628,000	\$650,000	\$674,000	\$697,000
4. Principal Payment Other Loans	\$14,746,000	\$2,114,000	\$344,000	\$332,000	\$349,000
5. Other: _____					
6. Total E 1 through 5	\$16,746,000	\$19,115,000	\$2,994,000	\$3,006,000	\$3,046,000
<i>Add</i>					
F. Beginning Cash Balances	\$6,154,000	\$6,264,000	\$6,170,000	\$8,862,000	\$10,763,000
G. Ending Cash Balances (<i>Total of D minus E 6 plus F</i>)	\$6,264,000	\$6,170,000	\$8,862,000	\$10,763,000	\$11,446,000
Item G Cash Balances Composed of:					
Construction Account					
Revenue Account					
Debt Payment Account					
O&M Account					
Reserve Account	\$0	\$148,000	\$296,000	\$444,000	\$592,000
Funded Depreciation Account					
Others: <u>Operating Cash</u>	\$6,264,000	\$6,022,000	\$8,566,000	\$10,319,000	\$10,854,000
Total - Agrees with Item G	\$6,264,000	\$6,170,000	\$8,862,000	\$10,763,000	\$11,446,000

Integra Realty Resources
Healthcare & Senior Housing

An Appraisal Report

Dickinson County Memorial Hospital
1721 South Stephenson Ave
Iron Mountain, Dickinson County, Michigan

Prepared For:
Dickinson Country Health System

Effective Date of the Appraisal:
As Completed Value January 1, 2020

Integra - Healthcare & Senior Housing
File Number: 205-2019-0199





July 19, 2019

Ms. Margaret Minerick, Chairperson
Dickinson County Health System
1721 South Stephenson Avenue
Iron Mountain, Michigan 49801

RE: Dickinson County Memorial Hospital
1721 South Stephenson Ave
Iron Mountain, Dickinson County, Michigan 49801
Integra - Healthcare & Senior Housing File Reference: 205-2019-0199

Dear Ms. Minerick:

In accordance with the signed engagement contract dated May 30, 2019 (shown as Exhibit A in this report), we have appraised the going concern of Dickinson County Memorial Hospital, an existing 49-bed short-term acute care hospital. The Hospital plans to make roof cover improvements to the hospital building and its home medical equipment building. Additionally, the Hospital plans to replace major pieces of medical imaging equipment and replace and/or upgrade various IT-related hardware and software. The appraisal assumes that the real and personal property improvements and replacements will be completed and in place by the end of the 2019 calendar year.

The purpose of the appraisal is to develop an opinion of the "as completed" market value for the going concern, including the fee simple and leased fee real property interest of the most significant pieces of real estate occupied by the going concern. As addressed in following sections of the appraisal report, the going concern also has leased fee and leasehold interests in other real estate that is of lesser importance to the operation of the going concern.

It is our understanding that the intended use of this appraisal is to assist the intended users with their effort to restructure existing debt, including a USDA-RD CF loan application. This report and its contents are solely for the intended use and should not be relied upon for any other purpose. Otherwise, neither the whole nor any part of this appraisal or any reference thereto may be included in any document, statement, appraisal, or circular without our explicit, prior written approval of the form and context in which it appears.

Our analyses, opinions, and conclusions were developed, and this report has been prepared in conformity with:

- Uniform Standards of Professional Appraisal Practice of the Appraisal Foundation
- Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute
- Title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA)
- Interagency Appraisal and Evaluation Guidelines

This appraisal is not based upon a requested minimum valuation, a specific valuation, or the approval of a loan.

Based on the data, analyses and conclusions presented in this appraisal report, it is our opinion that the prospective “as completed” market value of the going concern, including the outlined real property interest(s), as of January 1, 2020 is:

Allocation of Market Value Conclusion for the Going Concern		
		As Completed
Opinion of Market Value		\$ 55,000,000
Tangible Assets		
Real Property		
Land	\$ 1,690,000	
Improvements	40,050,000	
Total Real Property		\$ 41,740,000
Personal Property (FF&E)		\$ 7,702,900
Total Tangible Assets		\$ 49,442,900
Intangible Assets		
Working Capital (normalized)		\$ 4,300,000
Other		1,257,100
Total Intangible Assets		\$ 5,557,100
Allocated values represent contributory values in place under the going concern valuation premise.		

The value conclusion(s) expressed in this appraisal are subject to the following **extraordinary assumption(s)**. The extraordinary assumption(s) are explained in greater detail in the body of the report. Use of the extraordinary assumption(s) may affect the assignment results.

1. The prospective value conclusion reflects an extraordinary assumption that the proposed improvement to buildings, which are principally roof cover replacements, have been made. The estimated cost of the improvements is \$786,700.
2. The prospective value conclusion reflects an extraordinary assumption that the proposed personal property, consisting substantially of medical imaging and IT-related hardware and software, has been acquired and installed. It is noted that Certificate of Need (CON) approval is required for the replacement of some of the imaging equipment; thus, there is an implicit assumption that CON approval is obtained. The estimated cost of the of the personal property acquisition and replacement is \$10,125,500.

The valuation premise is that of an asset sale – not a member substitution. In an asset sale, the seller retains possession of the legal entity and the buyer purchases individual assets of the

company. Only those tangible and intangible assets and liabilities specifically listed in the purchase agreement are transferred. Generally, sellers retain excess cash, receivables, and payables. Normalized net working capital is included in the sale. In an asset sale, the seller provides fewer representations and warranties to the buyer, and the buyer avoids contingent and unknown liabilities. The owner/operator, Dickinson County Health System, has a significant unfunded pension liability – near \$20,000,000. Implicitly, in an asset sale, the buyer would not inherit that liability, nor would they incur ongoing employee benefit expenses to fund the deficit.

The date of this report is July 19, 2019.

The accompanying prospective financial analyses are based on assumptions and opinions developed while completing the appraisal. Some of those assumptions inevitably will not materialize. Furthermore, unanticipated events and circumstances may occur. Actual operating results achieved during the holding period will almost certainly vary from our forecasts, and these variations may be material. We have not been engaged to evaluate the effectiveness of management, and we are not responsible for actions by management that could impact the profitability of the going concern, such as the quality of care provided, marketing efforts, staffing and other business decisions that will impact operations.

Respectfully submitted,

Integra - Healthcare & Senior Housing

A handwritten signature in black ink, appearing to read 'Victor D. Cremeens', is written over a horizontal line.

By: Victor D. Cremeens, MAI
Managing Director
Michigan Certified General Real Estate Appraiser
1201073126

TABLE OF CONTENTS

Standard Appraiser-Client Contractual Agreements-----	1
Profile of Salient Data-----	2
Competency Rule-----	3
Prior Assignments Involving the Subject Property -----	3
Scope of Work -----	3
Problem Identification -----	4
Client-----	4
Intended User(s) of the Appraisal Report -----	4
Intended Use of the Appraisal Report-----	4
Type of Value -----	4
Identification of the Going Concern -----	4
Real Estate Interest Appraised -----	5
Asset Transaction-----	6
Working Capital-----	6
Effective Date of the Appraisal-----	7
Date of Report -----	7
Property Inspection -----	7
Assumptions and Limiting Conditions-----	7
Extraordinary Assumptions -----	7
History of the Ownership and Enterprise -----	8
Management-----	9
Reasonable Exposure Time -----	12
Micro-Economic Analysis -----	15
Regional Analysis-----	15
Physical Data -----	15
Demographic Data-----	17
Employment Sector Data -----	21
Dickinson County Major Employers -----	21
Regional Economy Overview -----	21
Unemployment -----	22
Conclusion-----	22
Neighborhood Analysis-----	26
Physical Data -----	26
Demographic Data-----	26
Health Resource Designations -----	28
Conclusion-----	28
Subject Property Description -----	29
Improvement Description-----	31
Hospital Building -----	31
Dickinson Medical Building (MOB in Condominium Ownership) -----	35
Condition and Functional Assessment-----	38
Environmental Assessment -----	40
Economic Life Expectancy, Effective Age & Remaining Economic Life -----	40
Condominium Matters -----	42
Personal Property (FF&E) -----	43
Real Estate and Personal Property Taxes -----	44
Level C Market Analysis-----	47
Subject Hospital Overview-----	47
Licensure-----	47

TABLE OF CONTENTS

CMS Certifications and Accreditation	47
Subprovider Units	48
Nonprofit Organization	48
Swing Bed Certification	48
Rural Health Clinic(s)	48
Provider-Based & Other Clinic(s)	49
Home Health Agency	50
Disproportionate Share Hospital (DSH)	50
Sole Community Hospital	52
Low-volume Hospital	52
Accountable Care Organization	54
Meaningful Use and Information Technology	54
Market Service Area	55
Physician Alignment and Staffing	56
Business Practice and Plan	57
Identification of Competitors	58
Supply and Demand Analysis	65
Certificate of Need (CON) Program	65
Bed Inventory per State	65
Occupancy Rates	65
Competitive Supply Summary	66
Strengths and Weaknesses	66
Base Hospital Service Demand	67
Inpatient Utilization Analysis	68
Payer Overview	68
Medicare and Medicare Advantage	69
Medicaid	72
Commercial Payers (Traditional Indemnity Insurance and Managed Care)	74
Self-Pay and Charity Care	75
Historical Trends and Forecast - Overview	76
Historical Utilization / Volume	77
Inpatient Volume Forecast	77
Payer Mix Analysis	79
Payer Mix Forecast	80
Average Length of Stay (ALOS) and Patient Days	80
ALOS Forecast	81
Patient Day Forecast	82
Medicare Case Mix Index (CMI)	82
Inflation Adjustments	83
Inpatient – Reimbursement Analysis	84
Contractual Allowance	84
Hospital Inpatient Payment	84
Traditional Medicare Fee-for-Service	84
Supplemental Medicare Payments & Adjustments	85
Medicaid	88
Commercial Payers	89
Self-Pay	91
Inpatient Net Revenue Forecast	91
Hospital Inpatient Services	91
Net Inpatient Revenue Comparison	93
Outpatient Utilization Analysis	95

TABLE OF CONTENTS

Overview	95
Gross Outpatient Revenue Percentage	96
Payer Mix	97
Outpatient Equivalent Conversion Factor Calculation	98
Outpatient Reimbursement Analysis	100
Outpatient Payment and Contractual Allowance	100
Traditional Medicare Fee-for-Service	100
Medicaid	103
Commercial Payers	104
Self-Pay	104
Outpatient Net Revenue Forecast	105
Total Net Patient Revenue Forecast	107
Bad Debt and Charity Care	107
Comparative Evaluation	108
Highest and Best Use Analysis	110
Highest and Best Use - As If Vacant	110
Highest and Best Use - As Improved	111
Valuation Procedures	113
Cost Approach	115
Land Valuation	115
Elements of Comparison	115
Site Value Conclusions	120
Improvement Valuation	122
Base Cost Estimate	122
Other Indirect Costs	126
Entrepreneurial Reward	127
Replacement Cost Summary	127
Accrued Depreciation	129
Furniture, Fixtures & Equipment (Personal Property) Valuation	131
Summation	132
Income Capitalization Approach	133
Income Analysis	135
Other Operating Revenue	135
Total Net Revenue Forecast	137
Operating Expense Analysis	137
Expense Comparables	139
Staffing, Wages and Benefits	141
Supplies	146
Purchased Services	147
Professional Fees	149
Other Operating	149
Maintenance & Utilities	151
Insurance	152
Management / Home Office Fees	153
Provider Tax	153
Property Taxes	154
Reserves for Replacement	154
Summary for Operating Expense Forecast	155
Stabilized Net Operating Income Forecast	155
Direct Income Capitalization Process	157
Technique #1 Analysis (Overall Capitalization Rate)	157

TABLE OF CONTENTS

Technique #2 Analysis (Effective Net Revenue Multiplier)-----	164
Income Approach Value Conclusion -----	165
Direct Sales Comparison Approach -----	166
Comparable Sales Data -----	166
Analysis of Sales Data -----	186
Public Hospital Units of Value -----	187
Conclusion -----	188
Reconciliation and Final Conclusion of Market Value -----	189
Allocation of Market Value -----	191
Certification -----	193
Assumptions and Limiting Conditions -----	194
About IRR -----	272

EXHIBIT SECTION

- Exhibit A -- Engagement Letter
- Exhibit B -- Legal Description
- Exhibit C -- Photographs of the Subject Facility
- Exhibit D -- Site and Improvement Description Exhibits
 - Property Assessment Parcel Identification Maps
 - Flood Plain Maps
 - Zoning Maps
 - Zoning Codes
 - Floor Plans for Dickinson MOB
- Exhibit E -- Qualifications

Standard Appraiser-Client Contractual Agreements

Advertising

Neither all nor any part of the contents of this appraisal report shall be conveyed to the public through advertising, public relations, news, sales or other media without the written consent and approval of Integra - Healthcare & Senior Housing.

Public Dissemination

Neither the report nor any portions thereof (especially any conclusions as to value, the identity of the appraisers, or Integra - Healthcare & Senior Housing) or any reference to the Appraisal Institute, American Society of Appraisers, or their relative professional designations, shall be disseminated to the public through public relations media, news media, sales media or any other public means of communication without the prior written consent and approval of the appraisers and Integra - Healthcare & Senior Housing.

Plagiarism

Neither all nor any part of the contents of this appraisal report shall be plagiarized for any purpose by the client or anyone else who obtains a copy of the report directly, or indirectly without the written approval of an officer of Integra - Healthcare & Senior Housing.

Court Testimony

Testimony or attendance in court pertaining to this appraisal shall not be required unless arrangements for such services are subsequently made between the client and appraiser.

Financial Information

The concluded opinion of value and prospective financial analyses in the report are intended for the information of the person or persons to whom they are addressed, solely for the purposes stated therein, and should not be relied upon for any other purpose. Neither our report, nor its contents, nor any reference to the appraisers or Integra - Healthcare & Senior Housing may be included or quoted in any offering circular or registration statement, prospectus, sales brochure, other appraisal, loan, or other agreement or document without our prior written permission. Permission will be granted only upon meeting certain conditions.

Profile of Salient Data

Name	Dickinson County Memorial Hospital
Hospital Address	1721 South Stephenson Ave Iron Mountain, Dickinson County, Michigan, 49801
Current Title Holder	Dickinson County Healthcare System
Ownership Interest Appraised	The tangible and intangible assets of the going concern, including the fee simple and leased fee interest in the real property
Property Type	Short-term acute care hospital
Land Area (Hospital Campus)	32.85 acres, or 1,430,990 square feet
Other Land Area	13.97 acres, or 608,356 square feet
Building Improvements General Description	Hospital building is a three-level structure with 179,300 square feet; used as a 49-bed short-term acute care hospital; erected in 1996 with additions in 2000, 2001, and 2006. The appraisal includes various other real property assets owned by Dickinson County Healthcare System. In total, approximately 273,574 square feet of building area is included.
Client	Dickinson Country Health System Ms. Margaret Minerick
Intended User(s)	Dickinson Country Health System (DCHS), United States Department of Agriculture, and other parties designated by DCHS
Intended Use	To assist the intended users with their effort to restructure existing debt, including a USDA-RD CF loan application
<u>Allocation of Going Concern Market Value Conclusion</u>	<u>As Completed</u>
Real Property Assets	\$41,740,000
Personal Property Assets (FF&E)	7,702,900
Intangible Assets	<u>5,557,100</u>
Market Value Conclusion	\$55,000,000
Significant Assumptions	As Completed value assumes proposed improvements to buildings, which are principally roof cover replacements, have been made. Estimated cost of the improvements is \$786,700. As Completed value assumes that proposed personal property (FF&E), which is substantially comprised of medical imaging and IT-related hardware and software, has been acquired and is in place. Estimated cost of the personal property acquisition and replacement is \$10,125,500.
Valuation Premise	Asset sale. In an asset sale, the seller retains possession of the legal entity and the buyer purchases individual assets of the company. Only those tangible and intangible assets and liabilities specifically listed in the purchase agreement are transferred. Generally, sellers retain excess cash, receivables, and payables. Normalized net working capital is included in the sale. In an asset sale, the seller provides fewer representations and warranties to the buyer, and the buyer avoids contingent and unknown liabilities.
Effective Date of the Appraisal	
As Completed Value	January 1, 2020

Competency Rule

Definition: “Prior to accepting an assignment or entering into an agreement to perform any assignment, an appraiser must properly identify the problem to be addressed and have the knowledge and experience to complete the assignment competently; or alternatively, must:

1. disclose the lack of knowledge and/or experience to the client before accepting the assignment;
2. take all steps necessary or appropriate to complete the assignment competently; and
3. describe the lack of knowledge and/or experience and the steps take to complete the assignment competently in the report.

Integra - Healthcare & Senior Housing exclusively specializes in appraisals and consulting assignments involving seniors housing and healthcare facilities, including short-term acute care hospitals. As a specialist, our strengths are analyzing industry-specific macroeconomic data as well as local markets.

We regularly perform assignments throughout the nation that necessitate familiarizing ourselves with local markets as part of the scope of work. Based on the general practices of our peers, we believe that we satisfy the industry norms relative to establishing competency relative to local markets.

Based upon our knowledge and experience, the appraisers who participated in this appraisal assignment are collectively competent.

Prior Assignments Involving the Subject Property

Prior to acceptance of this assignment, any services regarding the subject property performed by Integra - Healthcare & Senior Housing within the last three years, as an appraiser or in any other capacity, were disclosed to the client.

Victor D. Cremeens, MAI has not provided appraisal or other services pertaining to the subject property during the last three years. Victor D. Cremeens, MAI does not have any current or prospective interest in the subject property or the parties involved.

Scope of Work

Definition: “For each appraisal, appraisal review, and appraisal consulting assignment, an appraiser must:

1. identify the problem to be solved;
2. determine and perform the scope of work necessary to develop credible assignment results; and
3. disclose the scope of work in the report.

An appraiser must properly identify the problem to be solved to determine the appropriate scope of work. The appraiser must be prepared to demonstrate that the scope of work is sufficient to produce credible assignment results.” (USPAP)

The scope of work is the primary mechanism for tailoring an appraisal to the circumstances related to the assignment. The following sections detail the scope of work for this assignment.

Problem Identification

Client

Dickinson Country Health System is the client. Ms. Margaret Minerick engaged the assignment.

Intended User(s) of the Appraisal Report

The intended users of the appraisal report are Dickinson Country Health System (DCHS), the United States Department of Agriculture, and other parties designated by DCHS.

Intended Use of the Appraisal Report

It is our understanding that the appraisal will be used to assist the intended users with their effort to restructure existing debt, including a USDA-RD CF loan application.

Type of Value

The type of value for this assignment is market value.

Market Value

In accordance with **Federal Reserve System 12 CFR Part 225, Federal Deposit Insurance Corporation (12 CFR Part 323), The Office of the Comptroller of Currency (12 CFR Part 34)**, "Market Value" is defined as follows:

The most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller, each acting prudently, knowledgeably, and assuming the price is not affected by undue stimulus. Implicit in this definition are the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby:

- Buyer and seller are typically motivated;
- Both parties are well-informed or well-advised and each is acting in what they consider their own best interests;
- A reasonable time is allowed for exposure in the open market;
- Payment is made in terms of cash in U.S. dollars or in terms of financial arrangements comparable thereto; and
- The price represents a normal consideration for the property sold unaffected by special or creative financing, or sales concessions granted by anyone associated with the sale.

Identification of the Going Concern

The subject is best described as a real estate-intensive going concern in which key portions of the real estate it occupies are of a highly specialized nature; specifically, for providing inpatient, outpatient and emergent medical care.

The subject going concern is an existing 49-bed short-term acute care hospital known as Dickinson County Memorial Hospital. The hospital building, representing the principal real

estate asset owned by the Hospital, is located at 1721 South Stephenson Ave, Iron Mountain, Dickinson County, Michigan.

Legal descriptions for the real estate owned by the Hospital and included in this appraisal is presented in the Addenda as Exhibit B.

Definitions of going-concern, business enterprise value, and going-concern premise, follow:

Going concern: A going concern is a business having the ability to continue functioning as a business entity in the future. In accounting, a business is a going concern if it is likely to continue functioning 12 months into the future.¹

Business enterprise value (BEV): The value contribution of the total intangible assets of a continuing business enterprise such as marketing and management skill, an assembled workforce, working capital, trade names, franchises, patents, trademarks, contracts, leases, customer base, and operating agreements.²

Going-concern premise: One of the premises under which the total assets of a business can be valued; the assumption that a company is expected to continue operating well into the future (usually indefinitely). Under the going-concern premise, the value of a business as a going concern is equal to the sum of the value of the tangible assets and the value of the intangible assets, which may include the value of excess profit, where asset values are derived consistent with the going-concern premise.³

The primary underlying assets of this going concern are defined as follows.

Real property: “the interests, benefits, and rights inherent in the ownership of real estate.” *USPAP*, Appraisal Foundation.

Personal property: “identifiable tangible objects that are considered by the general public as being “personal” – for example, furnishings, artwork, antiques, gems and jewelry, collectibles, machinery and equipment; all tangible property that is not classified as real estate.” *USPAP*, Appraisal Foundation.

Intangible assets: “nonphysical assets, including but not limited to franchises, trademarks, patents, copyrights, goodwill, equities, securities, and contracts, as distinguished from physical assets such as facilities and equipment.” *USPAP*, Appraisal Foundation.

Real Estate Interest Appraised

Most the going concern's business operations are conducted in real property that Dickinson County Healthcare System holds a fee simple interest. The real estate included in this appraisal is predominately held in fee simple. The **Dictionary of Real Estate**

¹ *Dictionary of Real Estate Appraising, 5th Edition*, The Appraisal Institute, Chicago, Illinois, page 88

² *Ibid*, page 25

³ *Ibid*, page 88

Appraisal, 5th Addition defines the fee simple estate as: “Absolute ownership unencumbered by any other interest or estate, subject only to the limitations imposed by the governmental powers of taxation, eminent domain, police power, and escheat.”

However, it is noted that the going concern operates certain ancillary segments of its business in properties that are leased from unrelated parties. These properties are in various towns and cities in Michigan, including Iron Mountain, Norway, Gladstone, Bark River, and Iron River. In those cases, Dickinson County Healthcare System holds a leasehold interest. The **Dictionary of Real Estate Appraisal, 5th Addition** defines the leasehold estate as: “The tenant’s possessory interest created by a lease.”

Additionally, small amounts of the appraised property, more specifically, three suites in the Dickinson Medical Building, are leased to unrelated parties. In those cases, Dickinson County Healthcare System holds a leased fee interest. The **Dictionary of Real Estate Appraisal, 5th Addition** defines the leased fee estate as: “An ownership interest held by a landlord with the rights of use and occupancy conveyed by lease to others. The rights of the lessor (the leased fee owner) and the lessee are specified by contract terms contained within the lease.”

Asset Transaction

A business can be sold in one of two ways: an asset sale or a stock sale/member substitution. This appraisal reflects the conditions inherent in an **asset sale**.

In an asset sale, the seller retains possession of the legal entity and the buyer purchases individual assets of the company. Only those tangible and intangible assets and liabilities specifically listed in the purchase agreement are transferred. Generally, sellers retain excess cash, receivables, and payables. Normalized net working capital is included in the sale. In an asset sale, the seller provides fewer representations and warranties to the buyer, and the buyer avoids contingent and unknown liabilities. Any of a seller’s debt assumed by the buyer amounts to an increase in the purchase price for the buyer and represents additional consideration paid to the seller.

The term stock sale is used in corporate finance. In a stock sale, all the tangible and intangible assets and all the liabilities, including unknown and contingent liabilities from current or prior acts of the seller and its agents, are acquired by the buyer. The term member substitution (also referred to as an affiliation or system joinder) refers to a transaction among nonprofit hospitals, where one organization becomes the corporate member of the other hospital or health system’s parent organization. This is the most common structure between merging nonprofit hospital systems. Membership substitutions are analogous to a stock sale in corporate finance – “members” are the nonprofit counterpart to shareholders in a for-profit corporation.

Working Capital

Working capital is an acknowledged intangible asset in hospital acquisitions. Positive working capital is necessary for a business to achieve the operating results that support the enterprise and its value. There must be enough funds to satisfy both maturing short-term debt and upcoming operational expenses. Hospitals often experience a lag period of 1.5 to 2.0 months between the time when services are rendered and when payment is received (days in net patient accounts receivable).

When a buyer assesses a target business for acquisition, an estimate is made of the average net working capital needed for the business to operate post-closing without

requiring a capital infusion by the new owner. The seller is expected to deliver this normalized net working capital at the closing. The level of net working capital to transfer on the sale should be what is needed to continue running the business as is – no more, no less.

A common definition of working capital in a sale transaction is equal to current assets minus current liabilities, excluding deferred tax assets/liabilities, excess cash, surplus assets and/or deposit balances.

The appraisal provides an allocation(s) of value for tangible and intangible assets. Our allocation of value(s) in place for the intangible assets includes a breakout estimate for normalized working capital. This estimate is NOT tied to the operator's actual working capital as of the effective date of the appraisal.

Effective Date of the Appraisal

The following effective date applies for this appraisal: "as completed," January 1, 2020.

Date of Report

The date of this report is July 19, 2019.

Property Inspection

The inspection is viewed as an important step in the appraisal process. The complexity of this property type, along with the client's needs, warranted conducting an inspection.

The subject property was inspected by Victor D. Cremeens, MAI on June 26, 27 and 28, 2019.

During and after the inspection, the following Hospital staff members were interviewed regarding the operational and physical aspects of the short-term acute care hospital.

- Jeanne Goche, Interim Chief Executive Officer
- Jerry Worden, Interim Chief Financial Officer
- Susan Hadley, Chief Nursing Officer
- Debra Hanson, Controller
- James Stanchina, Budget Coordinator
- Robert Derwinski, Plant Operations Manager
- Dr. Donald Kube, Chief of Medical Staff
- Dean DeCremer, Director of Information Systems

Assumptions and Limiting Conditions

Standard assumptions and limiting conditions made for the appraisal are included in the addendum of the appraisal report.

Extraordinary Assumptions

Definition: "an assignment-specific assumption, as of the effective date regarding uncertain information used in an analysis, which, if found to be false, could alter the appraiser's opinions or conclusions." (USPAP)

Comment: "Extraordinary assumptions presume as fact otherwise uncertain information about physical, legal, or economic characteristics of the subject property; or about conditions external to the property, such as

market conditions or trends; or about the integrity of data used in an analysis.” (USPAP)

Completion of Construction

The prospective value conclusion reflects an extraordinary assumption that the proposed improvement to buildings, which are principally roof cover replacements, have been made. The estimated cost of the improvements is \$786,700.

Personal Property Replacement

The prospective value conclusion reflects an extraordinary assumption that the proposed personal property, consisting substantially of medical imaging and IT-related hardware and software, has been acquired and installed. It is noted that Certificate of Need (CON) approval is required for the replacement of some of the imaging equipment; thus, there is an implicit assumption that CON approval is obtained. The estimated cost of the of the personal property acquisition and replacement is \$10,125,500.

History of the Ownership and Enterprise

The subject property is currently owned by Dickinson County Healthcare System (DCHS). DCHS was involved in two prospective sales of the going concern in 2017-2018. These events are summarized below.

Bellin Health Systems

In 2017 Dickinson County Healthcare System (DCHS) and Bellin Health Systems, Inc. (BHS) entered into a Letter of Intent to explore the possibility of DCHS being acquired by BHS. DCHS and BHS have historically maintained a loose affiliation that includes providing contract services, a cardiology practice joint venture, and DCHS participation in a physician-hospital organization operated by BHS.

BHS is an integrated health care delivery system serving Northeastern Wisconsin and the Upper Peninsula of Michigan. BHS operates hospitals in Green Bay, Wisconsin (Bellin Hospital – 175 beds; and, Bellin Health Psychiatric Center – 80 beds) and Oconto, Wisconsin (Bellin Health Oconto Hospital – 10 beds). BHS also operates Bellin Health Partners, a physician-hospital organization with more than 200 specialty physician members. DCHS joined Bellin Health Partners in November 2016.

BHS operates a primary care and behavioral health clinic in Iron Mountain (Bellin Health Iron Mountain), and a cardiology clinic (Bellin Health Cardiology Associates - Iron Mountain) that operates in leased space in the Dickinson Medical Building on the hospital campus. Per their website, Bellin Health Iron Mountain has 13 family practice practitioners (7 doctors and 6 mid-levels), one internist, one general surgeon, one pediatrician, one audiologist, one mid-level endocrinologist, and five physical therapists. Reportedly, most of those practitioners formerly practiced independently in the community or were practicing at another former clinic located in Kingsford, which had been operated by a Marquette-based hospital. BHS’s website notes four cardiologists and three mid-levels practicing in the cardiology clinic.

In May 2018 DCHS and BHS announced that a prospective sale was no longer going forward. As a part of the due diligence process, BHS had been given full access to DCHS financial records and all other operating information. A plan was developed by BHS to assist DCHS with operating expense reductions that they believed were needed to improve profitability. As a part of that plan, DCHS closed its defined pension benefit plan. Ultimately, it was BHS’s decision to terminate the prospective acquisition, which they

claimed was a matter of the losses being incurred by DCHS. Reportedly, as a part of the plan BHS was only willing to commit itself to providing inpatient services in Iron Mountain for a period five years.

UP Health

Following the collapse of the sale negotiations with Bellin Health Systems, Inc., DCHS signed a Letter of Intent with UP Health System (UPHS) to evaluate a potential acquisition of DCHS by UPHS. The Letter of Intent was signed in July 2018. UPHS includes three hospital campuses in the Upper Peninsula: UPHS-Marquette – the system's tertiary campus (307 beds), UPHS-Portage in Hancock, and UPHS-Bell in Ishpeming. UPHS has other affiliate hospitals in the Upper Peninsula. UPHS is a Duke LifePoint hospital. Duke LifePoint Healthcare is a joint venture of Duke University Health System and LifePoint Health. LifePoint Health purchased Marquette General Hospital (now UPHS) in 2012. In June 2019 UPHS-Marquette moved into a new replacement hospital. The new facility is a nearly \$340 million investment. UPHS-Marquette is located about 80 miles northeast of Iron Mountain, at a drive time of about 1 hour 30 minutes. UPHS offers very limited services in Iron Mountain.

The negotiations between UPHS and DCHS were short lived. In September 2018 the two organizations announced that they had been unable to reach an agreement on the terms of an acquisition. UPHS indicated that they were willing to work with DCHS to explore collaborative efforts to provide health care in the community.

Other Ownership History Matters

There is no known offering, pending sale, or intent to sell the going concern.

The Hospital recently (Spring 2019) disposed of a clinic property it formerly operated in Goodman, Wisconsin. The Hospital had not operated a clinic at that location for roughly ten years. The sale price was \$65,000.

The Hospital is offering to sell a vacant clinic property it owns in Wausaukee, Wisconsin. That clinic was closed by the Hospital in early 2019. The property is offered for sale by the Hospital at a price of \$386,000. There is presently no real estate broker representation. Per management, interest in the facility has been limited and no offers to purchase have been made. This property is included in the appraised real property in this appraisal.

Management

The subject going concern is managed by the administrative team employed by the Board of Directors of Dickinson County Memorial Hospital. Jeanne Goche is the interim chief executive officer.

The Hospital experienced a period of subpar financial operating performance recently. The Hospital closed its 2017 fiscal year with a (13.035) million loss. Budgeting for the 2018 fiscal year, the Hospital's operating budget for 2018 originally projected a loss of around (\$3.3) million. Ongoing through the budget process numerous expenses and FTE's were reduced to balance the 2018 budget with a bottom line of \$839,133. After continued losses in January of 2018 (\$826,083) and February (\$924,702), management sought additional expense and FTE adjustments. March and April followed with more losses of (\$905,213) and April (\$819,348). It was not until May when some of the changes made in November 2017 – February 2018 started to take form. Combined May through November finished with a combined loss of (\$767,004). With an audit adjustment of \$8.4 million related to the lump sum payouts that reduced the net pension liability, DCHS was able to show a positive bottom line for 2018.

Various members of the staff report that accountability in the organization had become lax. There was limited oversight of spending throughout most if not all departments and little comparison of budgeted and actual spending. Money was spent too freely and without much questioning by management. Staffing adjustments were not made timely. Additionally, strategic investments weren't always successful, yet funding commitments to them were slow to be rebalanced. Overspending for operations sometimes led to inadequate spending where needs were greater for long-term strategic success.

Following the collapse of the negotiations with UPHS and amidst growing pressure and tension with the union and non-union staff, DCHS Chief Executive Officer (CEO), John Schon, chose to resign. His resignation was final on December 31, 2018.

The Hospital's Board of Trustees experienced some member changes recently. The Board consists of nine members. In June 2018 there were two resignations and another one in October 2018. Two replacements made included people that had held positions on the Board in the past. The acting CEO believes the new members have a greater, more sophisticated understanding of the Hospital's issues than the members that resigned.

In its efforts to shore up the Hospital's operations, the Board has hired various outside consultants.

- One of the leaders is Bart Stupak, a former Northern Michigan and North Lower Peninsula congressman and partner in the Washington, D.C. firm of Venable LLP. Mr. Stupak, whose practice focuses on healthcare system financial restructuring, has been providing consulting services to DCHS since late 2018.
- In late 2018 Dennis Smith was hired as the Chief Restructuring Officer. Mr. Smith is a consultant that formerly acted as president and CEO of the Upper Peninsula Health Plan, a consumer-centered health plan and provider service organization, which contracts with managed care firms, insurance companies, and governmental agencies to provide managed care and other health-related services in the Upper Peninsula.
- In late 2018 Jeanne Goche was hired as the Interim CEO. Ms. Goche is a lawyer and health system administrator that has acted as a transitional leadership consultant (turnaround expert) to hospitals for over two decades. Ms. Goche indicated that she has recently reached an agreement with the Hospital Board to remain in the CEO position for another year.
- Jerry Worden, CPA has been hired as Interim CFO. Mr. Worden has been in the healthcare industry for 40+/- years, as a hospital CFO and COO, as CFO/COO of a large private hospitalist group, and as an independent consultant for healthcare providers.

The Hospital's Interim CEO and others on the current management team are working on a restructuring plan for the organization. The restructuring that has been done thus far and which is still being defined is broad based. Reducing the FTEs and corresponding salaries was a major factor in improving cash flow, as has been efforts to closely monitor and reduce spending. Importantly, however, changing what might be characterized as a *laissez-faire* culture that seems to have developed over time has been replaced with one in which all things are questioned, and nothing is taken for granted. By all accounts, the leaders that were most complacent or lacking strong vision are no longer in the organization.

According to discussions with current management and department heads, the new/current management policies are in direct contrast to those of previous leadership. The current culture is based on oversight, vision, and adaptability to secure the future of the organization. A strategic management strategy developed in conjunction with the various organizational leaders will serve to avoid past obstacles such as reduced payment from Blue Cross – Blue Shield, Bellin Health System’s competitive actions, and will provide a more proactive approach to overcoming obstacles.

The Hospital replaced its budget coordinator approximately 22 months ago. With that change, the organization is now performing operating cost analyses in more detail and at greater review frequency. The March 2018 through December 2018 total operating expenses were better than budget and that trend has continued in 2019. Expense variance is performed monthly now, whereas it had reportedly been done quarterly in the past. Department heads are involved in line item reviews with the budget coordinator. For staffing levels, departments are benchmarking against their historical performance, using periods of best performance as a target, with a goal to minimize nonproductive FTEs.

Substantial reductions in FTEs were made in 2018 and 2019 in conjunction with the Hospital’s financial distress. The changes that have occurred, along with budgeted amounts for the current fiscal year, are summarized as follows.

Summary of FTE Changes and Operator Expectations

	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>4 Months YTD 2019</u>	<u>2019 Budget</u>
Productive	593.14	652.39	584.76	540.00	519.56
Nonproductive	134.81	83.99	80.15	61.20	58.88
Total Paid	727.95	736.38	664.91	601.20	578.44
Δ From Prior Period					
Productive	N/A	59.25	(67.63)	(44.76)	(65.20)
Nonproductive	N/A	(50.82)	(3.84)	(18.95)	(2.32)
Total Paid	N/A	8.43	(71.47)	(63.71)	(86.47)
Total Paid by Group					
Physician Svcs	122.75	122.41	111.44	100.30	96.50
All Other	605.20	613.97	553.47	500.90	481.94
Combined	727.95	736.38	664.91	601.20	578.44

4-Month YTD Actual and 2019 Budget are compared to 2018 for change.

2019 Budget amounts reflect a Total Paid figure allocated by the appraiser given the YTD distribution of FTEs.

Generally, there is a perception among current administration and department heads that staffing levels at the organization grew when business volumes increased but that reductions corresponding to decreases in business volumes were not made timely. In conjunction with that situation, productivity levels were low before the FTE reduction transpired. The FTE reduction was substantially achieved by attrition rather than layoffs. When the organization was struggling most, there were several employees that left the organization or retired.

Among the operational issues that the turnaround management team has assessed as having been most problematic is the revenue cycle. Revenue cycle refers to the administrative and clinical functions that contribute to the capture, management and

collection of patient service revenue. Effective hospital revenue cycle management practices are important to a hospital because they face strict regulations and billing requirements, thorough preauthorization and precertification, resulting in potential underpayments and delays in payments. Management notes that billing was slow, prior authorizations procedures were inconsistent, insurance information was not being collected correctly, and cross checking of billings and collections were not being made timely.

Some of the other operational and organizational matters that are being evaluated or implemented by management include:

- Evaluating service lines for patient need and profitability, with consideration to capital expenditures needed to sustain them.
- Evaluating physician compensation agreements. Legacy issues reportedly exist with expensive physician practice acquisitions that contribute to high ongoing expenses. Administration reports that there is too much variability in physician compensation agreements and insufficient productivity measures.
- Improving the payroll system.
- Updating the chargemaster. The chargemaster is a comprehensive listing of items billable to a hospital patient or a patient's health insurance provider, needs to be updated. An accurate hospital chargemaster is key to revenue integrity. An inadequate chargemaster can result in overpayment or underpayment, as well as claim rejections, undercharging for services, and compliance violations.
- Reviewing vendor contracts to negotiate the most advantageous terms possible. There is a belief that bargaining efforts in past negotiations were not as serious as they should have been.
- Reducing lab operating costs, along with lowering lab procedure costs to payers/patients.
- Improving the inventory control process.
- Evaluate hospice and behavioral health opportunities.
- Increasing community messaging and rebuilding trust.
- Improving interaction and integrations between departments.

The Hospital has a loan through Fifth Third Bank, N.A. with an outstanding balance near \$10,650,000. The loan is reportedly in technical default as a result of the organization being out of compliance with certain covenants.

Reasonable Exposure Time

USPAP requires the development of an opinion of reasonable exposure time when developing an opinion of market value for real and personal property. Exposure time is defined by USPAP as: "estimated length of time that the property interest being appraised would have been offered on the market prior to the hypothetical consummation of a sale at market value on the effective date of the appraisal." Exposure time is a retrospective opinion based on an analysis of past events assuming a competitive and open market. The reasonable exposure period is a function of price, time, and use, not an isolated opinion of time alone.

To estimate the reasonable exposure time for a property, three primary information sources provide the foundation of the analysis and conclusion.

1. 1. Statistical information pertaining to days-on-the-market for similar property types.
2. Information gathered through the comparable sales verification process.
3. Interviews of market participants involved with the marketing, management, buying and selling of the property type.

The market analysis section of the property discusses macroeconomic trends affecting the healthcare industry, particularly as it relates to hospitals. That activity is tied integrally to the mergers and acquisitions market for hospital properties.

U.S. healthcare reform is spurring merger and acquisition (M&A) activity because the new healthcare law stresses efficiencies, poses increased administrative burdens, and will likely result in additional pressure on business with managed-care payers. Acquisition targets during the ongoing wave of acquisitions fit into a broad range, such as ones in markets which have large populations of uninsured and could benefit the most from healthcare reform's increased access to health insurance.

The current market for hospital acquisitions is substantially comprised of:

1. Public and private hospital operating companies buying facilities that fit into their areas of geographic and community (rural, urban and suburban) concentration.
2. Regional healthcare systems, most of which are nonprofit, seeking to survive healthcare reform by expanding market share, improve economies of scale, and improve their leverage with managed care companies.
3. Both well-established and newer operating companies, often partnering with private equity firms, growing their companies in anticipation of larger populations of newly insured patients.

The sellers are frequently independent hospitals or small healthcare systems that have been unprofitable, lack the access to capital that is necessary to remain competitive, and lack the scale and management expertise needed to prosper under healthcare reform. They need stronger financial partners with greater scale and expertise to survive. Some regional systems, even if financially strong, are affiliating with other systems to build the economies of scale and clinical infrastructure necessary to compete in the arena of fee-for-value reimbursement. Most of these acquisitions are made as going concerns, and in many instances the parties are agreeing to significant future capital investment commitments as a part of the purchase agreement.

The Health Care M&A Report, published by Irving Levin Associates, shows hospital M & A activity by quarter. They reported 89 transactions in 2016, 78 in 2017, and 79 in 2018. Thus, the pace of activity has been strong. Providers have sought scale and breadth in order to thrive in the evolving landscape of changing reimbursement models, population health management, and the rise of consumerism. There is an expectation that M & A activity in 2019 will slow as health systems look to other business growth strategies.

On a micro level, a hospital's location is very important to its marketability, as are the physical and functional utility characteristics of the physical plant. Encompassed within the

location factor are the competitive landscape within the market service area; demographic and employment variables that influence reimbursement, payer mix and service line economics; and physician staffing opportunities. Dickinson County Memorial Hospital is in a market service area where poverty levels are moderate. Dickinson County Memorial Hospital has a payer mix that lends itself to, potentially, moderately profitable operations. Competitive conditions in the market service area are deemed fairly typical, although primary care competition is greater than normal. Rural locations are more inclined to experience physician shortages than suburban and urban ones.

Importantly, a formal transaction for a hospital going concern may take eight to 12 months or more to close and nonprofits tend to face added legal challenges in the process. Under the definition for market exposure, which is from initial offering to consummation of a sale, the due diligence burden in a hospital sale transaction adds significantly to the period.

Given the considerations noted, we are inclined to believe that a market exposure of 12 to 18 months would have been necessary to market the subject property prior to the effective appraisal date. Furthermore, it seems reasonable to believe that a marketing period of 12 to 18 months would be necessary to market the subject property following the effective appraisal date.

Micro-Economic Analysis

Regional Analysis

The regional analysis focuses primarily on the socioeconomic trends. Population data best explain current socioeconomic conditions. Demographic factors most relevant to the valuation analysis include changes in the elderly population, levels of income and poverty, and employment composition.

The optimum market area for an acute care hospital has a growing population, especially among the elderly, with high levels of income and wealth, and containing enough labor at reasonable wages. Income and wealth levels directly relate to the current and historical economic conditions of the region. Conversely, hospitals that serve market areas with declining population, and have low income and employment levels, will typically achieve higher levels of uninsured cases and bad debt, and may experience declining demand for services. Additionally, they will frequently experience greater difficulty attracting qualified professional staff. Hospitals in market service areas with greater numbers of poor people tend to experience more emergency department activity and provide a proportionately higher amount of healthcare services to people with chronic disease.

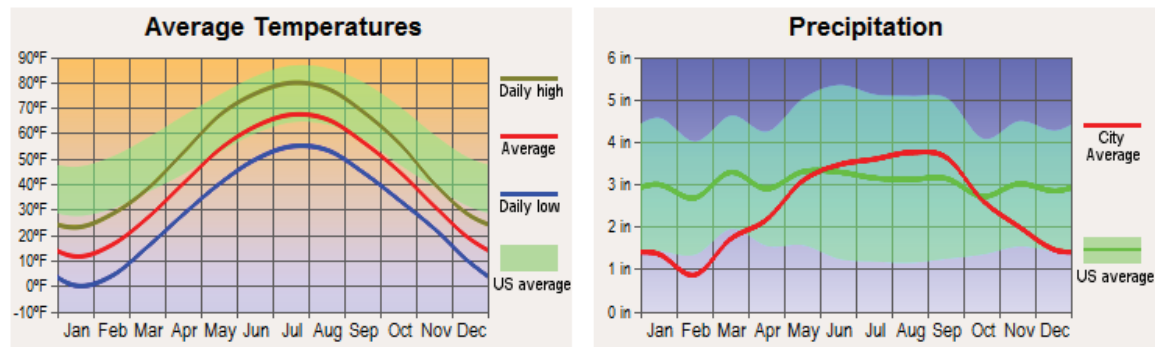
Physical Data

Dickinson County Memorial Hospital is located in Iron Mountain, Dickinson County, Michigan in the upper peninsula of the state -- 90 miles north of Green Bay, WI, and 180 miles north of Milwaukee, WI. Iron Mountain is located in the southwest corner of Dickinson County near the Michigan-Wisconsin border.

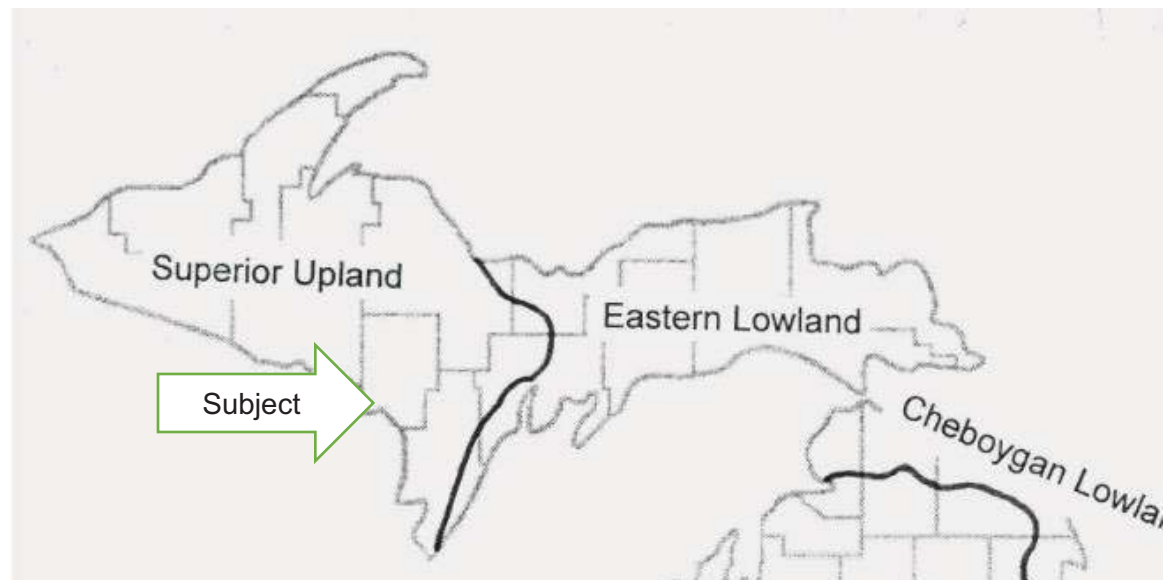
Iron Mountain is the county seat and has the largest population of all the cities located in Dickinson County. The population of Iron Mountain is approximately 7,600. Other population centers in the county include Kingsford, which abuts Iron Mountain. The two cities blend together and account for the largest population center in the county. The only other cities in the county with populations above 1,000 are Quinnesec and Norway, which are located three and eight miles east of Iron Mountain, respectively.

Additionally, the hospital owns/operates a clinic in Florence, Wisconsin, and owns and historically operated one in Wausaukee, Wisconsin. Florence is the county seat of Florence County. The population of Florence is approximately 2,300, while the overall county population is just over 5,000. Florence County is one of only two counties in Wisconsin with no incorporated communities. The clinic in Florence is approximately 12 miles northwest from the subject hospital.

Wausaukee, WI is a village in Marinette County, Wisconsin with a population of approximately 500. The largest city in the county is Marinette, which has a population around 16,000, while the total county is home to just over 40,000. The Wausaukee clinic is located approximately 30 miles south of the main hospital in Iron Mountain.



A physiographic region is an area with a pattern of relief features or landforms that are significantly different from that of adjacent regions. Dickinson County is in the Superior Upland region of Michigan, which is one of the most scenic regions in the state. The Huron Mountains to the north were formed from igneous rock and were part of the Precambrian Shield which extends north into Canada. The rocks were formed through glaciation, leaving the soil thin and infertile. The overall topography is quite hilly and densely covered with forests. The climate is a humid continental with cold snowy winters and cool summers.



Dickinson County gets about twice the national average in snowfall annually, and temperatures well below the national average year-round. The mild summer weather accompanied by scenic, relatively untouched wilderness has made the upper peninsula of Michigan a popular spot for tourists as well as a destination for summer homes.

U.S. Highway 2 is the main road in Iron Mountain. Known as Stephenson Ave within the city, it runs through the heart of town providing access east through Norway before culminating at U.S. Highway 41 about 25 miles east of town. U.S. Highway 2 runs west from Iron Mountain through Minnesota, North Dakota, Montana, and Washington, finally culminating in Seattle. U.S. Highway 141 runs concurrently with U.S. Highway 2 through the Iron Mountain area before continuing north and connecting to U.S. 41 which runs to the end of the peninsula to the north. U.S. 141 runs south from Iron Mountain through Wausaukee, and further into Green Bay.

Demographic Data

The trends for the total population are profiled as follows.

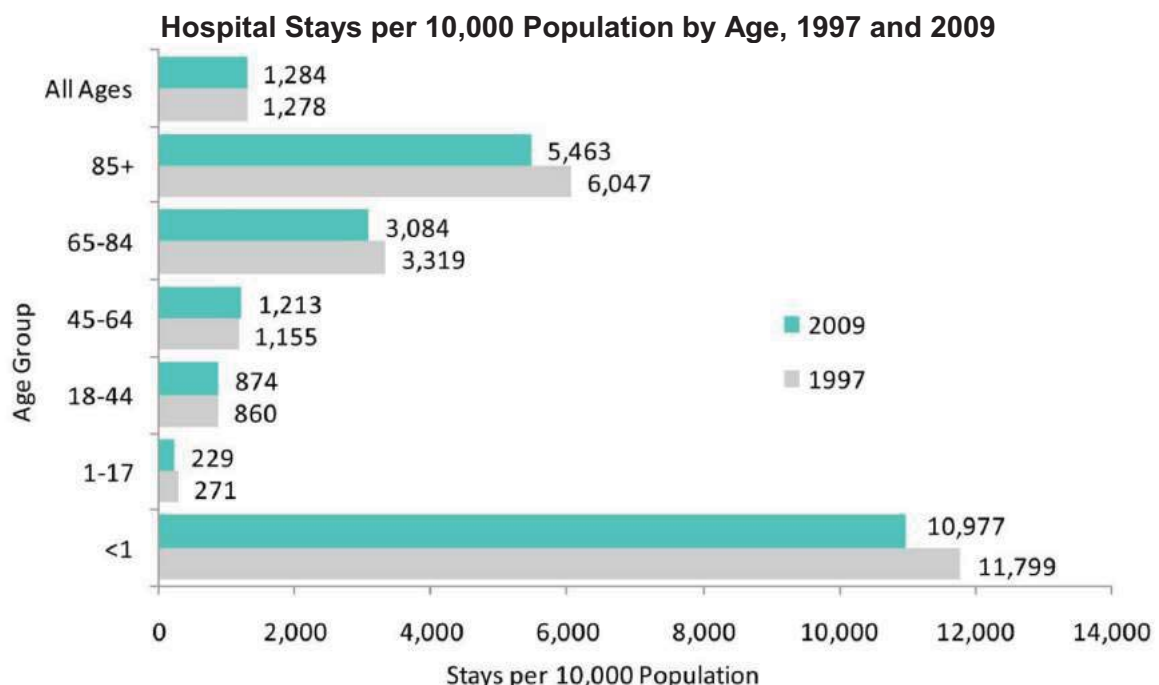
	United States	Michigan	Dickinson County
Total Population 2010	308,745,538	9,883,640	26,168
Total Population 2018	332,417,793	10,097,897	25,917
Total Population 2023	345,487,602	10,233,588	25,697
Annual Total Population Growth Rate			
2010 to 2018	0.93%	0.27%	-0.12%
2018 to 2023	0.77%	0.27%	-0.17%

Source: ESRI, 2018 (2010 Census)

The national population increased 0.93 percent annually from 2010 to 2018, and it is forecast to continue increasing at an annual rate of 0.77 percent from 2018 to 2023. The Michigan demographic trend lagged behind the national trend from 2010 to 2018; it is forecast to increase at 0.27 percent annually from 2018 to 2023 -- still lagging behind the national trend. The population within Dickinson County decreased slightly at an annual rate of -0.12 percent from 2010 to 2018, and it is forecast to decrease slightly at -0.17 percent annually from 2018 to 2023.

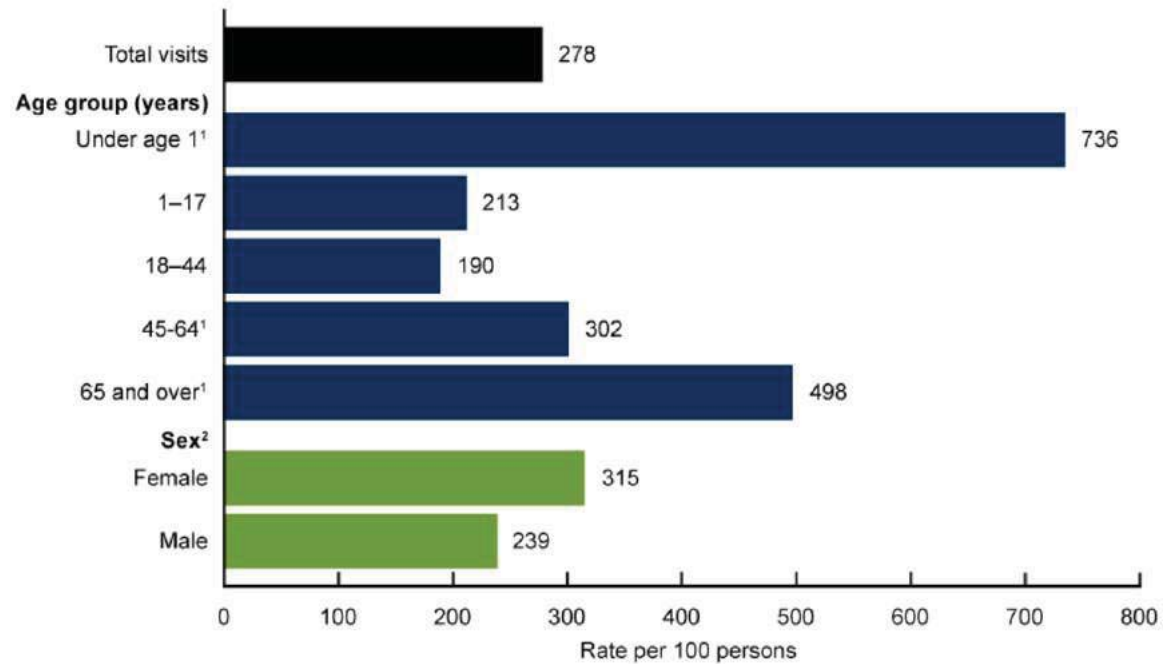
Major factors influencing the population trends include the generally southerly migration of the country's population to states with warmer climates, more job opportunities, and lower costs of living. Additionally, the population of many rural areas is flat or even declining as people are drawn to job opportunities in metropolitan areas.

Age demographics are important to isolate and analyze relative to bed demand and staffing forecasts for the industry. The following table illustrates the distribution of hospital discharges by age in the United States. This table is sourced from: *HCUP Facts and Figures: Statistics on Hospital-Based Care in the United States, 2009*.



Similarly, although with a somewhat different utilization pattern, office-based physician visit rates vary by patient age. The following table for physician visit rates is sourced from the NCHS, National Ambulatory Medical Care Survey, 2016.

Office-based Physician Visit Rates per 100 Population, 2016



For most providers of health care services, growth of the elderly population should provide the best correlation to growth in medical service demand. The population trends, per age group, are profiled in the following table.

Table R-2 Region: Population Trends By Age Group			
	United States	Michigan	Dickinson County
Total Population Ages 25 to 34			
2018	46,538,081	1,304,186	2,877
2023	47,160,231	1,276,670	2,779
Annual Change	0.27%	-0.43%	-0.69%
Total Population Ages 35 to 44			
2018	41,777,899	1,196,509	2,709
2023	45,546,486	1,267,285	2,782
Annual Change	1.74%	1.16%	0.53%
Total Population Ages 45 to 54			
2018	41,578,031	1,299,741	3,452
2023	40,614,259	1,223,210	3,075
Annual Change	-0.47%	-1.21%	-2.29%
Total Population Ages 55 to 64			
2018	43,400,752	1,438,293	4,408
2023	42,415,494	1,367,088	3,976
Annual Change	-0.46%	-1.01%	-2.04%
Total Population Ages 65 to 74			
2018	32,160,462	1,057,931	3,297
2023	36,488,106	1,204,233	3,798
Annual Change	2.56%	2.62%	2.87%
Total Population Ages 75 to 84			
2018	15,697,438	499,994	1,661
2023	20,004,179	636,012	2,012
Annual Change	4.97%	4.93%	3.91%
Total Population 85 and Over			
2018	6,716,109	220,321	936
2023	7,162,851	226,624	909
Annual Change	1.30%	0.57%	-0.58%
Total Population 75 and Over			
2010	18,554,555	636,821	2,603
2018	22,413,547	720,315	2,597
2023	27,167,030	862,636	2,921
Annual Change -- 2010 to 2018	2.39%	1.55%	-0.03%
Annual Change -- 2018 to 2023	3.92%	3.67%	2.38%
Source: ESRI, 2018 (2010 Census)			

Hospital values may be influenced materially by the overall economic condition of the community or region served. High levels of poverty result in elevated levels of Medicaid census, bad debt and charity health care. All other things being equal, hospitals located in market areas that have high-income levels and property values typically achieve higher commercial payer census mixes than ones located in poorer areas.

- Household and/or per capita income levels
- Home values
- Percentage of owner-occupied dwelling units
- Educational attainment

Demographic data providing insight as to the socioeconomic status of the region are profiled as follows.

Table R-3 Region: Socioeconomic Indicators			
	United States	Michigan	Dickinson County
Average Household Income, 2018	\$87,398	\$78,237	\$65,545
Per Capita Income, 2018	\$33,028	\$30,968	\$28,763
<u>Number of Households, 2018</u>			
<\$15,000	13,340,552	431,510	1,361
\$15,000 - \$24,999	11,279,705	381,227	1,200
\$25,000 - \$34,999	11,080,303	385,127	1,242
\$35,000 - \$49,999	15,573,889	561,638	1,804
\$50,000 - \$74,999	21,918,348	735,673	2,288
\$75,000 - \$99,999	15,821,130	507,638	1,479
\$100,000 - \$149,999	18,843,504	558,543	1,276
\$150,000 - \$199,999	8,156,047	217,690	432
\$200,000+	9,153,435	204,168	281
<u>Household Income Distribution, 2018</u>			
<\$15,000	10.7%	10.8%	12.0%
\$15,000 - \$24,999	9.0%	9.6%	10.6%
\$25,000 - \$34,999	8.9%	9.7%	10.9%
\$35,000 - \$49,999	12.4%	14.1%	15.9%
\$50,000 - \$74,999	17.5%	18.5%	20.1%
\$75,000 - \$99,999	12.6%	12.7%	13.0%
\$100,000 - \$149,999	15.1%	14.0%	11.2%
\$150,000 - \$199,999	6.5%	5.5%	3.8%
\$200,000+	7.3%	5.1%	2.5%
Median Home Value, 2018	\$234,154	\$172,136	\$117,216
Bachelor Degree or Higher (2018 Estimate)	20.0%	17.9%	18.5%
Source: ESRI, 2018 (2010 Census)			

A comparison of poverty levels is provided as follows.

2017 Poverty Rate Comparisons				
United States	Michigan	Dickinson County	Florence County, WI	Marinette County, WI
13.4%	14.1%	12.1%	12.1%	13.3%
Source: U. S. Census Bureau, Small Area Income and Poverty Estimates program.				
Note: Poverty thresholds vary by size of family and the ages of the members.				

The average household income for Dickinson County is 83.8 percent of the state average -- indicative of a modest standard of living. Dickinson County's average household income is higher than the CBSA average. In comparison to the CBSA, Dickinson County has a higher percentage of low-income households (under \$15,000), but also a higher percentage of high-income households (over \$100,000). The poverty rate in Dickinson County below the national level and below the state level.

Real estate values play an important role in measuring the level of wealth in an area because homes represent a primary asset for most people. Thus, home values and historical appreciation are important considerations. Home values in Dickinson County are relatively low, having a median value of \$117,216 (the national weighted median equals \$234,154). The average home value in the county is relatively low compared to the state median of \$172,136.

The county population attains a comparable level of educational achievement as the state based on college graduates.

Most of these demographic data suggest that the regional population has a modest level of affluence as compared to the statewide population, and that Medicaid utilization in acute-care hospitals in the region should be comparable to the statewide average.

Employment Sector Data

The following table provides a breakdown of employment by industry sectors.

Table R-4 Region: Employment By Industry			
Employment Sector	United States	Michigan	Dickinson County
Total (Civilian Employment, Age 16+)	150,271,675	4,760,106	15,422
Agriculture/Mining	1.5%	1.4%	0.7%
Construction	4.1%	3.2%	8.0%
Manufacturing	8.3%	11.7%	11.8%
Transportation	2.9%	2.4%	2.9%
Communication	0.9%	0.6%	0.4%
Utility	0.6%	0.5%	0.4%
Wholesale Trade	4.2%	6.3%	4.9%
Retail Trade	20.8%	20.5%	26.2%
Finance/Insur/Real Estate	6.6%	5.5%	4.0%
Service	43.5%	43.0%	35.7%
Government	6.1%	4.6%	4.9%
Unclassified Establishments	0.5%	0.4%	0.2%
Source: ESRI, 2018 (2010 Census)			

The civilian employment mix by sector for Dickinson County is weighted more with construction, and retail trade sector employment than the state. Conversely, the employment mix is weighted less with agriculture and service sector employment.

Dickinson County Major Employers

Employer	Product/Services	# of Employees
Systems Control	Manufacturing	705
Department of Veteran's Affairs	Healthcare	686
Dickinson County Healthcare System	Healthcare	600
Verso Paper	Paper Mill	430
American Axle & Manufacturing	Manufacturing	400
CCI Systems Inc	Manufacturing	400
Boss Snowplow/The Toro Co.	Manufacturing	325
MJ Electric, Inc.	Utility	212
Breitung Township Schools	Education	200
Louisiana Pacific – Sagola	Manufacturing	175

Regional Economy Overview

The regional economy has been stable in recent years. The area was a hub for mineral mining, mostly iron, gold, and copper around the turn of the 20th century, but that industry has long since disappeared. The current economy is primarily based on logging and tourism.

Agriculture

The heavily forested land, thin soil, short growing season, and a handful of logistical factors, such as very long and complicated routes to major markets, and lack of infrastructure have made it difficult for a thriving agricultural economy. There are some small farms mostly dedicated to potatoes, wheat, barley, and oats.

Manufacturing

BOSS is a manufacturing company focused on snow removal products. They are based in Iron Mountain and have been operating since 1985. The company offers various snow and ice control plows for all different types of vehicles as well as salt and sand spreaders.

Systems Control is the largest employer in Dickinson County. Systems Control works alongside utility companies manufacturing control panels. Systems Control was founded in 1962 in Iron Mountain as a division of the local electric company, MJ Electric, and became an independent company in 2001. They design and manufacture customized systems to transmit and distribute energy from the source to the consumers.

Healthcare

Dickinson County Healthcare System is a major employer in Dickinson County.

The Oscar G Johnson VA Medical Center is another major employer in the healthcare industry of Dickinson County. It is located less than a mile west of Dickinson Memorial Hospital.

OGJVAMC oversees six Community Based Outpatient Clinics (CBOCs) located in Ironwood, Hancock, Marquette, Sault Ste. Marie, and Menominee, MI, and Rhinelander, WI. It also operates a Rural Health Outreach Clinic in Manistique, MI. Per its website; OGJVAMC employs 686 staff at its main facility and CBOCs, including 39 licensed physicians, 217 nurses, and 62 mental health professionals. OGJVAMC is a primary and secondary level care facility with 17 acute care, general medicine beds. The main facility has an urgent care center but not have an ICU or emergency department. OGJVAMC also provides rehabilitation and extended care, including palliative and hospice care, in its 40-bed community living center.

Forestry

Michigan's forest products industry has a significant impact on the overall state economy. Over 38,000 jobs are provided in forestry with a total impact of \$20 billion annually.

The upper peninsula accounts for 29% of Michigan's land area but over 45% of the forests, and the very sparse population lends itself to prime logging country.

Tourism

The scenic woodlands, mild summers, and abundance of outdoor activities has made Dickinson County and the upper peninsula a popular summer getaway destination. Summer activities in the area include boating and fishing on one of the 84 lakes in the county encompassing almost 750 acres, golf, hunting and trapping, camping, mountain biking, among many others. In addition, the area is a hotspot for snow sports in the winter including cross-country, downhill skiing, and snowmobiling.

Unemployment

As of May 2019, the unemployment in Dickinson County was 3.5 percent -- representing no change over the May 2018 unemployment rate (national unemployment rate is 3.6 percent; Michigan rate is 3.9 percent).

Conclusion

The population forecast for Dickinson County is for slight decline, while the overall state is forecasted to slightly increase. The average household income for Dickinson County is 83.8 percent of the state average, indicative of a modest standard of living. Overall, the

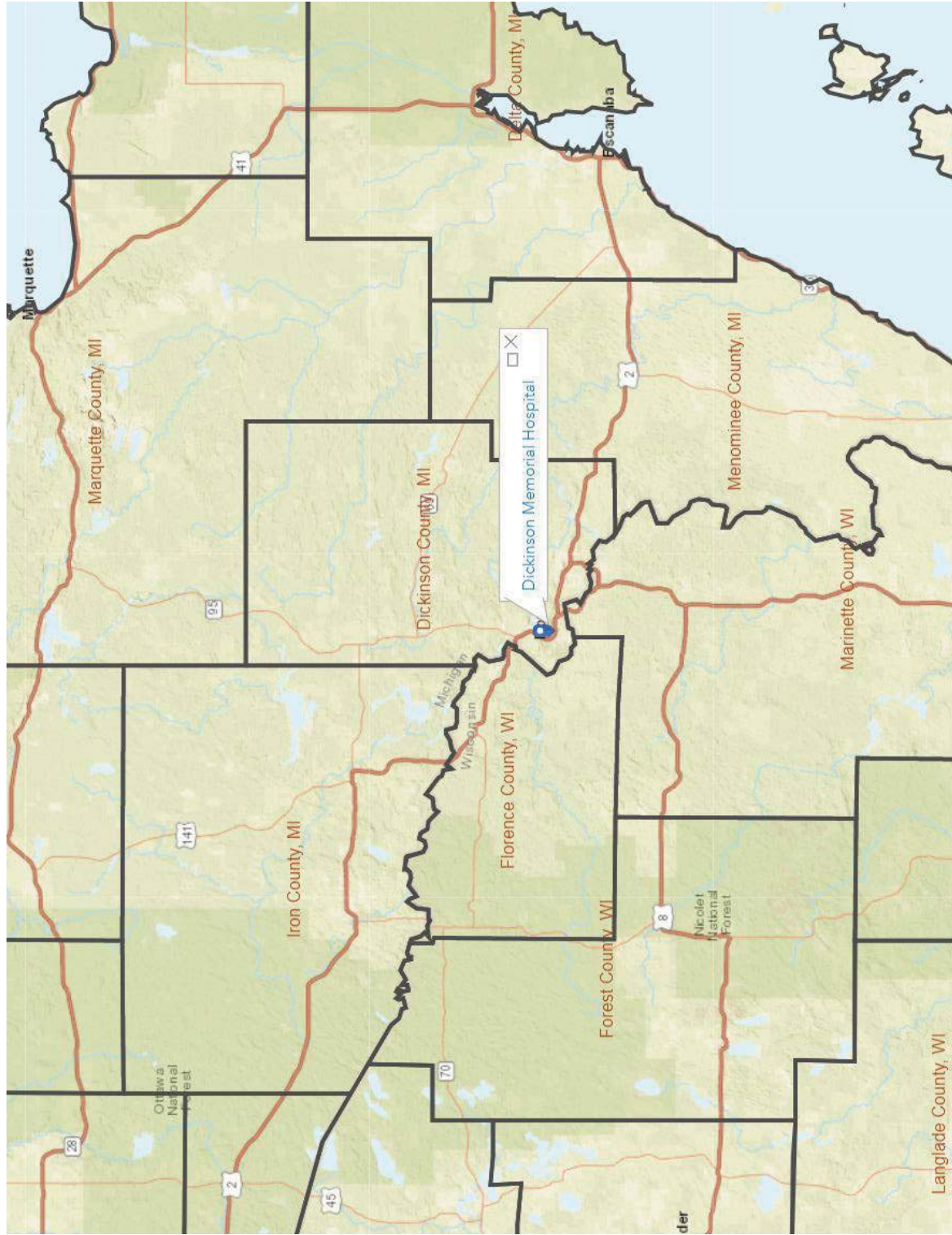
regional population has a modest level of affluence as compared to the statewide population. Based on these demographic indicators and economic trends, the region should provide average economic prospects for short-term acute care hospital operations.

← Z



COUNTIES MAP

N↑



Neighborhood Analysis

The Neighborhood Analysis identifies an area of surrounding properties that are influenced by the same or similar market forces. A neighborhood analysis determines the principal characteristics of an area and provides insight into land use and value trends. This analysis also includes a demographic profile for the Hospital's market service area.

Rural hospitals face unique challenges in the delivery of health care services. These challenges stem from lower patient volumes, limited financial resources, reimbursement matters, and workforce. They do not have the economy of scale that allows larger, urban hospitals to accommodate fluctuations in utilization patterns, mandated regulatory changes, and uncompensated care. The population in rural areas is generally older, poorer, and has less insurance coverage. Thus, rural hospitals typically receive a higher percentage of their income from government insurance plans that often pay less than commercial payers.

Physical Data

The subject is located in the eastern portion of Iron Mountain. I have defined the neighborhood as a three-mile ring centered on the subject property.

The neighborhood is characterized as a small city in a rural area of the state.

We have also profiled the market service area for Dickinson County Memorial Hospital. Data supporting our conclusion for the market service area boundaries is included in a subsequent section of the appraisal. We have defined the market service area as a 35-mile ring centered on the subject property.

Access to the neighborhood and market service area is achieved via the nearby U.S. highway's – 2,41, and 141. These routes allow the subject to draw potential patients from beyond the immediate neighborhood. South Stephenson Ave, which forms the southern boundary of the subject property, is a heavily traveled arterial street that winds through Iron Mountain. The subject is approximately one-mile southeast of the Iron Mountain central business district, and three miles north of the Michigan-Wisconsin border.

Demographic Data

The following table presents population data for comparison.

Table N-1 Neighborhood: Total Population Trends			
	Dickinson County	Neighborhood 3-mile radius	Market Service Area 35-mile radius
Total Population 2010	26,168	16,726	60,635
Total Population 2018	25,917	16,356	60,061
Total Population 2023	25,697	16,158	59,500
Annual Total Population Growth Rate			
2010 to 2018	-0.12%	-0.28%	-0.12%
2018 to 2023	-0.17%	-0.24%	-0.19%
Source: ESRI, 2018 (2010 Census)			

The population forecast for the neighborhood is for a similar trend as the county. We believe this is mostly a function of limited land availability in the defined neighborhood. Total population trends in the neighborhood are like those for the county and market service area.

Demographic data providing insight into socioeconomic status are profiled as follows.

Table N-3 Neighborhood: Socioeconomic Indicators			
	<u>Dickinson County</u>	<u>Neighborhood 3-mile radius</u>	<u>Market Service Area 35-mile radius</u>
Average Household Income, 2018	\$65,545	\$62,413	\$59,400
Per Capita Income, 2018	\$28,763	\$27,759	\$26,313
<u>Number of Households, 2018</u>			
<\$15,000	1,361	934	3,330
\$15,000 - \$24,999	1,200	855	3,418
\$25,000 - \$34,999	1,242	838	3,196
\$35,000 - \$49,999	1,804	1,135	4,322
\$50,000 - \$74,999	2,288	1,369	5,432
\$75,000 - \$99,999	1,479	913	3,156
\$100,000 - \$149,999	1,276	820	2,561
\$150,000 - \$199,999	432	209	694
\$200,000+	281	157	455
<u>Household Income Distribution, 2018</u>			
<\$15,000	12.0%	12.9%	12.5%
\$15,000 - \$24,999	10.6%	11.8%	12.9%
\$25,000 - \$34,999	10.9%	11.6%	12.0%
\$35,000 - \$49,999	15.9%	15.7%	16.3%
\$50,000 - \$74,999	20.1%	18.9%	20.4%
\$75,000 - \$99,999	13.0%	12.6%	11.9%
\$100,000 - \$149,999	11.2%	11.3%	9.6%
\$150,000 - \$199,999	3.8%	2.9%	2.6%
\$200,000+	2.5%	2.2%	1.7%
Median Home Value, 2018	\$117,216	\$97,839	\$118,363
Bachelor Degree or Higher (2018 Estimate)	18.5%	18.8%	14.6%
<u>Employment Sector</u>			
Total (Civilian Employment, Age 16+)	15,422	12,919	28,992
Agriculture/Mining	0.7%	0.6%	1.2%
Construction	8.0%	7.5%	5.5%
Manufacturing	11.8%	11.6%	11.7%
Transportation	2.9%	3.1%	3.2%
Communication	0.4%	0.6%	0.4%
Utility	0.4%	0.5%	0.4%
Wholesale Trade	4.9%	4.0%	4.0%
Retail Trade	26.2%	24.7%	21.4%
Finance/Insur/Real Estate	4.0%	4.3%	4.0%
Service	35.7%	37.8%	42.2%
Government	4.9%	5.0%	5.7%
Unclassified Establishments	0.2%	0.2%	0.3%
Source: ESRI, 2018 (2010 Census)			

Demographics for the market service area are reasonably like those of the county. The neighborhood population is less involved in service employment and more in the construction sector.

The neighborhood has similar average household income and similar per capita income than the county. Median home values however are substantially lower in the neighborhood compared to the overall county.

Most of these demographic data suggest that the population within the neighborhood has a similar level of affluence compared to the county.

The subject property is situated along the principal commercial corridor of the city. There has been limited development activity in the neighborhood recently. Future development activity near the subject property is likely to be limited, although it may be superior to most other areas of the city.

In the subject's more immediate neighborhood area, land uses include:

- A mobile home park to the west followed by more commercial and retail uses along Stephenson Ave, and single-family housing to the northwest.
- Several hotels and a Wal-Mart store to the east followed by a mobile home park before heading out of town.
- Largely undeveloped land to the north followed by a neighborhood with single-family housing bordering Lake Antoine.
- A few commercial buildings across the street to the south followed by mostly undeveloped land until the Michigan-Wisconsin border.

Overall, the composition of real estate within the neighborhood does not detract from the subject facility, and the remaining useful life of the subject facility should not be restricted by the neighborhood.

Health Resource Designations

Dickinson County Memorial Hospital is in a Health Professional Shortage Area (HPSA), as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. HPSAs are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Dickinson County Memorial Hospital's location is designated as having a shortage of mental health, and dental care professionals.

Conclusion

Overall, the neighborhood population has a similar level of affluence compared to the county. Based on these demographic indicators and surrounding land uses, the neighborhood should provide average economic prospects for short-term acute care hospital operations.

Subject Property Description

The following table summarizes the appraised real property owned by the Hospital.

Summary of Building Improvements & Occupied Space				
Property Owned by the Going Concern -- Real Estate & Operations Included in the Appraisal				
Building / Use	Gross Bldg. Area (Sq. Ft.)	Approximate Dates of Construction	Street Address	City & State
Dickinson Memorial Hospital	179,300	1996, 2000, 2001, 2006	1721 S Stephenson Ave	Iron Mountain, MI
Dickinson Medical Building GBA includes proportionate common area	37,836	1997	1711 S Stephenson Ave	Iron Mountain, MI
OB-GYN Clinic	6,700	2017	1721 S Stephenson Ave	Iron Mountain, MI
Occupational Health & Wound Healing Clinic	5,825	2012	1707 S Stephenson Ave	Iron Mountain, MI
Records Storage Building on Hospital Campus	4,500	1997	N/A	Iron Mountain, MI
Garage Building on Hospital Campus	1,600	1997	N/A	Iron Mountain, MI
Home Health	2,500	1972	722 River Ave	Iron Mountain, MI
Home Medical Equipment	4,273	early 1900s	710 Carpenter Ave	Iron Mountain, MI
Medical Park MOB	14,408	1970	1005 S Hemlock St	Iron Mountain, MI
Podiatry Services	3,120	2003	225 West "H" St	Iron Mountain, MI
UP Sleep Disorders Center	3,496	1971	1100 S Carpenter Ave	Kingsford, MI
Wausaukee Medical Center	4,016	2003	536 Kenny Dr	Wausaukee, WI
Florence Medical Center	6,000	2000	1010 Olive Ave	Florence, WI
Total Building Area Owned	273,574			

A table summarizing the subject sites is provided on the following page.

SUBJECT SITE SUMMARY TABLE

Parcel Group	County	Parcel #	Land Area (Sq. Ft.)	Group Land Area	Street 1	Length	Street 2	Length	Street 3	Length	Group Length	Zoning	Jurisdiction	Flood Map #	Flood Zone
A	Dickinson	1 051-000-257-00	1,276,308		S Stephenson Ave	1625'						OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	2 051-000-257-10	20,909									OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	3 051-104-813-10	86,249									B2 - Business	Iron Mountain	260430416C	X
	Dickinson	4 051-104-812-00	47,524									B2 - Business	Iron Mountain	260430416C	X
	Dickinson	5 051-502-003-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	6 051-502-002-50										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	7 051-502-004-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	8 051-502-004-50										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	9 051-502-005-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	10 051-502-006-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	11 051-502-007-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	12 051-502-008-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	13 051-502-009-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	14 051-502-010-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	15 051-502-011-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	16 051-502-012-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	17 051-502-013-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	18 051-502-016-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	19 051-502-016-10										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	20 051-502-018-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	21 051-502-001-00										OS - Office Svc	Iron Mountain	260430416C	X
	Dickinson	22 051-502-002-00									1625'	OS - Office Svc	Iron Mountain	260430416C	X
B	Dickinson	23 051-000-300-01	412,513		S Hemlock St	815'					815'	OS - Office Svc	Iron Mountain	260430404C	X, A?
				412,513											
C	Dickinson	24 051-101-353-10	30,405		West H St	150'	Prospect Ave	193'			343'	B2 - Business	Iron Mountain	260430412C	X
				30,405											
D	Dickinson	25 051-100-522-00	3,746		River Ave	50'	East D St	75'				B2 - Business	Iron Mountain	260430404C	X
	Dickinson	26 051-100-521-10	3,746		River Ave	50'						B2 - Business	Iron Mountain	260430404C	X
	Dickinson	27 051-100-051-00	7,492		River Ave	100'						B2 - Business	Iron Mountain	260430404C	X
	Dickinson	28 051-101-806-00	10,498		Carpenter Ave	46.5'					321.5'	B2 - Business	Iron Mountain	260430404C	X
E	Florence	29 010-01750-0025	56,628		US Highway 2	135'						CG - General Com	Florence	550370021A	X
				56,628							135'				
F	Wausaukee, WI	30 191-00611.013	37,897		Kenny Dr	200'	Main St.	200'				B2 - Highway Com	Wausaukee	550750575B	X
				37,897							400'				
G	Dickinson	31 052-001-107-00	45,430		S Carpenter Ave	295'	Parkway St	295'	Sagola Ave	154'		B2 - General Bus	Kingsford	260430412C	X
				45,430							744'				
		*Note: Land area for the MOB suites is included in the 051-100-257-10 parcel.													

Note: Based on location (proximity or contiguity), the parcels have been arranged into seven groups for purposes of valuation.

Note: Various supporting documents are provided in the addendum.



Improvement Description

The following improvement descriptions are based in part on field observations made on the date of our inspection, and more significantly, from our review of the site, architectural, structural and mechanical plans.

Hospital Building

The hospital was constructed in four phases, with about 86 percent being in the first phase. Building area utilization for the hospital building, by department or use, is summarized as follows.

Basement

- Materials management
- Dietary
- Plant operations – Bio Med, Communications, Maintenance, Safety
- Finance
- Human resources
- Public relations
- Employee health
- Information systems
- Environmental services
- Major mechanical

First Floor

- Lobby and registration
- Patient accounting and central scheduling
- Physician services
- Administration
- Nursing office
- Nursing education
- Medical records
- Quality management and social services
- Medical staff administration
- Obstetrics
- Pharmacy
- Operating rooms, pre surgery, post op recovery, sterile supply
- Emergency department
- Convenience care clinic
- Ambulatory care and infusion
- Medical imaging – X-ray, CT, nuclear medicine, ultrasound
- Radiation oncology
- Cardiac diagnostics
- Cardiac rehab
- Physical therapy

Second Floor

- Inpatient medical
- Inpatient pediatrics
- Inpatient surgical
- Outpatient infusion
- Intensive care

Details of the hospital building components are profiled as follows.

Class of Construction per Marshall Valuation Service

- Class A – Fireproofed structural steel frame (columns, girders and beams) with reinforced concrete or masonry floors and roof

Overall Quality of Construction

The categorization of construction quality is made relative to the class of construction (see above) and the category of use for the building. In general, hospital buildings are well constructed because there are high-level construction and design standards imposed by state authorities and federal agencies for purposes of licensing and certification.

We note that Marshall Valuation Services utilizes an “excellent, good, average, low cost” rating scale for their calculator method of pricing hospital buildings. In hospital Class A and B construction, their guide yields unit cost differences ranging from roughly \$60 to \$109 per square foot for each incremental difference in quality rating. Considering the spread in these unit price differences, we believe additional ratings are needed when expressing overall quality of construction, such as excellent/good or average/good.

In our opinion, the overall quality of construction for the subject facility is best categorized as average cost.

Structural Features

Site Preparation & Excavation

- General site preparation and grading
- Excavation for the walk-out basement
- Cut and fill with retaining walls

Foundation

- Concrete spread or strip footings with poured concrete foundation walls (T-shaped) and a reinforced concrete slab on compacted fill
- Daylight (or “walk-out”) basement – the building is situated on a slope and part of the basement is above ground; the basement walks out at grade on the south and west side of the building

Exterior Wall Construction (also see Envelope description)

- Nonbearing curtain walls

Floor Structure

- Site-cast reinforced concrete slab for the basement
- Long-span steel joists supporting a steel floor deck and poured-in-place concrete slab

Roof Style

- Flat -- horizontal roofing with no or very slight inclination (usually 10 degrees or less)

Roof Framing

- Steel joists/purlins and girders or open-web (bar) joists supporting a steel roof deck

Envelope -- Façade and CladdingExterior Walls

- Metal-framed, nonbearing curtain wall system with glazing and masonry (brick veneer) infills and an insulated, metal stud back-up wall assembly

Windows

- Natural finish aluminum
- Double pane insulated
- Storefront glazing system in a window wall

Doors

- Hollow metal doors in metal frames
- Glass storefront door system
- Sliding glass storefront door system

Roof Cover

- EPDM synthetic rubber membrane
- Rock ballast

Interior – Partitioning, Finishes and Built-insWalls

- Metal stud framing with gypsum board
- Masonry block walls
- Painted wall finishes
- Ceramic tiled wall finishes
- Vinyl wallpaper wall finishes
- Wood veneer finishes

Doors, Trim, Handrails & Cabinetry

- Hollow metal in metal frames
- Solid core wood (wood fiber core) in metal frames
- Fire rated metal doors in metal frames at fire wall locations
- Vinyl / rubber wall base trim
- Vinyl covered handrails
- Built-in cabinetry and shelving in nurse stations, examination rooms, treatment rooms, pharmacy, and laboratory
- Acrylic solid surface counter tops

Floor Coverings

- Carpeting
- Non-slip ceramic or porcelain tile
- Vinyl sheet and vinyl composition tile

Ceilings

- Suspended grid (recessed) with lay-in acoustical tiles in 2' x 4' and 2' x 2' grids
- Suspended channels with finished gypsum board

Mechanical and EnvironmentalHeating, Ventilation and Air Conditioning (HVAC)

- Hydronic system for heating and cooling – gas-fired boilers, chillers, circulating pumps and piping, terminal units, air handling units

Electrical and Lighting

- Fluorescent and incandescent light fixtures
- Wiring in conduit
- 750 KVA emergency generator, diesel fired

Plumbing, Laundry and Bathroom Fixtures

- Patient room bathrooms have sinks, showers and toilets

Fire Protection

- Fully sprinklered; wet pipe-type system
- Fire alarm system with a control panel and smoke and heat detectors

Elevators and Material Transport

- Three elevators
- Pneumatic tube network for light material transport
- Interior fire escape stairwells

Other ImprovementsAttached Construction

- Canopies
- Entry vestibules
- Crosswalk to medical office building
- Penthouse for housing mechanical equipment
- Loading dock

Support Buildings and Structures

- Records storage building of wood frame construction
- Garage building with capacity for three vehicles, of wood frame construction

Site Improvements

- Concrete sidewalks, patios and dumpster pads
- Asphalt-paved parking lots
- Metal ornamental fencing
- Parking lot lighting
- Signage
- Limited landscaping
- Landscape irrigation system
- Mechanical equipment enclosure
- Helipad

Dickinson Medical Building (MOB in Condominium Ownership)

The medical office building is designed to accommodate small medical practices. This is a three-story, above-grade structure located immediately southwest of the hospital building. The building has elevators and a separate entrance from the hospital, but it is connected to the hospital via an enclosed walkway.

Space and condominium units in the MOB are summarized as follows.

Dickinson Professional Office Building Condominium Form of Ownership		
Gross Building Area -- 50,971 Sq. Ft.		
Units owned by DMHS are highlighted.	Unit Sizes Area (Sq. Ft.)	Percent of Useable Area
Unit No. 100	3,553	8.8%
Unit No. 105	603	1.5%
Unit No. 110	1,126	2.8%
Unit No. 115	1,571	3.9%
Unit No. 120	4,097	10.2%
Unit No. 125	1,858	4.6%
Unit No. 200	2,891	7.2%
Unit No. 205	1,507	3.7%
Unit No. 210	1,753	4.4%
Unit No. 215	1,988	4.9%
Unit No. 220	1,426	3.5%
Unit No. 225	2,029	5.0%
Unit No. 230	567	1.4%
Unit No. 240	914	2.3%
Unit No. 300	4,160	10.3%
Unit No. 305	2,771	6.9%
Unit No. 310A	801	2.0%
Unit No. 310B	218	0.5%
Unit No. 315	3,453	8.6%
Unit No. 320	3,010	7.5%
Total Useable Building Area	40,296	100.0%
Ratio of Useable to Gross Building Area		79.1%
Note: Units 310A & 310B are counted as a single unit in the Consolidated Master Deed, although they are marked separately.		
DCHS owns 16 of the 19 units, or 74.2% of the useable area.		
DCHS's 16 units have 29,912 square feet of useable area.		
Gross building area allocated to DCHS (74.2%) is 37,836 square feet.		

Details of the medical office building components are profiled as follows.

Class of Construction per Marshall Valuation Service

- Class A – Fireproofed structural steel frame (columns, girders and beams) with reinforced concrete or masonry floors and roof

Overall Quality of Construction

The categorization of construction quality is made relative to the class of construction (see above) and the category of use for the building. In our opinion, the overall quality of construction for the subject MOB is best categorized as average.

This building principally has an EIFS exterior on curtain exterior walls. The roof is flat type and the cover is rubber membrane with rock ballast. The interior is all metal stud construction. The HVAC system is hydronic type, and it is independent from the hospital's system. The building is fully sprinklered with a wet type system. Interior finishes include

carpet, sheet vinyl, and terrazzo floor coverings. Ceilings are suspended acoustical tile. All interior spaces in the MOB are fully finished.

OB-GYN Clinic

The OB-GYN Clinic is located on the hospital campus, just north of the hospital building. This is the newest building on the hospital campus, having been constructed in 2017. The building is wood frame construction (Marshall Valuation Service – Class D) with fiber cement siding. The roof is flat type with rubber membrane or PVC covering. The HVAC system is forced air type with split units. Interior finishes include suspended grid ceilings, and vinyl, carpet and ceramic tile floor coverings. All interior spaces in the clinic building are fully finished. The construction quality is average.

Per information supplied to the appraiser, the construction cost for the building was \$1,341,538, or about \$200.23 per square foot of building area.

Occupational Health & Wound Healing Clinic

The Occupational Health & Wound Healing Clinic is located on the southwest corner of the hospital campus. Constructed in 2012, this building is very similar to the OB-GYN Clinic building with respect to type of construction, mechanical features, quality, and finishes. All interior spaces in the clinic building are fully finished. The construction quality is average.

Home Health

The Home Health building is not located on the hospital campus. This building is in an older commercial district of Iron Mountain, at the NWC of River Ave. and East “D” Street.

This is a one level building of load bearing, masonry block construction (Marshall Valuation Service – Class C). The building is finished for office use. There is a partial, walk-up type basement constructed with masonry block walls. The front has brick over the masonry block wall. The roof is gable type with wood framing and composition shingles. The HVAC system is forced air, split type units. The interior finishes include suspended grid (2' x 4') ceilings, painted drywall walls, and carpet floor coverings. The construction quality is low-average.

Home Medical Equipment (DME)

The Home Medical Equipment building is not located on the hospital campus. This building is in an older mixed-use area of Iron Mountain, along the west side of west side of Carpenter Avenue, between West “C” Street and West “D” Street. The site is split by a public alley. The building is connected to an adjacent building on a site immediately to the north.

This is an older building of load bearing, masonry type construction (Marshall Valuation Service – Class C). The design is part retail and part warehouse/shop. There is a small walk-up basement. The age of the building is unknown, but its style and construction materials make the appraiser believe it is likely 75 years of age or older.

The exterior walls are a mix of masonry block and brick, although there is metal siding affixed to the south wall. The roof is flat type of wood frame construction. The roof cover needs to be replaced. There is one overhead door in the warehouse/shop section.

The HVAC system is forced air in the retail section and includes two suspended heaters in the warehouse/shop section.

The interior finishes in the retail section are low-average quality.

The construction quality is average.

Medical Park MOB

The Medical Park MOB is not located on the hospital campus. This building is in a mixed-use (office and residential) area of Iron Mountain, along the west edge of Crystal Lake. Crystal Lake is a shallow, inland lake which historically was used to collect stormwater drainage from the city. This property includes two parcels of noncontinuous land, separated by an office property under different ownership.

Medical Park MOB is a two-level structure, with the upper floor walking out on the northwest side and the lower level walking out on the southeast side. There is one elevator and interior stairwells for access from one level to the other.

This building is metal stud (Marshall Valuation Service – Class D) construction with concrete walls along the earthen side of the lower level. The roof is flat type with bar joists supporting a metal deck and a rubber membrane or PVC type cover. The floor for the upper level is also supported by bar joists and a metal deck with poured concrete. The exterior is brick veneer and cedar shingles. There are vinyl and wood frame windows.

The HVAC system is forced air type with multiple roof mounted units.

The interior finishes include carpet and VCT floor coverings, painted drywall walls, wood doors in metal frames, and suspended grid ceilings with exposed frames. The interior finishes are dated and worn, particularly in areas of the building that are not utilized. Some lower-level area in the building is unfinished or partly finished.

The Hospital operates two clinics in the building (urology and family practice); however, unused space exceeds used space.

The Medical Park MOB is good quality construction.

Podiatry Services

The Podiatry Services building is not located on the hospital campus. This building is in a mixed-use (commercial and residential) area of Iron Mountain, at the southeast corner of West “H” Street and Prospect Avenue.

The Podiatry Services clinic is a one-level, medical office building of wood frame (Marshall Valuation Service – Class D) construction. The roof is hip style with composition shingles. The exterior is mostly vinyl siding but also has some brick veneer.

The HVAC is forced air, split type system.

Interior finishes include carpet and vinyl floor coverings, painted drywall walls, and suspended grid ceilings in 2’ x 4’ tile size.

The Podiatry Services building is average quality construction.

UP Sleep Disorders Center

The Sleep Disorders Center building is not located on the hospital campus. This building is in a mixed-use (commercial and residential) area of Kingsford, which is immediately south of Iron Mountain.

The Sleep Disorders Center is a pre-engineered steel frame (Marshall Valuation Service – Class S) building. The exterior walls have metal siding, stone veneer, and wood siding finishes. The building has a low pitch roof with metal cover. The windows are wood frame and show some deterioration. The building is finished as an office building. Interior finishes include carpet and vinyl floor coverings, suspended ceilings in 2' x 2' tiles, and drywall walls that are painted or covered with wallpaper. The interior finishes are somewhat dated.

The Sleep Disorders Center building is average quality construction.

Wausaukee Medical Center

The Wausaukee Medical Center is located at the northeast corner of Main Street and Kenny Drive in Wausaukee, Wisconsin. Main Street is US-141, and it is the main commercial corridor in Wausaukee.

The Wausaukee Medical Clinic is a one-level, medical office building of wood frame (Marshall Valuation Service – Class D) construction. The roof is hip style with composition shingles. The exterior is mostly vinyl siding but also has some cultured stone veneer.

The HVAC is forced air, packaged type system.

Interior finishes include carpet and vinyl floor coverings, painted drywall walls, and suspended grid ceilings in 2' x 4' tile size. All interior spaces in the building are fully finished.

The Wausaukee Medical Center building is average quality construction.

Florence Medical Center

The Florence Medical Center is located at the northwest quadrant of Olive Avenue and U.S. Highway 2, which is the primary commercial corridor for the community.

This building is very similar to the Wausaukee Medical Center building with respect to type of construction, mechanical features, quality, and finishes. All interior spaces in the building are fully finished. The construction quality is average.

Condition and Functional Assessment

Hospital Building

The subject hospital is specifically designed for use as a general acute care hospital. Hospitals are typically well maintained; thus, it tends to be the functional aspects of the design and/or economic factors that drive their effective age.

The subject facility's floor plan (design flow and relationship of space) is sufficiently functional by modern hospital standards. The building was constructed with a significantly higher licensed bed capacity with predominately semi-private occupancy, but the bed license was reduced and private patient rooms, which are standard in newer hospitals, are offered to all patients.

The allocation of space for diagnostics, consultation, patient rooms, family areas, surgery, etc. is reasonable for a modern hospital, although inpatient utilization was more prevalent when the building was designed. The amount of building area allocated to outpatient services is more limited than what would likely be designed today. The building design is believed to offer adequate efficiency for nurse staffing. The emergency department is sufficiently modern and functional. The obstetrics area is adequately functional. The

functionality of the facility's radiology and surgical departments appears to be reasonably good.

Physical wear and tear of the hospital building is moderate. Most mechanical systems are believed to have been adequately maintained. The building's décor is dated. The roof cover needs to be replaced, which is planned and assumed to be completed per the "as completed" valuation perspective.

Condominiums in Dickinson MOB

The Dickinson MOB is a modern building with good aesthetic appeal and great convenience to the hospital building. The subject condominium units have sufficiently modern finishes and floorplans that should be reasonably adaptable to the Hospital's needs for on-campus clinic space. Some of the Hospital's units are vacant, but most hospitals do not like to be space constrained so that they can add services and accommodate practitioners as needed.

OB-GYN Clinic and Occupational Health – Wound Healing Clinic

These on-campus clinics are modern, appealing and functional. Their convenience to the hospital building also adds to their appeal.

Home Health and Home Medical Equipment Buildings

These buildings appear to functional reasonably well for these lines of business service. They are low to moderate cost/value buildings that serve their purpose. The Home Medical Equipment facility has limited on-site parking, which is a drawback but not a major hindrance to operations. This building needs a new roof cover, which is planned and assumed to be completed per the "as completed" valuation perspective.

Medical Park MOB

The Medical Park MOB is a well-constructed building, but it is notably underutilized by the Hospital now and very dated inside. A significant investment would be needed to freshen the building, and it's possible that floorplan changes to make it more functional could be costly. The location is adequately convenient to the population residing in Iron Mountain and Kingsford, but traffic exposure is limited.

The Hospital had this building appraised recently. While it is not presently listed for sale, it may make sense for the Hospital to consolidate the practices it maintains in the building to other locations and sell this property.

Podiatry Services

The Podiatry Services building is adequately functional and reasonably well located. Presently, the Hospital doesn't fully utilize the building, having moved a service line (diabetes clinic) out of the facility at some point in the recent past. It seems reasonable to assume that the Hospital will continue to operate with enough service lines and space needs to continue its use of this building in the future.

Wausaukee Medical Center

This building is sufficiently modern and appealing for its designed use as a medical clinic, but it is not presently operated as such by the Hospital. The distance of the building from Iron Mountain, and it being in the direction toward Green Bay, reportedly made it a weak performer for the Hospital. The organization presently has it listed for sale. Given the Hospital's limited primary care physicians and its operating experience at that location, disposing of this asset seems to make good sense.

Florence Medical Center

The Florence Medical Center is an adequately modern and functional clinic building. The building is in average condition. This is reported to be a productive location for the Hospital.

Environmental Assessment

Site

The appraisers were not provided with any environmental site assessment reports. We are unaware of any site contamination by hazardous waste.

Building(s)

The appraisers are unaware of the presence of asbestos containing materials (ACMs) in the subject buildings. Asbestos was banned in most friable building materials (spray-applied surfacing materials and thermal system insulation) in 1978. Even so, the Occupational Safety and Health Administration (OSHA) deems spray applied surfacing materials, thermal system insulation materials, and vinyl flooring materials as “presumed asbestos-containing materials” (PACMs) if they are present in pre-1981 buildings. Some of the buildings were constructed prior to that time. The core buildings were constructed after that time, so the use of ACMS in their construction seems unlikely.

Economic Life Expectancy, Effective Age & Remaining Economic Life

It is important to understand the following concepts.

Effective Age: The age of property that is based on the amount of observed deterioration and obsolescence it has sustained, which may be different from its chronological age. (The Dictionary of Real Estate Appraisal, 5th Edition)

Comment: As indicated, the effective age may be different from the chronological age. A reduced effective age is achieved by replacing short-lived components and possibly some long-lived components. An increased effective age is caused by neglecting to replace fully deteriorated building components.

Economic Life: The period over which improvement to real property contribute to the property value. (The Dictionary of Real Estate Appraisal, 5th Edition)

Remaining Economic Life: The estimated period during which improvements will continue to represent the highest and best use of the property; an estimate of the number of years remaining in the economic life of the structure or structural components as of the date of the appraisal; used in the economic age-life method of estimating depreciation. (The Dictionary of Real Estate Appraisal, 5th Edition)

Per Marshall Valuation Service, Section 97, the economic life expectancies for general hospitals and medical office buildings are as follows:

Economic Life Expectancies				
General Hospitals	Class A	Class B	Class C	Class D
Good and Excellent	50	50	45	40
Low Cost and Average	45	45	40	35
Medical Office Buildings				
Good and Excellent	50	50	45	40
Low Cost and Average	45	45	40	35
Source: Marshall Valuation Service				

In our experience, hospital buildings tend to be well maintained and are remodeled or refurbished more often and extensively than many other building types. These buildings are usually well built and costly to construct, lending to a desire among owners to extend their economic lives as long as reasonably possible. The economic lives of these buildings are often extended with capital improvement projects. We believe the economic life expectancies for hospitals suggested by Marshall Valuation Service are on the low side of realistic ranges. For our analysis we have extended the economic life expectancy for the hospital building to 60 years.

Importantly, the remaining economic life of an on-campus MOB can be closely tied to the remaining economic life of the hospital building. For instance, if the hospital building was nearing the end of its economic life and a replacement building at a different location was planned or otherwise represented a near term, reasonable and probable highest and best use conclusion, then the economic life of an on-campus MOB could very well be cut short in conjunction with the development of a replacement hospital. Therefore, the MOB economic life expectancy figures suggested by Marshall Valuation Service must be regarded as guidelines that do not account for all possible situations.

Special purpose improvements like hospitals sometimes suffer from obsolescence because of the lack of a competitive market (limited prospective buyers) for the property. There are a variety of subject property and market considerations that serve to influence the number of prospective buyers and their level of motivation to acquire this type. Among these factors are:

- the existing market service providers and their need for additional plant capacity
- the location of the subject property and its ability to serve the potential needs for expanded service capacity by existing providers
- strategic motivations by existing providers to gain efficiencies or to prevent another competitor from gaining market share
- joint venture opportunities for existing providers looking to expand their scope of services
- the financial strength of prospective buyers and their ability to raise capital for a new acquisition
- the age and capital needs of existing physical plants in the market service area
- site constraints that may exist at existing physical plants in the market service area
- opportunities seen by tertiary providers to make inroads into a new market
- market service area characteristics that influence the profitability of healthcare ventures
- merger or acquisition activity that may be occurring among market service area providers and which could serve to distract those participants and/or utilize their financial resources for a larger, more significant transaction
- the prevailing relationships between hospitals and physicians in the market service area
- government regulations controlling the supply of new healthcare facilities
- provider reimbursement issues that may serve to alter the financial feasibility of certain healthcare services
- other regulations that serve to restrict certain types of ownership models for healthcare properties

Combined, these considerations represent a complex array of influences that are difficult to assess and quantify into a demand forecast for the subject property. Some of these topics are discussed in additional detail in other sections of the report.

Summary and Conclusion

Effective ages for improvements are influenced by their chronological ages. The following table summarizes chronological ages for the subject property improvements. Various buildings have been grouped for simplicity in the valuation analyses.

Building Area and Chronological Age Summary				
	Blended Year of Construcion	Chronological Age (Years)	Building Area (Sq.Ft.)	% of Total Building Area
As Completed				
Hospital	1997	22	179,300	67.0%
Dickinson MOB	1997	22	37,836	14.1%
OB-GYN & Occup. Health (2 buildings)	2015	4	12,525	4.7%
Home Health & DME (2 buildings)	1946	73	6,773	2.5%
Medical Park MOB & Sleep Disorders Ctr (2 buildings)	1970	49	17,904	6.7%
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)	2002	17	13,136	4.9%
Totals/Weighted Averages	1995	24	267,474	100.0%

Note: Chronological ages are based on years of construction. Renovations/remodeling are not factored. Garage & shed excluded.

Importantly, the Hospital has a recent history of poor profitability. This topic is discussed in greater detail in subsequent sections of the appraisal. A low operating margin can translate into value loss, particularly if the physical plant component of the going concern is aged. Reflecting competent, for-profit style management, the forecast profitability for the subject going concern exceeds historical profitability, but it remains relatively low in relation to the physically depreciated cost of the improvements. The appraiser believes the operational and staffing changes that have been made and which are expected to be made going forward should effectively permit the going concern to operate as profitability as forecast. Even so, given the history and the expectations, the average effective age of the building improvements is significantly greater than it otherwise would be due to uncontrollable influences which have a negative impact upon the Hospital's profitability.

Based upon the functional and physical condition assessments, the historical and forecast normalized NOI, and the comparable sales data, we have estimated that the building improvements will have "as completed" effective age(s) and remaining economic life/lives as illustrated in the following table.

Effective Age Schedule				
	Economic Life	Effective Age	Remaining Economic Life	Percent Depreciated
As Completed				
Hospital	60	35	25	58.3%
Dickinson MOB	60	35	25	58.3%
OB-GYN & Occup. Health (2 buildings)	40	5	35	12.5%
Home Health & DME (2 buildings)	40	25	15	62.5%
Medical Park MOB & Sleep Disorders Ctr (2 buildings)	45	30	15	66.7%
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)	40	15	25	37.5%
Other Improvements				
Campus Garage & Records Storage Buildings	25	10	15	40.0%

Condominium Matters

As previously noted, t Hospitals owns 16 of the 19 condominium units in Dickinson Professional Office Building (aka Dickinson MOB).

Copies of various documents pertaining to the condominium project were supplied to the appraisers for review. While the rules and regulations are too numerous to list in detail, the following highlights are noted for purposes of reference and understanding.

- Land area for the condominium consisting of 0.50 acre was originally leased to the developer, later reverting to the condominium association, for a term from 5-15-96 to 10-1-2094.
- The connector from the MOB to the hospital is not part of the MOB. An easement permits the connector from the hospital building to the MOB.
- Uses permitted in the building include medical office, pharmacy, and DME.
- Hospital permission is required to permit the operation of any medical equipment that is regulated by any governmental agency to limit the number of such equipment, or potential to limit the access to such equipment to the patients of the Hospital.
- Hospital permission is required to perform or offer any medical service, test or procedure performed or offered by the Hospital.
- Hospital permission is required to offer or perform a specified list of 34 services or procedures, subject to some of those being permitted but only to the extent they are incidental to the diagnosis and treatment of patients.
- The Hospital has right to purchase any unit at market value in the event the occupant of that unit ceases to qualify as a "permitted occupant," which is undefined in the document.

Personal Property (FF&E)

The tangible assets of a hospital going concern include real property and personal property. The following definitions are supplied to enhance the reader's understanding of the division of tangible property made for this appraisal. We have utilized multiple sources for the definitions supplied, including USPAP and The Dictionary of Real Estate Appraisal.

Personal Property – Identifiable tangible objects that are considered by the general public as being "personal." Personal property is movable without damage to itself or the real estate.

Furniture, Fixtures & Equipment (FF&E) -- Items of tangible personal property owned by a business, such as computers, partitions, and movable furniture, that are not directly connected to a building or other property but are included as assets on the company balance sheet.

Major Moveable Equipment (MME) -- Movable equipment can be moved, unlike fixed equipment which is attached or fastened to a building. Major moveable equipment includes large furniture and equipment having relatively fixed locations but capable of being moved and necessary to the function of the facility. MME is capitalized at the date of purchase or when placed into service.

For purposes of the appraisal the terms personal property and FF&E are used synonymously. With respect to equipment, the items treated as personal property are the movable items that are being carried on the company's balance sheet. Fixed equipment items are not treated as personal property; rather, they represent part of the real estate included in the real property assets.

The appraisal assumes the continuation of the going concern. The concept of "value in place" is implicit in the appraisal of a going concern. "Value in place" is defined as, "the amount a prudent purchaser would pay for an item, e.g., equipment, fixtures, in place; determined by the use the item contributes to the whole." Since the tangible personal property that is owned and utilized by the subject going concern is integral to the hospital's operation, it is more valuable under continued use than if it were removed and sold separately. Thus, the value is considered the "contributory value in place," which is consistent with the premise of going-concern value.

In addition to the IT/Information Systems that are behind schedule for upgrades and replacements, the Hospital has certain pieces of major equipment that need replacement due to their age, life expectancy, and functionality. Hospital management considers the near-term replacement of these items to be critical – needed as soon as possible.

- The Hospital's MRI is roughly 12 years old, which is well beyond its life expectancy. Replacement parts are reported to be expensive. The expected replacement cost for a new MRI is \$1.48MM.
- The Hospital's linear particle accelerator, used for cancer treatment, is at the end of its life expectancy. The expected replacement cost for a new machine \$3.04MM.
- The Hospital has two CT machines, one of which is modern and one of which is antiquated (16 slice) and in need of replacement. The Hospital indicates that it needs to acquire two new CT machines – a SPECT (single photon emission computed tomography) machine, and a wide-bore CT scanner. The expected replacement cost for the two scanners is \$1.27MM total.

With respect to the FF&E that is included in the subject appraisal, we have elected to utilize its depreciated book value (approximate) as a basis for the allocation of value. Additionally, the Hospital has a budgeted cost of \$10,125,500 for FF&E to be acquired. This figure is added to the net book value amount for existing FF&E to establish a basis for the total contributory value in place for personal property in the “as completed” scenario. However, a discount is applied to reflect the external obsolescence that we believe impacts the going concern and all tangible assets.

Real Estate and Personal Property Taxes

All real property in Michigan must be valued according to its highest and best use, which is not necessarily the property's current use. True Cash Value (effectively, market value) is the basis for ad valorem real property assessment. Property is valued using cost, income and sales comparison approach techniques. There are three valuations used in assessing real property in Michigan: assessed value, state equalized value, and taxable value.

The Assessed Value is established at 50 percent of True Cash Value.

The Assessed Value is used to establish State Equalized Value (SEV). Equalization serves to bring the total valuation across assessing units and counties as close to the 50 percent level as possible. SEV is typically the same as Assessed Value; however, in some cases, it may be slightly different due to an equalization factor, or multiplier, which the County or State imposes to “equalize” the assessments. State Equalized Value sets the basis for determining Taxable Value.

Property taxes are based on Taxable Value. For newly acquired property, the SEV is the property's taxable value. For each continued year of ownership, taxable value is the previous year's taxable value minus losses, adjusted for inflation, and plus new property improvements. The taxable value increase is capped at the rate of inflation or five percent, whichever is less, except for new construction. When a property is transferred, the cycle starts anew, and the following year's SEV becomes the property's taxable value, eliminating the cap of the rate of inflation or five percent.

Since the appraisal reflects market value subject to a sale, the state equalized value is applied in estimating the assessed value for real property taxes.

The property tax may be collected in the summer or the winter, or in some combination.

Personal property includes tangible items such as furniture, machines, and equipment belonging to a business and those items not permanently attached to land or buildings. Personal property value in Michigan equals its acquisition cost less depreciation. Personal property value is depreciated by multiplying acquisition cost times a depreciation multiplier, using multiplier tables. All depreciation multipliers are less than one. Personal property is also assessed at 50 percent.

Dickinson County Memorial Hospital

The subject property is presently owned by an entity that is exempt from property taxation. Presently there are no real or personal property assessments.

The current and forecast property tax assessments for the subject property are provided in the following tables.

Real Estate and Personal Property Taxes									
Real Estate Taxes		Assessor's Appraised Value(s)			Ratio of Assessment	Assessed Value	Tax Rate	Real Estate Taxes	Tax Exempt
#	Parcel ID	Land	Improvements	Total					
1	051-000-257-00	\$0	\$0	\$0	50.0%	\$0	6.22006%	\$0	Yes
2	051-000-257-10	0	0	0	50.0%	0	6.22006%	0	Yes
3	051-502-001-00	0	0	0	50.0%	0	6.22006%	0	Yes
4	051-502-002-00	0	0	0	50.0%	0	6.22006%	0	Yes
5	051-502-003-00	0	0	0	50.0%	0	6.22006%	0	Yes
6	051-502-002-50	0	0	0	50.0%	0	6.22006%	0	Yes
7	051-502-004-00	0	0	0	50.0%	0	6.22006%	0	Yes
8	051-502-004-50	0	0	0	50.0%	0	6.22006%	0	Yes
9	051-502-005-00	0	0	0	50.0%	0	6.22006%	0	Yes
10	051-502-006-00	0	0	0	50.0%	0	6.22006%	0	Yes
11	051-502-007-00	0	0	0	50.0%	0	6.22006%	0	Yes
12	051-502-008-00	0	0	0	50.0%	0	6.22006%	0	Yes
13	051-502-009-00	0	0	0	50.0%	0	6.22006%	0	Yes
14	051-502-010-00	0	0	0	50.0%	0	6.22006%	0	Yes
15	051-502-011-00	0	0	0	50.0%	0	6.22006%	0	Yes
16	051-502-012-00	0	0	0	50.0%	0	6.22006%	0	Yes
17	051-502-013-00	0	0	0	50.0%	0	6.22006%	0	Yes
18	051-502-016-00	0	0	0	50.0%	0	6.22006%	0	Yes
19	051-502-016-10	0	0	0	50.0%	0	6.22006%	0	Yes
20	051-502-018-00	0	0	0	50.0%	0	6.22006%	0	Yes
21	051-104-813-10	0	0	0	50.0%	0	6.22006%	0	Yes
22	051-104-812-00	0	0	0	50.0%	0	6.22006%	0	Yes
23	051-000-300-01	0	0	0	50.0%	0	6.22006%	0	Yes
24	051-101-353-10	0	0	0	50.0%	0	6.22006%	0	Yes
25	051-100-522-00	0	0	0	50.0%	0	6.22006%	0	Yes
26	051-100-521-10	0	0	0	50.0%	0	6.22006%	0	Yes
27	051-100-051-00	0	0	0	50.0%	0	6.22006%	0	Yes
28	051-101-806-00	0	0	0	50.0%	0	6.22006%	0	Yes
29	010-01750-0025	26,700	432,300	459,000	100.0%	459,000	1.84224%	8,456	No
30	191-00611.013	60,000	358,800	418,800	100.0%	418,800	2.09862%	8,789	No
Totals		\$86,700	\$791,100	\$877,800		\$877,800	1.96457%	\$17,245	

Personal Property Taxes							
Tax ID	Assessor's Appraised Value(s)		Ratio of Assessment	Assessed Value	Tax Rate	Personal Prop. Taxes	Tax Exempt
Not Assessed							
Totals	\$0			\$0	5.02006%	\$0	

Note: Adjustments represent special assessments or exemptions. Exempt amounts are shown as negative figures.

A property tax forecast is made for this analysis because for-profit ownership is typically an underlying assumption in market valuations – for prudence, there is no reason a

nonprofit entity should pay more for a property or going concern because it has a history of tax-exempt status or itself will be exempt from property taxation.

For this appraisal, we have based our assessed value forecasts upon our allocation of value for the going concern.

Property Tax Forecast -- As Completed							
	Assessor's Appraised Value	Integra Value Allocation	Concluded Values for Taxation	Ratio of Assessment	Assessed Value	Tax Rate	Tax Forecast
Real Estate							
Land	\$86,700	\$1,690,000	\$1,690,000				
Improvements	791,100	40,050,000	40,050,000				
New Land and Improvements Cost	0						
Total	\$877,800	\$41,740,000	\$41,740,000	50.0%	\$20,870,000	1.96457%	\$410,006
Tax Exemptions	Yes	None Assumed	None Assumed				
Personal Property							
Existing FF&E	\$0						
New FF&E Cost	0						
Total	\$0	\$7,702,900	\$7,702,900	50.0%	\$3,851,450	5.02006%	\$193,345
Tax Exemptions	Yes	None Assumed	None Assumed				
Real Estate and Personal Property Taxes							\$603,351

Level C Market Analysis

This section will cover the following:

- Provide a subject hospital overview, including licenses and certifications
- Identification of subject primary market service area based on source of discharges by ZIP codes
- Identification of subject's primary competitors and their primary market service areas

Subject Hospital Overview

Licensure

In Michigan, the Bureau of Community and Health Systems performs state licensing and federal certification regulatory duties as required by state and federal laws. Hospitals licensure is governed under Public Health Code 368-1978-17-215.

Dickinson County Memorial Hospital is licensed for 49 beds – 36 medical/surgical, 9 obstetrical, and 4 pediatric.

The Hospital reduced its licensed bed capacity from 96 to 49, effective January 1, 2018.

CMS Certifications and Accreditation

Medicare Certification

Hospitals are required to be compliant with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) to receive Medicare/Medicaid payment. This certification is based on a survey conducted by a state agency on behalf of the Centers for Medicare & Medicaid Services (CMS). Organizations seeking CMS approval may choose to be surveyed either by an accrediting body with deeming authority, such as the Joint Commission, DNV, and HFAP, or by state surveyors on behalf of CMS.

Medicare certifications for the licensed beds at Dickinson County Memorial Hospital are noted as follows. Other certifications may be discussed in subsequent sections of the overview.

Hospital Beds

Provider or Supplier Name:	DICKINSON COUNTY MEMORIAL HOSPITAL
CMS Certification Number:	230055
Provider or Supplier Type:	Hospital
Address:	1721 S STEPHENSON AVE IRON MOUNTAIN, MI 49801
Phone Number:	906 774-1313
Participation Date:	07/01/1966
Region:	(V) Chicago
Accreditation Organization:	JOINT COMMISSION
Accreditation Type:	Deemed Status
Number of Certified Beds:	96
Ownership Type:	Government
Subtype:	Short-Term

Subprovider Units

The term “distinct part” refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide a category of services (skilled nursing, rehabilitation, psychiatric) that is reimbursed by Medicare on a prospective payment system that is unique to that category. The distinct part must consist of all beds within the designated area. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However, the distinct part need not be confined to a single location within the institution or institutional complex’s physical plant. A DPU is issued a unique subprovider identification number from CMS.

Dickinson County Memorial Hospital does not have any beds in DPUs.

Nonprofit Organization

There are three classifications of community hospitals in the United States. Per the American Hospital Association, their distribution by type is as follows:

- Nongovernment nonprofit (58.9%)
- Investor-owned for-profit (21.4%)
- State and local government (19.7%)

Dickinson County Memorial Hospital is organized as a nonprofit entity.

A significant distinction between for-profit and nonprofit hospitals is how their net earnings are utilized. Per the Internal Revenue Service, an organization is NOT considered nonprofit if its net earnings (profits) inure to the personal benefit of individual persons or shareholders in the corporation. Therefore, the net earnings of nonprofit hospitals are theoretically used for investments or other activities, such as uncompensated care, teaching and medical research. Nonprofit hospitals have incentives to adjust discretionary spending and manage earnings to a range just above zero. In contrast, for-profit hospitals have the need to satisfy investors.

Benefits that arise from nonprofit status under federal law include exemption from federal income taxes, eligibility to receive tax-deductible contributions, and authority to use tax-exempt bond financing. To be tax-exempt under Section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes set forth in section 501(c)(3). Organizations described in Section 501(c)(3) are commonly referred to as charitable organizations.

Swing Bed Certification

Dickinson County Memorial Hospital has a swing bed agreement. The Social Security Act (the Act) permits certain small, rural hospitals to enter a swing bed agreement, under which the hospital can use its acute care beds, as needed, to provide either acute or skilled nursing care. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Swing bed certification is limited to the acute beds and does not include any distinct part rehabilitation or psychiatric units.

Rural Health Clinic(s)

A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement. There are about 4,000 Federally certified RHCs. The purpose of the RHC program is improving access to primary care in underserved rural areas. Rural communities have historically had difficulty attracting and retaining health professionals.

RHCs must be in non-urban rural areas with current health care shortage designations (Health Professional Shortage Area or Medically Underserved Area). Any area that is not in a U.S. Census-designated "urbanized area" is considered rural. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50 percent of the time with a midlevel practitioner. RHCs are required to provide outpatient primary care services and basic laboratory services.

RHCs are paid an all-inclusive rate (AIR) for medically necessary medical and mental health services, and qualified preventive health services furnished on the same day (with some exceptions). In general, the Medicare Administrative Contractor calculates the AIR for each RHC by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation. Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services. The AIR is subject to a payment limit, except that an RHC determined to be an integral and subordinate part of a hospital with fewer than 50 beds is not subject to the per-visit payment limit and its AIR is based on full reasonable cost (see below). Ordinarily, this payment methodology results in greater reimbursement than the Outpatient Prospective Payment System (OPPS).

Dickinson County Memorial Hospital

Dickinson County Memorial Hospital presently operates eight provider-based RHC(s). The Hospital closed two other RHCs recently.

Primary Care Clinics	Status
Florence Medical Center	Provider-based RHC
Dickinson Family and Geriatric Clinic	Provider-based RHC
Dickinson Internal Medicine/Nephrology Clinic	Provider-based RHC
Dickinson Family Practice Center--Kingsford	Provider-based RHC
Dickinson Family Practice Center--Norway	Provider-based RHC
Dickinson OB/GYN Clinic	Provider-based RHC
Dickinson Primary Care Center (was formerly known as Dickinson Pediatric Clinic)	Provider-based RHC
Convenient Care Clinic	Provider-based RHC
Nordic Medical Center (closed June 2018)	Provider-based RHC
Wausaukee Medical Center (closed January 2019)	Provider-based RHC

Provider-Based & Other Clinic(s)

For outpatient services, Medicare payments are a combination of three components.

- Technical (facility) component – Compensation for overhead costs, nursing and technical staff, and equipment and drugs directly related to the procedure.
- Professional fee (physician) component – Paid on the Medicare Physician Fee Schedule (MPFS). The MPFS includes both facility and non-facility rates. Under the MPFS, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility (hospital-based setting) or a non-facility (e.g., office). Generally, Medicare provides additional payment to physicians and other health care professionals for procedures performed in their offices because they are responsible for providing clinical staff, supplies, and equipment.
- Ancillary fees – Paid for therapy, laboratory services, and limited other services.

Many of the same healthcare services can be provided in either physician office settings or hospital outpatient departments. Medicare payment policies use two different payment

methodologies for outpatient procedures based on the site of service. The hospital-based procedures performed at hospital outpatient departments (HOPDs) are paid on the Hospital Outpatient Prospective Payment System (OPPS) while freestanding clinics are paid on the Medicare Physician Fee Schedule (PFS).

Under Medicare regulations, hospitals have the option of obtaining a determination of provider-based status for their clinics via a voluntary attestation process. Providers may obtain a determination of provider-based status by submitting an attestation stating that the facility meets the relevant provider-based requirements for on-campus or off-campus locations. Provider-based status means the location bills as part of the hospital to which it is provider-based. Outpatient clinics that qualify for provider-based outpatient department (HOPD) status under Medicare have traditionally benefitted financially.

The basic methodology for determining prospective payment rates for HOPD services under the OPPS is set forth in regulations at 42 CFR Part 419, Subparts C and D.

Dickinson County Memorial Hospital

The provider-based and other clinics operated by Dickinson County Memorial Hospital are summarized as follows, as is a recently closed clinic.

<u>Specialty and Other Clinics</u>	
Dickinson Hematology/Oncology	Provider based
Dickinson Orthopedic Practice	Provider based
Dickinson Podiatry Services	Provider based
Dickinson Urology Clinic	Provider based
Dickinson Surgery and Endoscopy Services	
U.P. Sleep Center	Provider based
Dickinson Occupational Clinic	
Dickinson ENT Clinic (closed February 2019)	Provider based

Home Health Agency

Home health care is a wide range of health care services that can be provided in a patient's home for an illness or injury. Nursing, physical therapy, occupational therapy, and speech therapy are considered skilled care by Medicare. Medicare certification for a home health agency in the United States requires provision of skilled nursing services and at least one additional therapeutic service.

Dickinson County Memorial Hospital operates a home health agency.

Provider or Supplier Name:	DICKINSON HOME HEALTH
CMS Certification Number:	237292
Provider or Supplier Type:	Home Health Agency
Address:	722 RIVER AVE IRON MOUNTAIN, MI 49801
Phone Number:	906 776-1925
Participation Date:	07/01/1996
Region:	(V) Chicago
Accreditation Organization:	JOINT COMMISSION
Accreditation Type:	Deemed Status
Ownership Type:	Government

Disproportionate Share Hospital (DSH)

Disproportionate Share Hospital (DSH) Payments and Upper Payment Limit (UPL) payments historically have been used to subsidize uncompensated care costs and backfill

for low reimbursement rates under Medicaid for hospitals serving large numbers of Medicaid and uninsured patients. More recently, supplemental payments are being used to provide additional Medicaid revenue to a wider array of hospitals, often to compensate for budget-driven cuts to base payment rates and to offset provider taxes used to generate the states' share of Medicaid costs. DSH and UPL payments can be a critical source of revenue to hospitals, especially safety-net hospitals. Federal statute requires that states make DSH payments to hospitals. Since 1991 Congress has enacted several laws to control federal DSH spending.

Medicare DSH

There are two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method is for a hospital to qualify based on a complex statutory formula that results in the DSH patient percentage. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. Patient days include only those attributable to units or wards of the hospital furnishing acute care services payable under IPPS (not applicable to cost-based reimbursement). The DSH patient percentage is defined as:

$$\text{DSH Patient Percentage} = \left(\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} \right) + \left(\frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}} \right)$$

The alternate special exception method is for urban hospitals that have more than 100 beds and can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid). These hospitals are also known as "Pickle" hospitals. If a hospital qualifies under this method, the statute provides for a specific Medicare DSH adjustment.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment based on another statutory formula. The formula varies for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospital that qualify as rural referral centers or sole community hospitals, and other hospitals.

Section 3133 of the Affordable Care Act revises the method for computing the Medicare DSH adjustment for discharges occurring on or after October 1, 2013. The computation includes the following:

1. Instead of the amount that would otherwise be paid as the DSH adjustment, hospitals receive 25 percent of the amount determined under the current Medicare DSH payment method beginning in fiscal year (FY) 2014 (for discharges occurring on or after October 1, 2013); and
2. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, becomes available for an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH receives an uncompensated care payment based on its share of insured low-income days (the sum of Medicaid days and Medicare SSI days) reported by Medicare DSHs.

Dickinson County Memorial Hospital

Dickinson County Memorial Hospital has received Medicare DSH payments in the financial periods reviewed.

FY 2017	\$176,356
FY 2018	\$141,752

Sole Community Hospital

Rural hospitals are more dependent on Medicare revenue and financially vulnerable to prospective payment because of the high percentage of Medicare beneficiaries that live in rural areas. Hospitals located in a rural area and meeting certain conditions receive additional operating and capital payments for services provided to Medicare beneficiaries.

Per MedPAC, 16 percent of rural hospitals are classified as sole community (SCH). Dickinson County Memorial Hospital is designated as a Sole Community Hospital.

To qualify for the SCH program, a hospital must be located at least a 35-mile drive from the nearest like hospital (i.e., a hospital furnishing short-term, acute care; excluding CAHs), or meet other federal criteria for being deemed a community's sole source of care. SCH reimbursement is the higher of:

- a) standard inpatient prospective payment rates, or
- b) payments based on the hospital's costs in a base year (1982, 1987, 1996 or 2006) updated to the current year and adjusted for changes in their case mix.

The SCH payment methodology differs in two significant ways from CAH cost-based payments. First, SCHs are only eligible to receive cost-based payments for inpatient care; CAHs receive cost-based payments for inpatient, outpatient, lab, therapy, and post-acute services in swing beds. Second, SCHs' payments are based on historical costs trended forward. Therefore, if a SCH increases its expenditures per patient, its payments will not be affected unless and until those costs are adopted as a new base year. In contrast, if a CAH increases its expenditures per patient, Medicare payments increase accordingly for that period.

For discharges occurring on and after October 1, 2012, SCH payments also include any applicable adjustments under the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program.

SCHs may also qualify for a payment adjustment for hospitals experiencing a significant volume decrease; referred to as the low-volume hospital payment adjustment.

Low-volume Hospital

Low-volume hospitals are eligible to receive a payment adjustment to account for their higher costs per discharge. A low-volume hospital is defined as an acute care hospital that is located more than 25 road miles from another comparable hospital and that has less than 200 total discharges during the fiscal year. Under Present Law, the Secretary is required to determine an appropriate percentage increase for these low-volume hospitals based on the empirical relationship between the standardized cost-per-case for such hospitals and their total discharges to account for the additional incremental costs (if any) that are associated with such number of discharges. The low-volume adjustment is limited to no more than 25 percent. Accordingly, under regulations, qualifying hospitals (those located more than 25 road miles from another comparable hospital) with less than 200 total discharges can receive enhanced payments for all Medicare discharges (25% for FY 2014).

The Patient Protection and Affordable Care Act made temporary changes to the hospital payment adjustment for low-volume hospitals, including making it easier for hospitals to qualify. These adjustments have continued with subsequent legislation.

In April 2019, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule to update the Medicare fee-for-service (FFS) inpatient prospective payment system (IPPS) for fiscal year (FY) 2020. Before a rule can go into effect, a final rule must first be published in the Federal Register. The agency (CMS) may alter the rule in response to public comments received prior to it becoming a final rule.

Dickinson County Memorial Hospital

Michigan Health & Hospital Association (MHA) utilizes a third-party consultant, DataGen, to provide reimbursement impact analyses for its member hospitals. In May 2019 MHA supplied to its member hospitals the DataGen impact information pertaining to the proposed rule for FFY 2020. A summary table from the hospital-specific analysis for Dickinson Memorial Hospital is provided below. The analysis compares estimated FFY 2019 and FFY 2020 IPPS payments based on the proposed changes in reimbursement.

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2019 IPPS Payments	\$8,514,600		\$547,300		\$9,061,900	
Marketbasket Update (Includes Budget Neutrality)	\$280,400	3.3%	\$6,500	1.2%	\$287,000	3.2%
ACA-Mandated Marketbasket Reductions	(\$42,500)	-0.5%	Not Applicable		(\$42,500)	-0.5%
MACRA-Mandated Coding Adjustment	\$0	0.0%	Not Applicable		\$0	0.0%
Wage Index/GAF	\$0	0.0%	\$11,000	2.0%	\$11,000	0.1%
Reducing Wage Index Disparities	(\$14,800)	-0.2%	(\$1,300)	-0.2%	(\$16,100)	-0.2%
> Budget Neutrality Due to 5% Stop-Loss	(\$14,800)	-0.2%	(\$1,300)	-0.2%	(\$16,100)	-0.2%
DSH: UCC Payment Changes [1]	\$0	0.0%	Not Applicable		\$0	0.0%
MS-DRG Updates	(\$43,000)	-0.5%	\$500	0.1%	(\$42,500)	-0.5%
Quality Based Payment Adjustments [2]	\$15,800	0.2%	\$0	0.0%	\$15,800	0.2%
Net Change due to Low Volume Adjustment	\$747,000	8.8%	\$48,400	8.8%	\$795,400	8.8%
Estimated FFY 2020 IPPS Payments	\$9,457,500		\$612,400		\$10,069,800	
Total Estimated Change FFY 2019 to FFY 2020 *	\$942,900	11.1% ▲	\$65,100	11.9% ▲	\$1,007,900	11.1% ▲

The proposed IQR marketbasket (MB) penalty for FFY 2020 is a 25% reduction to the full MB increase of 3.2% or 0.8 percentage points. If this facility were to receive the penalty, the impact on FFY 2020 IPPS-specific payments would be: -\$68,000.

The EHR meaningful use marketbasket (MB) penalty for FFY 2020 is a 75% reduction to the full MB increase of 3.2% or 2.4 percentage points. If this facility were to receive the penalty, the impact on FFY 2020 IPPS-specific payments would be: -\$203,900.

¥ The values shown in the table above do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2027. It is estimated that sequestration will reduce FFY 2020 IPPS-specific payments by: \$201,400.

Medicare reimbursement is a complex mix of payment systems. There are programs, payments, and modifiers to Medicare reimbursement that are established by short-term legislation known as “extenders.” Extenders must be passed or funded by Congress every year or two. An example of a Medicare extender is the Low-Volume Adjustment Program. The Bipartisan Budget Act of 2018 extended the relaxed low-volume adjustment criteria (>15-mile/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019-2022 with a change to the discharge criteria by requiring that a hospital have less than 3,800 total discharges (rather than 1,600 Medicare discharges).

Dickinson Memorial Hospital has historically received Medicare reimbursement through this program – reportedly, in the \$90,000 to \$200,000 range in the last couple of years. For FFY 2020, due to changes in the program, the analysis shows that almost \$800,000 in additional reimbursement is expected if the proposed changes become final.

Accountable Care Organization

Provider networks are a growing trend in healthcare, particularly via the development of accountable care organizations (ACOs). ACOs are healthcare delivery organizations that utilize payment and care delivery models that link provider reimbursement to quality outcome measures and a reduction in the overall cost of care for a specified population of patients.

The Affordable Care Act introduced ACOs on a voluntary basis via Medicare Shared Savings Program. Under this program, ACOs must be willing to become accountable for the quality, cost, and overall care of a defined population of Medicare fee-for-service beneficiaries. Providers participating in ACOs continue to receive payments under the original Medicare fee-for-service program Parts A and B. However, these providers are eligible to receive additional payment for shared savings.

Dickinson County Memorial Hospital

Effective January 1, 2018, the Healthcare System is a member of the NextGen ACO. This agreement runs through December 31, 2019. Prior to joining NextGen ACO, the Hospital participated in the NRACO (later called Caravan Health) from January 1, 2016 – July 2017, a period of 1.5 years.

Meaningful Use and Information Technology

Information technology in the hospital setting is expensive. Over the last decade, the expense of acquiring and maintaining these systems is one of the principal reasons that smaller hospitals and health systems sought larger partners through acquisition, mergers, affiliations, etc.

Dickinson County Memorial Hospital

The Hospital is reportedly well behind schedule for replacement of information technology systems. Per a discussion with the Hospital's Director of Information Systems, Hospital management historically treated the IT capital budget too much as an elective area for spending rather than an area for consistent and necessary spending. Reviewing the current five-year capital budget (2019 – 2023), it is noted that, as planned, information system spending represents 42 percent of total budgeted capital spending for that period.

The Hospital has achieved Stage 1 and 2 Meaningful Use requirements to avoid reimbursement penalties from Medicare, but still needs to achieve Stage 3. The organization utilizes different electronic health record systems for the hospital, the emergency department, and the clinics. There is no interoperability between these systems. Disparate electronic health record systems add hardship for physicians, which can contribute to burnout and impact patient safety and quality of care.

The three-year (2019-2021) detailed Information System budget reviewed reveals capital expenditure needs on a variety of systems, including electronic health records, supply chain management, nurse call system, phone system, time and attendance, HIPAA compliance, networking, etc. The needs include infrastructure costs, new software systems, and modules to update systems already in use. Upgrades and replacements are needed throughout the organization, including most if not all hospital departments and the clinics.

With the IT capital spending that is budgeted, it is assumed that what presently represents IT-related deferred maintenance will be substantially cured. Even so, the evolving market shift from payments based on volume toward payments that emphasize outcomes and risk will require ongoing integration across platforms to improve care coordination.

Market Service Area

The catchment area for a health facility is determined by several factors:

1. Politico-administrative boundaries are usually the strongest determinant, as they set a defined area and imply an established organization which directs, manages and operates the affairs of the population within its jurisdiction.
2. Geographical boundaries are natural physical barriers to population movement and can therefore also be strong determinants of catchment areas.
3. Time boundaries, although invisible, determine catchment areas in regions without roads and easy means of transport. Populations gravitate towards the facilities that are most easily accessible; that is, the facility they can get to in the shortest time.

The use of healthcare resources in the United States is highly localized. Most Americans use the services of physicians whose practices are nearby. Physicians, in turn, are usually affiliated with hospitals that are near their practices. Thus, when patients are admitted to hospitals, the admission generally takes place within a relatively short distance of where the patient lives.

Dickinson County Memorial Hospital

The following tables, which are based upon utilization data supplied by the Hospital, provide good insight into the primary market service area for the Hospital.

Outpatient Market Service Area for Dickinson County Healthcare System				
<u>City of ZIP Code</u>	<u>% Visits</u>	<u>ZIP Code</u>	<u>County</u>	<u>State</u>
Iron Mountain, MI	24.5%	49801	Dickinson	MI
Kingsford, MI	16.7%	49802	Dickinson	MI
Norway, MI	7.5%	49870	Dickinson	MI
Niagara, WI	7.1%	54151	Marinette	WI
Florence, WI	6.1%	54121	Florence	WI
Crystal Falls, MI	4.2%	49920	Iron	MI
Vulcan, MI	4.0%	49892	Dickinson	MI
Pembine, WI	2.7%	54156	Marinette	WI
Quinnesec, MI	2.6%	49876	Dickinson	MI
Moline, MI	2.2%	49335	Allegan	MI
All Others	22.4%			
Combined FYs 2017 and 2018				

Inpatient Market Service Area for Dickinson County Healthcare System				
<u>City of ZIP Code</u>	<u>% Admissions</u>	<u>ZIP Code</u>	<u>County</u>	<u>State</u>
Iron Mountain, MI	23.3%	49801	Dickinson	MI
Kingsford, MI	18.9%	49802	Dickinson	MI
Niagara, WI	7.0%	54151	Marinette	WI
Florence, WI	6.7%	54121	Florence	WI
Norway, MI	6.4%	49870	Dickinson	MI
Crystal Falls, MI	4.2%	49920	Iron	MI
Iron River, MI	3.6%	49935	Iron	MI
Vulcan, MI	3.3%	49892	Dickinson	MI
Pembine, WI	2.7%	54156	Marinette	WI
Quinnesec, MI	2.3%	49876	Dickinson	MI
All Others	21.6%			
Combined FYs 2017 and 2018				

Physician Alignment and Staffing

The number of physicians affiliated with a hospital, along with their geographic and health service areas of practice, serves to substantially influence its market share and service line penetration.

To remain viable, hospitals must successfully align their interests with those of physicians. A hospital's ability to attract and retain physicians and other professional staff is among its greatest challenges. Complicating this situation is a national shortage of physicians and expanded health insurance coverage under the Affordable Care Act. The physician shortage is also influenced by population growth, an aging population that requires more health services, an aging physician population, and increased physician visits. The shortage underscores the importance of physician retention to minimize new recruitment effort and expense.

Physician recruitment is very competitive. In general, hospitals located in rural areas experience greater shortages and struggle more to fill those positions than their urban/suburban counterparts. Many graduates from health care profession institutes are drawn to metropolitan areas because there is the potential to earn higher incomes.

Health care reform is impacting the relationship of hospitals and physicians in various ways. A variety of payment changes and care delivery models are proliferating under the Affordable Care Act. Payment is expected to shift from predominately fee-for-service to value-based care where the provider is at risk based upon patient outcomes. Hospital systems must manage the health of their patient populations as they will be held accountable for meeting cost and outcome goals. The shift to a value-driven care delivery and payment system puts a premium on prevention and team-based care coordination, led by primary care practitioners. Having a strong physician network makes alternative payment and delivery models more viable. Physician alignment strategies for hospitals can vary considerably, including direct employment, professional service agreement, and physician-hospital organization.

There is a growing trend of direct employment of physicians in the hospital industry. The Physicians Advocacy Institute conducts a Physician Practice Acquisition Study on an occasional basis to study the growth in physician employment by hospitals and health system. Their most recent study indicates that as of January 2018, U.S. hospitals employed 44.2 percent of physicians, an increase from a July 2016 measure of 41.7 percent. The study reveals regional variations, as indicated below.

- South – 39.2 percent
- West – 41.2 percent
- Midwest – 55.1 percent
- Northeast – 45.7 percent

By acquiring physician practices, hospitals gain a level of control over their own networks and the surrounding catchment area. Accelerating the trend is the influence of healthcare reform, where hospitals and physicians will likely have to share payments via bundling. Because quality-of-care will impact reimbursement, there is the notion that employing physicians helps a hospital align their incentives with those of the employed physicians.

Primary care physicians are among those currently in greatest demand. The demand for primary care physicians is driven in part by the growth of healthcare sites. Organizations are reaching into communities with a growing number of freestanding facilities that are convenient and accessible.

According to Medscape Physician Compensation Report 2019, average physician pay in 2019 is \$313,000.

Dickinson County Memorial Hospital

One of the principal issues confronting the organization is its physician makeup. The Hospital has historically had too few primary care physicians on staff, which handicaps the organization in establishing relationships and building system loyalty with people residing in the market service area. Reportedly, the organization has relied significantly on mid-levels (e.g., nurse practitioners and physician assistants) to provide coverage in its primary care clinics. As the Hospital has operated CMS-designated Rural Health Clinics, which require that a clinic must be staffed at least 50 percent of the time with a midlevel practitioner, this mode of operation has worked to some degree, but having more physician access at the subject clinics would have been better policy. Because the Hospital operated satellite clinics in other towns in the region, and with limited primary care physicians on staff, physician coverage was spread thin.

An overwhelming focus on growing specialty services, a lack of hiring and recruiting of primary care physicians, lopsided contract negotiations, and the actions of Bellin Health Systems, are large contributing factors to the Hospital's recent financial struggles. From a broader perspective, it is also important to note that hospitals in rural communities often struggle to recruit physicians for various reasons, including lifestyle considerations and the differential in earnings opportunities.

Going back in time, it is reported that around 15+/- years ago the Hospital had a good opportunity to hire some of the primary care doctors that were practicing in Iron Mountain, but that opportunity was lost as a result of negotiations by Hospital management. Today, some of those physicians practice for Bellin Health Systems at their local clinic -- Bellin Health Iron Mountain.

Management indicates that the Hospital recently recruited a primary care physician that will begin work September 1, 2019. The organization is reported to be actively recruiting other primary care doctors and pediatricians. Future recruiting needs for areas of specialty include ENT and pulmonology.

Dickinson County Healthcare System employs Hospitalists of Sound Inpatient Physicians to provide a high-quality Hospitalist Program for inpatients of Dickinson Memorial Hospital. Hospitalists are hospital-based general physicians that assume the care of hospitalized patients in the place of patients' primary care physician. Management believes that the Hospital's hospitalist program is one of the real keys to it achieving the high quality of care for which it is recognized.

The Hospital outsources the professional component medical imaging program. The radiologists are on site but are not employed nor do they have a professional service agreement. They do their own professional billing. The Hospital has maintained a relationship with the radiologists for roughly 20 years and characterizes it as great.

Business Practice and Plan

Dickinson County Memorial Hospital is a community hospital providing short-term acute care services on an inpatient, outpatient and emergency basis.

DCHS has been recognized as a Top Performer on Key Quality Measures by The Joint Commission, the leading accreditation agency of health care organizations in the U.S. The

Hospital has been recognized as a top achiever for patient safety by the Leapfrog Group and Healthgrades. Quality and value-based purchasing initiatives are reportedly now adding about \$1.3MM in reimbursement benefit.

The Hospital has various well-respected service lines, particularly for a rural hospital. The closest comparable services are in Marquette and Green Bay. In one way, the greater historical focus on medical specialties than on primary care has resulted in strong specialties. Among the programs that are well-respected include obstetrics, surgery, orthopedic surgery, podiatry, urology, emergency medicine, home health, and radiation oncology services.

In its effort to stem losses and cease providing financial support to satellite locations that were not deemed sufficiently beneficial to the organization, the Hospital closed its primary care clinic in Felch, MI on June 1, 2018. That clinic, located in leased premises, had been operated by the Hospital for 22 years. Felch is located 31 miles north of Iron Mountain. The Hospital also closed its primary care clinic in Wausaukee, Wisconsin on January 18, 2019. Wausaukee is located 35 miles south of Iron Mountain.

In conjunction with the BHS sale endeavor, the cardiology practice at DCHS was taken over by BHS in April 2018. The practitioners that had been working for DCHS transferred to BHS. BHS is renting space for that program in the Dickinson Medical Building, and the Hospital provides support staffing and services for the cardiology practice, upon which they are reimbursed by BHS. Reportedly, the Hospital had been subsidizing the cardiology program which had a (472,314) loss in 2017 and a (652,498) loss in 2016 and a decision was made to forego control of it to stem operating losses.

The turnaround effort discussed in the Management section of the appraisal provides additional information about recent operating issues and the efforts being made to stabilize the Hospital.

CAH Consideration

Management notes that DCHS has given some consideration to seeking Critical Access Hospital (CAH) status for the Hospital. Critical access hospitals are reimbursed by Medicare for both inpatient and outpatient services based on their current Medicare-allowable costs. They are exempt from the inpatient and outpatient prospective payment systems (PPSs) but are subject to the home health and skilled nursing facility PPS. CAH swing bed services are also exempt from the SNF PPS.

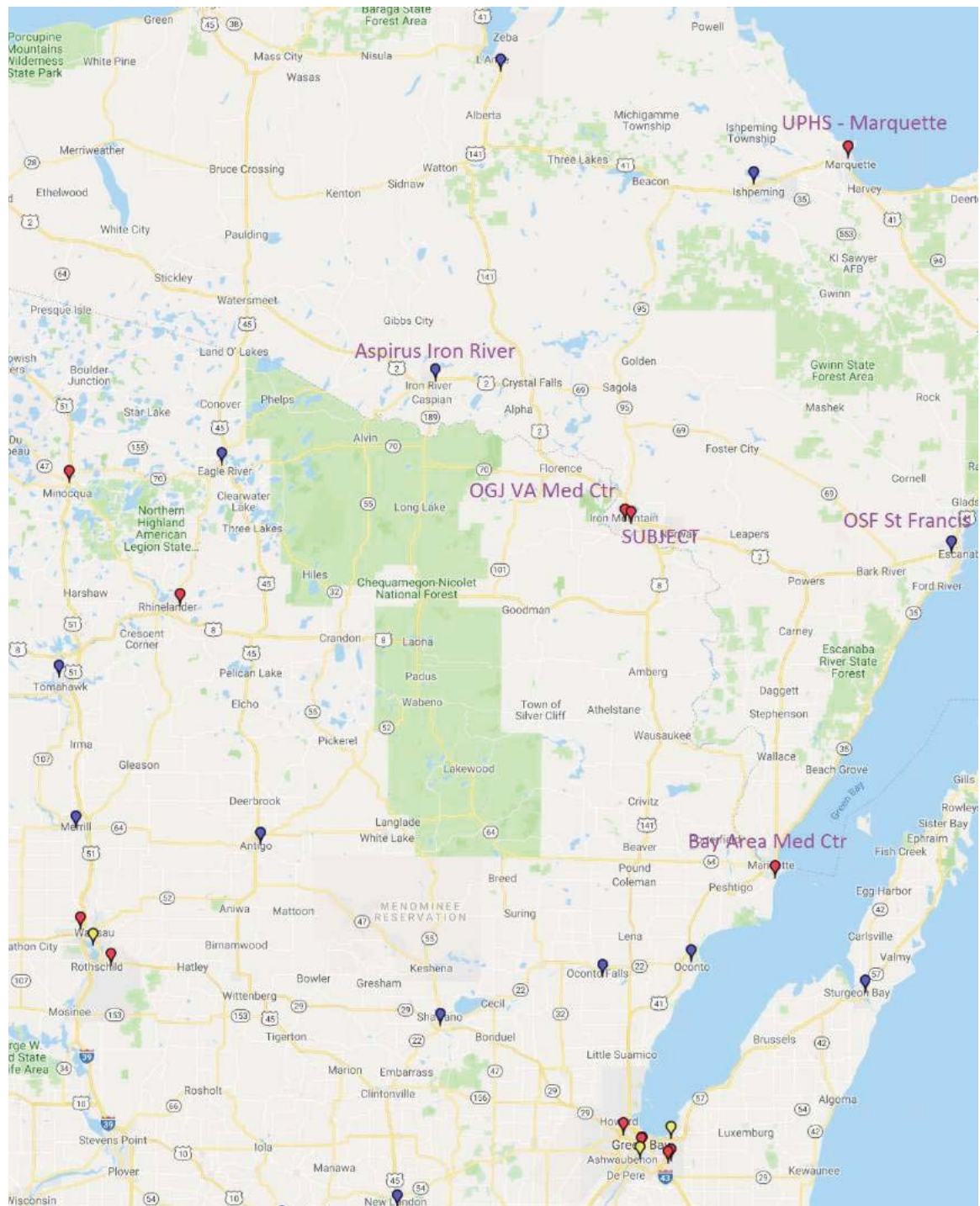
Because Medicare reimburses CAHs for both inpatient and outpatient services based on reasonable cost, their opportunity to operate profitably is enhanced. The subject maintains Sole Community Hospital (SCH) status from CMS, which improves financial viability through certain payment enhancements and protections to the hospital. The Medicare payment enhancements that SCHs receive are meant to protect against financial distress so that these institutions can continue to serve communities.

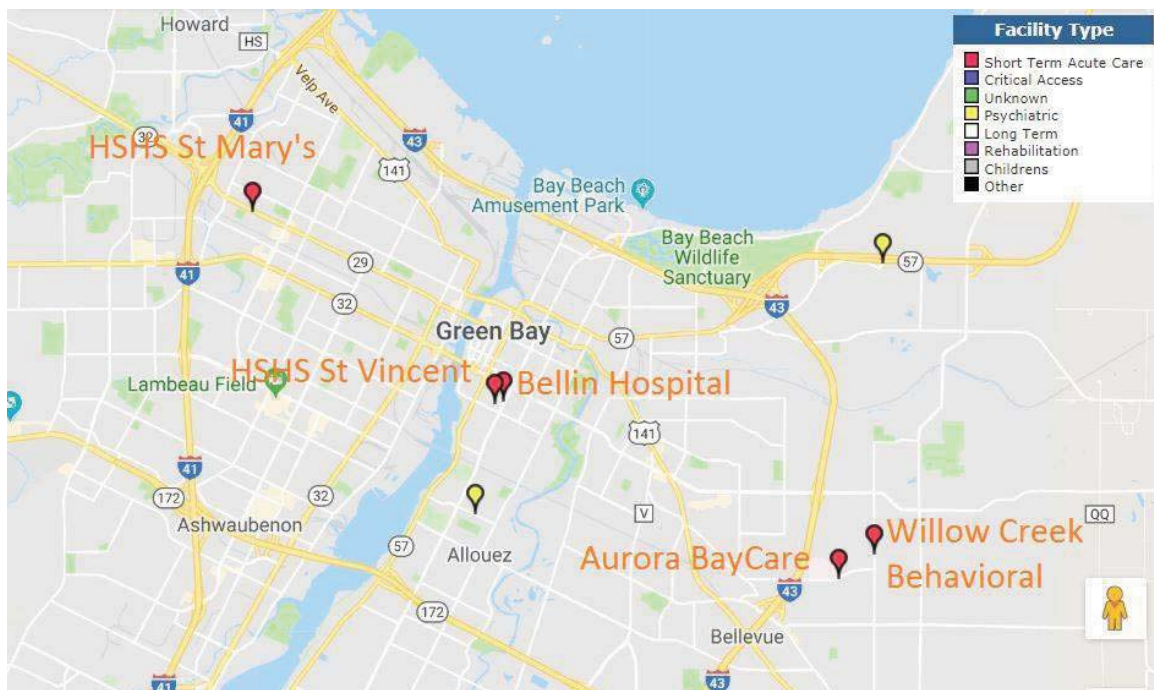
On a cursory basis, management believes the Hospital's case mix index is high enough that remaining SCH might be financially advantageous. However, a full evaluation by a reimbursement consultant is needed to have certainty about the matter. Management acknowledges that this matter should be investigated further.

Identification of Competitors

The following map identify short-term acute and critical access hospitals that are in the broader region. Given the isolation of the subject hospital, most of these hospitals have

limited or no meaningful competitive overlap with the subject facility, but they are identified for perspective. Because one of the competitors, Bellin Hospital, operates a sizable clinic in Iron Mountain, a map for the acute care hospitals in Green Bay, Wisconsin is also provided. If the subject were offered for sale or otherwise sought a larger hospital or health system partner, hospitals in Green Bay would be logical candidates.





The following table notes the critical access and short term acute care hospitals have been selected for analysis as competitors given their proximity to Dickinson County Memorial Hospital or their established interest in providing healthcare services in the market service area.

Competitive Short-Term Acute Care Hospitals				
Hospital / Competitor	Acute Beds	Location	Direction	Drive Distance (miles)
SUBJECT -- Dickinson County Healthcare System	49	Iron Mountain, MI		
1 Bellin Hospital	161	Green Bay, WI	S	100
2 Aspirus Iron River Hospital	25	Iron River, MI	NW	45
3 OSF Saint Francis Hospital	25	Escanaba, MI	E	50
Note: Bed counts reflect set-up beds reported by the provider for a recent yet unspecified fiscal year.				
Note: Bed counts exclude ones in distinct part subprovider units.				
Data Source: American Hospital Directory				

COMPETITOR NO. ONE

Name and Address:		Bellin Hospital 744 South Webster Avenue Green Bay, WI 54305					CMS Certification Number: 520049
Type of Facility:		Short Term Acute Care					
Acute Care (Sub-provider, Swing, & NF/SNF Excluded)		Medicare FFS	Medicare MC	Medicaid FFS	Medicaid MC	Other	Total
Discharges		2,069	1,835	376	678	2,959	7,917
Average Length of Stay		3.6		3.9		3.4	3.6
Case Mix Index		2.084		N/A		N/A	N/A
Acute Care (Swing Bed - SNF Excluded)		# of Beds	Inpatient Days				
Routine Services		145	—	—	—	—	—
Other Beds		16	—	—	—	—	—
Total Acute		161	7,445	5,885	1,470	3,614	28,533
Total Acute Inpatient Average Daily Census							78.2
Total Acute Inpatient Occupancy Rate							48.6%
Rehabilitation DPU		14					
Discharges			118	N/A	142	0	266
Inpatient Days			1,142	844	125	152	2,961
Average Length of Stay							11.1
Rehabilitation Unit Average Daily Census							8.1
Rehabilitation Unit Occupancy Rate							57.9%
Nursing Unit and/or Swing Beds							
Swing Beds							
Swing Beds - SNF							
Swing Beds - NF							
Totals for Swing in Acute Beds		0	0	0		0	0
Swing Bed Occupancy Rate							0.0%
Total Nursing & Swing Bed			0	0		0	0
Total Nursing & Swing Census Mix			0.0%	0.0%		0.0%	
Total Nursing & Swing Avg Daily Census							N/A
Total Hospital Beds (All Acute & Nursing)							175
Total Hospital Average Daily Census							86.3
Total Hospital Occupancy Rate							49.3%
Note: Swing and NF/SNF discharges are not available from the data source: American Hospital Directory							

The following table, which is based upon Medicare utilization data, helps to demonstrate the primary market service area for the Hospital.

Medicare Market Service Area for Bellin Hospital				
<u>City of ZIP Code</u>	<u>% Admissions</u>	<u>ZIP Code</u>	<u>County</u>	<u>State</u>
De Pere, WI	6.3%	54115	Brown	WI
Green Bay, WI	6.1%	54313	Brown	WI
Green Bay, WI	5.6%	54304	Brown	WI
Green Bay, WI	5.2%	54311	Brown	WI
Green Bay, WI	4.8%	54303	Brown	WI
Green Bay, WI	4.7%	54302	Brown	WI
Green Bay, WI	4.2%	54301	Brown	WI
Kewaunee, WI	2.7%	54216	Kewaunee	WI
Crivitz, WI	2.6%	54114	Marinette	WI
Sturgeon Bay, WI	2.6%	54235	Door	WI
All Others	55.2%			
For calendar year 2017				

The contemplated sale of the subject property to Bellin Health Systems, Inc. is discussed in the History of the Ownership section of the report.

The asset purchase endeavor with BHS effectively provided DCHS with a playbook for operational improvement and financial survival, but also resulted in BHS developing a complete understanding of DCHS's strengths and weaknesses. Most knowledgeable parties believe that BHS effectively strategizes for long-term success of its organization.

Because they control most of the family practice medicine practiced in the Hospital's core market service area, they tend to have an oversized influence on patient referrals for specialty medical care. However, the distance from Iron Mountain to Belin Hospital in Green Bay is considerable (about 100 miles, or a drive time of almost two hours); thus, there is a logistical hurdle for BHS to overcome for self-referrals from the market service area of DCHS. Subject management notes that some of BHS's providers in Iron Mountain are approaching retirement age, which is likely to result in the need to replace some of them soon if BHS is to maintain a primary clinic practice as large as their present one.

For roughly a 10-year period prior to August 2018, the Hospital operated a clinic in the Bellin Health Iron Mountain clinic, providing medical imaging and lab services to patients seen by BHS. Bellin Health ended that contract in August 2018. BHS was reportedly interested in partnering with the Hospital (presumably via a joint venture) to maintain a service agreement, but DCHS management chose not to pursue that arrangement. The Hospital indicated that losing that contract will result in it providing about 4,000 fewer lab and imaging procedures a month, or 48,000 annually.

COMPETITOR NO. TWO

Name and Address:		Aspirus Iron River Hospital 1400 West Ice Lake Road Iron River, MI 49935					CMS Certification Number: 231318
Type of Facility:		Critical Access					
Acute Care (Sub-provider, Swing, & NF/SNF Excluded)		Medicare FFS	Medicare MC	Medicaid FFS	Medicaid MC	Other	Total
Discharges		383	122	3	54	140	702
Average Length of Stay		3.7		10.0		3.2	3.5
Case Mix Index		1.277		N/A		N/A	N/A
Acute Care (Swing Bed - SNF Excluded)		# of Beds	Inpatient Days				
Routine Services		22	—	—	—	—	—
Other Beds		3	—	—	—	—	—
Total Acute		25	1,402	476	30	115	2,471
Total Acute Inpatient Average Daily Census							6.8
Total Acute Inpatient Occupancy Rate							27.1%
Rehabilitation DPU							
Discharges							
Inpatient Days							
Average Length of Stay							
Rehabilitation Unit Average Daily Census							N/A
Rehabilitation Unit Occupancy Rate							N/A
Nursing Unit and/or Swing Beds							
Swing Beds							
Swing Beds - SNF		22	206	0		84	290
Swing Beds - NF		0	N/A	12		35	47
Totals for Swing in Acute Beds		22	206	12		119	337
Swing Bed Occupancy Rate							4.2%
Total Nursing & Swing Bed			206	12		119	337
Total Nursing & Swing Census Mix			61.1%	3.6%		35.3%	
Total Nursing & Swing Avg Daily Census							0.9
Total Hospital Beds (All Acute & Nursing)							25
Total Hospital Average Daily Census							7.7
Total Hospital Occupancy Rate							30.8%
Note: Swing and NF/SNF discharges are not available from the data source: American Hospital Directory							

The following table, which are based upon Medicare utilization data, helps to demonstrate the primary market service area for the Hospital.

Medicare Market Service Area for Aspirus Iron River Hospital				
City of ZIP Code	% Admissions	ZIP Code	County	State
Iron River, MI	50.4%	49935	Iron	MI
Crystal Falls, MI	20.9%	49920	Iron	MI
Caspian, MI	6.1%	49915	Iron	MI
Gaastra, MI	3.1%	49927	Iron	MI
Long Lake, WI	3.0%	54542	Florence	WI
All Others	16.5%			
For calendar year 2017				

The hospital in Iron River is part of Aspirus Network, Inc. (ANI) is a Clinically Integrated Network of primary and specialty care physicians, hospitals and allied health care professionals. Aspirus Network negotiates contracts on behalf of its members with employers and health plans. There are four hospitals in Wisconsin and four in Michigan that are a part of ANI.

COMPETITOR NO. THREE

Name and Address:		OSF Saint Francis Hospital				
		3401 Lubington Street				
		Escanaba, MI 49829				
		CMS Certification Number: 231337				
Type of Facility:		Critical Access				
Acute Care (Sub-provider, Swing, & NF/SNF Excluded)		Medicare FFS	Medicare MC	Medicaid FFS	Medicaid MC	Other
						Total
Discharges		669	211	212	0	930
Average Length of Stay		2.9		2.2		1.3
Case Mix Index		1.260		N/A		N/A
Acute Care (Swing Bed - SNF Excluded)		# of Beds	Inpatient Days			
Routine Services		16	—	—	—	—
Other Beds		9	—	—	—	—
Total Acute		25	1,942	568	461	430
Total Acute Inpatient Average Daily Census						1,235
Total Acute Inpatient Occupancy Rate						50.8%
Rehabilitation DPU						
Discharges						
Inpatient Days						
Average Length of Stay						
Rehabilitation Unit Average Daily Census						N/A
Rehabilitation Unit Occupancy Rate						N/A
Nursing Unit and/or Swing Beds						
Swing Beds						
Swing Beds - SNF		16	0	0		111
Swing Beds - NF						
Totals for Swing in Acute Beds		16	0	0		111
Swing Bed Occupancy Rate						1.9%
Total Nursing & Swing Bed			0	0		111
Total Nursing & Swing Census Mix			0.0%	0.0%		100.0%
Total Nursing & Swing Avg Daily Census						0.3
Total Hospital Beds (All Acute & Nursing)						#N/A
Total Hospital Average Daily Census						#N/A
Total Hospital Occupancy Rate						#N/A
Note: Swing and NF/SNF discharges are not available from the data source: American Hospital Directory						

The following table, which is based upon Medicare utilization data, helps to demonstrate the primary market service area for the Hospital.

Medicare Market Service Area for OSF Saint Francis Hospital				
City of ZIP Code	% Admissions	ZIP Code	County	State
Escanaba, MI	43.6%	49829	Delta	MI
Gladstone, MI	23.3%	49837	Delta	MI
Rapid River, MI	8.3%	49878	Delta	MI
Bark River, MI	6.0%	49807	Delta	MI
Wilson, MI	2.4%	49896	Menominee	MI
Powers, MI	2.1%	49874	Menominee	MI
Wells, MI	1.8%	49894	Delta	MI
Rock, MI	1.8%	49880	Delta	MI
Cornell, MI	1.7%	49818	Delta	MI
All Others	9.1%			
For calendar year 2017				

OSF HealthCare is an integrated health system owned and operated by The Sisters of the Third Order of St. Francis, headquartered in Peoria, Illinois. OSF operates 13 hospitals. The OSF HealthCare physician network employs 1,300 primary care, specialist and advanced practice providers.

Supply and Demand Analysis

Certificate of Need (CON) Program

Certificate-of-need programs attempt to curtail the construction of unnecessary healthcare facilities and to limit the acquisition of costly equipment that provides little benefit. In 1974, Congress mandated that states adopt certificate-of-need laws and required states to establish comprehensive health plans. This mandate was repealed effective January 1, 1987. Today, 36 states operate certificate-of-need programs. There is considerable debate about the effect of those programs on the availability, access, and cost of healthcare.

Michigan

Bed Inventory per State

Michigan keeps a hospital bed inventory for health service areas and sub areas within those HSAs. The bed inventory is utilized for certificate of need analyses. The subject is in Hospital Group 29 of HSA 8. Per the bed inventory statistics, Hospital Group 29 has a surplus of 39 hospital beds.

Hospital Group (HG) 29		Hospital Bed Inventory (Baraga, Dickinson, Iron)			
Hospital Name	Facility Number	HSA	City	Licensed Beds	Department Inventory*
Baraga County Memorial Hospital**	07-0020	8	L'Anse	15	15
Dickinson County Memorial Hospital**	22-0020	8	Iron Mountain	49	49
Aspirus Iron River Hospital & Clinics, Inc. **	36-0021	8	Iron River	25	25
Hospital Group Total				89	89
Hospital Group Bed Need					50
Unmet Bed Need (Excess)					(39)

Occupancy Rates

According to 2018 version of the AHA Hospital Statistics, the 2016 national occupancy rate for hospital beds in all community hospitals (based upon staffed beds, not licensed beds) in the bed size category of 25 to 49 was estimated to be 40.8 percent, with ones in the bed size category of 50 to 99 being 50.0 percent.

AHA Hospital Statistics reports that the 2016 occupancy rate for all community hospitals in Michigan was 62.9 percent. Community hospitals are defined by the source as nonfederal, short-term general and other special hospitals.

As is evidenced in the following table, occupancy rates based solely upon acute inpatient care are in a wide range, but generally reflect a moderately strong rate of utilization.

Inpatient Occupancy Rates for Competitive Short-Term Acute Care Hospitals			
Hospital / Competitor	Acute Beds	Acute Occupancy	Acute + Swing Occupancy
SUBJECT -- Dickinson County Healthcare System	49	55.7%	56.9%
1 Bellin Hospital	161	48.6%	48.6%
2 Aspirus Iron River Hospital	25	27.1%	31.3%
3 OSF Saint Francis Hospital	25	50.8%	52.7%
Total Beds	260		
Unweighted Average Occupancy Rate		45.5%	47.4%
Weighted Average Occupancy Rate		48.1%	48.9%
Median		49.7%	50.6%

Note: Bed counts and occupancy rates reflect set-up beds reported by the provider for a recent yet unspecified fiscal year.

Note: Acute is Short-Term Acute Care; any acute beds in DPUs are excluded from figures.

Note: For facilities with swing bed utilization, acute + swing occupancy will exceed acute only.

Note: Periods for data may represent more than one specific fiscal year.

Data Source: American Hospital Directory

Acute and Swing Average Daily Census (ADC) for Competitive Short-Term Acute Care Hospitals				
Hospital / Competitor	Beds	Acute ADC	Swing ADC	Total Acute & Swing ADC
SUBJECT -- Dickinson County Healthcare System	49	27.3	0.6	27.9
1 Bellin Hospital	161	78.2	0.0	78.2
2 Aspirus Iron River Hospital	25	6.8	1.0	7.8
3 OSF Saint Francis Hospital	25	12.7	0.5	13.2
Average	70	31.2	0.5	31.8
Median	37	20.0	0.5	20.5
Total		124.9	2.1	127.1

Note: Periods for data may represent more than one specific fiscal year.

Note: Swing census represents NF/SNF care provided in licensed hospital beds.

Note: Acute is Short-Term Acute Care; any acute beds in DPUs are excluded from figures.

Competitive Supply Summary

Based on our research, we are not aware of any additional development of new or replacement hospitals, or major capital improvement projects that will change the bed supply or the relative appeal of inpatient units. Similarly, we are not aware of any additional development of ambulatory surgery centers, freestanding emergency departments, or medical clinics within the primary market area of the subject.

Strengths and Weaknesses

In each market service area, each hospital typically possesses strengths and weaknesses relative to the competing facilities. There are also certain market influences that may universally impact all hospitals. In this instance, the subject property and/or market are perceived to have the following strengths and weaknesses. Physical plant considerations reflect the proposed construction project as though completed.

Strengths

- Modest level of poverty in the market service area -- providing good prospects for a payer mix that lends itself to better opportunities for profitable business operation
- Located along a main street or highway that provides high visibility and easy access

- Good quality physical plant
- Adequate and convenient parking
- Well-maintained physical plant
- Strong reputation for providing quality healthcare
- Medicare status as a sole community serves to enhance profitability
- Strong history in surgical services
- Patient satisfaction scores are strong
- Management is aggressively addressing initiative to control costs and enhance revenues

Weaknesses

- Relative isolation of the hospital adds to the difficulty in attracting
- Local VA hospital competes for qualified staff
- Capital spending for FF&E is behind schedule
- Too few family practice doctors are aligned with the Hospital

Base Hospital Service Demand

Demand for general acute care hospital services is need driven. Demand is closely related to population trends within the Hospital's market service area. A hospital's service area, however, is also influenced by its location, size and staffing, and the availability of healthcare services in the region. The market service area population trends and demographic variables are discussed in the Neighborhood section of the appraisal.

Inpatient Utilization Analysis

This section will cover the following:

- Provide an overview of primary payer sources for the subject hospital
- Disclose historical and budgeted inpatient utilization information
- Forecast acute inpatient utilization volume
- Forecast the inpatient payer mix
- Forecast the average length of stay (ALOS) and patient days
- Forecast the Medicare case mix index (CMI)

Payer Overview

Health coverage for individuals in the U.S. can be categorized into four major segments: employer-based, public, private non-group (individual coverage), and uninsured. Employer-based coverage is health insurance funded through employers and is the largest health insurance market. The public system is made up of government programs, including Medicare, Medicaid, the military system (TRICARE), and other federal, state and local programs. The smallest segment of the market is those who contract on an individual basis with health plans and insurers. The final segment is those who have no health insurance coverage.

Managed Care Concept

Managed Care is a term that is used to describe a health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members. Managed care is an approach to the delivery of healthcare services that requires providers to accept and share financial risk. It currently represents the main financing and delivery mechanism for healthcare within the United States. Managed care is utilized by the Medicare program, most states' Medicaid programs, TRICARE, and the commercial payer segment of the healthcare insurance industry. The financial risk-sharing mechanism for a hospital is discounted reimbursement (contract and case rates; per diem rates).

HMOs, PPOs, and POSs are the principal types of managed care plans offered by managed care organizations (MCOs).

Transition from Volume to Value

The ACA set into motion the healthcare industry's move toward population health and value-based care delivery and payment models. Population health means improving the overall health status and lowering the cost of care for a specific population. Value-based purchasing (VBP) is a health care payment methodology that rewards quality of care through payment incentives and transparency.

Under the ACA, CMS launched numerous programs and alternative payment models to encourage care coordination, cost savings and improved clinical outcomes. While Accountable Care Organizations (ACOs) are often associated with Medicare, this CMS program has also spurred growth in commercial ACO contracts. Providers have increasingly shown a willingness to accept the downside risk inherent in VBP and surveys suggest they expect more of their payments to come from risk-based payment models in the future. Surveys suggest that hospitals now generate about half their revenues from some type of value-based arrangements, including ACOs, capitation payments, shared savings/risk, and bundled payments.

In the federal sector, while Medicare Advantage (MA) is often viewed as a capitated payment model, providers largely are being paid on an FFS basis from MA plans.

On the commercial side, shared savings products make up the largest share of non-FFS payments, but these products largely do not require downside financial risk. The commercial risk-based market remains immature. Many insurance company margins remain relatively healthy under FFS and for-profit companies have a fiduciary duty to increase shareholder value.

Medicare and Medicare Advantage

Medicare is the health insurance program for retired United States citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by the Centers for Medicare and Medicaid Services (CMS). In 2018, Medicare covered 60 million people: 51.3 million people aged 65 and older, and 8.7 million people with disabilities.

Medicare (Part A and Part B)

The original Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and supplementary medical insurance, known as Medicare Part B. Parts A and B operate under fee-for-service payment systems.

Under the Medicare fee-for-service payment system, a Medicare beneficiary can choose any licensed physician and use the services of any hospital, healthcare provider or facility that has signed a participation agreement and meets applicable certification requirements with Medicare. CMS reimburses providers if Medicare covers the service, if the service is “medically necessary” and if other applicable coverage criteria are met. Preventative services such as yearly wellness visits are covered under Part B.

Medicare has individualized payment systems for acute, psychiatric, long-term acute and rehabilitation hospitals, plus various sub-category, service provided, and supplemental payment provisions. Medicare pays for treatment of alcoholism and substance use disorders in both inpatient and outpatient settings.

All physician services are paid under the Medicare Physician Fee Schedule. For most hospitals, the technical component of hospital services is either paid under Diagnostic Related Groups for inpatient procedures, or under the Hospital Outpatient Prospective Payment System for outpatient service.

Part A

Medicare Part A covers hospital care and some nursing home, hospice and home healthcare. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65.

Part B

Enrollment in Medicare Part B is voluntary. Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80 percent of the cost of services; beneficiaries pay the remaining 20 percent after the beneficiary has satisfied a \$185 deductible (2019).

Medicare Advantage (Part C)

In addition to the original Medicare "fee-for-service" program, Medicare offers an alternative **managed care** program known as Medicare Advantage (MA). This program offers beneficiaries the option to receive health care through private insurance plans. A beneficiary must specifically opt to receive Medicare coverage and care through an MA insurance plan. As of May 2019, approximately 22.6 million, or 35 percent of Medicare beneficiaries were enrolled in a MA plan. CMS expects Medicare Advantage enrollment to jump to nearly 23 million people in 2019.

Under the MA program, Medicare buys insurance coverage for its beneficiaries from private insurers via specific platforms or plans. By law, Part C plans must at least be "equivalent" to regular Part A and Part B coverage. In most cases, MA plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Medicare HMOs are also required to provide additional services, over and above those available through the traditional Medicare program, without additional charge to Medicare enrollees.

Each Medicare Advantage plan has a service area. This is a geographic area where the plan is available and offers coverage. A service area is usually a county, state or region. A beneficiary must live in a plan's service area to enroll in that plan.

Market Service Area Penetration

The following table utilizes CMS Medicare Advantage (MA) statistics to illustrate the prevalence of MA participation within the core market areas served.

Medicare Advantage Penetration Among Medicare Eligibles as of May 2019			
Primary Service Area Counties	Eligibles	Enrollees	Penetration
Dickinson	7,242	2,178	30.1%
Florence	1,564	443	28.3%
Marinette	12,637	5,248	41.5%
Total	21,443	7,869	36.7%
Secondary Service Area Counties			
Iron	4,084	1,144	28.0%
State(s)			
Michigan	2,180,888	859,388	39.4%
Wisconsin	1,234,670	507,783	41.1%
National	64,552,226	22,609,604	35.0%
Data is sourced from CMS Medicare Advantage penetration tables.			

The number and share of Medicare beneficiaries enrolling in Medicare Advantage plans has continued to climb since the enactment of the ACA. Significant growth is occurring due to seniors switching out of the traditional Medicare program and into an MA plan.

Hospital Reimbursement – Medicare Managed Care vs. Medicare Fee-for-Service

In a 2018 working paper by the Congressional Budget Office, titled An Analysis of Private-Sector Prices for Physicians' Services, the author notes that although there is limited information on physician prices for Medicare Advantage patients, the evidence suggests that Medicare Advantage prices for physicians' services often are similar to Medicare FFS prices. The author notes that those findings are consistent with recent research showing that prices paid by Medicare Advantage plans and Medicare FFS for hospital services are

similar. Medicare Advantage plans and hospitals often peg their MA payment rates to rates used by traditional Medicare.

For critical access hospitals, Medicare Advantage rates of payment are established by negotiation between the insurer and provider.

Medicare Spending Measures

The Budget Control Act of 2011 requires \$1.2 trillion in automatic, across-the-board Federal spending cuts over a 10-year period -- also known as sequestration. As required by law, President Obama issued a sequestration order on March 1, 2013. In general, Medicare fee-for-service claims with dates-of-service or dates-of-discharge on or after April 1, 2013, incur a 2.0 percent reduction in Medicare payment.

The Bipartisan Budget Act of 2013 was signed into law on December 26, 2013. This legislation extends Medicare's sequester cuts through 2023.

Value-Based Purchasing

Historically, the U.S. system of care was built on silos of medical services—where physicians, hospitals, and other providers each performed separate and detached components of the patient's care, where each provider was paid separately based on the amount of services it provided, and where financial relationships between providers were viewed with rigid scrutiny. Fee-for-service payment systems facilitated these silos.

The implementation of the ACA shifted the structure and design of public and private health care delivery and payment systems. To curb health care spending and improve quality of care and health outcomes, using value as a criterion for health insurance options offered by payers has come into vogue.

Value-based purchasing (VBP) is a health care payment methodology that rewards quality of care through payment incentives and transparency. The concept of VBP is that buyers should hold providers of healthcare accountable for both cost and quality of care. VBP brings together information on the quality of healthcare, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the healthcare system to reduce inappropriate care and to identify and reward the best-performing providers. Key VBP strategies include: (1) pay-for-performance (P4P); (2) accountable care organizations (ACOs), and (3) bundled payments.

Rural hospitals, due to financial and professional limitations, will naturally be slower to participate in value-based purchasing models; however, it's reasonable to assume that even critical access hospitals will become part of these Medicare programs at some time in the future. The ability of many smaller critical access hospitals to be the lead provider in a bundled payment methodology could be difficult, but they can provide many of the ancillary services surrounding the initial care. At a minimum, the critical access hospital may be in place to provide the post-acute care services and physician follow-up. This could include swing bed, nursing home, home health and physician follow-up.

Physician Service Reimbursement

Medicare pays for physicians' services via the Physician Fee Schedule (PFS). The system relies on national relative values that are established for work, PE (practice expense), and MP (malpractice), which are adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the RVUs into payment rates.

Medicare splits hospital billing into facility charges and professional charges. The professional component represents physician and other non-physician clinical services. The hospital only bills professional services when the physician is employed by or under contract with the hospital. Otherwise, each physician bills charges for his or her services to the patient and third-party payers.

The professional component of services furnished in hospital provider-based departments are based on the PFS, just like the payment made for services in a freestanding physician office. However, the physicians who provide these services are supposed to be paid using the “facility practice expense” revenue value unit (RVU) methodology in the MPFS. Using this methodology, the physician reimbursement is lower to account for the fact that the services were furnished in the hospital outpatient department, rather than in the physician’s office setting. The payment is reduced because the physician is not incurring the facility costs to furnish the service.

Medicaid

Medicaid is a joint federal and state health insurance program that provides medical assistance to low-income individuals and individuals with disabilities. Medicaid does not provide medical assistance for all poor people—only for designated groups (categories). Most of the people served are pregnant women, children, people with disabilities and the elderly. Because the program only serves designated groups, it is a means-tested entitlement program.

The Medicaid statute identifies certain populations that states are required to cover and other populations that states may choose to cover. Each state establishes its own eligibility standards, benefits package, payment rates and program administration under broad federal guidelines. Thus, there are essentially 56 different Medicaid programs - one for each state, territory, and the District of Columbia. State Medicaid programs must cover “mandatory services” specified in federal law to receive any federal matching funds; these include inpatient and outpatient hospital care.

Program Financing

The states and the federal government jointly finance the Medicaid program. Federal spending levels are determined by the number of people participating in the program and services provided. Federal funding for Medicaid comes from general revenues. The federal government contributes between roughly 50 percent and 75 percent of the payments for services provided under each state Medicaid program. This federal matching assistance percentage (FMAP) varies from state to state and year to year because it is based on the average per capita income in each state. States with lower per capita incomes relative to the national average receive a higher federal match rate. The FMAP for Michigan in FY 2019 is 64.45 percent.

Fee-for-Service and Managed Care

Medicaid programs purchase services on a fee-for-service basis, by paying premiums to managed care plans under contracts, or by using a combination of both approaches. Most Medicaid enrollees receive care through private managed care plans. The two main models of managed care in Medicaid are managed care organizations (MCOs) and primary care case management (PCCM). MCOs are paid on a capitation basis and assume the financial risk for comprehensive Medicaid services or a defined set of services (e.g., ambulatory care, dental services). In PCCM, the primary care provider receives a small fee per person per month to provide basic care and coordinate specialist care and other needed services, which are usually paid fee-for-service.

State-level Medicaid managed care enrollment ratio information is noted in the following table.

Medicaid Managed Care Ratios	
State(s)	Medicaid MC Enrollment as a % of Total Enrollment
Michigan	77.6%
Wisconsin	67.0%
Effective Date: July 1, 2018	
Source: Kaiser Family Foundation	

Medicaid Expansion

Since 2014 the Affordable Care Act (ACA) has expanded Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level (FPL); \$16,400 for an individual or \$27,800 for a family of three in 2017. Even though the ACA states that the new eligibility threshold is 133 percent of the FPL, it is effectively 138 percent due to the disregard of five percent of income in the calculation.

Prior to the ACA-based change, Medicaid eligibility for parents and other adults was more limited in many states. Per the Kaiser Commission on Medicaid and the Uninsured, as of January 2013, nearly two-thirds of states (33) limited Medicaid eligibility for working parents to less than 100 percent FPL, with 16 states limiting eligibility to less than half the federal poverty level. Only nine states (CT, DC, IL, MN, NJ, NY, RI, VT, WI) provided full Medicaid benefits to other adults, and some of these states limited coverage to very low incomes and/or limited the number of adults that may enroll.

The change to 138 percent FPL made millions of formerly uninsured adults eligible for the program. The Supreme Court's Affordable Care Act Ruling maintained the Medicaid expansion, but limits the Secretary's authority to enforce the expansion. If a state does not implement the expansion, the Secretary can withhold federal ACA expansion funds, but not pre-ACA federal program funds. Even if a state does not implement the Medicaid expansion for adults, people with incomes between 100% and 400% of the federal poverty limit can get premium payment assistance (subsidies) on a sliding scale to help purchase coverage through new health insurance exchanges (beginning in 2014). However, those with incomes below the poverty level are not eligible for these subsidies.

The federal-state financing partnership that supports the pre-ACA Medicaid program continues post ACA. The cost of Medicaid coverage stemming from health reform is fully financed by the federal government in the first three years of reform (2014-2016). In subsequent years, the federal government continues to finance most of the cost, phasing down to 90 percent in 2020 and thereafter. Overall, federal funds will finance 96 percent of the cost of the Medicaid expansion over the first decade. Basic Medicaid payment methodologies are unaffected by the ACA.

One of the biggest arguments in favor of state expansion under the federal plan is that hospitals stand to lose disproportionate share payments (DSH) that they receive for treating the uninsured. Under PPACA, those payments are, theoretically, replaced by increased Medicaid coverage of the poor. Many states, however, worry that the federal government will be unable to afford the expanded coverage, leaving them saddled with the extra financial burden.

Michigan Decision on Medicaid Expansion

Michigan obtained approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Affordable Care Act's (ACA) Medicaid expansion through a Section 1115 demonstration waiver, called the "Healthy Michigan Plan." The waiver was approved on December 30, 2013 and was implemented beginning April 1, 2014. The legislation enacting the Medicaid expansion required the state to submit a waiver amendment for CMS approval, which was approved on December 17, 2015.

The waiver allows individuals who are between 100% and 133% of the federal poverty level and have had Healthy Michigan Plan coverage for 48 cumulative months to choose one of the following options:

1. Purchase private insurance through the federal Marketplace (with eligibility for advanced premium tax credits and cost sharing reductions), or
2. Remain in the Healthy Michigan Plan with increased cost-sharing up to 7% of income. This option also includes an increase in enrollee contributions to 3.5% of income (with the opportunity for reductions).

The individuals described above who do not choose one of these options will remain in the Healthy Michigan Plan under option 2.

Commercial Payers (Traditional Indemnity Insurance and Managed Care)

The commercial segment of the healthcare insurance market, which is dominated by employer-based coverage, is the largest part of the total national market.

Traditional Insurance

Traditional insurance, also known as indemnity or fee-for-service, allows members to select any provider. Traditional insurance provides members with the most freedom of choice and offers the most healthcare control for insureds. A referral is not needed to see specialists. A fee-for-service plan will generally pay for most, but not all the costs to treat medical conditions covered by the policy. Traditional insurance represents a relatively small part of the commercial payer segment. Traditional insurance principally comprises the private non-group segment.

Managed Care

The managed care industry attempts to contain the cost of healthcare by negotiating contracts with hospitals, physicians and other providers to deliver healthcare to plan members at favorable rates. Managed care insurance products usually feature medical management and other quality and cost optimization measures. Providers may have incentives to achieve certain quality measures or may share medical cost risk. Members or their employers generally pay co-payments, coinsurance and deductibles when enrollees receive services.

Managed care penetration in the commercial segment of the healthcare insurance industry is high (around 95 percent). In most MSAs there is relatively high concentration of market share among a few insurers. Managed care is principally provided via employer-based (sponsored) health plans. There are fully insured plans and self-funded plans.

Hospital Reimbursement – Commercial vs. Medicare Fee-for-Service

In a 2017 presentation titled An Analysis of Hospital Prices for Commercial and Medicare Advantage Plans was presented at the Congressional Budget Office's Annual Research Meeting. The researchers found that, on average, commercial rates for inpatient services were 89 percent higher than Medicare's FFS rates—or Medicare's FFS rates were 47

percent lower than commercial rates. The ratio of commercial rates to Medicare's FFS rates varied greatly across metropolitan areas and across hospitals within metropolitan areas.

Commercial Payer Summary

The following table, which provides estimates for people insured in the commercial segment, is per the Kaiser Family Foundation.

Location	2014	2015	2016	2017
	Employer	Employer	Employer	Employer
United States ¹	150,832,100	152,351,600	153,701,600	156,199,800

Location	2014	2015	2016	2017
	Non-Group	Non-Group	Non-Group	Non-Group
United States ¹	19,607,200	21,836,100	21,924,600	20,525,500

Employer: Includes those covered by employer-sponsored coverage either through their own job or as a dependent in the same household.

Non-Group: Includes individuals and families that purchased or are covered as a dependent by non-group insurance.

Most covered workers face cost sharing for the medical services they use via deductibles, copayments, and/or coinsurance. According to the 2017 Employer Health Benefits Survey by the Kaiser Family Foundation, the share of covered workers in plans with a general annual deductible (85% in 2018) has increased significantly over time, as have the average deductible amounts for covered workers in plans with deductibles (\$1,543 in 2018).

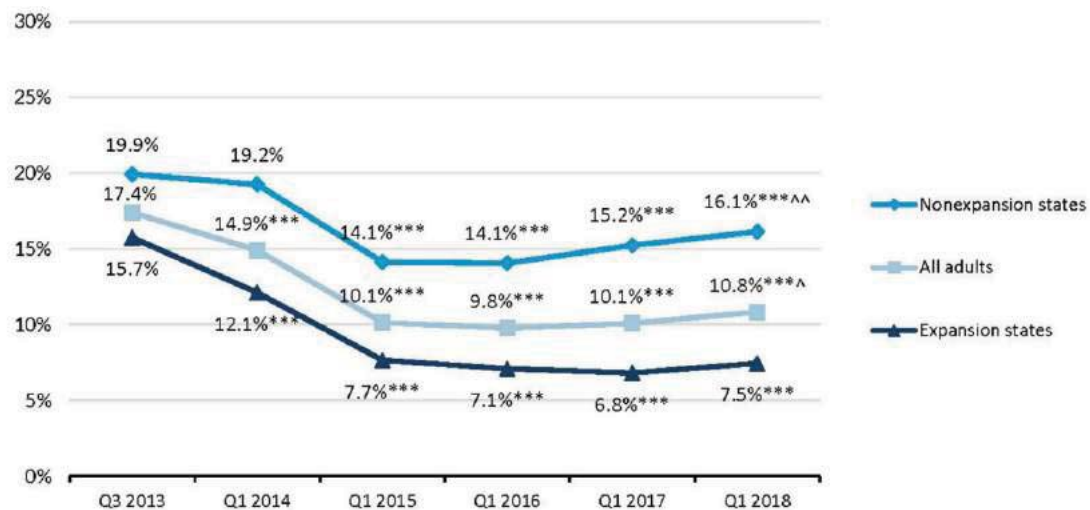
Self-Pay and Charity Care

Self-pay refers to patients who are uninsured. This group of payers does not have private insurance, does not qualify for government programs, and tends to include a large portion of the working poor. They pay the costs of medical expenses out of pocket.

Charity care is when services are provided to patients without expectation of payment. Charity care is typically provided to uninsured patients (self-payers) that meet certain guidelines established by the provider, such as prescribed financial criteria of the patient. In some cases, patients that would qualify for charity care per the provider's criteria do not receive it because they are unable to provide documentation of their qualification. Charity care does not qualify for recognition as revenue in the financial statements.

The number of uninsured Americans spiked during the Great Recession but has dropped considerably with the improving economy and because of the Affordable Care Act. The following table, which is based on data from the Urban Institute's Health Reform Monitoring Survey, illustrates these trends.

Exhibit 1: Trends in Uninsurance Among Adults Ages 18 to 64, by 2018 State ACA Medicaid Expansion Status, Quarter 3 2013 to Quarter 1 2018



Following implementation of the coverage provisions of the Affordable Care Act (ACA) in 2014, the share of nonelderly adults with health insurance increased substantially. This rise in coverage was associated with improvements in health care access and affordability. However, evidence from several studies suggests that coverage gains began to level off after 2016 and may have started to reverse direction in 2017 and 2018. This downward trend may be associated with recent premium increases in the nongroup market, reductions in outreach and enrollment support for Medicaid and the Marketplace, and public uncertainty about the continuation of the ACA's coverage options associated with the debate around repeal efforts.

Historical Trends and Forecast - Overview

Historical and budgeted inpatient utilization information for Dickinson County Memorial Hospital is summarized in the following tables.

Historical and Operator's Budgeted Inpatient Utilization					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	3-Year Avg	Operator's Budget for 12/31/2019
Hospital Beds					
Acute Adult / Pediatrics					
Discharges	2,803	2,325	2,148	2,425	2,255
Patient Days	9,306	7,531	7,347	8,061	7,430
Average Daily Census (ADC)	25.5	20.6	20.1	22.1	20.4
Average Length of Stay (ALOS)	3.3	3.2	3.4	3.3	3.3
Swing Bed (SNF/NF in Acute Beds)					
Discharges	46	9	9	21	461
Patient Days	158	24	21	68	981
Average Daily Census (ADC)	0.4	0.1	0.1	0.2	2.7
Average Length of Stay (ALOS)	3.4	2.7	2.3	2.8	2.1
Newborns / Nursery					
Births	417	400	360	392	N/A
Nursery Days	945	917	849	904	N/A
Average Daily Census (ADC)	1.1	1.1	0.3	0.8	N/A
Average Length of Stay (ALOS)	2.3	2.3	2.4	2.3	N/A
Totals for Hospital Beds					
Discharges	2,849	2,334	2,157	2,447	2,716
Patient Days (w/o nursery days)	9,464	7,555	7,368	8,129	8,411
Average Daily Census (ADC)	25.9	20.7	20.2	22.3	23.0
Average Length of Stay (ALOS)	3.3	3.2	3.4	3.3	3.1

Historical and Operator's Budgeted Bed Count and Occupancy Rate Statistics					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	3-Year Avg	Operator's Budget for 12/31/2019
Hospital Beds					
Acute Adult / Pediatrics					
Licensed Beds	96	49	49	65	49
Set-Up Beds	96	49	49	65	49
Average Daily Census (ADC)	25.5	20.6	20.1	22.1	20.4
Occupancy Rate -- Licensed Beds	26.6%	42.0%	41.0%	34.1%	41.6%
Occupancy Rate -- Set-Up Beds	26.6%	42.0%	41.0%	34.1%	41.6%
Swing Bed (SNF/NF in Acute Beds)					
Average Daily Census (ADC)	0.4	0.1	0.1	0.2	2.7
Combined Acute / Pediatrics and Swing Bed					
Average Daily Census (ADC)	25.9	20.7	20.2	22.3	23.1
Occupancy Rate -- Licensed Beds	27.0%	42.2%	41.2%	34.4%	47.1%
Occupancy Rate -- Set-Up Beds	27.0%	42.2%	41.2%	34.4%	47.1%
Totals for Hospital Beds					
Licensed Beds	96	49	49	65	49
Set-Up Beds	96	49	49	65	49
Average Daily Census (ADC)	25.9	20.7	20.2	22.3	23.0
Occupancy Rate -- Licensed Beds	27.0%	42.2%	41.2%	34.4%	46.9%
Occupancy Rate -- Set-Up Beds	27.0%	42.2%	41.2%	34.4%	46.9%

Historical Utilization / Volume

The following observations are made:

- Inpatient utilization declined significantly in FY 2018. This is attributed to the financial struggles experienced by the Hospital and the resulting loss of some providers.

Inpatient Volume Forecast

Many variables influence the inpatient and outpatient volume forecasts. From the start, an assumption is made that the hospital is managed competently, which may ultimately prove to be true or untrue. Beyond that consideration, the forecasts consider socioeconomic trends, physical plant factors, physician alignment and staffing, specialist referral patterns, competitive forces in the marketplace, business development activities by management, changes in insurance contracts, government reimbursement policies, and historical performance. These influences are discussed in greater detail in other sections of the

report. Because the future actions of healthcare organizations and government policy makers have limited predictability, there are obvious limitations inherent in the forecasting process.

Inpatient volumes have shrunk for many providers during the past few years. Among factors that have contributed to this trend, and which will continue to influence the inpatient/outpatient healthcare utilization dynamic, include:

- Advances in imaging, surgery and anesthesia continue to make it safer for patients to receive most care on an outpatient basis
- Growth in minimally invasive surgeries helps to minimize hospital stays
- Employers have increasingly shifted to health plans for employees that have higher deductibles, copayments and coinsurance, dampening demand for elective procedures that require hospitalization
- Physician-owned ambulatory surgery centers have been growing in number
- Government audits of hospitalizations that result in reimbursement denials on a retroactive basis have contributed to hospitals being conservative in medical coding – increased use of observation status for patients, which is a valid outpatient payment category under Medicare PPS; the Two-Midnight rule is anticipated to further exacerbate the shift from inpatient to outpatient volumes and pressure reimbursement by paying hospitals on observation status instead of inpatient status
- The growing use of hospitalists to manage patients' care during hospital stays is helping achieve shorter lengths of stay
- The growing focus on clinical quality in the shift from fee-for-service to value-based purchasing (aka fee-for-value) will keep downward pressure on inpatient volumes as providers build clinically integrated networks and care models
- Medicare policies have boosted the financial incentives for hospitals to strengthen management of chronic diseases and keep patients out of hospitals

Dickinson County Memorial Hospital

Aside from the macro-level considerations noted above, some of the factors most likely to influence inpatient utilization trends for Dickinson County Memorial Hospital include:

- Changes in physician staffing and/or alignment
- Increasing demand due to healthcare reform
- Changes in the size and health needs of the population within the market service area
- Actions of competitors
- Changes in Dickinson County Memorial Hospital's outreach efforts, service lines and physical plant

Most of these topics are discussed in other sections of the appraisal.

Based on the Hospital's recent struggles and turnaround efforts, I am inclined to believe that the level of inpatient cases experienced in FY 2018 represents an approximate low for near-term operation. With ongoing stabilization activities and effective management, the Hospital should recapture some of the loss experienced. In a small hospital like the subject, the actions of physicians can materially impact the volume of inpatient cases, be it through retirement or changes in physician alignment. The Hospital will need to replenish its primary care physician base to maintain the momentum it needs to achieve optimal

operating results. As with many rural hospitals, this will likely be among the most significant challenges for the Hospital going forward.

Payer Mix Analysis

The following HCUP payer mix information for acute care discharges is specific to Michigan, with national figures for comparison. In the HCUP data Medicare includes fee-for-service and managed care Medicare (Medicare Advantage). Similarly, Medicaid includes fee-for-service and managed care Medicaid.

Discharge Mix and Patient Age Comparisons by Payer Group 2015 Statistics					
Discharge Mix	Medicare	Medicaid	Commercial	Uninsured	Other
National	39.0%	22.6%	30.6%	4.7%	2.9%
Michigan	46.6%	21.5%	29.5%	1.0%	1.3%
Relationship of State Mix to National Mix	119.5%	95.1%	96.3%	21.4%	46.7%
Patient Age (Median)					
National	72.3	27.0	36.6	37.3	41.4
Michigan	72.3	29.0	37.0	33.7	39.9
"Other" payer includes Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs.					
Statistics based on estimates with standard errors deemed not reliable are designated with an asterisk (*).					
Data is per the U.S. Department of Health & Human Resources, Agency for Healthcare Research and Quality (HCUPnet).					

To a significant degree, the primary payer for hospitalizations varies by age because government programs design eligibility criteria to target specific groups (e.g., children, pregnant women and families, and the elderly) that are concentrated in specific age ranges. Medicaid coverage for children is high, as is Medicare coverage for the elderly.

The following table provides a comparative analysis for short-term acute care discharges by payer source for hospitals included as competitors. This information is obtained from American Hospital Directory, Inc. (AHD).

Payer Mix by Discharge for Competitive Short-Term Acute Care Hospitals				
Hospital / Competitor	Medicare	Medicaid	Other Census	
SUBJECT -- Dickinson County Healthcare System	56.3%	17.7%	26.0%	
1 Bellin Hospital	49.3%	13.3%	37.4%	
2 Aspirus Iron River Hospital	71.9%	8.1%	19.9%	
3 OSF Saint Francis Hospital	43.5%	10.5%	46.0%	
Unweighted Average	55.3%	12.4%	32.3%	
Weighted Average	51.6%	13.7%	34.7%	
Median	52.8%	11.9%	31.7%	
Note: Bed counts and occupancy rates reflect set-up beds reported by the provider for a recent yet unspecified fiscal year.				
Note: Payer mix shown if for Short-Term Acute Care beds; any DPU's are excluded.				
Note: Medicare includes fee-for-service and HMO managed care (Medicare Advantage).				
Note: Medicaid is fee-for-service and all Medicaid managed care.				
Data Source: American Hospital Directory				

Based on the data, Dickinson County Memorial Hospital achieved the following relationships in the period of comparison.

- higher Medicare mix
- higher Medicaid mix
- lower Other mix (non-HMO Medicare managed care and non-government census)

Payer Mix Forecast

The following table provides the history of acute discharge payer mixes for the subject, along with the budgeted and Integra forecast amounts. Again, this information is in greater detail than the AHD payer mix data because commercial and private payers are separated.

Inpatient Discharge History and Forecast -- As Completed						
Discharges by Payer for All Licensed Hospital Beds						
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	3-Year Avg	Operator's Budget for 12/31/2019	As Completed Forecast
Payer						
Medicare	1,680	1,320	1,242	1,414	1,746	1,471
Medicaid	353	312	240	302	271	314
Commercial	792	661	642	698	654	726
Self Pay	24	41	33	33	45	34
Total	2,849	2,334	2,157	2,447	2,716	2,545
Payer Mix						
Payer						
Medicare	59.0%	56.6%	57.6%	57.8%	64.3%	57.8%
Medicaid	12.4%	13.4%	11.1%	12.3%	10.0%	12.3%
Commercial	27.8%	28.3%	29.8%	28.5%	24.1%	28.5%
Self Pay	0.8%	1.8%	1.5%	1.3%	1.7%	1.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Average Length of Stay (ALOS) and Patient Days

Average length of stay (ALOS) is influenced by the type and complexity of inpatient treatments performed and by operational efficiencies (influenced by management aspects and facility design).

The following HCUP ALOS information for acute care discharges is specific to Michigan, with national figures for comparison.

Average Length of Stay (days) by Payer Group 2015 Statistics			
	National	Michigan	State % of National
All Payers Combined	4.6	4.6	99.4%
Medicare	5.3	5.3	99.8%
Medicaid	4.5	4.2	92.7%
Commercial	3.9	3.8	97.0%
Uninsured	4.1	3.1	76.6%
Other	4.6	5.4	117.6%
"Other" payer includes Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs.			
Statistics based on estimates with standard errors deemed not reliable are designated with an asterisk (*).			
Data is per the U.S. Department of Health & Human Resources, Agency for Healthcare Research and Quality (HCUPnet).			

Historical census information for Dickinson County Memorial Hospital is provided in the following table.

Historical Statistics for Discharges, Patient Days and Average Length of Stays by Payer												
Payer	Acute - Adults / Peds											
	Actual FYE 12/31/2017				Actual FYE 12/31/2018				4 Months Annualized 12/31/2019			
	ALOS	Days	DCs	% of DCs	ALOS	Days	DCs	% of DCs	ALOS	Days	DCs	% of DCs
Medicare	3.7	6,024	1,634	58.3%	3.5	4,638	1,311	56.4%	3.8	4,674	1,233	57.4%
Medicaid	3.0	1,053	353	12.6%	2.9	893	312	13.4%	3.0	708	240	11.2%
Commercial	2.7	2,169	792	28.3%	2.9	1,895	661	28.4%	2.9	1,890	642	29.9%
Self Pay	2.5	60	24	0.9%	2.6	105	41	1.8%	2.3	75	33	1.5%
Total	3.3	9,306	2,803	100.0%	3.2	7,531	2,325	100.0%	3.4	7,347	2,148	100.0%
Medicare	Swing (SNF/NF in Hospital Beds)											
	Actual FYE 12/31/2017				Actual FYE 12/31/2018				4 Months Annualized 12/31/2019			
	ALOS	Days	DCs	% of DCs	ALOS	Days	DCs	% of DCs	ALOS	Days	DCs	% of DCs
Total	3.4	158	46	100.0%	2.7	24	9	100.0%	2.3	21	9	100.0%
	3.4	158	46	100.0%	2.7	24	9	100.0%	2.3	21	9	100.0%
Medicare	Hospital Bed Stats (Acute/Swing/SubP)											
	Actual FYE 12/31/2017				Actual FYE 12/31/2018				4 Months Annualized 12/31/2019			
	ALOS	Days	DCs	% of DCs	ALOS	Days	DCs	% of DCs	ALOS	Days	DCs	% of DCs
Medicare	3.7	6,182	1,680	59.0%	3.5	4,662	1,320	56.6%	3.8	4,695	1,242	57.6%
Medicaid	3.0	1,053	353	12.4%	2.9	893	312	13.4%	3.0	708	240	11.1%
Commercial	2.7	2,169	792	27.8%	2.9	1,895	661	28.3%	2.9	1,890	642	29.8%
Self Pay	2.5	60	24	0.8%	2.6	105	41	1.8%	2.3	75	33	1.5%
Total	3.3	9,464	2,849	100.0%	3.2	7,555	2,334	100.0%	3.4	7,368	2,157	100.0%

A comparison of the subject's case-mix-adjusted lengths of stay for short-term acute-only discharges is provided in the following below. Differences that exist in ALOS figures in the preceding table and the following table may be the result of different categorizations of patients (e.g., managed care Medicare and Medicaid) or different fiscal year ending periods.

Acute Average Length of Stay (ALOS) for Competitive Short-Term Acute Care Hospitals						
Hospital / Competitor		Medicare	Medicaid	Other Census	Combined	Adjusted to 1.0 CMI
SUBJECT -- Dickinson County Healthcare System		3.6	5.3	2.8	3.6	2.3
1	Bellin Hospital	3.6	3.9	3.4	3.6	1.7
2	Aspirus Iron River Hospital	3.7	10.0	3.2	3.5	2.8
3	OSF Saint Francis Hospital	2.9	2.2	1.3	2.3	1.8
Unweighted Average		3.4	5.3	2.7	3.2	2.1
Average CMI-adjusted		2.2	3.5	1.7	2.1	
Median		3.6	4.6	3.0	3.5	2.1
Note: Medicare and Medicaid are FFS census only. Other Census is all non-Medicare and Medicaid.						
Combined includes all Medicare and Medicaid (FFS + managed care), plus non-Medicare and Medicaid.						
Note: The CMI adjustment is based upon the Medicare CMI, not the all-patient average.						
Note: ALOS figures exclude distinct part subprovider, swing, and NF/SNF census.						
Data Source: American Hospital Directory						

In relation to the comparable set, Dickinson County Memorial Hospital experienced a typical short-term acute, all-payer, CMI-adjusted ALOS in the period of comparison. We view this neutral with respect to the opportunity to control future operating costs relative to historical ones.

ALOS Forecast

The subject ALOS history, along with the operator's budgeted forecast and Integra forecast are provided in the following table. In contrast to the preceding table, the ALOS figures in the following table are for combined acute and swing/SNF census. The swing/SNF has longer ALOSs.

Average Length of Stay by Payer -- As Completed						
Stays in All Licensed Hospital Beds						
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	3-Year Avg	Operator's Budget for 12/31/2019	As Completed Forecast
Payer						
Medicare	3.7	3.5	3.8	3.7	3.1	3.7
Medicaid	3.0	2.9	3.0	3.0	3.0	3.0
Commercial	2.7	2.9	2.9	2.8	3.0	2.8
Self Pay	2.5	2.6	2.3	2.5	3.5	2.5
Average	3.3	3.2	3.4	3.3	3.1	3.3

Generally, the need for payers to constrain spending on healthcare services has led to shorter inpatient stays, a trend that we expect to continue. There is no reason to expect that future ALOSs will deviate significantly from historical experiences.

Patient Day Forecast

Based upon the payer mix and ALOS forecasts, the forecast patient days are as follows.

Inpatient Days by Payer -- As Completed						
Inpatient Days for Stays in All Licensed Hospital Beds						
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	3-Year Avg	Operator's Budget for 12/31/2019	As Completed Forecast
Payer						
Medicare	6,182	4,662	4,695	5,180	5,479	5,443
Medicaid	1,053	893	708	885	813	942
Commercial	2,169	1,895	1,890	1,985	1,962	2,033
Self Pay	60	105	75	80	157	85
Total	9,464	7,555	7,368	8,129	8,411	8,503
# of Licensed Beds	96	49	49	65	49	49
Occupancy Rate	27.0%	42.2%	41.2%	34.4%	47.0%	47.5%
# of Staffed Beds	96	49	49	65	49	49
Occupancy Rate	27.0%	42.2%	41.2%	34.4%	47.0%	47.5%

Medicare Case Mix Index (CMI)

A comparison of Medicare case-mix indices for the subject and competing hospitals is provided in the table below.

Medicare CMI for Competitive Hospitals	
Hospital / Competitor	CMI
SUBJECT -- Dickinson County Healthcare System	1.5536
1 Bellin Hospital	2.0839
2 Aspirus Iron River Hospital	1.2772
3 OSF Saint Francis Hospital	1.2603
Unweighted Average	1.5438
Median	1.4154
Note: Data is for fee-for-service census only.	
Note: CMI figures exclude distinct part subprovider, swing, and NF/SNF census.	
Data Source: American Hospital Directory	

The subject's Medicare CMI is somewhat higher than the average, but well below that of the urban competitor, Bellin Hospital. This relationship reflects the size and scope of

services offered by the respective hospitals. Larger hospitals that offer a broader range of clinical services and which have more specialists on staff will experience higher case mixes because they treat more complex cases.

The following Medicare case-mix history is noted for the subject facility.

Subject Medicare Case-Mix History and Forecast	
Fiscal Year	CMI
FY 2014	1.481
FY 2015	1.521
FY 2016	1.599
FY 2017	1.504
FY 2018	1.554
Historical Average	1.532
Market Average	1.544
Forecast	1.535
Ratio of Forecast to Market Average	99%

Inflation Adjustments

Inflation adjustments are made in this appraisal to update historical revenue and expense data to the forecast period(s). As applicable, these adjustments are made to subject and comparable data. The following table includes the benchmarks that have been analyzed to derive the inflation rates adopted for adjusting purposes. Because wages are a significant cost component that can be measured separate from other operating costs, both nursing (wage) and non-nursing inflation rates are utilized.

Historical Inflation Rates						
Year	Average Hourly Earnings of All Hospital Employees (National)		Consumer Price Index All Urban Consumers U.S. city avg. for all items		Consumer Price Index All Urban Consumers U.S. city avg. for medical care	
	Hourly Rate	Change	Index	Change	Index	Change
2013	\$29.55	N/A	233.55	N/A	427.11	N/A
2014	30.03	1.62%	237.09	1.52%	437.25	2.37%
2015	31.05	3.40%	237.77	0.29%	448.85	2.65%
2016	31.48	1.38%	241.24	1.46%	468.29	4.33%
2017	32.13	2.06%	246.16	2.04%	476.93	1.85%
2018	32.95	2.55%	252.13	2.42%	485.61	1.82%
5-Year Average		2.20%		1.55%		2.60%
2016, 2017, & 2018 Average		2.00%		1.97%		2.66%

Source: Bureau of Labor Statistics, Annual Averages

Reflecting the data profiled the following inflation rates have been applied in this appraisal.

Nursing (wages): 2.00%
 Non-nursing: 3.30%
 50/50 blend: 2.65%

Inpatient – Reimbursement Analysis

This section will cover the following:

- Provide inpatient reimbursement and historical contractual allowance information for the primary payer sources for Dickinson County Memorial Hospital
- Forecast net inpatient revenues by payer based upon the forecast volume, case mix, and rates of contractual allowance

Within this section of the appraisal, historical rates of contractual allowance.

Contractual Allowance

Providers have a standard charge for each specific good sold or service rendered. The standard charge amount, reflected on all bills issued, is the amount initially recorded as an account receivable on the financial books when the service is rendered or the good is sold. However, providers have contractual agreements with most third-party payers regarding the amount that the payer will reimburse for specific goods and services (i.e., the contract provides a discount for enumerated goods and services). The amount of discount typically differs in contracts between a provider and different payers and, in fact, often differs between different plans offered by the same payer. Thus, a provider typically receives different amounts from different payers in full satisfaction of claims for the same goods or services provided. While payment of the actual amount due comes from one or all the sources to whom bills are issued, payment from all sources is dictated by the terms of the contractual agreements in force.

Contractual allowance does not constitute bad debt, since the provider was never entitled to collect the difference under the terms of the relevant contract. A provider's book contractual allowance represents the difference between the amount recorded on its books as a receivable at the time of the initial billing and the estimated net realizable value (NRV) of gross receipts reported for book purposes under GAAP. Contractual allowances often reduce the gross income of a healthcare provider by fifty percent or more.

Hospital Inpatient Payment

Traditional Medicare Fee-for-Service

Rural Hospital Reimbursement (non-CAH)

Most rural hospitals are either CAHs or sole community hospitals (SCHs). Rural Referral Center (RRC) is another classification. Historically, there has also been a program for Medicare-dependent hospitals (MDHs). Hospitals located in a rural area and meeting certain conditions receive additional operating and capital payments. As previously noted, Dickinson County Memorial Hospital is designated as an SCH.

To qualify for the SCH program, a hospital must be located at least 35 miles from the nearest like hospital (i.e., a hospital furnishing short-term, acute care; excluding CAHs), or meet other federal criteria for being deemed a community's sole source of care. SCHs receive the higher of either:

1. standard inpatient prospective payment rates, or
2. payments based on the hospital's costs in a base year (1982, 1987, 1996 or 2006) updated to the current year and adjusted for changes in their case mix.

The SCH and former MDH payment methodology differs in two significant ways from CAH cost-based payments. First, SCHs and MDHs only receive cost-based payments for

inpatient care; CAHs receive cost-based payments for inpatient, outpatient, lab, therapy, and post-acute services in swing beds. Second, SCHs' and MDHs' payments are/were based on historical costs trended forward. Therefore, if a SCH or MDH increases its expenditures per patient, its payments will/would not be affected unless and until those costs are adopted as a new base year. In contrast, if a CAH increases its expenditures per patient, Medicare payments increase accordingly for that period.

With respect to the readmissions adjustment factor, the difference between the SCH's payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Supplemental Medicare Payments & Adjustments

This section covers Medicare payments and adjustments that are supplemental to PPS. Payments for these considerations are calculated in the Medicare cost report. Categorically, these adjustments may be referred to as "policy" or "provider specific."

Low-Volume Hospital Payment Adjustment

Low-volume hospitals are eligible to receive a payment adjustment to account for their higher costs per discharge. A low-volume hospital is defined as an IPPS-paid acute care hospital that:

- is located more than 25 road miles from another comparable hospital; and
- has less than 200 total (not just Medicare) discharges during the fiscal year.

The Secretary is required to determine an appropriate percentage increase for low-volume hospitals based on the empirical relationship between the standardized cost-per-case for such hospitals and their total discharges to account for the additional incremental costs (if any) that are associated with such number of discharges. The low-volume adjustment is limited to no more than 25 percent of payments made for all Medicare discharges. The low-volume add-on payment amount is based on all other per discharge payments made under section 1886 of the Act, including capital, DSH, IME, and outliers.

As previously discussed, the subject property has received low-volume hospital payments recently, and the proposed rule issued by CMS in 2019, should be finalized, would yield significant additional reimbursement in FFY 2020.

Disproportionate Share

Medicare provides special funding to hospitals that treat significant populations of indigent patients through the Disproportionate Share Hospital (DSH) programs. The program seeks to encourage hospitals to provide health services for these individuals. There are two methods for a hospital to qualify for the Medicare DSH adjustment.

The primary method is for a hospital to qualify based on a statutory formula that results in the DSH patient percentage. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A.

The DSH patient percentage is defined as:

$$\text{DSH Patient Percent} = (\text{Medicare SSI Days} / \text{Total Medicare Days}) + (\text{Medicaid, Non-Medicare Days} / \text{Total Patient Days})$$

The alternate special exception method is for large urban hospitals that can demonstrate that more than 30 percent of their total net inpatient care revenues come from state and local governments for indigent care (other than Medicare or Medicaid).

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment based on another statutory formula. The formula varies for urban hospitals with 100 or more beds, rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or sole community hospitals, and other hospitals.

Medicare DSH payments were reduced substantially beginning in FFY 2014 in accordance with the Affordable Care Act. The distribution of Medicare DSH payments also changed. Hospitals that qualify for Medicare DSH payments receive two separately calculated payments:

1. 25 percent of the amount they would have received under the statutory formula for Medicare DSH payments prior to the ACA amendments (referred to as the “empirically justified Medicare DSH payment;”
2. “uncompensated care payments,” paid from a pool comprised of the remaining amount, which equals the Secretary’s estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured

Outliers

For cases that are unusually costly, known as outlier cases, the IPPS payment is increased. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. In general, a hospital receives an outlier payment when the estimated operating and capital costs of a case exceed a fixed loss threshold that is adjusted to reflect local market labor costs. The Centers for Medicare and Medicaid Services annually establish the threshold. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH or IME adjustments.

Transfer Policy

Medicare IPPS policy includes a provision to reduce the DRG payment under the following circumstances.

- The beneficiary’s length of stay is at least one day less than the geometric mean length of stay for the DRG
- The beneficiary is transferred to another hospital covered by the Acute Care Hospital IPPS or, for certain MS-DRGs, discharged to a post-acute setting
- The beneficiary is transferred to a hospital that does not have an agreement to participate in the Medicare Program
- The beneficiary is transferred to a critical access hospital

Bad Debt

Medicare traditionally reimbursed PPS hospitals for 70 percent of bad debts resulting from beneficiaries’ nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. The Middle-Class Tax Relief and Job Creation Act of 2012 reduced that figure to 65 percent beginning in FY 2013.

Medicare Advantage (managed care)

Medicare Advantage is the current Medicare managed care program. Medicare makes payments to private health insurance companies, which in turn create and market

Medicare managed care products for Medicare beneficiaries. Medicare Advantage can be offered through various types of plans, including HMO, PPO and POS.

MA Contract Providers

In instances where hospitals and other providers directly contract with MA organizations, the terms and conditions of the relationship between the parties are largely governed by written agreement. There is no statutory or regulatory requirement that the contract payment correlate, in any way, to what the provider would have received under the original Medicare program. Payment methodology varies based on market conditions, including local competition, hospital reputation and areas of specialty. Importantly, the MA rates Medicare pays to plan organizations is an influence.

Non-Contract Providers

Non-contract providers are to be paid what they would have received under original Medicare. This means that MA organizations must pay providers consistent with the complex payment rules that apply in the “original Medicare” context for the services at issue.

Private Fee-for-Service Plans

An MA PFFS plan must establish uniform payment rates for all contracted providers. PFFS plans are permitted to establish their own fee-schedules and balance-billing rules. However, where a PFFS plan establishes payment rates that are less than original Medicare for designated types of providers, the plan must demonstrate to CMS that it has enough providers of each such type under written contract to meet Medicare access standards. A non-contracted provider must accept as payment in full the amount that it would have received under original Medicare for the item or service, and the PFFS plan must pay the provider that amount minus the enrollee’s cost-sharing under the plan.

CMS Overpayment

The Centers for Medicare and Medicaid Services decided that it has overpaid the Hospital during the 2017 fiscal year in an amount of approximately \$2.5MM. A representative of the Hospital negotiated with CMS to have repayment of the \$2.5MM occur over a 36-month period.

Medicare Prospective & Supplemental Inpatient Payment Summary

The following table illustrates the historical and budgeted rates of contractual allowance and net reimbursement per day for inpatient services paid by prospective payment from Medicare. Supplemental payments are included with prospective payments in the data shown.

Medicare -- Inpatient Net Revenue Per Patient Day in Hospital Beds				
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
Gross Revenues	\$ 37,684,494	\$ 32,620,674	\$ 31,307,634	\$ 34,439,421
Contractual Allowances	(22,862,772)	(20,814,166)	(19,639,293)	(21,259,689)
Net Inpatient Medicare Revenue	\$ 14,821,722	\$ 11,806,508	\$ 11,668,341	\$ 13,179,732
Contractual Allowance Ratio	60.7%	63.8%	62.7%	61.7%
Net Reimbursement Per Patient Day	\$2,398	\$2,532	\$2,485	\$2,405
Change in PPD Net Amount	N/A	5.6%	-1.9%	N/A

Medicaid**Fee-for-Service Reimbursement**

Michigan's inpatient reimbursement methodology for hospitals is found in the state's Medicaid Provider Manual, available at:

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

An abbreviated summary of the reimbursement methodology is provided as follows. The Michigan Department of Community Health (MDCH) utilizes prospectively determined payment for its Medicaid inpatient program. The system involves calculating per-case reimbursements, which are determined prospectively based on the patient's condition. The Medicaid diagnosis related group (DRG) reimbursement system uses the same Grouper logic that the Medicare Program uses to assign DRGs to claims. However, because Michigan Medicaid develops its own weights and prices based on its own paid claims, Medicaid may not use the same version of the Grouper program as Medicare is currently using.

The statewide relative weights calculated for the Michigan system utilize Medicaid and Children's Special Health Care Services (CSHCS) inpatient claims for admissions during four consecutive state fiscal years and hospital specific cost report data drawn from three consecutive cost report years used to establish the relative weights.

The DRG price for each hospital is calculated using the following steps:

1. Hospital's adjusted charges.
2. Inpatient cost to charge ratio.
3. Hospital's adjusted costs (line 1 x line 2).
4. Hospital's episodes.
5. Cost per discharge (line 3 / line 4).
6. Hospital's case mix.
7. Weighted inflation.
8. Hospital's base price (line 5 x line 7 / line 6)
9. Establish the statewide base limit (mean plus one standard deviation).
10. Hospital's limited base price (lesser of lines 8 or 9).
11. Establish the statewide operating cost limit (truncated, weighted mean of line 10).
12. Hospital's DRG base price (lesser of lines 8 or 11).
13. Calculate the hospital's incentive (if line 12 < line 11, 10 percent of line 12 – line 11; otherwise 0).
14. Hospital's DRG base price plus any incentive (line 12 + line 13).
15. Hospital's Area Cost Adjustor.
16. Apply budget neutrality factor.
17. Hospital's final DRG price (line 14 x line 15 x line 16). The DRG price is rounded to the nearest whole dollar amount.

Capital costs relating to Medicaid patients are paid on a cost reimbursement method. Medicare's Principles of Reimbursement are used to determine Medicaid's share of allowable capital costs. MDCH policy is used to determine capital reimbursement. The initial reimbursement for capital is paid by separate Capital Interim Payment (CIP). CIPs are made using a semi-monthly schedule (24 payments per year). The CIP amount is set using the most recent available cost data and an estimated impact of any applicable limits on capital. CIP amounts are set annually at the beginning of the hospital's fiscal year. CIPs may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report.

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds. Occupancy is tabulated as: total inpatient days (including nursery days) / net licensed bed days. If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full. If a hospital is in a rural area, as defined below, capital reimbursement is limited if occupancy in the hospital is less than 60 percent during the hospital's fiscal year. A hospital is considered a rural hospital if it is located outside a city of 40,000 or more people by 10 or more miles (U.S. Census Bureau population data is used). For rural hospitals with occupancy less than 60 percent, the Medicaid reimbursement for capital is: (occupancy / 0.6) x Medicaid share of capital. If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement is limited if occupancy in the hospital is less than 75 percent during the hospital's fiscal year.

Disproportionate Share

Michigan's Medicaid plan creates several DSH funding pools. Medicaid inpatient DSH payments are made annually in a single distribution, based on charges converted to cost, using the hospital's cost-to-charge ratio. The payment is made at the end of the state fiscal year. Each hospital's indigent volume is taken from hospital cost reporting periods ending during the second previous state fiscal year.

Medicaid Managed Care

As previously illustrated, a majority of Medicaid enrollees in Michigan are covered through managed care plans. For those enrollees, reimbursement rates for services provided by providers that contract with participating health plans are negotiated between the hospital or doctor and the MCO. The state Medicaid fee-for-service rates are usually the starting point for negotiations between the parties.

Medicaid Inpatient Payment Summary

The following table illustrates the historical and proforma rates of contractual allowance and net reimbursement per day for inpatient services paid by Medicaid. Supplemental UPL and/or DSH payments are included with prospective payments in the data shown.

Medicaid -- Inpatient Net Revenue Per Patient Day in Hospital Beds				
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
Gross Revenues	\$ 6,936,067	\$ 6,379,072	\$ 4,796,244	\$ 7,016,819
Contractual Allowances	(4,918,729)	(3,518,749)	(3,982,791)	(4,288,938)
Net Inpatient Medicaid Revenue	\$ 2,017,338	\$ 2,860,323	\$ 813,453	\$ 2,727,881
Contractual Allowance Ratio	70.9%	55.2%	83.0%	61.1%
Net Reimbursement Per Patient Day	\$1,916	\$3,203	\$1,149	\$3,355
Change in PPD Net Amount	N/A	67.2%	-64.1%	N/A
Note: QAAP assessments (provider taxes) are treated as a contractual allowance for Medicaid.				

Commercial Payers

Generally, PPO, POS and HMO health insurance plans make use of provider networks. Indemnity plans typically do not. An in-network provider is one contracted with the health insurance company to provide services to plan members for specific pre-negotiated (discounted) rates. An out-of-network provider is one not contracted with the health insurance plan. In most cases, the use of an out-of-network provider by an insured will result in greater out-of-pocket costs for services received.

Fee-for-Service Commercial Payers

Typically, when a health care provider performs a service for an insured patient the provider bills the patient's health insurer for that service. The bill that the provider submits to the health insurer is referred to as a claim, and the process of paying providers per claim is often referred to as a fee-for-service (FFS) method of payment. Under a fee-for-service payment arrangement, health insurers pay each claim based on the agreed upon price for each service rendered.

Generally, health insurers and hospitals negotiate prices for inpatient hospital services using a base case rate for each patient admitted to a hospital. That base rate is then adjusted by a set of standard case weights that reflect the complexity of each case admitted; it may be further modified if the case becomes atypical or an outlier case.

Contracted Commercial Payers

Hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Some of the most common arrangements include:

- a per diem rate, which is a fixed, all-inclusive rate per day
- a case rate or bundled fee, which is an all-inclusive rate per admission
- a discounted charge for approved hospital services
- a capitated amount per covered member that is paid periodically
- a DRG-based methodology, whereby a fixed amount is paid to the provider according to how the patient is categorized by injury, illness, or medical condition

These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Many hospital contracts include a "pay for performance" component where reimbursement levels are linked to improved clinical performance, patient safety, and medical error reduction.

Blue Cross Blue Shield

Management estimates that roughly one-quarter of its current patient volumes (IP, OP, and clinic) are for people commercially insured by Blue Cross Blue Shield of Michigan (BCBSM), the largest health insurer in the state. The one-quarter figure does not include the Medicare and Medicaid plans administered by BCBSM.

For reimbursement contracting, BCBSM places hospitals into one of seven Peer Groups based upon their size (number of licensed beds and number of admissions), teaching status and location (rural versus urban). Dickinson Memorial Hospital is in Peer Group 4.

Historically, management reports that the Hospital received add-on reimbursement (in addition to standard Peer Group 4 reimbursement) per a letter of understanding. The Hospital does not presently receive add-on reimbursement (does not have the letter of understanding). The appraiser does not have a good understanding of the reason for the loss of that agreement, which is believed to have occurred in a recent fiscal year. Getting that add-on back in the BCBSM reimbursement contract may represent an opportunity for the Hospital.

Commercial Inpatient Payment Summary

The following table illustrates the historical and budgeted rates of contractual allowance and net reimbursement per day for inpatient services paid by commercial payers.

Commercial -- Inpatient Net Revenue Per Patient Day in Hospital Beds				
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
Gross Revenues	\$ 14,395,080	\$ 13,532,036	\$ 14,758,662	\$ 15,318,837
Contractual Allowances	(5,229,863)	(4,980,265)	(5,398,905)	(4,814,566)
Net Inpatient Commercial Revenue	\$ 9,165,217	\$ 8,551,771	\$ 9,359,757	\$ 10,504,271
Contractual Allowance Ratio	36.3%	36.8%	36.6%	31.4%
Net Reimbursement Per Patient Day	\$4,226	\$4,513	\$4,952	\$5,354
Change in PPD Net Amount	N/A	6.8%	9.7%	N/A

Self-Pay

Self-pay refers to patients who are uninsured and expected to pay for services; not qualifying for charity care. Historically, for billings to self-pay (uninsured) patients, hospitals have recognized revenue at the gross charge amount (or based on discounted rates, if negotiated or provided by policy) along with a relatively high bad-debt provision (expense) in the period of service. As discussed in the expense forecast section of the appraisal, hospitals with emergency departments are now required under FASB guidance to treat bad debt as a reduction of gross patient service revenue to arrive at net patient service revenue. Unless otherwise noted, the contractual allowances shown in the following table are strictly contractual allowances and do not include bad debt. Bad debt is forecast as a separate revenue deduction to derive net patient revenue.

The following table illustrates the historical and budgeted rates of contractual allowance and net reimbursement per day for inpatient services paid by self-payers. With respect to any charity care provided by the Hospital, because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue. Those amounts are typically recognized as a contractual allowance or other discount.

Self Pay -- Inpatient Net Revenue Per Patient Day in Hospital Beds				
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
Gross Revenues	\$ 450,412	\$ 776,083	\$ 92,208	\$ 1,219,346
Contractual Allowances	(514,212)	(323,852)	-	(10,675)
Net Inpatient Self Pay Revenue	\$ (63,800)	\$ 452,231	\$ 92,208	\$ 1,208,671
Contractual Allowance Ratio	114.2%	41.7%	0.0%	0.9%
Net Reimbursement Per Patient Day	(\$1,063)	\$4,307	\$1,229	\$7,699
Change in PPD Net Amount	N/A	-505.0%	-71.5%	N/A

Note: The reason for the indication of negative PPD reimbursement in FY 2017 is unknown.

Inpatient Net Revenue Forecast

Hospital Inpatient Services

Historical and budgeted inpatient net revenues are summarized in the following tables.

Historical Inpatient Net Revenue by Financial Period						
Historical Net Inpatient Revenue - FYE 12/31/2017						
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance	Hospital Bed Patient Days	Net Per Patient Day
Medicare	\$ 37,684,494	\$ (22,862,772)	\$ 14,821,722	60.7%	6,182	\$ 2,398
Medicaid	6,936,067	(4,918,729)	2,017,338	70.9%	1,053	1,916
Commercial	14,395,080	(5,229,863)	9,165,217	36.3%	2,169	4,226
Self Pay	450,412	(514,212)	(63,800)	114.2%	60	(1,063)
Total	\$ 59,466,053	\$ (33,525,576)	\$ 25,940,477	56.4%	9,464	\$ 2,741
Historical Inpatient Net Revenue - FYE 12/31/2018						
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance	Hospital Bed Patient Days	Net Per Patient Day
Medicare	\$ 32,620,674	\$ (20,814,166)	\$ 11,806,508	63.8%	4,662	\$ 2,532
Medicaid	6,379,072	(3,518,749)	2,860,323	55.2%	893	3,203
Commercial	13,532,036	(4,980,265)	8,551,771	36.8%	1,895	4,513
Self Pay	776,083	(323,852)	452,231	41.7%	105	4,307
Total	\$ 53,307,865	\$ (29,637,032)	\$ 23,670,833	55.6%	7,555	\$ 3,133
Historical Inpatient Net Revenue - FYE 12/31/2019						
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance	Hospital Bed Patient Days	Net Per Patient Day
Medicare	\$ 31,307,634	\$ (19,639,293)	\$ 11,668,341	62.7%	4,695	\$ 2,485
Medicaid	4,796,244	(3,982,791)	813,453	83.0%	708	1,149
Commercial	14,758,662	(5,398,905)	9,359,757	36.6%	1,890	4,952
Self Pay	92,208	-	92,208	0.0%	75	1,229
Total	\$ 50,954,748	\$ (29,020,989)	\$ 21,933,759	57.0%	7,368	\$ 2,977

Figures represent 4 months annualized.

Budgeted Inpatient Net Revenue - FYE 12/31/2019						
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance	Hospital Bed Patient Days	Net Per Patient Day
Medicare	\$ 34,439,421	\$ (21,259,689)	\$ 13,179,732	61.7%	5,479	\$ 2,405
Medicaid	7,016,819	(4,288,938)	2,727,881	61.1%	813	3,355
Commercial	15,318,837	(4,814,566)	10,504,271	31.4%	1,962	5,354
Self Pay	1,219,346	(10,675)	1,208,671	0.9%	157	7,699
Total	\$ 57,994,423	\$ (30,373,868)	\$ 27,620,555	52.4%	8,411	\$ 3,284

Inflation-Adjusted Amounts

The historical net revenue per patient day figures from the preceding table are inflation-adjusted to the forecast period in the following table. The inflation-adjusted figures are deemed more pertinent to the development of our forecasts. The adjustments reflect a 50/50 blend of nursing and non-nursing inflation rates previously discussed. The 50/50 blended inflation rate applied is 2.65 percent.

Inpatient Net Revenue Per Patient Day in Hospital Beds -- Inflated to 6-30-2020								
Period Ending >>>	Actual FYE 12/31/2017	Inflation Adjusted 12/31/2017	Actual FYE 12/31/2018	Inflation Adjusted 12/31/2018	4 Months Annualized 12/31/2019	Inflation Adjusted 12/31/2019	Inflation Adjusted 3-Yr Avg	Operator's Budget for 12/31/2019
Payer								
Medicare	\$ 2,398	\$ 2,559	\$ 2,532	\$ 2,634	\$ 2,485	\$ 2,518	\$ 2,570	\$ 2,405
Medicaid	1,916	2,045	3,203	3,331	1,149	1,164	2,180	3,355
Commercial	4,226	4,511	4,513	4,693	4,952	5,017	4,740	5,354
Self Pay	(1,063)	(1,135)	4,307	4,479	1,229	1,246	1,530	7,699
Total	\$ 2,741	\$ 2,926	\$ 3,133	\$ 3,258	\$ 2,977	\$ 3,016	\$ 3,067	\$ 3,284

Note: Inflation adjustments are to the end date of the forecast period.

Hospital Bed Net Revenue Forecast

The following table includes our inpatient net revenue forecast for revenues in licensed hospital beds. The forecast net revenue per patient day figures are based upon historical

rates and all the circumstantial changes and/or influences.

Inpatient Net Revenue Forecast for Hospital Beds -- As Completed								
Period Ending >>> Payer	Net Revenue Per Patient Day				Operator's Budget for 12/31/2019	\$ PPD Forecast	Forecast Patient Days	Forecast Inpatient Net Revenue
	Period Ending, Inflation Adjusted Figures							
	12/31/2017	12/31/2018	12/31/2019	3-Yr Avg				
Medicare	\$ 2,559	\$ 2,634	\$ 2,518	\$ 2,570	\$ 2,405	\$ 2,570	5,443	\$ 13,988,510
Medicaid	2,045	3,331	1,164	2,180	3,355	2,415	942	2,274,930
Commercial	4,511	4,693	5,017	4,740	5,354	4,863	2,033	9,886,479
Self Pay	(1,135)	4,479	1,246	1,530	7,699	2,329	85	197,965
Total	\$ 2,926	\$ 3,258	\$ 3,016	\$ 3,067	\$ 3,284	\$ 3,099	8,503	\$ 26,347,884

Net Inpatient Revenue Comparison

The following table provides a comparative illustration of the case-mix and inflation-adjusted net inpatient revenues for the expense comparables and our subject forecast.

Comparison of Inpatient Net Revenues Per Discharge & Patient Day -- Case Mix & Inflation Adjusted to Forecast Period							
Provider	Estimated IP Net Revenue	# of IP Cases	Estimated IP Net Revenue Per Discharge	Per Discharge Amount Adj. to Subject CMI	Case Mix Amount Adj for Inflation	Total Patient Days	PPD Case Mix Amount Adj. for Inflation
West Branch Regional Medical Center	\$ 17,028,947	2,135	\$ 7,976	\$ 7,950	\$ 8,250	7,272	\$ 2,422
Midnichigan Medical Center - Alpena	36,649,876	4,502	8,141	8,282	8,531	20,902	1,837
Community Health Center Branch Cty	16,302,477	2,776	5,873	7,274	7,604	12,065	1,749
Mclaren Port Huron	92,892,862	12,708	7,310	7,440	7,835	44,669	2,229
Tawas St. Joseph Hospital	8,245,475	1,745	4,725	5,521	5,687	3,933	2,523
North Ottawa Community Hospital	10,235,303	1,742	5,876	6,108	6,291	3,283	3,338
Midnichigan Medical Center-Clare	6,311,062	983	6,420	7,734	7,967	2,449	3,198
Otsego Memorial Hospital	21,965,848	2,103	10,445	11,371	11,886	16,348	1,529
Mclaren Northern Michigan	104,603,300	10,470	9,991	7,968	8,391	40,233	2,184
Midnichigan Medical Ctr	165,972,760	15,290	10,855	8,623	8,883	54,434	2,495
Averages for Competitors / Comparables	\$ 48,020,791	5,445	\$ 7,761	\$ 7,827	\$ 8,132	20,559	\$ 2,351
Subject Forecast	\$ 25,997,884	2,545	\$ 10,215	\$ 10,215	\$ 10,215	8,503	\$ 3,057
Subject Forecast as % of Competitor / Comparable Average					126%		130%
Notes: Swing & SNF/NF discharges are excluded from competitor IP cases due to data availability; however, revenues are included if applicable. SNF/NF discharges are excluded from the subject forecast, but swing (if applicable) discharges are included. All patient days are included, so depending on the number of NF/SNF days at the subject or a competitor, the indications can be irregular. The estimated IP net revenue for competitors assumes that IP and OP contractual allowances are proportionate to gross revenues. If applicable, the subject forecast includes additional cost-based reimbursement for capital projects, mgmt. expense, and property taxes.							

There can be wide variations in the adjusted PPD amounts for hospitals resulting from various considerations, including:

- Differences that exist in wage rates at different locations.
- The assumption regarding IP and OP contractual allowances being proportionate to gross revenues.
- The correlation between overall patient acuity and Medicare patient acuity may not be high. This analysis relies upon Medicare acuity, which is the only measure of acuity that is widely reported.
- For SCHs, reimbursement is the greater of IPPS or historical costs updated to the current year; thus, if historical costs are being used, there is the potential to have higher payments than an IPPS-paid hospital, or even to other SCHs being reimbursed on their own historical operating costs.
- All patient days are used in the calculations, including swing and nursing bed days. Facilities with higher ratios of non-acute patient days will realize lower rates of payment when measured on a per patient day basis.

- Variations in payer mix, whereby there can be significant differences in reimbursement rates for the various payers.
- Differences in commercial rates of reimbursement that vary based on negotiated rates and managed care penetration, both in totality and by specific MCO.

The per-discharge measure shows an indication that is above the comparable average; however, two of the comparable indicators are relatively low in relation to the other eight comparable indicators. The PPD measure also shows an indication that is above the comparable average; however, three of the comparable indicators are relatively low in relation to the other seven comparable indicators. Although there are some lower indications in the comparable data that may skew the averages somewhat to the low side, the higher indicators for the subject may be an indication of additional risk in the forecast on a sustained basis.

Outpatient Utilization Analysis

This section will cover the following:

- Disclose historical and budgeted outpatient utilization information
- Forecast outpatient utilization volume based upon gross revenue
- Forecast the outpatient payer mix
- Illustrate the process by which outpatient volume is converted to equivalent discharges and patient days for the purposes of making comparisons and forecasts

Outpatient revenue is a significant revenue source for hospitals. Outpatient surgeries, laboratory analyses, radiology services, rehabilitation services and ER visits generally constitute most outpatient revenue activities. Due to both cost containment and advancements in medical technology over the past two decades, many procedures that once required hospital visits with overnight stays are now performed on an outpatient basis.

With healthcare reform, a larger insured population and greater emphasis on cost control will lend to outpatient care becoming a larger piece of the combined inpatient / outpatient pie. Due to affordability matters, much of the newly insured population had not been receiving adequate preventive and wellness care. All too often their point of entry into the healthcare services arena had been the emergency room. Under the Emergency Medical Treatment & Labor Act, Medicare-participating hospitals are required to offer emergency services regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs.

The geographic market area for outpatient services is usually tighter than the market area for inpatient business. Smaller hospitals typically have higher outpatient revenue ratios than larger ones. Similarly, rural hospitals typically have higher outpatient revenue ratios than urban ones.

Overview

As previously noted, many variables influence the inpatient and outpatient volume forecasts. From the start, an assumption is made that the hospital is managed competently, which may ultimately prove to be true or untrue. Beyond that consideration, the forecasts consider socioeconomic trends, physical plant factors, physician alignment and staffing, competitive forces in the marketplace, business development activities by management, government reimbursement policies, and historical performance. These influences are discussed in greater detail in other sections of the report. Because the future actions of healthcare organizations and government policy makers have limited predictability, there are obvious limitations inherent in the forecasting process.

As the pressure increases to control healthcare spending, payers are increasingly incentivizing providers to care for patients in outpatient settings to avoid higher inpatient care costs. Additionally, the evolution of healthcare is such that more procedures can be performed with less invasive techniques, resulting in greater opportunities for outpatient treatment.

Another trend occurring is for office-based primary care providers to concentrate solely on wellness and chronic disease management. Patients with more urgent complaints, often

requiring more sophisticated tests and procedures, are increasingly being sent to hospital emergency departments.

Dickinson County Memorial Hospital

Aside from the macro-level considerations noted above, some of the factors most likely to influence outpatient utilization trends for Dickinson County Memorial Hospital include:

- Changes in physician staffing and/or alignment
- Increasing demand due to healthcare reform
- Changes in the size and health needs of the population within the market service area
- Actions of competitors
- Changes in Dickinson County Memorial Hospital's outreach efforts, service lines and physical plant

Most of these topics are discussed in other sections of the appraisal.

As previously mentioned, for roughly a 10-year period prior to August 2018, the Hospital operated a clinic in the Bellin Health Iron Mountain clinic, providing medical imaging and lab services to patients seen by BHS. Bellin Health ended that contract in August 2018. BHS was reportedly interested in partnering with the Hospital (presumably via a joint venture) to maintain a service agreement, but DCHS management chose not to pursue that arrangement. The Hospital indicated that losing that contract will result in it providing about 4,000 fewer lab and imaging procedures a month, or 48,000 annually.

Expectations for population-based growth in demand for the market service area are weak. While the population-based growth in demand is slightly negative, age-related growth in service demand is expected.

Rather than forecasting outpatient procedural volumes to develop an outpatient revenue forecast, we have instead based our forecast upon the relationship of gross outpatient revenues to total revenues. Trends in the historical relationship are given consideration, as are the same relationships for competing or like-kind hospitals. Issues discussed above are also factored into the forecast.

Gross Outpatient Revenue Percentage

A definite relationship exists between hospital size and outpatient revenue percentage; whereby smaller hospitals are typically more dependent upon outpatient services because their scope of inpatient specialties tends to be narrower and people are willing to travel greater distances (typically to urban areas) for inpatient services.

The following table provides a comparison of outpatient to total gross patient revenue relationships for the subject property and selected expense comparables.

Gross Outpatient Revenues as a Percentage of Total Gross Patient Revenue	
Hospital	Ratio
SUBJECT -- Dickinson County Healthcare System	81.0%
West Branch Regional Medical Center	63.8%
MidMichigan Medical Center - Alpena	71.7%
Community Health Center Branch Cty	73.5%
McLaren Port Huron	55.0%
Tawas St. Joseph Hospital	82.7%
North Ottawa Community Hospital	80.7%
MidMichigan Medical Center-Clare	87.4%
Otsego Memorial Hospital	76.8%
McLaren Northern Michigan	56.9%
MidMichigan Medical Ctr	58.2%
Unweighted Average	71.6%
Subject Percentage of Average	113.1%
Source: Medicare Cost Reports	

Among the comparables, the subject's outpatient revenue percentage is somewhat above average. This relationship suggests that the Hospital has developed its outpatient-based business in a manner consistent with industry standards for hospitals of its type and size.

The Hospital's relationship trend for gross outpatient to total patient revenue, along with our forecast, is summarized in the following table.

Historical and Forecasted Outpatient Revenue Ratios					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Total Gross Patient Revenue	\$313,086,604	\$308,606,376	\$294,965,829	\$292,173,580	N/A
Gross Outpatient Revenue	253,620,551	255,298,511	244,011,081	234,179,157	N/A
Outpatient as % of Total Gross	81.0%	82.7%	82.7%	80.2%	80.6%
Equivalent Conversion Factor	19.0%	17.3%	17.3%	19.8%	19.4%
Note: The equivalent conversion factor is used to calculate equivalent discharges and patient days.					
Note: If applicable, IP gross revenues from nursing beds are deducted from the total gross patient revenue.					

The ratio of outpatient revenue to total patient revenue has been notably consistent over the periods observed. I anticipate that the Hospital will maintain a gross OP revenue ratio that is like the levels achieved recently.

With the stability being brought about by the turnaround team and their restructuring efforts, I believe the revenues realized in FYs 2017 and 2018 are realizable targets for future performance. Because a Hospital's ability to perform optimally is tied to so many factors, including its physician alignment, regaining lost business momentum could take some time. As this appraisal uses direct capitalization as the principal measure of market value for the going concern, the forecasts for revenue and NOI reflect some degree of stabilization.

Payer Mix

The following table provides the history of gross outpatient revenues by payer source.

Gross Outpatient Revenue History							
Gross Outpatient Revenues							
Period Ending >>>	Actual FYE 12/31/2017	Inflation Adjusted 12/31/2017	Actual FYE 12/31/2018	Inflation Adjusted 12/31/2018	4 Months Annualized 12/31/2019	Inflation Adjusted 12/31/2019	Inflation Adjusted 3-Year Avg
Payer							
Medicare	\$ 112,235,893	\$ 119,815,662	\$ 114,874,869	\$ 119,466,984	\$ 108,309,996	\$ 109,731,788	\$ 116,338,145
Medicaid	31,361,152	33,479,104	29,321,054	30,493,161	26,991,051	27,345,364	30,439,210
Commercial	106,052,212	113,214,370	106,351,270	110,602,655	104,170,362	105,537,813	109,784,946
Self Pay	3,971,294	4,239,492	4,751,318	4,941,252	4,539,672	4,599,265	4,593,336
Total	\$ 253,620,551	\$ 270,748,629	\$ 255,298,511	\$ 265,504,051	\$ 244,011,081	\$ 247,214,230	\$ 261,155,637
Outpatient Revenue Payer Mix							
Payer							
Medicare	44.3%	44.3%	45.0%	45.0%	44.4%	44.4%	44.5%
Medicaid	12.4%	12.4%	11.5%	11.5%	11.1%	11.1%	11.7%
Commercial	41.8%	41.8%	41.7%	41.7%	42.7%	42.7%	42.0%
Self Pay	1.6%	1.6%	1.9%	1.9%	1.9%	1.9%	1.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Note: Inflation adjustments are to the end date of the forecast period.							
Note: N/A							

The following observations for payer mix are made:

- Inflation-adjusted outpatient revenue is down in the current year, which is believed to have resulted from some loss in providers and other extenuating circumstances surrounding the financial struggles and change in management that occurred in late 2018 and 2019
- The outpatient revenue payer mix has been notably steady in the fiscal years reviewed

Outpatient Equivalent Conversion Factor Calculation

Outpatient services include a broad variety of procedures and visits. Unlike inpatient services, whereby discharges and patient days provide readily measurable units of comparison, the analysis of outpatient services does not lend itself as well to an outpatient-based unit of comparison. Furthermore, there is a universal desire to analyze a hospital on a unit of comparison that reflects both inpatient and outpatient services. Due to these considerations, the use of equivalent discharges and patient days is standard practice for the industry.

The equivalent discharge and patient day calculations are based on gross outpatient revenues as a percentage of total gross patient revenues. This percentage is used to calculate equivalent discharges and patient days. The calculations are made by dividing discharges and patient days by 1.0 minus the gross outpatient revenue percentage. The following is an example of the calculations.

Discharges	4,000
Patient Days	20,000
Gross OP Revenues	\$20MM
Total Patient Revenues	\$50MM
OP Revenue Percent	40% (\$20MM / \$50MM)
Conversion Factor	60% (100% – 40%)
Equivalent Discharges	6,667 (4,000 / 60%)
Equivalent Patient Days	33,333 (20,000 / 60%)

Note that when converting equivalent patient days, if applicable, we are excluding nursing bed patient days and revenues derived for nursing beds from the “gross up” calculations

made for hospital patient days. When applicable, swing bed days, which occur in hospital beds, are included in the gross up calculations.

The following table summarizes the equivalent calculations applicable to this appraisal.

Outpatient Equivalent Conversion				
	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
OP Gross Revenue as % of Total Gross Patient Revenue (Note: IP Gross Revenue for Nursing Beds is Excluded)	81.0%	82.7%	82.7%	80.2%
Equivalent Conversion Factor (IP Gross %)	19.0%	17.3%	17.3%	19.8%
Hospital Beds				
Discharges	2,849	2,334	2,157	2,716
Equivalent Discharges	15,000	13,512	12,486	13,683
Patient Days	9,464	7,555	7,368	8,411
Equivalent Patient Days	49,828	43,737	42,652	42,374
Average Daily Census	25.9	20.7	20.2	23.0
Equivalent Average Daily Census	136.4	119.8	116.9	115.9

Outpatient Reimbursement Analysis

This section will cover the following:

- Provide outpatient reimbursement and historical contractual allowance information for the primary payer sources for Dickinson County Memorial Hospital
- Forecast net outpatient revenues by payer based upon the inflation-adjusted historical and budgeted amounts.

Within this section of the appraisal historical rates of contractual allowance are studied by the respective payer categories.

Outpatient Payment and Contractual Allowance

Traditional Medicare Fee-for-Service

In calendar year 2000, CMS implemented a prospective payment system for hospital outpatient department services paid by Medicare. The Outpatient Prospective Payment System (OPPS) applies to most hospitals, although there are some exceptions such as Critical Access Hospitals.

Ambulatory Payment Classification (APC)

In most cases, the unit of payment under the OPPS is the APC. APC payments apply to outpatient surgery, outpatient clinics, emergency department services and observation services. APC payments also apply to outpatient testing (such as radiology, nuclear medicine imaging) and therapies (such as certain drugs, intravenous infusion therapies, and blood products).

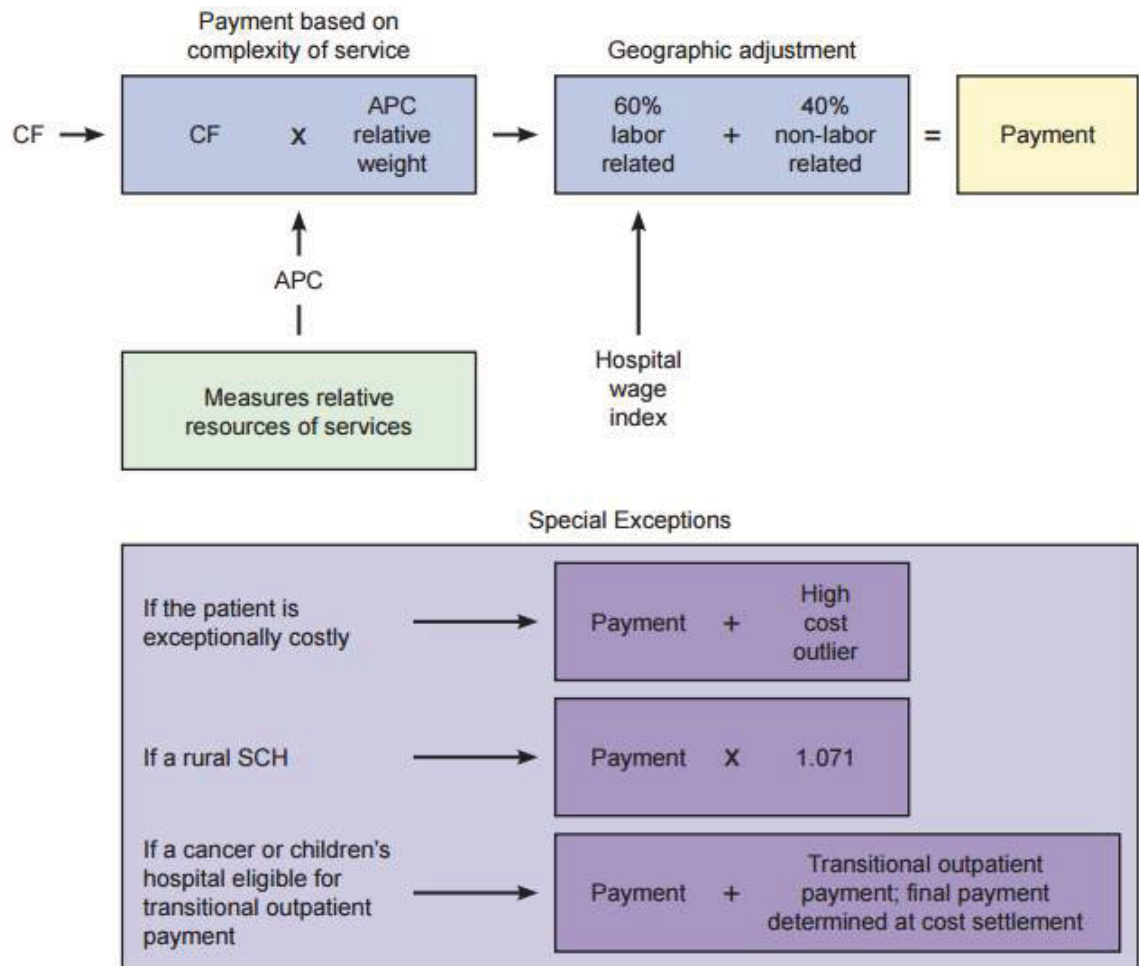
CMS pays separately for professional services, such as physician services, under the Physician Fee Schedule. There are two payment schedules for the professional service component, one for services provided in hospitals or other settings with hospital outpatient provider-based department (HOPD) status, and one for services provided outside of hospitals or other settings with hospital provider-based department status.

Packaging is a critical feature of the OPPS. Within each APC, payment for dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service. CMS assigns individual services (HCPCS codes) to APCs based on similar clinical characteristics and similar costs. The payment rate and copayment calculated for an APC apply to each service within the APC.

The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.

To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.

The following table illustrates the basic principles of OPPS.



Hospitals can receive payments in addition to the standard OPPS payments:

- pass-through payments for specific drugs, biologicals and devices
- outlier payments for unusually costly services
- rural sole community hospital adjustment
- an adjustment for certain cancer hospitals
- transitional outpatient payments (TOPs) for certain
 - cancer hospitals
 - children's hospitals

Sole Community Hospitals

Since 2006, CMS has applied a 7.1% payment increase for rural sole community hospitals (SCHs) for all services and procedures paid under the OPPS, excluding:

- separately payable drugs and biologicals
- devices paid under the pass-through payment policy, and
- items paid at charges reduced to costs

Essential access community hospitals (EACHs) are also eligible to receive this same adjustment.

Emergency Department (ED)

APC payments are made to hospitals when the Medicare outpatient is discharged from the ED or clinic or is transferred to another hospital (or other facility) which is not affiliated with the initial hospital where the patient received outpatient services. If the patient is admitted from a hospital clinic or ED, then there is no APC payment, and Medicare pays the hospital under inpatient DRG methodology.

Observation Status Payments

Observation status is an administrative classification of patients seen in hospital emergency rooms or outpatient clinics who have unstable or uncertain conditions potentially serious enough to warrant close observation, but usually not so serious to warrant admission to the hospital. These patients may be placed in beds usually for less than 24 hours without formal admission to the hospital. Observation care must be provided hourly for a minimum of 8 hours for hospitals to be paid for observation care.

Observation status is an outpatient payment category under Medicare PPS. Under OPSS, observation is defined as "Extended Assessment and Management Composite" services. CMS reimburses hospitals for observation using a "composite" APC when the service is provided in conjunction with an appropriate Type "A" or "B" ED visit, critical care, clinic visit, or a direct referral to observation.

Fee Schedules and Other Payment Systems

While most hospital outpatient services are payable under the OPSS, section 1833(t)(1)(B)(iv) of the Act excludes payment for services made under fee schedules or other payment systems, including:

- ambulance
- physical and occupational therapy
- speech-language pathology services
- mammography
- an annual wellness visit providing personalized prevention plan services
- the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS)
- laboratory services paid under the Clinical Laboratory Fee Schedule (CLFS)
- services for beneficiaries with end-stage renal disease (ESRD) paid under the ESRD prospective payment system
- partial hospitalization

OPSS Rate Adjustments

Recent and proposed changes to OPSS rates payable for hospital outpatient services are summarized as follows.

CY 2012	+1.68%
CY 2013	+1.90%
CY 2014	+1.70%
CY 2015	+2.30%
CY 2016	-0.30%
CY 2017	+1.70%
CY 2018	+1.35%
CY 2019	+1.35%
8-Year Avg	+1.46%

We note that the rate updates for CYs 2013-18 do not reflect any effects of sequestration that took effect April 1, 2013.

Hospital Outpatient Quality Reporting (OQR) Program

The Medicare Improvements and Extension Act (MIEA-TRHCA) of 2006 authorized the Health and Human Services (HHS) Secretary to develop a quality data pay-for-reporting program for hospitals paid under the OPps. Hospitals that fail to successfully participate in what is now known as the Hospital Outpatient Quality Reporting (OQR) Program receive reduced payments through a reduction of 2.0 percentage points to the hospital market basket update. CMS makes these payment determinations each year.

Medicare Advantage

Medicare Advantage is the current Medicare managed care program. Medicare makes payments to private health insurance companies, which in turn create and market Medicare managed care products for Medicare beneficiaries. Many of these plans pay based upon the OPps methodology.

Medicaid

Michigan's inpatient reimbursement methodology for hospitals is found in the state's Medicaid Provider Manual, available at:

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

An abbreviated summary of the reimbursement methodology is provided as follows.

Reimbursement for outpatient hospital services is made in accordance with an Outpatient Prospective Payment System (OPps). No facilities (i.e. critical access or children's hospitals) are excluded from Medicaid's Ambulatory Payment Classification reimbursement methodology. Payment made under OPps is calculated utilizing current Medicare rates, with a MDHHS reduction factor applied. Reimbursement for outpatient hospital services is adjusted, as necessary, to ensure spending limits fall within the MDHHS appropriation. MDHHS does not utilize Medicare wage indices; rather, a wage index of 1.0 is applied for all hospitals. Medicare's APC weights are utilized. MDHHS utilizes Medicare's APC outlier payment policy. A reduction factor is not applied to outlier payments.

Payments made under the MDHHS OPps methodology are calculated utilizing the current Medicare conversion factors/rates with an MDHHS reduction factor (RF) applied to the calculated payment (Medicare fee x RF = Medicaid fee). A history of recent reduction factors is summarized as follows.

<u>Date Effective</u>	<u>Factor</u>
January 1, 2013	54.3%
January 1, 2014	53.4%
January 1, 2015	52.3%
January 1, 2016	52.6%
January 1, 2017	51.7%
January 1, 2018	50.9%
January 1, 2019	50.7%

Rural Health Clinics are reimbursed on a per visit basis in accordance with section 1902(bb) of the Social Security Act. The PPS per visit payment is equal to 100 percent of the average of the RHC's reasonable costs of providing Medicaid services during fiscal years 1999 and 2000. MDHHS defines reasonable costs as the per-visit amount approved

and paid by Medicare. The per-visit amount is adjusted each year by 100 percent of the Medicare Economic Index for the prior calendar year.

Commercial Payers

Third-party, non-governmental payers (commercial insurance and managed care organizations) typically pay for outpatient hospital services on a contractual basis using one of the following methods.

- a discount to approved charges
- predetermined fee schedules
- flat rate by type of service
- ambulatory payment classifications (APCs)
- fixed case rates

Some insurers have standard fee schedules where they set hospital outpatient standard fees for radiology, laboratory work, observation, behavioral health, and other outpatient services, and set standard fees for physician professional services. The insurer and provider negotiate a specific multiplier to each of these standard fees; for example, a provider with a 1.2 multiplier for radiology services would be paid 120 percent of the standard fee schedule rates for various radiology services.

Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

In conjunction with healthcare reform, provider engagement and contracting strategies are moving away from "unit price" or volume-based payment models to payment models that align compensation with the value delivered as measured by health care, quality and cost.

Self-Pay

Historically, no federal law has limited what hospitals can charge their patients. A few states (CA, IL, MN and NY) do impose some restrictions. Otherwise, hospitals were free to set their own prices.

Each hospital sets its gross prices in a complex document called the "chargemaster." Self-payers have historically paid per the Hospital's chargemaster fee schedule. Chargemaster prices are the basis for calculating the discounts given to insurers. Chargemaster prices are generally inflated relative to average rates of reimbursement, vary widely from hospital to hospital, and have a limited relationship to the actual cost of providing care. Because self-pay patients have no market power, they have no real leverage to negotiate a discount and could be charged the full chargemaster price for hospital care.

Under the Patient Protection and Affordable Care Act, nonprofits hospitals are limited to what they can charge to people covered under the hospital's financial assistance policy. Specifically, the Act prohibits the use of gross charges and limits amounts charged for emergency or other medically necessary care provided to individuals eligible under the financial assistance policy to not more than the lowest amounts charged to individuals who have insurance covering such care.

The Act only covers those individuals that are eligible under the nonprofit hospital's financial assistance policy. Those individuals will typically be patients that are uninsured

or underinsured, and which meet federal or state guidelines for poverty. Other patients in a nonprofit or for-profit hospital may still be charged per the chargemaster.

Outpatient Net Revenue Forecast

The outpatient revenue forecast is made based upon net patient revenue. Historical and budgeted outpatient net revenues are summarized in the following tables.

Historical Outpatient Net Revenue by Financial Period				
FYE 12/31/2017 (Actual FYE)				
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance %
Medicare	\$ 112,235,893	\$ (83,479,829)	\$ 28,756,064	74.4%
Medicaid	31,361,152	(27,140,249)	4,220,903	86.5%
Commercial	106,052,212	(59,870,867)	46,181,345	56.5%
Self Pay	3,971,294	(2,030,166)	1,941,128	51.1%
Total	\$ 253,620,551	\$ (172,521,111)	\$ 81,099,440	68.0%
FYE 12/31/2018 (Actual FYE)				
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance %
Medicare	\$ 114,874,869	\$ (84,913,969)	\$ 29,960,900	73.9%
Medicaid	29,321,054	(25,562,896)	3,758,158	87.2%
Commercial	106,351,270	(61,524,551)	44,826,719	57.9%
Self Pay	4,751,318	(573,795)	4,177,523	12.1%
Total	\$ 255,298,511	\$ (172,575,211)	\$ 82,723,300	67.6%
FYE 12/31/2019 (4 Months Annualized)				
Payer	Gross Revenue	Allowance	Net Revenue	Allowance %
Medicare	\$ 108,309,996	\$ (80,219,790)	\$ 28,090,206	74.1%
Medicaid	26,991,051	(23,417,355)	3,573,696	86.8%
Commercial	104,170,362	(61,414,848)	42,755,514	59.0%
Self Pay	4,539,672	(527,301)	4,012,371	11.6%
Total	\$ 244,011,081	\$ (165,579,294)	\$ 78,431,787	67.9%
Note: QAAP assessments (provider taxes) are treated as a contractual allowance for Medicaid.				
Note: N/A				

Budgeted Outpatient Net Revenue - FYE 12/31/2019				
Payer	Gross Revenue	Contractual Allowance	Net Revenue	Contractual Allowance %
Medicaid	27,398,622	(24,689,665)	2,708,957	90.1%
Commercial	97,097,493	(57,604,981)	39,492,512	59.3%
Self Pay	4,401,157	(162,617)	4,238,540	3.7%
Total	\$ 234,179,157	\$ (159,121,291)	\$ 75,057,866	67.9%
Note: QAAP assessments (provider taxes) are treated as a contractual allowance for Medicaid.				

Outpatient Net Revenue Forecast

The forecast net revenue per patient day figures are based upon historical rates and all the circumstantial changes and/or influences.

As discussed, with the stability being brought about by the turnaround team and their restructuring efforts, I believe the revenues realized in FYs 2017 and 2018 are realizable targets for future performance. Because a Hospital's ability to perform optimally is tied to so many factors, including its physician alignment, regaining lost business momentum could take some time. As this appraisal uses direct capitalization as the principal measure of market value for the going concern, the forecasts for revenue and NOI reflect some degree of stabilization.

Outpatient Net Revenue Forecast -- As Completed						
Period Ending >>>	Period Ending, Inflation Adjusted Figures				Operator's Budget for 12/31/2019	Forecast Outpatient Net Revenue
	12/31/2017	12/31/2018	12/31/2019	3-Year Avg		
Payer						
Medicare	\$ 30,698,084	\$ 31,158,585	\$ 28,458,948	\$ 30,105,205	\$ 28,617,857	\$ 29,972,362
Medicaid	4,505,959	3,908,390	3,620,608	4,011,652	2,708,957	3,790,218
Commercial	49,300,168	46,618,664	43,316,768	46,411,867	39,492,512	45,337,506
Self Pay	2,072,221	4,344,519	4,065,042	3,493,927	4,238,540	4,069,362
Total	\$ 86,576,431	\$ 86,030,158	\$ 79,461,366	\$ 84,022,652	\$ 75,057,866	\$ 83,169,447
Note: Inflation adjustments are to the end date of the forecast period.						

Total Net Patient Revenue Forecast

Bad Debt and Charity Care

The following adjustments are supplemental to the inpatient and outpatient forecasts made to this point in the appraisal.

Uncompensated Care

Uncompensated care is defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.

Charity Care

Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Charity care is the cost of services (net of any contractual allowances) that patients have been deemed unable to pay. Charitable care is most typically associated with non-profits providing care to patients that have little or no ability to pay for services. This is a requirement of their non-profit organization for federal tax-exempt status. As for-profit ownership is typically an underlying assumption in market valuations, there is no expectation for significant expenses associated with charitable care.

Bad Debt

Bad debt generally constitutes all other unpaid services for which a hospital expected but did not receive payment (excluding Medicare bad debt). Bad debt in a hospital principally represents amounts considered to be uncollectible from accounts created while providing healthcare services. Bad debt differs from contractual adjustments in that bad debt is revenue that a hospital expected to collect, whereas contractual allowances are deductions from revenue that are agreed upon prior to billing.

Bad Debt Accounting

Bad debt expense relating to patient service revenue was historically displayed on hospital income statements as an operating expense. In 2011, the Financial Accounting Standards Board (FASB) issued new guidance on bad debt for healthcare organizations, including hospitals. Essentially, FASB's guidance, ASU 2011-07, said that if healthcare providers are required to treat patients without having the ability to assess patients' credit risk – in other words, healthcare providers with emergency departments – then they should treat bad debt as a reduction of gross patient service revenue to arrive at net patient service revenue. Prior to ASU 2011-07, hospitals would recognize revenue from self-pay patients who do not qualify for charity care at the gross charge amount (or based on discounted rates, if negotiated or provided by policy) along with a relatively high bad-debt provision (expense) in the period of service.

Important Points about Bad Debt

- Revenue cycle management, which involves all administrative and clinical functions that contribute to the capture, management and collection of patient service revenue, is key to minimizing bad debt.
- Medicare reimburses acute care hospitals for a portion of bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts.
- The Middle-Class Tax Relief and Job Creation Act of 2012 reduced Medicare bad

debt reimbursement for non-critical access hospitals from 70 percent to 65 percent beginning in FY 2013. Starting in FY 2013, bad debt reimbursement for critical access hospitals was reduced in phases from 100 percent to 65 percent: 88 percent in FY 2013, 76 percent in FY 2014 and 65 percent in FY 2015 and thereafter.

- One phenomenon hospitals have experienced in recent years is that copays and out-of-pocket costs for commercially insured patients have risen, giving hospitals greater exposure to bad debt in this payer class.

Subject Forecast

As a hospital with an emergency department, bad debt has been accounted for in the net patient revenue forecast. No "expense" forecast for bad debt is applicable to this analysis.

Our bad debt and charity care forecasts for Dickinson County Memorial Hospital reflects the following factors.

- Historical ratios and any apparent trend
- Economic and unemployment conditions during the periods under review
- Payer mix considerations, including shifting that may occur because of healthcare reform
- Perceived effectiveness of revenue cycle management
- For-profit operating assumption

Historical and forecast utilization and net patient revenue data are summarized in the following table.

Utilization and Net Patient Revenue Summary					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Utilization					
OP Gross Rev. as % of Total Gross Patient Rev. (IP Gross Rev. for Nursing Beds is Excluded)	81.0%	82.7%	82.7%	80.2%	80.6%
Equivalent Conversion Factor (IP Gross %)	19.0%	17.3%	17.3%	19.8%	19.4%
Hospital Beds					
Discharges	2,849	2,334	2,157	2,716	2,545
Equivalent Discharges	15,000	13,512	12,486	13,683	13,086
Patient Days	9,464	7,555	7,368	8,411	8,503
Equivalent Patient Days	49,828	43,737	42,652	42,374	43,720
Revenue					
Net Patient Revenue					
Hospital Inpatient Services	\$ 25,940,477	\$ 23,670,833	\$ 21,933,759	\$ 27,620,555	\$ 26,347,884
Hospital Outpatient Services	81,099,440	82,723,300	78,431,787	75,057,866	83,169,447
IP Charity	(252,290)	(370,389)	(261,195)	(401,143)	(350,000)
OP Charity	(2,359,166)	(2,586,081)	(2,834,331)	(2,498,755)	(2,500,000)
Bad Debt	(3,099,981)	(4,091,854)	(3,790,872)	(4,076,069)	(4,266,693)
Total Net Patient Revenue	\$ 101,328,480	\$ 99,345,809	\$ 93,479,148	\$ 95,702,454	\$ 102,400,638

Comparative Evaluation

The following table includes basic per-bed measurements for net patient revenue. A comparison of subject facility and industry averages provides a rudimentary basis for evaluating relative performance.

Net Patient Revenue per Bed Comparisons				
Source: AHA Hospital Statistics for U.S. Community Hospitals (2018 Edition)				
Bed Size Category	Hospitals Reporting	Average # of Beds	Net Patient Revenue / Bed	Gross OP Rev Ratio
6-24 beds	518	17	\$ 1,098,890	79%
25-49 beds	1,131	31	1,061,306	68%
50-99 beds	913	62	940,651	59%
100-199 beds	963	133	1,085,983	54%
200-299 beds	531	233	1,144,637	48%
Michigan	146	165	\$ 1,289,063	53%
Dickinson County Memorial Hospital				
Actual FYE for Period Ending 12/31/2017		96	\$ 1,055,505	81%
Actual FYE for Period Ending 12/31/2018		49	2,027,465	83%
4 Months Annualized for Period Ending 12/31/2019		49	1,907,738	83%
Operator's Budget for Period Ending 12/31/2019		49	1,953,111	80%
As Completed Forecast for Period Ending 06/30/2020		49	2,089,809	81%
Notes				
1. The AHA data reflects fiscal year 2016 operations for facilities participating in the survey.				
2. The average Medicare CMI for all short-term acute care hospitals is near 1.73				
3. Community hospitals are defined as all nonfederal, short-term general, and special hospitals whose facilities and services are available to the public. Special hospitals include obstetrics gynecology; eye, ear, nose and throat; rehabilitation; orthopedic; and other individually described specialty services. Psychiatric and long-term general hospitals are excluded.				
4. All bed and per-bed figures utilize set-up (staffed) hospital beds; NF/SNF beds are excluded. Revenues, however, include those earned for NF/SNF units and swing bed services.				

Our forecast net patient revenue per bed for the subject going concern is well above the industry averages for hospitals in similar bed size categories. Furthermore, our forecast net patient revenue per bed for the subject going concern is well above the average for hospitals located in Michigan.

The subject forecast and indications of historical performance, excluding FY 2017, are substantially influenced by the subject's comparatively high ratio of outpatient revenue and limited bed count. Before the subject downsized to 49 beds, its net patient revenue per bed was more closely aligned with the comparable data indicators.

Highest and Best Use Analysis

Highest and best use is defined as:

The reasonably probable and legal use of vacant land or an improved property that is:

- physically possible
- appropriately supported
- financially feasible, and
- that results in the highest value

The four criteria the highest and best must meet are:

- legally permissible
- physically possible
- financially feasible, and
- maximally productive

Highest and best use may be either that of the land alone (assuming the improvements are demolished) or that of the land as presently improved.

The subject property includes various off-campus locations in addition to the hospital property. Given the relative importance of the hospital property to the going concern and this appraisal, along with the related usage of the satellite properties in conjunction with the operation of the hospital going concern, this highest and best use analysis focuses on the campus property and hospital operations.

Highest and Best Use - As If Vacant

The hospital campus is a 32.85-acre site that has a nearly rectangular configuration and level to gently sloping topography. There are no significant physical limitations for improvements that can be contained within the dimensions of the site. The site frontage and access are suitable for a variety of uses. The site has convenient access, good exposure, and considerable frontage along an important highway for the county, U.S. Highway 2 (aka Stephenson Avenue). U.S. 2 is the principal commercial corridor for the city. In the immediate neighborhood, much of the land with frontage along U.S. 2 is developed with commercial property, but some undeveloped land is still available.

As discussed in the regional and neighborhood analysis section of the appraisal, near-term population forecasts for the county and neighborhood (effectively Iron Mountain and Kingsford) are slightly negative. Reflecting those trends, there is limited demand for land suitable to new development.

A majority of the site is zoned OS, Office Service, which mostly permits office uses but also a few service businesses, like hospitals and nursing homes, and places of worship. The OS zoning is fairly use restrictive, particularly for a site as large as the subject in a community that is relatively small. The balance of the site is zoned B-2, General Business. The B-2 district permits a wide range of commercial and business uses. The subject OS zoning is a bit of an island, as land to the east, west and south, all along the U.S. 2 corridor, is zoned B-2. It seems likely that the B-2 zoning was placed on most of the subject property in connection with its intended use as a hospital location. Given the surrounding zoning

and development, it would be a reasonable expectation that if the site were vacant, a considerable portion of the subject's OS zoned site area could be rezoned to B-2.

Considering the size of the subject site and its considerable frontage, multiple uses of the site are physically possible and, potentially, more probable than a single use.

Although feasibility analyses have not been performed for any possible use, we believe the physical characteristics and location, along with existing site zoning and probable rezoning opportunities, lend themselves to commercial use for most or all the site. In particular, the site area fronting along U.S. 2 would be appealing for retail use. Beyond the site area immediately fronting the highway, less intense usage, such as the uses permitted in the OS district, represent reasonable highest and best use possibilities.

Highest and Best Use - As Improved

The subject property is improved with an 49-bed short-term acute care hospital that was developed approximately 24 years ago. While the subject physical plant is middle aged, it has, by and large, been adequately maintained. The building is presently in need of a new cover.

Importantly, the hospital has sole community hospital status for Medicare reimbursement. That designation provides for cost-based inpatient reimbursement for medical services provided to Medicare beneficiaries, which may in turn allow a small hospital to operate profitably (normalized NOI) where it might otherwise be unable to recover its operating costs if paid under the Federal prospective payment reimbursement.

The Hospital serves a rural geographic area that experiences moderate levels of poverty. The population is declining slightly and aging. The Hospital provides basic and specialty care services. The closest availability of some of the specialty care services provided is Marquette and Green Bay, both of which are significant drives from Iron Mountain and the Hospital's market service area. The healthcare market is fairly competitive due to a Green Bay-based health system that has, to some extent, capitalized on past missteps made by DCHS – most specifically, too little primary care physician alignment.

Hospitals typically operate at low operating margins. The subject has a recent history of financial struggle and, as discussed throughout the appraisal, is in a true action mode now to stabilize the going concern. The Hospital made significant changes in staffing, expense control, revenue cycle activity, etc. DCHS has a sizable unfunded pension liability that it must fund in pursuit of achieving full funding. The Hospital's FY 2018 contribution to the plan was around \$2.157MM. This is an excessive employee benefit cost that a buyer of the going concern, in an asset sale, would not inherit. Losing that expense would free up cash flow for future capital improvements and other strategic endeavors.

Despite the recent financial difficulty experienced by the Hospital, I believe its highest and best use is for its continued use as a short-term acute care hospital. As a small independent hospital (not part of a system), being profitable (normalized NOI) will require attentive and astute management. Management will need to control costs, achieve effective physician alignment, continue to be innovative in its business strategy, evaluate the feasibility of service lines, strive to achieve quality outcomes, and otherwise execute business practices successfully to improve profitability and remain viable.

In this era of healthcare reform, whereby reimbursement is shifting from fee-for-service to value-based methodologies, size does matter. Some of the reasons that being part of a larger system may be beneficial include:

- Greater volume offers the potential for greater efficiencies
- Larger health systems have more leverage in negotiating payment rates with insurers
- With reimbursement rate compression under way, what might have been a lean operating margin can easily erode into negative territory
- There is the threat of insurers moving toward “narrow networks” (more selective networks of doctors and hospitals), which could exclude community doctors and hospitals from their networks
- Better access to capital at a time when major IT investments are needed to improve patient outcomes and receive full or better reimbursement from payers
- More sophisticated marketing strategy with better brand identification
- Better ability to achieve clinical integration -- collaboration among different health care providers and sites to ensure higher quality, better coordinated and more efficient services for patients

Thus, while remaining independent may be a viable option for some small- to medium-sized hospitals, many stand to benefit by being owned, operated or closely affiliated with a larger system or company. The highest and best use of the subject property is its continued use as a short-term acute care hospital; however, pairing itself with a larger health system or hospital would likely reduce the financial risks that exist operating independently.

Valuation Procedures

The appraisal problem is defined, and relevant data are collected to understand the forces and influences affecting the value of the subject property. Typically, three appraisal approaches are used to derive separate indications of value.

The Cost Approach

The cost approach relies on the basic principles of substitution, supply and demand, contribution, and externalities. The current replacement or reproduction cost of the improvements is estimated, and accrued depreciation is deducted to estimate value contribution. Depreciation results from three sources: physical deterioration, functional obsolescence, and external obsolescence. The market value of the land, assumed vacant, is added to the depreciated costs of the improvements and personal property to derive an estimate of total market value of the tangible property.

The subject property is a going concern and includes intangible property such as a certificate of need (tantamount to a franchise), assembled workforce, goodwill and contracts associated with the operation of the business. The value of intangible property is most accurately measured as a residual calculation (going concern value less tangible asset value). An alternative technique would be to build-out the value based upon its component parts and add that number as an adjustment in the cost approach. Reflecting our preference for handling intangible property value, we do not include a built-out calculation for intangibles; instead, our allocation of value for the going concern utilizes the “value in place” estimates for tangible assets, and the intangible property value is calculated as a residual amount.

The Income Capitalization Approach

The income capitalization approach utilizes a set of procedures to derive a value indication for an income-producing property by converting its anticipated benefits (cash flow and reversion) into property value. Direct capitalization is the conversion of a single year's income expectancy into an indication of value. Yield and value change are implied but not specifically identified. The income is measured by estimating the most likely census mix, rate structure and utilization levels for the going concern. The operating expenses are based on inflation-adjusted historical expenses for the subject and comparable facilities and are relative to any proposed changes in staffing and acuity levels.

Yield capitalization, which is the process of converting future benefits into present value by discounting each benefit at an appropriate yield rate, has not been utilized in this assignment. We have discussed the relevance of the application of discounted cash flow analysis with various buyers and sellers of hospital going concerns. Those parties have stated that they place very little emphasis on any DCF analysis due to the difficulty in making accurate long-term forecasts in a rapidly changing industry. As the use of DCF modeling is uncommon among market participants, and as we believe it is difficult to accurately forecast reimbursement beyond the near term, we have not utilized yield capitalization for this appraisal.

The Sales Comparison Approach

Because income/earnings drive the value of a hospital going concern, there is no reasonable method of applying a sales comparison approach that is independent from the income capitalization approach.

Our analyses of the hospital sales are limited to a cursory, objective analysis for general verification of the income approach value indication. The comparison presented in this

section simply compares the concluded value of the subject hospital from the income capitalization approach to the price-per-unit averages and ranges of the comparable sales. The unit prices reviewed include price-per-bed, price-per-square foot, price-per-equivalent patient day, net revenue multiplier, and overall capitalization rate.

Cost Approach

The steps in the cost approach are summarized as follows.

1. Determine the value of the land as if vacant and available to be developed to its highest and best use.
2. Estimate the reproduction or replacement cost of the real property improvements as of the effective date of the appraisal.
3. Estimate and deduct the amount of accrued depreciation in the improvements to arrive at an estimate of contributory value for them.
4. Determine the contributory value of the personal property (FF&E). Integra - Healthcare & Senior Housing typically utilizes the net book value of the personal property as the basis for that estimate.
5. Add the depreciated cost of the improvements and FF&E to the land value to arrive at a total indication of value for the tangible assets.

Note: Because there is no specific addition for intangible components, the cost approach does NOT provide an indication of value for the going concern. The intangible value of a hospital going concern encompasses its licenses and certificate of need (if applicable); Medicaid and Medicare certifications; contracts with commercial payers; physician and other professional service contracts; assembled workforce; computer software; as well as in-place management, staff, and patients.

Land Valuation

The most common and, typically, the most accurate method of land valuation is based on a comparison of the subject site with land parcels that sold recently and/or are available for sale. This comparative process is made based upon the characteristics perceived to influence value. The prices paid for the comparable properties are reduced to a unit price, such as price per acre or square foot, and are adjusted for the following elements of comparability:

Elements of Comparison

Property Rights Conveyed: The subject land is valued based on an unencumbered fee simple interest. If necessary, the sales are adjusted to reflect any deviation from full property rights. In this instance, all the land sales were conveyed as unencumbered fee simple interests.

Financing Adjustments: Properties occasionally sell with the seller providing financing to facilitate the transaction. In some instances, the interest rate will be lower than those available via commercial or government lenders. In instances where sellers finance the sale at interest rates below market levels, prices are usually inflated somewhat to compensate for the lower interest rate. In these instances, the mortgaged amount can be discounted at an appropriate market mortgage rate to reflect a cash equivalent price. In other cases, the seller may provide subordinate financing that effectively allows the purchaser to acquire the property with limited equity investment, or no equity investment. Again, the sale price may be inflated to compensate the seller for providing such favorable financing conditions.

To our knowledge, none of the sales in this analysis involved seller financing.

Conditions of the Sale: This adjustment considers any abnormal circumstances of the sale, such as if the buyer or seller were atypically motivated to make the transaction or if other conditions deviate from those outlined in the definition of market value of this report. If relevant, the comments section for each of the respective sales discusses the specific conditions.

Market Conditions: Comparable sales that occurred under market conditions different from those applicable to the subject on the effective date of value require adjustment to reflect whatever appreciation or depreciation that has occurred since their respective transaction dates. As best as possible, we have focused on recent sales activity that will reflect current market conditions so that no market condition adjustments are required for comparison.

Location: Adjustments are applied as necessary to compensate for significant differences in location between the subject property and the respective land sales. Relative desirability of cities and neighborhoods is considered in this adjustment.

Zoning and Legal Restrictions: Zoning differences can influence values because certain permitted uses can support higher land values than others. In some cases, there may be the potential to upzone a site or a portion thereof, which can make it more valuable than it otherwise would be if the rezoning opportunity were improbable or nonexistent. Some rezoning risk may remain in these cases; thus, an adjustment may be necessary to reflect the upside but with recognition of any risks and costs associated with the rezoning. Other legal restrictions that may impact value include the prohibition of certain uses and other atypical deed restrictions, planned use development conditions, or other municipally imposed requirements or limitations.

Size: Normally, larger parcels command lower unit prices than smaller but otherwise comparable parcels. This relationship is like a quantity discount typically found in other transactions. This physical aspect has been isolated from the other adjustments.

Physical Characteristics: When appropriate, adjustments are made for differences in shape, topography, access and exposure. Sites with very irregular configurations or ones with narrow shapes have less utility and are more difficult to develop to full potential; consequently, they possess less value. Terrain, degree of slope, soil conditions and drainage qualities can greatly impact the cost of developing a site. Similarly, sites with wetlands have additional regulatory burdens that may impose added costs or otherwise restrict useable site area. Those sites with fewer physical problems command higher unit values. Sites with two street frontages often command a premium to those that only offer frontage along a single street. Likewise, sites with good exposure to thoroughfares that carry high volumes of traffic often command a premium.

Off Sites – Utilities & Infrastructure: The costs to extend or otherwise provide utilities and street infrastructure necessary to develop a property and meet applicable municipal requirements can be significant. As such, sales that are substantially different from the subject property with respect to size-proportionate cash outlays that will be incurred for the extension of utilities and/or infrastructure have been adjusted.

Other: Adjustments may be needed for extraordinary factors such as the cost of demolition of existing improvements, mitigation of environmental conditions, or other extraordinary factors that might require curing.

The following land sales and/or listings were identified during our research. The sale prices have been confirmed through government records and/or other primary and secondary sources.

Land Sale One	
Intended Use	Dollar General
Location/Address	1000 N Stephenson St.
City, ST	Iron Mountain, MI
Date of Sale / Effective Appraisal Date	19-Mar-18
Sale Price	\$175,000
Seller	TIFinancing Authority
Buyer	DGOIronmountainmi09132017 LLC
Confirmation	Public Records
Physical Description	
Size	
Acres	1.75
Square Feet	76,230
Shape of Site	Lightly Irregular
Topography of Site	Level
Drainage of Site	Adequate
Zoning of Site	B-2 General Business
Accessibility of Site	Good
Visibility of Site	Good
Utilities Available to Site	All
Location of Site	Good
Unit Price Per Acre	\$100,000
Unit Price Per Square Foot	\$2.30
Additional Comments: This site is situated along the main commercial artery of Iron Mountain in the northern section of town. The site contains approximately 220 feet of frontage along N. Stephenson Ave. The land was purchased to develop a Dollar General store which was completed in 2018.	

Land Sale Two

Intended Use	
Location/Address	Plaza Dr at Blumenstein Rd
City, ST	Minocqua, WI, MI
Date of Sale / Effective Appraisal Date	27-Aug-18
Sale Price	\$140,000
Seller	V & H INC
Buyer	True Blue North LLC
Confirmation	Public Records
Physical Description	
Size	
Acres	1.57
Square Feet	68,389
Shape of Site	Nearly Rectangular
Topography of Site	Level
Drainage of Site	Adequate
Zoning of Site	B-2 Business
Accessibility of Site	Good
Visibility of Site	Good
Utilities Available to Site	All
Location of Site	Good
Unit Price Per Acre	\$89,172
Unit Price Per Square Foot	\$2.05

Additional Comments: This is a commercial lot at the NW corner of Plaza Dr and Blumenstein Rd in Minocqua, WI. This site is directly south of a Wal Mart store. The neighborhood is a mix of commercial and residential land use.

Land Sale Three

Intended Use	
Location/Address	1415 S. Stephenson Ave
City, ST	Iron Mountain, MI
Date of Sale / Effective Appraisal Date	11-May-17
Sale Price	\$60,000
Seller	Peter D'Albarto
Buyer	Neuns William Realty LLC
Confirmation	Broker
Physical Description	
Size	
Acres	0.66
Square Feet	28,662
Shape of Site	Nearly Rectangular
Topography of Site	Level
Drainage of Site	Adequate
Zoning of Site	B-2 General Business
Accessibility of Site	Good
Visibility of Site	Good
Utilities Available to Site	All
Location of Site	Good
Unit Price Per Acre	\$91,185
Unit Price Per Square Foot	\$2.09

Additional Comments: This site is along the north side of Stephenson Ave, a principal commercial corridor of Iron Mountain. The buyer presently has the site listed for sale for \$8.32/SF as a 0.77-acre site. The current owner razed a home, removed excess dirt from the property, and had an undeveloped "paper" street vacated since the 2017 sale.

Land Listing One

Intended Use	
Location/Address	TBD U.S. Highway 2
City, ST	Iron Mountain, MI
Date of Sale / Effective Appraisal Date	Current Listing
Sale Price	\$360,000
Seller	Moon Lake Bus. Ctr LLC
Buyer	N/A
Confirmation	Broker
 Physical Description	
Size	
Acres	1.78
Square Feet	77,537
Shape of Site	Irregular
Topography of Site	Level
Drainage of Site	Adequate
Zoning of Site	I-1 Industrial
Accessibility of Site	Good
Visibility of Site	Good
Utilities Available to Site	All
Location of Site	Good
Unit Price Per Acre	\$202,247
Unit Price Per Square Foot	\$4.64

Additional Comments: This site is in the northern portion of Iron Mountain. The neighborhood is a mix of industrial and commercial land use. The site is situated between Moon Lake to the north, and Lake Antoine to the south. The site is across the street from Bay College West Campus.

Land Listing Two

Intended Use	
Location/Address	N. Stephenson Ave.
City, ST	Iron Mountain, MI
Date of Sale / Effective Appraisal Date	Current Listing
Sale Price	\$24,900
Seller	DARP, LLC
Buyer	N/A
Confirmation	Broker
 Physical Description	
Size	
Acres	0.67
Square Feet	29,185
Shape of Site	Triangular
Topography of Site	Level
Drainage of Site	Adequate
Zoning of Site	B-2 General Business
Accessibility of Site	Good
Visibility of Site	Good
Utilities Available to Site	All
Location of Site	Good
Unit Price Per Acre	\$37,164
Unit Price Per Square Foot	\$0.85

Additional Comments: This site is located just north of the Holiday Inn Express in the 1500 block of N Stephenson Ave. The site is small and has a triangular configuration, lending some inutility.

Site Value Conclusions

I have elected to utilize a qualitative approach to the site valuation process. The parcels are grouped according to the table provided in the site description section of the appraisal.

Three sales and two listings are considered in this analysis. Few comparable sales were identified despite various efforts to search databases (Integra Realty Resources and CoStar) and via contacts with local people in real estate related occupations, including a broker, an appraiser, and the city assessor for Iron Mountain. Attempts to identify comparable data through these local contacts were fruitless. Generally, because the community is not growing in population and experiences modest prosperity, commercial land sale activity is limited.

The sales and listing identified are commercial sites, all less than two acres in size. Many of the satellite subject sites are in the same general size range as the comparables, but the hospital campus is much larger. Due to its large size and other physical characteristics, the hospital campus property, in my opinion, would likely be subdivided for multiple uses/users. Prospective end users needing that much site area in a community of Iron Mountain's size and growth prospects may never materialize. Thus, the point to be made for appraisal purposes is that the large size of the hospital campus property means, if unimproved, it is likely to need infrastructure development to accommodate multiple end users, and sales of subdivided lots are likely to occur over an extended period of time. These considerations serve to discount the bulk land unit value significantly from unit prices realized in sales of smaller sites with street and utility infrastructure in place.

The unit sale and listing prices range from \$0.85 to \$4.64 per square foot. The average for the five is \$2.39 per square foot. The average for the three actual sales is \$2.15 per square foot. One of the sales has been improved with grading and demolition, plus assemblage with vacated land, and is now offered at a significantly higher unit price.

My unit value conclusions for the subject parcels vary from \$0.50 to \$2.00 per square foot. Most of the adopted unit values are \$1.75 or \$2.00 per square foot. From a location standpoint, the satellite subject property parcels in Iron Mountain and Kingsford are in inferior locations than the comparables. The Medical Park MOB subject site is significantly larger and has less exposure than the comparables. A lower unit price of \$0.50 per square foot is adopted for that site. The size of the hospital campus is large enough to expect a subdivision being necessary. A unit price of \$1.00 per square foot is adopted for that site. The clinic sites in Florence and Wausaukee front to the principal highways that serve those respective communities. They are smaller communities and I believe there is generally less price support for land there than in Iron Mountain. I have adopted unit price of \$2.00 per square foot for those sites.

The table provided on the following page summarizes the site value conclusions.

Land Value Conclusion (Hospital Campus - Parcel A)	
Concluded Value Per Square Foot	\$1.00
Land Area	<u>1,430,990</u>
Concluded Value	\$1,430,990
Rounded	\$1,430,000
Land Value Conclusion (Medical Park MOB - Parcel B)	
Concluded Value Per Square Foot	<u>\$0.50</u>
Land Area	<u>412,513</u>
Concluded Value	\$206,257
Rounded	\$210,000
Land Value Conclusion (Podiatry Clinic - Parcel C)	
Concluded Value Per Square Foot	<u>\$1.75</u>
Land Area	<u>30,405</u>
Concluded Value	\$53,209
Rounded	\$50,000
Land Value Conclusion (HH & DME - Parcel D)	
Concluded Value Per Square Foot	<u>\$2.00</u>
Land Area	<u>25,483</u>
Concluded Value	\$50,965
Rounded	\$50,000
Land Value Conclusion (Florence Clinic - Parcel E)	
Concluded Value Per Square Foot	<u>\$1.75</u>
Land Area	<u>56,628</u>
Concluded Value	\$99,099
Rounded	\$100,000
Land Value Conclusion (Wausaukee Clinic - Parcel F)	
Concluded Value Per Square Foot	<u>\$2.00</u>
Land Area	<u>37,897</u>
Concluded Value	\$75,794
Rounded	\$80,000
Land Value Conclusion (Sleep Disorders Ctr - Parcel G)	
Concluded Value Per Square Foot	<u>\$2.00</u>
Land Area	<u>45,430</u>
Concluded Value	\$90,860
Rounded	\$90,000
Land Value Summary	
Parcel A	\$1,430,000
Parcel B	210,000
Parcel C	50,000
Parcel D	50,000
Parcel E	100,000
Parcel F	80,000
Parcel G	90,000
Combined Total	<u>\$1,690,000</u>

Improvement Valuation

The following table summarizes the building improvements included in the cost approach analysis.

Building Area and Chronological Age Summary				
	Blended Year of Constructon	Chronological Age (Years)	Building Area (Sq.Ft.)	% of Total Building Area
As Completed				
Hospital	1997	22	179,300	67.0%
Dickinson MOB	1997	22	37,836	14.1%
OB-GYN & Occup. Health (2 buildings)	2015	4	12,525	4.7%
Home Health & DME (2 buildings)	1946	73	6,773	2.5%
Medical Park MOB & Sleep Disorders Ctr (2 buildings)	1970	49	17,904	6.7%
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)	2002	17	13,136	4.9%
Totals/Weighted Averages	1995	24	267,474	100.0%

Note: Chronological ages are based on years of construction. Renovations/remodeling are not factored. Garage & shed excluded.

Base Cost Estimate

The next step in the cost approach is to estimate the development cost of the improvements. The development cost may be based on either reproduction and/or replacement costs per new construction – RCN.

For this appraisal, we have elected to develop replacement cost estimates. Replacement cost is defined as the cost to construct, at current prices, a building with utility equivalent to the building being appraised, using modern materials and current standards, design, and layout. In the development of a replacement cost estimate, any building component deemed to be a superadequacy is eliminated from the RCN. A superadequacy is defined as something which exceeds market requirements and does not add to value an amount equal to its cost.

Appraisers often derive RCN estimates from nationally recognized providers of construction cost data such as Marshall & Swift and RSMeans. However, Integra – Healthcare & Senior Housing has found that these cost manuals are poor guides for healthcare facilities such as hospitals, cancer centers and ambulatory surgery centers. At the quality scale utilized by these sources, the unit costs are consistently too low when compared to the actual unit costs for known projects. Per our observations, the cost manuals offer more reliable unit cost indications of RCN for medical office buildings.

Comparable cost data from construction projects in which the actual development costs are known typically represents the best alternative for estimating RCN of healthcare facilities. In this appraisal, we have principally relied upon development cost data identified for specific projects.

Cost Comparables

Hospital

The following table provides project costs for recently constructed and proposed hospitals either Integra - Healthcare & Senior Housing has appraised or that have been recently reviewed for certificate of need approval. These cost figures provide an excellent basis from which to gauge reasonable reproduction cost parameters for the subject hospital. Items included and excluded from the costs are noted in the table.

Recent Hospital Facility Construction Projects								
<u>Project</u>	<u>Scope</u>	<u>Beds</u>	<u>Bldg. Area Sq. Ft.</u>	<u>Bldg. Area Per Bed</u>	<u>Local Cost Index</u>	<u>Project Costs</u>	<u>Costs per Sq. Ft. of Bldg. Area</u>	<u>CON Project # and Status</u>
Encore Medical Center 3204 AR Highway 5 Bryant, AR	Construct a new short-term acute care hospital	24	107,390	4,475	0.90	\$46,829,000	\$436.06	No CON; Integra - HC & SH appraised; 4-story building with one level to remain shell space at completion; construction began Nov 2018; completion expected in 2020
Gundersen St. Joseph's Hospital & Clinics 400 Water Avenue Hillsboro, WI	Construct a replacement critical access hospital	12	64,000	5,333	1.06	\$30,450,000	\$475.78	No CON; Integra - HC & SH appraised; 2-story building; construction began Oct 2018; completion is expected in April 2020
ProMedica Bixby Hospital 5640 N. Adrian Highway Adrian, MI	Construct a replacement short-term acute care hospital	70	220,000	3,143	1.04	\$123,867,000	\$563.03 not used used \$517.58	# 17-0053; construction began June 2017; completion in 2020; site prep & utility costs are very high - \$64/SF; estimated normalized cost is \$10MM less
Taylorville Memorial Hospital; 201 E Pleasant St Taylorville, IL	Construct a new critical access hospital to replace old one	25	93,599	3,744	1.07	\$49,769,786	\$531.73	# 18-003; construction began in June, 2018; completion expected in early 2021
Mercy Hospital Joplin 100 Mercy Way Joplin, MO	Construct a replacement short-term acute care hospital	260	825,000	3,173	0.93	\$345,000,000	\$418.18	No CON; construction occurred between 1/2012 and 3/2015; 9-story IP tower & 5-story clinical tower
St. Vincent Ortho Hospital 10388 Warrick Trail Newburgh, IN	Construct a new surgical specialty hospital	48	136,197	2,837	1.01	\$63,092,000	\$463.24	No CON; construction began May 2017, and is expected to be complete summer 2019; 4-story bldg, initially w/24 beds; 4th floor (20,270 SF) to be shell for future 24 beds
West Feliciana Hospital 5266 Commerce Street St Francisville, LA	Construct a replacement critical access hospital	23	53,000	2,304	0.88	\$22,000,000	\$415.09	No CON; construction occurred between Feb 2016 and Sept 2017; 1-story design, no surgical suite
Rock Regional Hospital 3251 N. Rock Road Derby, KS	Construct a new short-term acute care hospital	31	87,025	2,807	0.92	\$38,081,857	\$437.60	No CON; construction occurred between Sept 2017 and April 2019; 4 ORs
Unweighted Averages Average Cost per Sq. Ft. Adjusted to 1.0 Index		62	198,276	3,477	0.98	\$89,886,205	\$461.91 \$473.15	
Projects may include "modernization" in addition to new construction. Building areas and costs for modernization of existing space are excluded from the figures included in the table. Only projects that are substantially comprised of new construction are included in the table. Project costs exclude land acquisition, off-site work, and movable equipment. Project costs include amounts for contingencies, bond issuance, design fees, and interest expense during construction.								

Considerable variation can exist in unit construction/development costs for hospital buildings due to specific design elements and finish packages, unique site conditions, building size, etc. Some locations may be subject to higher standards and thresholds for design, permitting and project monitoring. Wage rates vary by location, and there may be prevailing wage rate requirements for some projects that are nonexistent in others. Material costs, which are influenced by transportation costs, can also vary by location. Building size is a factor, whereby smaller hospitals may have a higher concentration of clinical space and otherwise lose the construction cost efficiency that can be realized with larger buildings.

I note that the approximate local cost index for this class of construction (Marshall Valuation Service – Class A) in this region of Michigan is 1.00.

The subject is a short-term acute care hospital of average-quality construction. Roughly 30 percent of the building is walk-out basement grade, which is less expensive building area to construct than fully above-grade area. Generally, we believe that the quality and construction features of the subject hospital building are somewhat inferior to the comparable average. At 90 percent of the 1.00 local cost-indexed amount, a figure of \$425.83 per square foot is indicated. At 80 percent of the 1.00 local cost-indexed amount, a figure of \$378.52 per square foot is indicated. A unit cost in this range has been adopted for the replacement cost of the subject hospital building.

Medical Office Building

The following table provide project costs for recently constructed and proposed outpatient/medical office buildings either Integra - Healthcare & Senior Housing has appraised, that have been recently reviewed for certificate of need approval/waiver, or that have been discussed sufficiently in public forums such that we believe the information is worthy of consideration. These buildings are generally similar in class to the Dickinson MOB (condominium) on the hospital campus, and to the Medical Park MOB.

Recent or Planned Outpatient & MOB Facility Construction Projects in Illinois						
Project	Scope	Bldg. Area Sq. Ft.	Local Cost Index	Project Costs	Costs per Sq. Ft. of Bldg. Area	CON Project # and Status
Griffin Medical Office Bldg. Pekin, IL	Construct a new MOB for physician clinics; design is 3-stories above-grade plus partial basement; being built-to-suit for lease to a sister company of Pekin Hospital	59,580	1.10	\$17,546,566	\$294.50	# 16-017 project approved June 2016; project completion date is expected in early 2018
Memorial Hospital-East Medical Clinics Building Shiloh, IL	Construct a new MOB for clinical services and physician offices; 3-story freestanding building design	70,500	1.10	\$19,475,111	\$276.24	# 16-018 project approved September 2016; construction was completed in October 2017
John H. Stroger Hospital of Cook County -- Central Campus Health Center Chicago, IL	Construct a new 9-story outpatient MOB (278,914 SF) and modernize 41,105 SF of existing hospital space for outpatient services	325,576	1.28	\$116,915,660	\$359.10	# 16-030 project approved September 2016; project completion date is expected in October 2018
Rush Oak Brook Orthopaedic Center Oak Brook, IL	Construct a 3-story professional building for orthopaedic-related services, including an ASC, lab, imaging, and physician offices	105,000	1.28	\$40,983,600	\$390.32	# 16-032 construction began April 2017; project completion date is expected to be June 2019
Carle Foundation Hospital Orthopedic and Sports Medicine Facility Champaign, IL	Construct a 2-story outpatient facility with 32,806 SF of clinical space and 19,194 SF of non-clinical areas	52,000	1.09	\$19,280,000	\$370.77	# 15-002 construction began Sept. 2015; project completion occurred in January 2017
NorthShore University Health System Niles Medical Clinics Bldg. Niles, IL	Construct a 2-story medical clinics building building with minimal clinical space	34,800	1.27	\$11,567,642	\$332.40	# 15-055 construction began in March 2016; project completion occurred in December 2017
Unweighted Averages		107,909	1.20	\$37,628,097	\$337.22	
Average Cost per Sq. Ft. Adjusted to 1.0 Index					\$280.09	
Projects may include "modernization" in addition to new construction. Building areas and costs for modernization of existing space are excluded from the figures included in the table. Only projects that are substantially comprised of new construction are included in the table. Project costs exclude land acquisition, off-site work, and movable equipment. Project costs include amounts for contingencies, bond issuance, design fees, and interest expense during construction.						

I note that the approximate local cost index for this class of construction (Marshall Valuation Service – Class A) in this region of Michigan is 1.00.

The average unit cost for the comparables, adjusted to a 1.00 local cost index, is \$280.09 per square foot. Some of the comparables have surgical spaces that add disproportionately to their construction costs, and one of the buildings is a 9-story structure. The greater heights/# of floors adds to the costs of construction.

The Dickinson MOB is of average quality construction. We believe that the quality and construction features of the subject building are inferior to the comparable average. At 80 percent of the 1.00 local cost-indexed amount, a figure of \$224.07 per square foot is indicated. A unit cost near the 80 percent figure has been adopted as the base unit replacement cost for the Dickinson MOB (condominium).

The Medical Park MOB is of good quality construction, but it does not have surgical space and its lower level is partially below grade. A unit replacement cost of \$250 per square foot is considered reasonable for this facility.

Clinics/Other MOBs

The OB-GYN Clinic located on the hospital campus was constructed in 2017. The building is wood frame construction (Marshall Valuation Service – Class D). All interior spaces in the clinic building are fully finished. The construction quality is average. Per information supplied to the appraiser, the construction cost for the building was \$1,341,538, or about \$200.23 per square foot of building area.

One other cost comparable considered is as follows.

Newman Grove Medical Clinic
108 N. 1st Street
Newman Grove, NE

This clinic/medical office building was constructed for Boone County Health Center, located in Albion, Nebraska. This is a one-level, prefabricated structural steel building with approximately 2,720 square feet of building area. This building was constructed in 2018. The reported construction costs were \$674,581, or \$248 per square foot of building area.

Overall, the historical costs for the OB-GYN Clinic are considered the best indication of replacement cost for the subject's two other on-campus clinics – OB-GYN and Occupational Health/Wound Healing.

The Sleep Disorders Center building is very similar in construction to the Newman Grove Medical Clinic cost comparable cited above; thus, a similar unit cost is adopted for this building.

The three other clinic/medical office buildings appraised include the Podiatry Clinic, the Wausaukee Medical Clinic, and the Florence Medical Clinic. These are low-average quality, wood frame construction buildings. A unit cost below the reported OB-GYN building unit cost has been utilized for these buildings.

Calculator Costs

The RCN estimates for two subject buildings were obtained from Marshall Valuation Service, a cost manual published by Marshall & Swift, a nationally recognized provider of

building cost data. The specific improvements for which the cost manual was applied include: (1) the home health building; and, (2) the medical equipment sales building.

The RCN estimates are based upon the comparative-unit method. The comparative-unit method utilizes known costs of similar structures, which are adjusted for market conditions and physical differences. These costs are expressed on a per-unit basis, such as price-per-square-foot of building area. In Marshall Valuation Service, these unit costs are referred to as *Calculator Costs*. They represent final costs to the owner, including all direct costs and most indirect costs. They do not include entrepreneurial profit and developer's overhead.

Marshall Valuation Service (MVS) classifies buildings by occupancy (e.g., hotel, office, hospital, warehouse, etc.). Additionally, MVS utilizes a Class of Construction system to divide buildings into five basic cost groups by type of framing, walls, floors and roof structures, and fireproofing. The Class of Construction system is summarized as follows.

- **Class A** buildings have fireproofed structural steel frames with reinforced concrete or masonry floors and roofs.
- **Class B** buildings have reinforced concrete frames and concrete or masonry floors and roofs.
- **Class C** buildings have masonry or concrete exterior walls, and wood or steel roof and floor structures, except for concrete slab on grade.
- **Class D** buildings generally have wood frame, floor, and roof structure. They are considered combustible construction.
- **Class S** buildings have frames, roof, and walls of incombustible metal. This class includes pre-engineered metal buildings.

We have categorized both buildings as average cost, Class C type construction, using the indices for Retail Stores.

Other Indirect Costs

Indirect costs are expenditures or allowances for items other than labor and materials that are necessary for construction but are not typically part of the construction contract. The RCNs used in this analysis typically include many of the indirect costs that were incurred or expected to be incurred in project development. However, we find that the accounting for indirect costs by project developers is very often incomplete; particularly when the real estate development undertaken is a one-off event rather than the owner/developer's principal line of business. As another consideration, in certain cases, indirect costs may also be proportionately unique to the project. We have therefore provided a line item adjustment to account for indirect costs that are either likely understated in the RCN cost sources and/or are, in the appraisers' opinion, atypical in the direct-to-indirect cost relationship that is or would be expected in the development of the subject property.

The other indirect costs adjustment(s) applied in this appraisal are as follows.

As Completed	1.0%

Importantly, the adjustment(s) for other indirect costs is NOT an addition for intangible assets of the going concern. There is no addition for intangible assets made in this analysis. As such, this cost approach does NOT provide an indication of value for the going concern. Instead, this cost approach analysis provides indications of the contributory value in place for the tangible assets of the going concern, per the going concern valuation premise.

Entrepreneurial Reward

In our analysis, entrepreneurial profit is treated distinct from developer's overhead, which we consider to be an indirect cost that represents payment for overseeing the development of a project.

When developing the Cost Approach, the appraiser must recognize the contribution of the entrepreneur in addition to direct and indirect costs. Entrepreneurial reward is typically expressed as a percentage of other development costs. In our analysis, entrepreneurial profit is treated distinct from developer's overhead, which we consider to be an indirect cost that represents payment for overseeing the development of a project.

For the subject property, which represents a management intensive going concern that has non-traditional investment characteristics, a higher profit of margin may seem intuitive. However, in an industry that is strongly influenced by the actions of nonprofit players and is otherwise subject to government payment systems and ongoing negotiations with payers trying to control their own costs, we are inclined to believe that entrepreneurial incentives for new development are modest.

Based upon our valuation analyses, we have not added an entrepreneurial profit margin to the cost approach. This property suffers from enough external obsolescence to effectively negate any earning of entrepreneurial profit.

Ratios of entrepreneurial incentives and profits applied in the appraisal are summarized as follows.

Entrepreneurial Reward	
	As Completed
Entrepreneurial/Developer Incentive	2%
Entrepreneurial/Developer Profit	0%

Replacement Cost Summary

The RCN of the subject improvements is summarized in the following tables. When applicable, adopted base unit costs are adjusted for unfinished building area.

Improvement Development Cost New -- Table 1			
Hospital	As Completed		
	Unit Cost \$ per SF	Building Area Square Feet	Amount
Category of Building Area			
Base - Unadjusted	\$400.00		
Current Cost Multiplier	1.00		
Local Cost Multiplier	1.00		
Total GBA →	\$400.00	179,300	\$ 71,720,000
Budgeted Construction/Development Cost -- Includes Site Improvements			
Dickinson MOB			
Category of Building Area	Unit Cost \$ per SF	Building Area Square Feet	Amount
Base - Unadjusted	\$225.00		
Current Cost Multiplier	1.00		
Local Cost Multiplier	1.00		
Total GBA →	\$225.00	37,836	\$ 8,513,100
Per Cost Comparables -- Unit Cost Includes Site Improvements			
OB-GYN & Occup. Health (2 buildings)			
Category of Building Area	Unit Cost \$ per SF	Building Area Square Feet	Amount
Base - Unadjusted	\$200.00		
Current Cost Multiplier	1.00		
Local Cost Multiplier	1.00		
Total GBA →	\$200.00	12,525	\$ 2,505,000
Per Cost Comparables -- Unit Cost Includes Site Improvements			
Home Health & DME (2 buildings)			
Category of Building Area	Unit Cost \$ per SF	Building Area Square Feet	Amount
Base - Unadjusted	\$85.00		
Current Cost Multiplier	1.00		
Local Cost Multiplier	1.00		
Total GBA →	\$85.00	6,773	\$ 575,705
Per Cost Comparables -- Unit Cost Includes Site Improvements			
Medical Park MOB & Sleep Disorders Ctr (2 buildings)			
Category of Building Area	Unit Cost \$ per SF	Building Area Square Feet	Amount
Base - Unadjusted	\$250.00		
Current Cost Multiplier	1.00		
Local Cost Multiplier	1.00		
Total GBA →	\$250.00	17,904	\$ 4,476,000
Per Cost Comparables -- Unit Cost Includes Site Improvements			
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)			
Category of Building Area	Unit Cost \$ per SF	Building Area Square Feet	Amount
Base - Unadjusted	\$175.00		
Current Cost Multiplier	1.00		
Local Cost Multiplier	1.00		
Total GBA →	\$175.00	13,136	\$ 2,298,800
Per Cost Comparables -- Unit Cost Includes Site Improvements			
Other Improvements			Amount
Campus Garage & Records Storage Buildings			183,000
Misc. Other Improvements			-
Total Other Improvements			\$ 183,000
Preliminary Improvement Cost		As Completed	\$ 90,271,605

Improvement Development Cost New -- Table 2		
	% of Amount	Amount
Preliminary Improvement Cost		\$ 90,271,605
Indirect Cost Not Included in Preliminary Amount	1%	902,716
Improvement Cost w/o Entrepreneurial Reward		\$ 91,174,321
Entrepreneurial/Developer Incentive	2%	1,823,486
Entrepreneurial/Developer Profit	0%	-
Improvement Cost with Entrepreneurial Reward		\$ 92,997,807
Allocations to Improvements (Rounded #s)		
Hospital		\$ 73,886,000
Dickinson MOB		8,770,000
OB-GYN & Occup. Health (2 buildings)		2,581,000
Home Health & DME (2 buildings)		593,000
Medical Park MOB & Sleep Disorders Ctr (2 buildings)		4,611,000
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)		2,368,000
Other Improvements		
Campus Garage & Records Storage Buildings		189,000
Total Improvement Development Cost		\$ 92,998,000
Note: The Dickinson MOB building area represents owned condominium area and a proportionate share of the common area.		

Accrued Depreciation

Accrued depreciation is a loss in value from the RCN of the improvements due to any cause as of the date of the appraisal. The three principal methods for estimating depreciation are: the market extraction method; the economic age-life method; and, the breakdown method.

The economic age-life method has been utilized for this appraisal. Using this method, total depreciation is estimated by calculating the ratio of the effective age of the property to its economic life expectancy and applying this ratio to the property's total cost. The formula is: $(\text{Effective Age} / \text{Total Economic Life}) \times \text{Total Cost} = \text{Depreciation}$.

Loss in value results from one or more of three sources: physical deterioration, functional obsolescence, and external obsolescence.

Physical deterioration includes curable and incurable physical deterioration.

Curable deterioration, aka deferred maintenance, refers to components in need of repair on the date of the appraisal. This category is measured as the cost of restoring an item to new or reasonably new condition. For this appraisal, per the "as completed" valuation perspective, an extraordinary assumption is made that the roof cover replacements for the hospital building and the Medical Equipment building have been completed.

Incurable physical deterioration reflects items of deterioration that cannot be practically or economically corrected at the effective date of the appraisal. If the cost to cure is more than the anticipated increase in value that would result from curing the condition, then the item is incurable. Incurable items are classified as short-lived and long-lived. Short-lived components have an economic life that is shorter than the remaining economic life of the structure.

Physical deterioration affecting the subject property is discussed in the property description.

Functional obsolescence is caused by a flaw in the structure, materials, or design of the improvement when compared with the highest and best use and most cost-effective functional design requirements at the time of appraisal. Functional obsolescence is attributable to defects within the property; as opposed to external obsolescence, which is caused by factors outside the property.

Functional obsolescence can be curable or incurable and is either caused by a deficiency or superadequacy. If the cost to cure the item will not result in a value increment greater than the loss in value caused by the item or building component, then the item is considered incurable. Curable functional obsolescence is measured as the cost to correct the condition through addition, substitution or modernization.

We did not identify any major functional problems in our review of the hospital building floor plans and site footprint. Nevertheless, there is functional obsolescence inherent in any aging building, and this can be particularly true for a healthcare service building because the evolution of medical care is occurring rapidly and competition among providers is keen, resulting in the steady deployment of capital investment for new physical plant construction and renovation. The shift that has occurred from the prevalence of inpatient care to outpatient care is an event driving functional obsolescence in middle aged and older hospital buildings.

External obsolescence is a loss in value caused by factors outside a property. Examples include changes in neighborhoods, traffic flow, governmental regulations, reimbursement policies, and economic events. External obsolescence can be either temporary or permanent. External obsolescence may affect a single property when its cause is location, but typically has a marketwide effect and influences a whole class of properties.

In a complex going concern like a hospital, quantifying external obsolescence can be quite difficult because matching paired sales is basically impossible due the complexity of variables that can influence sales. Quantifying the net income loss may be possible to a certain degree, but there will likely be a significant amount of conjecture in the development process.

In this instance, we believe there is external obsolescence that results from the modest level of wealth and prosperity in the region, the financial squeeze being experienced by the healthcare industry due to the need to control costs, inroads that have been made in healthcare delivery by a Green Bay-based competitor, and management-related issues discussed in other areas of this report.

Our depreciation calculations utilize the effective age and economic life concept and thereby include physical deterioration, functional obsolescence, and external obsolescence.

Effective Age Schedule				
	Economic Life	Effective Age	Remaining Economic Life	Percent Depreciated
As Completed				
Hospital	60	35	25	58.3%
Dickinson MOB	60	35	25	58.3%
OB-GYN & Occup. Health (2 buildings)	40	5	35	12.5%
Home Health & DME (2 buildings)	40	25	15	62.5%
Medical Park MOB & Sleep Disorders Ctr (2 buildings)	45	30	15	66.7%
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)	40	15	25	37.5%
Other Improvements				
Campus Garage & Records Storage Buildings	25	10	15	40.0%

Based on the foregoing conclusions, accrued depreciation is summarized as follows.

Accrued Depreciation Calculations				
	Improvement Development Cost	Accrued Depreciation Percentage	Accrued Depreciation Rounded	Depreciated Contributory Value
As Completed				
Hospital	\$ 73,886,000	58.3%	\$ 43,100,000	\$ 30,786,000
Dickinson MOB	8,770,000	58.3%	5,116,000	3,654,000
OB-GYN & Occup. Health (2 buildings)	2,581,000	12.5%	323,000	2,258,000
Home Health & DME (2 buildings)	593,000	62.5%	371,000	222,000
Medical Park MOB & Sleep Disorders Ctr (2 buildings)	4,611,000	66.7%	3,074,000	1,537,000
Wausaukee & Florence Clinics, & Podiatry Clinic (3 buildings)	2,368,000	37.5%	888,000	1,480,000
Other Improvements			-	
Campus Garage & Records Storage Buildings	189,000	40.0%	76,000	113,000
Total	\$ 92,998,000		\$ 52,948,000	\$ 40,050,000
Combined Ratio		56.9%		

Furniture, Fixtures & Equipment (Personal Property) Valuation

The appraisal assumes the continuation of the going concern. The concept of "value in place" is implicit in the appraisal of a going concern. "Value in place" is defined as, "the amount a prudent purchaser would pay for an item, e.g., equipment, fixtures, in place; determined by the use the item contributes to the whole." Since the tangible personal property that is owned and utilized by the subject going concern is integral to the hospital's operation, it is more valuable under continued use than if it were removed and sold separately. Thus, the value is considered the "contributory value in place," which is consistent with the premise of going-concern value.

With respect to the FF&E that is included in the subject appraisal, we have elected to utilize its depreciated book value (approximate) as a basis for the allocation of value. Additionally, the Hospital has a budgeted cost of \$10,125,500 for FF&E to be acquired. Per the "as completed" valuation perspective, an extraordinary assumption is made that the proposed FF&E has been acquired and is in place. Thus, the budgeted cost for that FF&E is added to the net book value amount for existing FF&E to serve as a basis for the total contributory value in place for personal property. Because the property suffers from external obsolescence, that loss in value experienced by the real estate extends to the personal property, as well. A discount has been applied to the basis amount to reflect its estimated true contributory value in place.

Contributory Value in Place for Personal Property		
		As Completed
Net Book Value of FF&E		\$ 5,280,400
Budget for New Project FF&E		10,125,500
Existing Net Book Value + Budgeted Amount		\$ 15,405,900
Discount to Net Book Value + Budgeted Amount	50%	7,703,000
Contributory Value in Place for Personal Property		\$ 7,702,900
Note: The net book values are those effective as of 5-31-2019		

Summation

The final step in the cost approach is to sum the indications of value for the land, improvements and personal property. This process yields an indication of value for the tangible assets.

Cost Approach Summary		
		As Completed
Depreciated Value of Improvements	\$ 40,050,000	
Land Value Estimate	1,690,000	
Subtotal for Real Property		\$ 41,740,000
Contributory Value in Place of Personal Property		7,702,900
Cost Approach Conclusion		\$ 49,442,900
Note: The Cost Approach analysis does not include intangible asset value.		

Income Capitalization Approach

The income capitalization approach is applied to an income-producing property via a set of procedures which converts anticipated benefits (cash flow and reversion) into an indication of property value.

For hospital going concerns, direct capitalization is the principal technique employed by most investors to evaluate investment opportunities. Direct capitalization is the conversion of a single year's income expectancy into an indication of value. Yield and value change are implied, but not specifically identified.

We have utilized two direct capitalization techniques for this appraisal, summarized as follows.

Technique #1 - Division of net operating income by income capitalization rate.

1. Develop a net revenue estimate for the subject hospital based on anticipated inpatient and outpatient utilization of the facility and applicable reimbursement rates. These forecasts reflect historical and current utilization patterns, the operating results of competing hospitals, and any proposed changes in the physical plant, business services offered, staffing practices, and other management actions that could impact the Hospital's business. These steps were substantially performed in the Market Analysis section of the report.
2. Estimate and deduct expenses typically incurred in the operation of a hospital to arrive at an estimate of stabilized net operating income attributable to the going concern. The operating cost estimates are based on actual historical performance of the subject facility and on comparable hospitals.
3. Capitalize the net operating income into a value indication by use of an appropriate capitalization rate. In this case the net operating income is divided by an overall capitalization rate derived from market data.

Technique #2 – Multiplication of effective net revenue by an income factor.

1. Same as step #1 above.
2. The stabilized net revenue forecast is capitalized into an indication of value by multiplying that figure by a capitalization rate developed from market data and chosen based upon reasoned considerations. The capitalization rate is the net revenue multiplier (NRM), which is derived by dividing the sale price of a hospital going concern by its total net revenue, whereby total net revenue includes amounts from patient and non-patient sources.

The operating income and expense history for Dickinson County Memorial Hospital is summarized in the following table.

Historical and Operator's Budgeted Financial Data				
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
Gross Patient Revenue				
Hospital Inpatient Services	\$ 59,466,053	\$ 53,307,865	\$ 50,954,748	\$ 57,994,423
Hospital Outpatient Services	253,620,551	255,298,511	244,011,081	234,179,157
Total Gross Patient Revenue (a)	\$ 313,086,604	\$ 308,606,376	\$ 294,965,829	\$ 292,173,580
Contractual Allowances & Discounts				
Hospital Inpatient Services	\$ (33,525,576)	\$ (29,637,032)	\$ (29,020,989)	\$ (30,373,868)
Hospital Outpatient Services	(172,521,111)	(172,575,211)	(165,579,294)	(159,121,291)
IP Charity	(252,290)	(370,389)	(261,195)	(401,143)
OP Charity	(2,359,166)	(2,586,081)	(2,834,331)	(2,498,755)
Total Contractual Allowances & Discounts (b)	\$ (208,658,143)	\$ (205,168,713)	\$ (197,695,809)	\$ (192,395,057)
Bad Debt (c)	\$ (3,099,981)	\$ (4,091,854)	\$ (3,790,872)	\$ (4,076,069)
Net Patient Revenue (a - b - c)	\$ 101,328,480	\$ 99,345,809	\$ 93,479,148	\$ 95,702,454
Other Revenue				
Other Operating Revenue (Hospital)	\$ 2,929,806	\$ 4,800,650	\$ 6,130,335	\$ 4,985,389
Total Other Revenue	\$ 2,929,806	\$ 4,800,650	\$ 6,130,335	\$ 4,985,389
Total Operating Revenue	\$ 104,258,286	\$ 104,146,459	\$ 99,609,483	\$ 100,687,843
Operating Expenses				
Salaries & Wages	\$ 46,991,982	\$ 44,541,242	\$ 39,575,598	\$ 36,586,938
Payroll Taxes & Emp. Benefits	18,577,979	7,010,570	14,569,572	14,881,307
Supplies	22,329,233	21,443,552	18,413,070	22,164,212
Purchased Services	9,431,944	8,787,084	5,846,589	7,454,224
Professional Fees	12,090,325	9,696,416	7,566,777	11,968,698
Other Operating	1,777,998	1,868,436	4,224,963	1,702,468
Maintenance & Utilities	1,694,476	1,413,126	1,563,579	1,432,657
Insurance	490,501	429,210	886,521	570,367
Central Office / Management	-	-	-	-
Property Taxes	45,087	59,518	-	46,906
Total Operating Expense	\$ 113,429,525	\$ 95,249,154	\$ 92,646,669	\$ 96,807,777
Net Operating Income (w/o reserves deducted)	\$ (9,171,239)	\$ 8,897,305	\$ 6,962,814	\$ 3,880,066
Total Operating Expense	\$ 113,429,525	\$ 95,249,154	\$ 92,646,669	\$ 96,807,777
Minus: Actual Central Office / Management Fee	-	-	-	-
Plus: Central Office / Management Fee @ 1.5% of Net PR	1,519,927	1,490,187	1,402,187	1,435,537
Plus: Reserves for Replacement @ 2.0% of Net PR	2,026,570	1,986,916	1,869,583	1,914,049
Total Normalized Operating Expenses	\$ 116,976,022	\$ 98,726,257	\$ 95,918,439	\$ 100,157,363
Normalized Net Operating Income	\$ (12,717,736)	\$ 5,420,202	\$ 3,691,044	\$ 530,480
Expense Margin	112.2%	94.8%	96.3%	99.5%
Operating Margin	-12.2%	5.2%	3.7%	0.5%

Income Analysis

The net patient revenue, which comprises most the stabilized net revenue estimate, was developed in the Market Analysis section of the appraisal. The following section adds an analysis of Other Revenue (non-patient) to complete the total net revenue forecast. Nonoperating revenues such as income from investments, endowment income and gain or losses on the sale of assets are excluded from our analysis.

Other Operating Revenue

In addition to the revenues discussed in the Market Analysis section, the Hospital derives income from cafeteria revenue and various other non-patient or indirect patient sources. The following table summarizes the history of Other Revenue for the Hospital, and our forecast.

Detail for Other Operating Revenue (Hospital)					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast
Cafeteria	\$ 374,240	\$ 354,318	\$ 342,363	\$ 361,965	\$ 358,970
Office Rent	110,973	385,670	142,155	193,391	205,116
Electronic Health Records	513,328	-	-	-	-
340B Retail Pharmacy	385,681	2,270,786	3,576,318	2,724,496	2,336,355
Occupational Health Clinic	1,343,134	1,511,348	1,281,150	1,349,134	1,366,780
Other	202,450	278,528	788,349	356,403	439,621
Total	\$ 2,929,806	\$ 4,800,650	\$ 6,130,335	\$ 4,985,389	\$ 4,706,843

340B Drug Pricing Program

The 340B program was created by Congress in 1992 to help vulnerable or uninsured patients access prescription medicines at safety-net facilities. This drug pricing program requires pharmaceutical manufacturers participating in the Medicaid program to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. The 340B program is intended to reduce operating costs for hospitals that disproportionately serve those populations. Providers generate net revenues if the reimbursements for the drugs from payers exceed the discounted prices they pay for them.

Providers can contract with outside pharmacies to expand access to 340B drugs under limited and controlled circumstances. The ACA expanded access to the 340B program to CAHs and certain sole community hospitals and rural referral centers. However, the program expansion did not include coverage for inpatient drugs.

The number of hospitals that participate in 340B has grown, increasing by 60 percent between 2011 and 2016 from 1,465 to nearly 2,400, according to a 2018 report by the U.S. Government Accountability Office.

Many federal lawmakers have concerns that the 340B program benefits are not being used for the intended populations. Because the program has experienced exponential growth, the federal government has explored policy changes to rein in costs and abuse. Drug companies have also pushed for greater program oversight since they benefit if fewer drugs are sold under 340B.

For calendar year 2018, CMS implemented a major change in how certain 340B Covered Entities (Rural Referral Centers, Critical Access Hospitals, and Disproportionate Share Hospitals) would be reimbursed for specified covered outpatient drugs and biologicals that were purchased under the 340B Program. Specifically, Medicare Part B reimbursement

for 340B-acquired drugs was reduced from Average Sales Price (ASP) plus a 6 percent add-on to ASP minus 22.5 percent. Rural Sole Community Hospitals were spared the lowered reimbursement methodology.

The CY 2018 payment reduction introduced did not apply to hospital outpatient departments (HOPDs) since they were not billing through OPps – instead, they bill through the Medicare Physician Fee Schedule or the Ambulatory Surgical Center (ASC) payment system, a requirement under the Balanced Budget Act of 2015.

In its final rule for 2019, CMS expanded the reimbursement cut to 340B-acquired drugs prescribed in non-excepted, off-campus provider-based departments (PBDs).

Despite an unusual national focus on the 340B Program over the last few years, the overall state of the program remains relatively consistent. Going forward, and with the prospect of a divided government over at least the next two years, it is quite unlikely for any significant legislative changes to the 340B Program to occur. Nonetheless, CMS has signaled through the imposition of the Part B reimbursement cuts that it is willing to use its regulatory powers to rein in what it perceives as overutilization of certain 340B Program benefits.

Dickinson County Memorial Hospital

The Hospital participates in the 340B Drug Pricing Program. 340B covered entity hospitals must meet a certain threshold for disproportionate share adjustment (DSH) payment percentage: >11.75% for Disproportionate Share Hospitals, and ≥8% for Rural Referral Centers and Sole Community Hospitals. Critical Access Hospitals do not have to meet a DSH percentage threshold. The DSH adjustment percentage is based on the share of a hospital's inpatients who are Medicaid and low-income Medicare patients.

Effective July 2016, the Hospital System was eliminated as a participant in the program because its DSH percentage was slightly below the threshold for Sole Community Hospitals. As of July 2017, the Hospital was readmitted to the program. Management believes the Hospital missed out on about \$3.0MM in 340B reimbursement during that one-year period.

The DSH percentage realized in FY 2018 was reportedly around 8.6 percent. In the current fiscal year, however, management reports that the Hospital is not quite meeting the threshold.

Electronic Health Records

The Health Information Technology for Economic and Clinical Health (HITECH) Act created a 2015 deadline for hospitals and physician offices to implement a certified Electronic Health Records (EHR) system and meet a set of “meaningful use” requirements to receive Medicare and/or Medicaid incentive payments and avoid Medicare payment penalties. The EHR Incentive Program consists of 3 stages. Each stage has its own set of requirements to meet to demonstrate meaningful use (MU). Beginning on a voluntary basis in 2017 and required beginning in 2018, all providers will attest to Stage 3 objectives and measures. The last year to receive a Medicare EHR incentive payment is CY 2016. The last year to receive a Medicaid EHR incentive payment is CY 2021.

Dickinson County Memorial Hospital has received EHR incentive payments in the FY 2017 period. Those incentive payments were of a temporary nature and there were extraordinary capital costs incurred to earn them. Thus, we have not forecast EHR incentive payments.

Occupational Health Clinic

The Hospital bills employers for the occupational health services provided on behalf of their respective employees. There is no patient liability or billing.

Total Net Revenue Forecast

Based on the foregoing revenue analysis, we have forecast the following total net revenue.

Total Operating Revenue History and Forecast					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Total Net Patient Revenue	\$ 101,328,480	\$ 99,345,809	\$ 93,479,148	\$ 95,702,454	\$ 102,400,638
Total Other Revenue	2,929,806	4,800,650	6,130,335	4,985,389	4,706,843
Total Operating Revenue	\$ 104,258,286	\$ 104,146,459	\$ 99,609,483	\$ 100,687,843	\$ 107,107,480

Operating Expense Analysis

The operating expenses of a hospital include general services, patient services, and ancillary services.

- General and patient services include the cost of providing nursing; dietary, laundry, housekeeping, medical and social services; physical maintenance; utilities; administration; management; property taxes; and insurance.
- Ancillary expenses include a wide array of diagnostic testing, therapy, pharmacy, emergency room services, radiology, operating room costs, and clinical services.

We have relied significantly on the operating expenses of Dickinson County Memorial Hospital for the past two whole fiscal years, year-to-date amounts for the current fiscal year, and the budget for the current fiscal year. Additionally, we have analyzed operating data from ten comparable hospitals.

Operating expenses will vary by facility and are influenced by local labor market conditions, occupancy levels, inpatient and outpatient business ratios, case mix, staffing levels, quality of services, and a variety of management practices. Facilities with higher business volumes may experience greater economies of scale that results in lower per-patient-day variable and fixed expenses. Facilities offering medical services with elevated case mixes, such as intensive care units, will incur higher inpatient routine and ancillary costs. Outpatient services tend to have lower expense margins; thus, facilities with higher outpatient revenue ratios may experience proportionately lower expenses. Labor expenses can vary dramatically from one geographic location to another and even from rural to urban/suburban settings within a geographic area.

Another point that must be understood in evaluating a going concern is that the operating expenses have fixed and variable components. Fixed expenses generally do not fluctuate or only fluctuate mildly with utilization because the business is obligated to pay these expenses regardless of utilization levels. Variable expenses tend to fluctuate more directly with the level of utilization or extent of services provided. Most of the expense categories have both fixed and variable components. Since a hospital is a labor-intensive enterprise, there is a constant need for management to monitor the relationship between utilization and staffing. With respect to a change in business volume, certain departmental expenses may increase or decrease disproportionately. The addition or expansion of a medical

service program can result in increased variable unit costs within a department. From a broad perspective, fixed expenses should decrease on a unit basis with higher volumes of business, and vice versa.

Other considerations which often impact the expenses and the operating expense ratio a hospital experiences include the profit status (for-profit or nonprofit) of the business entity and whether the facility operates independently or as part of a larger health system. For-profit hospitals are often operated with stricter cost control measures in place than nonprofit ones. The EBITDA margins of public hospital operators are often in the mid-teens. Nonprofits typically provide more charity care to meet the “community benefit” standard established by the IRS. Because the net earnings (profits) of a nonprofit hospital cannot inure to the personal benefit of individual persons or shareholders in the corporation, there is less incentive to hold down operating costs. In contrast, for-profit hospitals have the need to satisfy investors.

Hospitals which operate independently, as opposed to being part of a system, naturally tend to incur higher operating expenses because they do not benefit from the managerial expertise or size-based bargaining power of a larger, more sophisticated organization.

For analytical purposes, we have inflation-adjusted the historical expenses for Dickinson County Memorial Hospital to the end of the “as completed” forecast period. Inflation data used to support the adjustments is provided in the following table. The actual and inflation-adjusted figures are provided in the second table.

Historical Inflation Rates						
Year	Average Hourly Earnings of All Hospital Employees (National)		Consumer Price Index All Urban Consumers U.S. city avg. for all items		Consumer Price Index All Urban Consumers U.S. city avg. for medical care	
	Hourly Rate	Change	Index	Change	Index	Change
2013	\$29.55	N/A	233.55	N/A	427.11	N/A
2014	30.03	1.62%	237.09	1.52%	437.25	2.37%
2015	31.05	3.40%	237.77	0.29%	448.85	2.65%
2016	31.48	1.38%	241.24	1.46%	468.29	4.33%
2017	32.13	2.06%	246.16	2.04%	476.93	1.85%
2018	32.95	2.55%	252.13	2.42%	485.61	1.82%
5-Year Average		2.20%		1.55%		2.60%
2016, 2017, & 2018 Average		2.00%		1.97%		2.66%

Source: Bureau of Labor Statistics, Annual Averages

Operating Expenses - Actual and Inflation Adjusted								
Expense Category	Actual Figures			Rate of Inflation Applied	Figures are Inflation Adjusted to Period Ending 6-30-2020			
	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019		12/31/2017	12/31/2018	12/31/2019	3-Yr Avg
Salaries & Wages	\$ 46,991,982	\$ 44,541,242	\$ 39,575,598	2.00%	\$ 49,375,603	\$ 45,882,894	\$ 39,968,311	\$ 45,075,602
Payroll Taxes & Benefits	18,577,979	7,010,570	14,569,572	2.00%	19,520,328	7,221,739	14,714,147	13,818,738
Supplies	22,329,233	21,443,552	18,413,070	3.30%	24,216,161	22,512,716	18,713,587	21,814,155
Purchased Services	9,431,944	8,787,084	5,846,589	3.30%	10,228,989	9,225,203	5,942,010	8,465,401
Professional Fees	12,090,325	9,696,416	7,566,777	3.30%	13,112,016	10,179,874	7,690,273	10,327,388
Other Operating	1,777,998	1,868,436	4,224,963	3.30%	1,928,247	1,961,595	4,293,918	2,727,920
Maintenance & Utilities	1,694,476	1,413,126	1,563,579	3.30%	1,837,667	1,483,584	1,589,098	1,636,783
Insurance	490,501	429,210	886,521	3.30%	531,951	450,610	900,990	627,850
Central Office / Mgmt	-	-	-	N/A	-	-	-	-
Property Taxes	45,087	59,518	-	3.30%	48,897	62,486	-	37,128
Total Operating Expense	\$ 113,429,525	\$ 95,249,154	\$ 92,646,669		\$ 120,799,859	\$ 98,980,701	\$ 93,812,335	\$ 104,530,965
Inflation Periods for Adjustments (Years)					2.4986	1.4986	0.4986	

Central Office / Management expenses are not adjusted for inflation because they are forecast on a percentage of net revenue basis.

Expense Comparables

In our comparative analysis, we use expense comparables for comparable type hospitals that are in the same region. This information is obtained from Medicare cost reports.

The following tables identify and profile the expense comparables utilized for the appraisal.

Expense Comparable Identification							
Expense Comparable	Location	Acute Beds	Other Beds	Medicare Provider #	Medicare MS-DRGs		
					Fiscal Yr	% Medical	% Surgical
SUBJECT -- Dickinson County Healthcare System	Iron Mountain, MI	96	0	230055	2017	80.8%	19.2%
West Branch Regional Medical Center	West Branch, MI	88	0	230095	2018	76.6%	23.4%
MidMichigan Medical Center - Alpena	Alpena, MI	113	26	230036	2018	79.8%	20.2%
Community Health Center Branch Cty	Coldwater, MI	87	0	230022	2017	86.9%	13.1%
McLaren Port Huron	Port Huron, MI	163	23	230216	2017	79.6%	20.4%
Tawas St. Joseph Hospital	Tawas, MI	47	0	230100	2018	84.4%	15.6%
North Ottawa Community Hospital	Grand Haven, MI	81	0	230174	2018	67.8%	32.2%
MidMichigan Medical Center-Clare	Clare, MI	49	0	230180	2018	88.7%	11.3%
Otsego Memorial Hospital	Gaylord, MI	46	34	230133	2017	72.9%	27.1%
McLaren Northern Michigan	Petoskey, MI	187	15	230105	2017	65.4%	34.6%
MidMichigan Medical Ctr	Midland, MI	324	0	230222	2018	66.4%	33.6%

Note: Acute beds include primary service line plus any acute distinct part units (e.g., psychiatric or rehabilitation).
Other beds include NF/SNF, long-term care and distinct part hospice.

Note: MS-DRG is Medicare Severity-Diagnosis Related Group. Surgical MS-DRGs are ones in which an operating room procedure was performed.

Patient Day Distribution for Expense Comparables					
	Short-Term Acute Beds		All Acute Beds		
	% Acute	% Swing	% Short-Term	% Swing	% Subprovider
SUBJECT -- Dickinson County Healthcare	98.3%	1.7%	98.3%	1.7%	0.0%
West Branch Regional Medical Center	100.0%	0.0%	100.0%	0.0%	0.0%
MidMichigan Medical Center - Alpena	100.0%	0.0%	76.3%	0.0%	23.7%
Community Health Center Branch Cty	100.0%	0.0%	100.0%	0.0%	0.0%
McLaren Port Huron	100.0%	0.0%	85.9%	0.0%	14.1%
Tawas St. Joseph Hospital	100.0%	0.0%	100.0%	0.0%	0.0%
North Ottawa Community Hospital	100.0%	0.0%	100.0%	0.0%	0.0%
MidMichigan Medical Center-Clare	100.0%	0.0%	100.0%	0.0%	0.0%
Otsego Memorial Hospital	100.0%	0.0%	100.0%	0.0%	0.0%
McLaren Northern Michigan	100.0%	0.0%	90.3%	0.0%	9.7%
MidMichigan Medical Ctr	100.0%	0.0%	100.0%	0.0%	0.0%
Average	99.8%	0.2%	95.5%	0.2%	4.3%
Subject Percentage of Average	98.4%	1100.0%	102.9%	1100.0%	0.0%

Note: Subprovider beds include any acute distinct part units (e.g., psychiatric or rehabilitation).

The Medicare cost reports are organized by service center groupings (general, inpatient routine, ancillary, outpatient, special purpose, and nonreimbursable). Within each grouping are various cost centers (e.g., the inpatient routine group includes adults and pediatrics, intensive care unit, subprovider, and nursery). Costs for each cost center are shown in two columns: salaries and other. The other category is not broken down into component amounts. Therefore, it includes a broad range of expenses such as supplies, professional fees, and contracted services. Due to the lack of additional detail in those reports and the fact that hospitals typically do not report their financials using a chart of accounts that resembles the cost report, there are significant limitations for expense comparison analysis.

These considerations compel the appraisers to rely significantly upon historical expenses for many expense categories. However, there are enough line item expenses in the cost reports to permit the intuitive grouping of other accounts for the purposes of testing and

comparing the largest non-labor expense categories: supplies and combined professional fees / purchased services.

Due to the limitations that exist for making many categorical expense comparisons, we believe it is important to analyze the overall expense margin as a basic reference point in the forecasting process. Comparing the historical experience for the subject to its competitors or other similar hospitals provides a window into the degree and adequacy of cost control and management oversight that has been in place. Furthermore, it helps to illustrate reasonable performance expectations for the subject under the competent management and for-profit operating entity assumptions.

The following table compares the total operating expense margins for the subject and the expense comparables selected for this analysis. Figures for the subject hospital represent internal financials instead of cost report figures.

Total Operating Expense Ratio				
Hospital	FYE	Net Revenues	Operating Expenses	Operating Expense Ratio
SUBJECT -- Dickinson County Healthcare System	12/31/2017	\$ 102,205,547	\$ 111,516,495	109.1%
West Branch Regional Medical Center	3/31/2018	48,180,703	42,040,410	87.3%
MidMichigan Medical Center - Alpena	6/30/2018	140,577,360	128,764,738	91.6%
Community Health Center Branch Cty	12/31/2017	63,928,917	57,425,505	89.8%
McLaren Port Huron	9/30/2017	205,563,189	179,846,945	87.5%
Tawas St. Joseph Hospital	6/30/2018	52,959,576	53,139,054	100.3%
North Ottawa Community Hospital	6/30/2018	60,589,354	64,739,933	106.9%
MidMichigan Medical Center-Clare	6/30/2018	52,963,631	48,127,310	90.9%
Otsego Memorial Hospital	12/31/2017	104,344,675	93,695,307	89.8%
McLaren Northern Michigan	9/30/2017	271,580,565	225,016,805	82.9%
MidMichigan Medical Ctr	6/30/2018	454,790,839	366,737,741	80.6%
Average				92.4%
Average Excluding Any Which Exceed 100%				87.5%
Note: There are no reserves for replacement included in the operating expenses.				
Note: Revenues may include electronic health record incentive payments and nonoperating income from contributions and governmental appropriations.				

As shown, the subject has experienced a notably high operating expense ratio in relation to the expense comparables for the respective fiscal periods. FY 2017 was a period of great financial distress for DCHS.

Collectively, the expense ratios for the comparables illustrates that, relative to FY 2017 performance, there was considerable room for improvement in the operating margin via the implementation of better cost control measures. Hospitals are very management intensive businesses that require focused policies and a culture of operating efficiency to effectively control costs. In this case, we believe prospective buyers of the Hospital would expect to make it more profitable than it has been in the recent past via the implementation of their own operating policies and procedures. Our expense forecasts reflect what we believe would represent the expectations of prospective buyers assuming a reasonably cautious posture.

The following table provides the conversion data for patient days and discharges to equivalent patient days and equivalent discharges, which are the unit measures utilized for expense comparison.

Equivalent Day and Discharge Figures for Expense Comparables

	SCH	FY Ending	OP Rev % of Patient Rev	Patient Days	% of Days Med/Surg	Equivalent Patient Days	Non-Swing Discharges	Equivalent Discharges
SUBJECT -- Dickinson County Healthcare System	Yes	12/31/2017	81.0%	9,193	98.3%	44,309	2,803	14,758
West Branch Regional Medical Center	Yes	3/31/2018	63.8%	7,272	100.0%	20,096	2,135	5,900
MidMichigan Medical Center - Alpena	Yes	6/30/2018	71.7%	20,902	76.3%	73,764	4,502	15,888
Community Health Center Branch Cty	No	12/31/2017	73.5%	12,065	86.6%	41,002	2,776	10,467
Mclaren Port Huron	No	9/30/2017	55.0%	44,669	85.9%	99,332	12,708	28,259
Tawas St. Joseph Hospital	Yes	6/30/2018	82.7%	3,933	100.0%	22,761	1,745	10,099
North Ottawa Community Hospital	No	6/30/2018	80.7%	3,283	100.0%	17,007	1,742	9,024
MidMichigan Medical Center-Clare	No	6/30/2018	87.4%	2,449	100.0%	19,486	983	7,822
Otsego Memorial Hospital	Yes	12/31/2017	76.8%	16,348	35.7%	37,434	2,103	9,070
Mclaren Northern Michigan	Yes	9/30/2017	56.9%	40,233	90.3%	93,333	10,470	24,288
MidMichigan Medical Ctr	Yes	6/30/2018	58.2%	54,434	100.0%	130,146	15,290	36,557
Average			71.6%	19,526	88.5%		5,205	
Subject Percentage of Average			113.1%	47.1%	111.1%		53.9%	

Note: Swing discharges are not included as they are absent from the cost reports. Swing patient days are included in the figures shown.

Note: SNF & NF discharges in subprovider units may or may not be included in the figures shown. SNF & NF patient days are included.

Note: Nursery days and discharges are not included in the figures shown.

SCH = Sole Community Hospital

Note: For facilities with NF/SNF days in nursing beds, those days are excluded from the "gross up" calculations to hospital bed days when deriving equivalent patient days.

Staffing, Wages and Benefits

Salaries and wages are a very substantial component of the operating expense of any hospital. This category includes all wages, salaries, overtime and bonuses. Contracted and agency staffing expenses are not included in this expense item. Salaries and wages are a function of full-time equivalents (FTEs) and wage rates. FTEs are influenced by case-mix, patient volume, inpatient and outpatient business ratios, building design, and management policy and effectiveness. Wage rates are influenced substantially by geographic location and urban/suburban or rural setting, competitive conditions for employees, labor union membership, and benefit packages offered.

Payroll taxes and employee benefits (PTEBs) typically include the employer's share of social security, health and disability insurance benefits, unemployment taxes, workers' compensation, retirement benefits and educational expenses. Paid vacations and rest periods (paid time off or PTO) are included in regular wages and hours.

The following tables show various measures of comparison for employee staffing, salaries and wage costs, and PTEB costs.

Historical Wage and PTEB Costs as a Percentage of Net Patient Revenues

Hospital	Net Patient Revenue	Wages	Wages as % of NPR	Total Wages & PTEB	Wages & PTEB as % of NPR
SUBJECT -- Dickinson County Healthcare Sys	\$ 101,328,480	\$ 46,991,982	46.4%	\$ 65,569,961	64.7%
West Branch Regional Medical Center	47,058,184	14,623,533	31.1%	16,792,608	35.7%
MidMichigan Medical Center - Alpena	129,338,391	50,189,699	38.8%	74,339,429	57.5%
Community Health Center Branch Cty	61,467,534	28,640,211	46.6%	33,026,668	53.7%
Mclaren Port Huron	206,569,862	81,180,837	39.3%	107,694,607	52.1%
Tawas St. Joseph Hospital	47,717,624	17,967,051	37.7%	22,261,133	46.7%
North Ottawa Community Hospital	53,022,306	26,679,286	50.3%	32,347,789	61.0%
MidMichigan Medical Center-Clare	50,215,938	14,991,279	29.9%	17,231,229	34.3%
Otsego Memorial Hospital	94,736,922	49,475,346	52.2%	61,874,614	65.3%
Mclaren Northern Michigan	242,659,241	74,229,116	30.6%	93,384,850	38.5%
MidMichigan Medical Ctr	396,824,535	117,366,194	29.6%	138,069,042	34.8%
Average	\$ 130,085,365	\$ 47,484,958	36.5%	\$ 60,235,630	46.3%
Subject Percentage of Average			127.0%		139.7%

Source: Medicare Cost Reports

Wage Compensation and Labor Productivity Comparisons							
Hospital	Total Beds	FTEs	Medicare CMI	FTEs per EADC	Wages & PTEB per FTE	Wages per FTE Hour	Wages & PTEB per FTE Hour
SUBJECT -- Dickinson County Healthcare Sy	96	652	1.504	5.4	\$100,507	\$ 34.63	\$ 48.32
West Branch Regional Medical Center	88	304	1.540	5.5	55,230	23.12	26.55
MidMichigan Medical Center - Alpena	139	810	1.509	4.0	91,740	29.78	44.11
Community Health Center Branch Cty	87	476	1.239	4.2	69,438	28.95	33.38
McLaren Port Huron	186	1,111	1.508	4.1	96,968	35.14	46.62
Tawas St. Joseph Hospital	47	278	1.314	4.4	80,209	31.12	38.56
North Ottawa Community Hospital	81	492	1.477	10.5	65,693	26.05	31.58
MidMichigan Medical Center-Clare	49	308	1.274	5.8	55,958	23.41	26.90
Otsego Memorial Hospital	80	628	1.410	6.1	98,603	37.91	47.41
McLaren Northern Michigan	202	1,177	1.925	4.6	79,337	30.32	38.14
MidMichigan Medical Ctr	324	1,925	1.932	5.4	71,710	29.31	34.48
Average	125	742	1.512	5.5	\$ 78,672	\$ 29.98	\$ 37.82
Subject Percentage of Average	76.6%	87.9%	99.5%	98.3%	127.8%	115.5%	127.8%
Note: Total beds includes subprovider units and skilled nursing beds.							
Note: Any Home Health Agency FTEs recorded by a hospital are not included in the FTE figures.							
Note: Wage and PTEB rates shown are actual, not inflated.							
Note: FTEs shown are considered "productive" rather than "paid."							
Sources: Medicare Cost Reports and American Hospital Directory							

The period of comparison in the chart represents FY 2017 for DCHS. Substantial reductions in FTEs were made in 2018 and 2019 in conjunction with the Hospital's financial distress. The changes that have occurred, along with budgeted amounts for the current fiscal year, are summarized as follows.

Summary of FTE Changes and Operator Expectations

	2016	2017	2018	4 Months YTD 2019	2019 Budget
Productive	593.14	652.39	584.76	540.00	519.56
Nonproductive	134.81	83.99	80.15	61.20	58.88
Total Paid	727.95	736.38	664.91	601.20	578.44
Δ From Prior Period					
Productive	N/A	59.25	(67.63)	(44.76)	(65.20)
Nonproductive	N/A	(50.82)	(3.84)	(18.95)	(2.32)
Total Paid	N/A	8.43	(71.47)	(63.71)	(86.47)
Total Paid by Group					
Physician Svcs	122.75	122.41	111.44	100.30	96.50
All Other	605.20	613.97	553.47	500.90	481.94
Combined	727.95	736.38	664.91	601.20	578.44

4-Month YTD Actual and 2019 Budget are compared to 2018 for change.

2019 Budget amounts reflect a Total Paid figure allocated by the appraiser given the YTD distribution of FTEs.

Generally, there is a perception among current administration and department heads that staffing levels at the organization grew when business volumes increased but that reductions corresponding to decreases in business volumes were not made timely. In conjunction with that situation, productivity levels were low before the FTE reduction transpired. The FTE reduction was substantially achieved by attrition rather than layoffs. When the organization was struggling most, there were several employees that left the organization or retired.

The following table reveals a national average PTEB expense relationship to wages for hospitals, per the Bureau of Labor Statistics.

Hospital Employer Costs for Employee Compensation - 4th Qtr 2018

	Salaries & Wages	Payroll Taxes	Employee Benefits	Combined PTEB
Hourly Amounts	\$39.09	\$3.26	\$7.52	\$10.78
% of Wages	N/A	8.3%	19.2%	27.6%

Note: The report treats paid time off (PTO) and supplemental pay (SP) as benefits. Integra groups PTO and SP with salaries and wages.

Date Source: Bureau of Labor Statistics -- U.S. Department of Labor

With limited exceptions, most hospitals do not achieve payroll tax and employee benefit expense ratios under 20 percent of wages, and many are within the 25 to 30 percent range. However, if a hospital self-insures for its employee healthcare benefits, the PTEB-to-wage ratio can vary more widely. For a self-insured hospital, revenues are lower than they would be if a commercial insurer covered the employees. More commonly, where the PTEB-to-wage ratios are below reasonable levels, most likely there are cost reporting irregularities and some of the PTEB costs incurred are being reported in other categories. In cases where the PTEB-to-wage ratio exceeds around 35 percent, the benefits may be too generous, although matters such as competition for employees and wage rates paid factor into the equation. As an example, a facility that offers a generous benefits package may be more successful in keeping wage rates lower, and vice versa.

The following table provides a comparison of PTEB expenses as a percentage of wages for Dickinson County Memorial Hospital and the expense comparables.

Payroll Taxes and Employee Benefits Expense as a % of Wage Expense

Hospital	Wages & Salaries	Payroll Taxes & Employee Benefits (PTEB)	PTEB as a % of Wages
SUBJECT -- Dickinson County Healthcare Sys	\$ 46,991,982	\$ 18,577,979	39.5%
West Branch Regional Medical Center	14,623,533	2,169,075	14.8%
MidMichigan Medical Center - Alpena	50,189,699	24,149,730	48.1%
Community Health Center Branch Cty	28,640,211	4,386,457	15.3%
McLaren Port Huron	81,180,837	26,513,770	32.7%
Tawas St. Joseph Hospital	17,967,051	4,294,082	23.9%
North Ottawa Community Hospital	26,679,286	5,668,503	21.2%
MidMichigan Medical Center-Clare	14,991,279	2,239,950	14.9%
Otsego Memorial Hospital	49,475,346	12,399,268	25.1%
McLaren Northern Michigan	74,229,116	19,155,734	25.8%
MidMichigan Medical Ctr	117,366,194	20,702,848	17.6%
Average	\$ 47,484,958	\$ 12,750,672	26.9%

Note: There are inconsistencies in cost reporting; thus, PTEB expenses do not necessarily include all payroll taxes or employee benefits incurred by the providers.

Note: Physician fees and various other positions for ancillary services are typically reported as professional fees or contracted services.

Source: Medicare Cost Reports

In the period noted, Dickinson County Memorial Hospital maintained a PTEBs-to-wages expense ratio at the upper end of the range.

Dickinson County Health System has a defined benefit pension plan. The following history for the Plan is taken from the 2018 financial audit of DCHS.

- Plan established in 1965.
- Plan amended in 2011 and closed to new entrants for many of the participating employee groups.
- On January 27, 2018, the Plan was frozen (no additional benefits to accrue) for all non-Michigan Nurses Association (MNA) participants.
- On February 10, 2018, the Plan was frozen for all MNA participants.

- For the non-MNA participants, any benefit payment commencement date on or after February 2, 2018 was paid in one lump sum.
- For the MNA participants, any benefit payment commencement date on or after March 2, 2018 will be paid in one lump sum.

Resulting from lump sum payouts made in FY 2018 that reduced the net pension liability, the accounting for that event resulted in an \$8.4MM lower employee benefit expense for the year. Thus, on a normalized basis, the employee benefit expense for FY 2018 would be \$8.4MM greater than recorded.

The defined benefit pension plan is underfunded. The net liability is near \$20MM and the current funded ratio is near 67 percent. The Hospital's FY 2018 contribution to the plan was around \$2.157MM.

Reportedly, a lawsuit was filed in 2019 by the Michigan Nurses Association over matters pertaining to the closure of the defined benefit pension plan. The appraiser has not investigated this matter as it is beyond the scope of the assignment.

Effective May 1, 2011, a 401(a) defined contribution plan was added to the Healthcare System retirement program. The 401(a) Plan provides eligible employees with an employer base contribution and/or an employer matching contribution. Defined contribution plan expenses were \$1,126,016 and \$639,598 for the years ended December 31, 2018 and 2017.

The following table shows the PTEB expense trend for Dickinson County Memorial Hospital. These figures are amounts reported in the operator's financial records rather than the Medicare cost reports.

Payroll Taxes & Employee Benefits (PTEB) Expense History				
	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019
Wages & Salaries	\$46,991,982	\$44,541,242	\$39,575,598	\$36,586,938
Payroll Taxes & Employee Benefits	18,577,979	7,010,570	14,569,572	14,881,307
PTEB % of Wages & Salaries	39.5%	15.7%	36.8%	40.7%

Forecast Staffing Ratio: For the forecast, we have reduced FTEs per-average-equivalent daily census somewhat based on the management's expectation to continuing reducing some FTEs. In conjunction with regaining some business and greater staffing efficiency via an intense focus on maximizing FTE productivity, a lower FTE per-average-equivalent daily census should be achieved.

Forecast Wage Rate: For the wage rate forecast, consideration must be given to wage rate inflation, particularly in the healthcare industry, whereby growth is occurring and competition for skilled labor can have an unfavorable impact on wages and salaries.

Hospital management indicates that wage rates are believed to be below market. The history of wage rate changes at the Hospital is unknown by the appraiser. However, it is believed that wage rate adjustments have not been made for at least a couple of years due to the financial hardship experienced by the organization. Management indicates that there hasn't been any recent wage benchmarking work performed or obtained, although that is a near-term goal for the Human Resources department.

There are two labor unions representing employees of the Hospital – Michigan Nurses Association (MNA) and AFSCME. MNA represents registered nurses at the Hospital. AFSCME is the nation's largest and fastest growing public services employee's union. A breakdown of the employee representation by unions and the non-unionized employees is provided in the following table.

AFSME	241.49	42%
MNA	112.52	19%
NON-UNION	183.82	32%
PHYS	40.60	7%
	578.44	100%

The Collective Bargaining Agreement in place now between the Hospital and MNA is an extension of the one that expired February 28, 2019. The two parties met to bargain a new agreement in December 2018; however, given the Hospital's financial situation at the time, it was agreed that the in-place agreement be extended until August 28, 2019, in anticipation of a more stable financial position for the Hospital.

Our forecast considers historical and budgeted figures, management input, plus the expense comparable information.

Forecast Payroll Taxes and Employee Benefits (PTEB) Ratio: Implicitly, because the appraisal reflects terms of an asset sale, whereby the seller would retain and/or retire its liabilities, seller-specific liabilities of this nature are not considered in this analysis. More specifically, the employee benefit forecast is not inclusive of pension liability deficit funding.

The forecast for the PTEB expense ratio reflects the comparable data and historical figures adjusted for the defined benefit deficit funding.

Forecast Summary for Staffing, Wages and Benefits

Total historical and forecast FTEs, salaries and wages, and PTEBs are as follows.

Forecast for Staffing, Wages, and Payroll Taxes and Benefits					
	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Full-time Equivalent Employees (FTEs)	652	585	540	520	513
Total Patient Days	9,464	7,555	7,368	8,411	8,503
Total Equivalent Patient Days	49,828	43,737	42,652	42,374	43,720
Average Daily Census (ADC)	25.9	20.7	20.2	23.0	23.3
Equivalent ADC (EADC)	136.4	119.8	116.9	115.9	119.8
FTEs per EADC (rounded)	4.8	4.9	4.6	4.5	4.28
Total Wages - Historical Amounts are Uninflated	\$46,991,982	\$44,541,242	\$39,575,598	\$36,586,938	\$39,501,821
Average Wage Rate per Hour	\$34.65	\$36.61	\$35.23	\$33.83	N/A
Wage Rate Inflated to As Completed Period @ 2%	\$36.41	\$37.71	\$35.58	\$33.83	\$37.02
Wage Rate Inflated to Not Applicable Period	\$36.41	\$37.71	\$35.58	\$33.83	N/A
Total Payroll Taxes & Emp. Benefits	\$18,577,979	\$ 7,010,570	\$14,569,572	\$14,881,307	\$11,613,535
PTEB as % of Wages	39.5%	15.7%	36.8%	40.7%	29.4%
The Medicare cost report utilizes hours worked (productive FTEs -- NOT paid FTEs). To keep the comparisons on equal terms, productive FTEs are also utilized for the subject property and this analysis.					
Note: N/A					

Supplies

The Association for Healthcare Resource & Materials Management (AHRMM) has developed a definition for supply expense in healthcare organizations. This standard definition was created as a benchmarking tool for hospitals and other healthcare organizations. Supply expense is defined as:

The net cost of all tangible items that are expensed, including freight, standard distribution cost and sales, and use tax rebates. This excludes labor, labor-related expenses and services, as well as some tangible items that are frequently provided as part of service costs. Among the items included are: surgical supplies, general medical supplies, pharmaceuticals, lab supplies, medical gases, radiologic films and chemicals, dialysis supplies, linens and patient apparel, dietary products, housekeeping supplies, office-type supplies, the supply portion of outsourced contracts (e.g., dietary or environmental services), and the supply portion of any equipment rental or lease. Among the items not included are: vending supplies, supply costs for in-house laundry, routine maintenance items, reference lab costs, grounds maintenance items, repair parts, and vehicle consumables.

Supplies are a substantial component of the operating expense of a hospital. Supply expenses can range broadly as a percentage of a hospital's operating expenses, from between 5 and 35 percent. Lower acuity hospitals experience proportionately lower ratios of supply expenses to total expenses, and vice versa.

Supply cost benchmarking is an important activity for hospital management in the effort to control healthcare costs. Most providers rely on third parties to assist them with this process because limited data availability and reporting inconsistencies restrict self-help possibilities. The appraisers, like hospitals, find it difficult to obtain supply cost data that is suitable for use in forecasting.

The Medicare cost reports do not provide enough detail to completely isolate this expense. As previously noted, expenses in the cost reports are basically shown in two categories: salaries and other. However, there is enough detail to provide a reasonable measure of cost efficiency for supply costs. As reported in the cost reports, the other costs incurred in certain departments within the general service and ancillary service center groupings have been utilized for this analysis.

The laundry and linen, housekeeping, dietary, cafeteria, central services and supply, pharmacy and other general service costs centers (non-salary) under the general service grouping are deemed to be substantially comprised of supply costs. Under the ancillary grouping, non-salary medical supplies, implantable devices and drugs charged to patients, plus blood costs, are also included. Organ acquisitions costs under the special purpose cost centers are included, as is durable medical equipment under the other reimbursable cost centers. Figures reported by the subject hospital are included for comparison. We acknowledge that these totals are not completely identical to the subject's historical and forecast supply costs. However, there is a significant degree of correlation and the analysis therefore serves its intended purpose as a measure of cost efficiency. The following table illustrates the data and comparisons.

Supply Expense Comparisons				
	Expense	\$ / Equivalent Patient Day	\$ / Equivalent Discharge	% of Days Med/Surge
SUBJECT -- Dickinson County Healthcare System	\$ 22,329,233	\$ 504	\$ 1,513	98.3%
West Branch Regional Medical Center	12,659,572	630	2,146	100.0%
Midmichigan Medical Center - Alpena	28,164,795	382	1,773	76.3%
Community Health Center Branch Cty	9,334,192	228	892	86.6%
Mclaren Port Huron	35,079,207	353	1,241	85.9%
Tawas St. Joseph Hospital	8,129,382	357	805	100.0%
North Ottawa Community Hospital	9,370,356	551	1,038	100.0%
Midmichigan Medical Center-Clare	6,248,121	321	799	100.0%
Otsego Memorial Hospital	15,315,263	409	1,689	35.7%
Mclaren Northern Michigan	56,531,570	606	2,328	90.3%
Midmichigan Medical Ctr	72,396,827	556	1,980	100.0%
Average	\$ 25,050,774	\$ 445	\$ 1,473	88.5%
Subject Percentage of Average	89.1%	113.2%	102.7%	111.1%
Note: N/A				

Based upon this data, Dickinson County Memorial Hospital operated reasonably efficient with respect to supply costs during the period analyzed.

The following table provides the history of supply costs for Dickinson County Memorial Hospital, plus our forecast. The Hospital's supplies expense is lower in the year-to-date period but, considering the degree of apparent efficiency achieved per the comparison, we are inclined to adopt unit costs that are like historical ones.

Supplies					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Supplies Expense	\$ 24,216,161	\$ 22,512,716	\$ 18,713,587	\$ 22,164,212	\$ 21,264,053
Change from Prior Period	N/A	-7.0%	-16.9%	18.4%	13.6%
Amount Per Equivalent Discharge	\$ 1,614	\$ 1,666	\$ 1,499	\$ 1,620	\$ 1,625
Amount Per Equivalent Patient Day	\$ 486	\$ 515	\$ 439	\$ 523	\$ 486

Purchased Services

Purchased services represent contractual services or agreements with outside institutions for a wide variety of services. With most purchased services, the services are purchased from third parties, but the functions are completed internally.

Purchased services in a hospital typically include routine operating services such as plant operations, laundry, housekeeping, health information management, legal and accounting, case management, patient financial services, etc. However, on a cost basis, services purchased for ancillary and emergency cost centers tend to be much greater. Laboratory, imaging, therapy and anesthesia services are common purchased services representing large expenditures. Contract nursing is also a purchased service.

Hospitals purchase services for a variety of reasons, including:

- Resources may not be available internally
- To reduce operating costs
- To free up resources for other purposes
- The function is difficult to manage or is out-of-control
- To focus on patient care

The need to monitor and manage the costs incurred for purchased services is great. Importantly, however, an organization's size and location can impact its ability to achieve savings in this expense area. These costs are influenced by the increasing demand for a broader array of healthcare services.

The Medicare cost reports do not provide enough detail to isolate this expense. As previously noted, expenses in the cost reports are basically shown in two categories: salaries and other. However, there is enough detail to provide a broad gauge of cost efficiency for the combined purchased services and professional fees accounts. As reported in the cost reports, most of the other costs incurred in the inpatient routine, ancillary, outpatient service, and other reimbursable center groupings have been utilized for this analysis.

Aside from medical supplies, implantable devices and drugs charged to patients, plus blood costs and durable medical equipment, we have grouped all non-salary costs identified under those headings. Figures reported by the subject hospital are included for comparison. We acknowledge that these totals are not completely identical to the subject's historical and forecast purchased services and professional fees. However, there is a significant degree of correlation and the analysis therefore serves its intended purpose as a broad gauge of cost efficiency for these expense categories. The following table illustrates the data and comparisons.

Combined Purchased Services and Professional Fees Expense Comparisons				
	Expense	\$ / Equivalent Patient Day	\$ / Equivalent Discharge	% of Days Med/Surge
SUBJECT -- Dickinson County Healthcare System	\$ 21,522,269	\$ 486	\$ 1,458	98.3%
West Branch Regional Medical Center	7,187,634	358	1,218	100.0%
Midmichigan Medical Center - Alpena	17,515,081	237	1,102	76.3%
Community Health Center Branch Cty	9,117,746	222	871	86.6%
McLaren Port Huron	22,153,977	223	784	85.9%
Tawas St. Joseph Hospital	6,145,500	270	609	100.0%
North Ottawa Community Hospital	10,371,959	610	1,149	100.0%
Midmichigan Medical Center-Clare	18,473,713	948	2,362	100.0%
Otsego Memorial Hospital	8,797,581	235	970	35.7%
McLaren Northern Michigan	40,717,969	436	1,676	90.3%
Midmichigan Medical Ctr	88,927,913	683	2,433	100.0%
Average	\$ 22,811,940	\$ 428	\$ 1,330	88.5%
Subject Percentage of Average	94.3%	113.5%	109.6%	111.1%
Note: N/A				

Based upon this data, Dickinson County Memorial Hospital operated somewhat inefficiently with respect to combined purchased services and professional fees during the period analyzed. As a small independent hospital, there greater potential for inefficiencies to exist when purchasing services.

On unit bases, the Hospital's purchased services expense in FY 2018 was like FY 2017. On unit bases, budgeted amounts for FY 2019 are lower both in total and on per diem bases. The YTD performance on unit bases is even better than the budgeted amounts.

Given that combined purchased services and professional fees seemed somewhat high in FY 2017, an expectation that lower expenditure levels can be achieved seems reasonable. The forecast for purchased services places some weight on the lower unit cost indications of the comparables and the YTD and budgeted amounts.

Purchased Services					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Purchased Services Expense	\$ 10,228,989	\$ 9,225,203	\$ 5,942,010	\$ 7,454,224	\$ 7,758,487
Change from Prior Period	N/A	-9.8%	-35.6%	25.4%	30.6%
Amount Per Equivalent Discharge	\$ 682	\$ 683	\$ 476	\$ 545	\$ 593
Amount Per Equivalent Patient Day	\$ 205	\$ 211	\$ 139	\$ 176	\$ 177

Professional Fees

This account represents the cost of fees to professional medical staff for services rendered under contract (professional service agreement). These fees are commonly paid for surgery, radiology, lab, pharmacy, emergency room, outpatient clinic, psychiatric services, etc. Hospitals frequently pay physicians and specialists under contract arrangements for their services provided in the emergency department. Therapists can also represent a significant professional fee expense. These fees vary by hospital based upon its location, the range of healthcare services offered, physician staffing and other management policies. These professionals are NOT employees of the hospital.

The comparative analysis presented in the purchased services analysis is also applicable to the professional fees analysis. As noted, that comparative analysis is for combined purchased services and professional fees.

The Hospital's professional fees expense, both in total and on unit bases, decreased significantly in FY 2018. The budgeted amount for FY 2019 shows an expectation of unit costs like those achieved in FY 2018. I note that YTD FY 2019 costs are markedly lower than historical and budgeted amounts. While business volumes are down somewhat in this period, the lower unit costs may provide evidence that these costs can be controlled better than they have been in the past.

Given the major reduction in costs achieved in FY 2018, the forecast relies most heavily on the FY 2018 experience.

Professional Fees					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Professional Fees Expense	\$ 13,112,016	\$ 10,179,874	\$ 7,690,273	\$ 11,968,698	\$ 10,128,227
Change from Prior Period	N/A	-22.4%	-24.5%	55.6%	31.7%
Amount Per Equivalent Discharge	\$ 874	\$ 753	\$ 616	\$ 875	\$ 774
Amount Per Equivalent Patient Day	\$ 263	\$ 233	\$ 180	\$ 282	\$ 232

Other Operating

This expense is substantially comprised of administrative and general expenses. Most of these are included under the general service group in the Medicare cost report. However, it also includes expenses that are categorized as "nonreimbursable" in the cost report. The cost report historically included bad debt expense in this grouping, but the accounting has changed with the adoption of Form 2552-10. Provider taxes may be included, but they are treated as a net tax/benefit calculation as part of our revenue analysis and forecast for the subject going concern. Also included is that portion of any interest expense reported under the special purpose cost centers group which is reclassified as allowable interest under the administrative and general group. The allowable portion is comprised of working capital interest expense.

For forecasting purposes, we have elected to split out insurance and property taxes from other expenses that should be included in the cost reports under the administrative and general category. For comparison purposes, there is no way to adjust out these particular expenses for the expense comparables. Therefore, those expenses are included with the subject property as well. While this is contrary to our forecast, it provides the most meaningful basis for comparison given the limitations that exist with the comparable data. The following table illustrates the data and comparisons.

Other Operating Expense Comparisons				
	Expense	\$ / Equivalent Patient Day	\$ / Equivalent Discharge	% of Days Med/Surge
SUBJECT -- Dickinson County Healthcare System	\$ 2,313,586	\$ 52	\$ 157	98.3%
West Branch Regional Medical Center	4,050,299	202	686	100.0%
MidMichigan Medical Center - Alpena	6,318,707	86	398	76.3%
Community Health Center Branch Cty	4,697,675	115	449	86.6%
Mclaren Port Huron	9,331,113	94	330	85.9%
Tawas St. Joseph Hospital	15,498,947	681	1,535	100.0%
North Ottawa Community Hospital	11,560,827	680	1,281	100.0%
MidMichigan Medical Center-Clare	5,260,183	270	672	100.0%
Otsego Memorial Hospital	6,181,979	165	682	35.7%
Mclaren Northern Michigan	29,153,907	312	1,200	90.3%
MidMichigan Medical Ctr	58,538,404	450	1,601	100.0%
Average	\$ 13,900,512	\$ 282	\$ 817	88.5%
Subject Percentage of Average	16.6%	18.5%	19.2%	111.1%
Note: This expense category includes property taxes and non-wage related insurance.				

Based upon this data, Dickinson County Memorial Hospital operated very efficiently with respect to other operating costs during the period analyzed. The degree of efficiency suggested leads the appraiser to believe that, among the comparables, many of them have categorized various expenses in their cost reports in ways that dramatically increase "Other" expenses, which consequently means that other expense accounts for them are understated. Unfortunately, inconsistent cost reporting among different providers lends to difficulties in making true comparisons.

The following table provides the history and our forecast for other operating costs. Again, this forecast excludes insurance and property taxes. The Hospital's other operating expense was consistent from FYs 2017 to FY 2018. The annualized YTD FY 2019 costs are much higher, but the short period being annualized serves to limit the reliability of this indication. In FY 2019, it seems likely that extraordinary costs are being incurred for the turnaround endeavor.

Based upon our experience appraising hospital going concerns, we have found that this expense generally ranges between 3.0 and 5.0 percent of a hospital's net operating revenues; with 3.5 to 4.5 percent being typical. Given the history of holding these expenses well below this ratio, I have elected to give weight to that experience. The forecast equates to approximately 2.3 percent of the forecast net operating revenue.

Other Operating					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Other Operating Expense	\$ 1,928,247	\$ 1,961,595	\$ 4,293,918	\$ 1,702,468	\$ 2,447,312
Change from Prior Period	N/A	1.7%	118.9%	-60.4%	-43.0%
Amount Per Equivalent Discharge	\$ 129	\$ 145	\$ 344	\$ 124	\$ 187
Amount Per Equivalent Patient Day	\$ 39	\$ 45	\$ 101	\$ 40	\$ 56

Maintenance & Utilities

Maintenance and utility expenses are identified as operation of plant and maintenance and repairs in the Medicare cost report. The maintenance expense does not include costs which must be capitalized to comply with tax laws. The following table illustrates the data and comparisons.

Maintenance and Utilities Expense Comparisons					
	Expense	\$ / Equivalent Patient Day	\$ / Equivalent Discharge	% of Days Med/Surge	
SUBJECT -- Dickinson County Healthcare System	\$ 1,694,476	\$ 38	\$ 115	98.3%	
West Branch Regional Medical Center	1,350,297	67	229	100.0%	
Midmichigan Medical Center - Alpena	2,426,726	33	153	76.3%	
Community Health Center Branch Cty	1,249,224	30	119	86.6%	
Mclaren Port Huron	5,588,041	56	198	85.9%	
Tawas St. Joseph Hospital	1,104,092	49	109	100.0%	
North Ottawa Community Hospital	1,089,002	64	121	100.0%	
Midmichigan Medical Center-Clare	914,064	47	117	100.0%	
Otsego Memorial Hospital	1,525,870	41	168	35.7%	
Mclaren Northern Michigan	5,228,509	56	215	90.3%	
Midmichigan Medical Ctr	8,805,555	68	241	100.0%	
Average	\$ 2,815,987	\$ 50	\$ 162	88.5%	
Subject Percentage of Average	60.2%	76.6%	70.8%	111.1%	
Note: Many facilities do not report maintenance costs correctly; thus, costs noted may be solely for utilities.					

Based upon this data, Dickinson County Memorial Hospital operated very efficiently with respect to maintenance and utility costs during the period analyzed. Often, however, we find that providers report maintenance costs in general service costs, which makes the comparison unequal.

The following table provides the history and our forecast for maintenance and utility costs. Maintenance and utility costs are influenced by the size of the physical plant and its age. These costs have been analyzed based upon the building area that existed in respective prior and forecast periods.

The Hospital's maintenance and utilities expense were reduced in FY 2018. The forecast considers indications from all historical periods and the budget.

Maintenance & Utilities					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Maintenance & Utilities Expense	\$ 1,837,667	\$ 1,483,584	\$ 1,589,098	\$ 1,432,657	\$ 1,565,318
Square Feet of Building Area	267,474	267,474	267,474	267,474	267,474
Amount Per Square Foot	\$ 6.87	\$ 5.55	\$ 5.94	\$ 5.36	\$ 5.85
Per SF Change from Prior Period	N/A	-19.3%	7.1%	-9.8%	-1.5%
Amount Per Equivalent Discharge	\$ 123	\$ 110	\$ 127	\$ 105	\$ 120
Amount Per Equivalent Patient Day	\$ 37	\$ 34	\$ 37	\$ 34	\$ 36

Insurance

This account includes general and liability insurance and other non-liability and non-benefit forms of insurance coverage. The Medicare cost reports do not provide enough detail to isolate this expense. Rather, it is included in the administrative and general category for the general service cost center.

General and Professional Liability Insurance: Under current law, individuals may pursue civil claims against physicians and other health care providers for alleged torts—breaches of duty that result in personal injury. Currently, individual states establish medical liability laws, not the federal government. Many states do not require hospitals to carry malpractice insurance.

Under a general liability insurance policy, the insurer is obligated to pay the costs a business incurs in a covered liability claim or lawsuit. General liability insurance protects insureds from most liability exposures other than automobile and professional liability. Professional liability insurance for hospitals covers their liability for professional acts, errors, or omissions. Professional liability insurance is usually written on a combined basis with commercial general liability (CGL) policies.

A tactic commonly used to control costs is to shift from an occurrence policy, which covers all incidents in the policy year regardless of when the claim is filed, to claims-made policies, which cover only claims filed in the policy year. Coverage is more meager under a claims-made policy because it leaves a long tail of exposure for incidents that haven't yet become claims.

Other Insurance: This expense covers all other non-liability and non-benefit forms of insurance incurred; including the basic causes of loss form (ISO), which provides coverage for the following named perils: fire, lightning, explosion, smoke, windstorm, hail, riot, civil commotion, aircraft, vehicles, vandalism, sprinkler leakage, sinkhole collapse, and volcanic action. Costs incurred for non-liability insurance coverage are substantially less than costs for liability insurance.

Forecast: Dickinson County Memorial Hospital carries general and professional liability insurance. The Healthcare System's professional liability insurance coverage provides protection for professional liability losses up to \$1 million per claim and \$3 million annual aggregate on a claims-made basis subject to a settlement deductible per claim of \$50,000 and an annual aggregate deductible for all claims of \$150,000 for claims that were in process prior to August 1, 2018. General liability claims are insured on a claims-made basis subject to limits of \$1 million per claim and \$3 million annual aggregate for all claims. For new medical claims reported subsequent to July 31, 2018, there is no deductible. The Healthcare System also has excess layered coverage of \$5 million. The policies end August 1, 2019.

Insurance					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Insurance Expense	\$ 531,951	\$ 450,610	\$ 900,990	\$ 570,367	\$ 539,912
Change from Prior Period	N/A	-15.3%	99.9%	-36.7%	-40.1%
Amount Per Equivalent Discharge	\$ 35	\$ 33	\$ 72	\$ 42	\$ 41
Amount Per Equivalent Patient Day	\$ 11	\$ 10	\$ 21	\$ 13	\$ 12

Management / Home Office Fees

For Medicare and/or Medicaid purposes, a chain organization consists of a group of:

1. Two or more healthcare facilities, or;
2. At least one healthcare facility and any other business or entity owned, leased, or, through any other device, controlled by one organization.

Home offices for these organizations usually furnish central management and administrative services to their facilities. Those services typically include centralized accounting, purchasing, personnel services, management direction and control, and other services.

Management fees charged between related organizations are not allowable costs except as provided in CMS Pub. 15-I, Chapter 10. However, when management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are included as allowable costs of the provider. Home office costs directly related to those services performed for individual providers and which relate to patient care plus an appropriate share of indirect costs (e.g., overhead, rent for home office space, administrative salaries) are allowable to the extent they are reasonable.

The subject is owner operated, paying no management fees to a third-party operator. Most of the management functions are carried out by on-site personnel and fees that would normally be paid to a third-party operator are substantially reflected in the existing salaries. However, as multi-facility operators with centralized management represent likely buyers for the subject property, it is prudent to expect that a typical buyer would incur some home office costs and pass those through to the facility. Additionally, the inclusion of a management expense is consistent with the way in which the comparable sales have been analyzed for capitalization rate calculations. We have estimated that an operator would incur and could successfully claim home office costs equal to 1.5 percent of the net patient revenue.

Central Office / Mgmt					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Net Patient Revenue	\$ 101,328,480	\$ 99,345,809	\$ 93,479,148	\$ 95,702,454	\$ 102,400,638
Central Office / Management Exp.	-	-	-	-	1,536,010
Central Office / Management Ratio	0.0%	0.0%	0.0%	0.0%	1.5%

Provider Tax

The Federal Social Security Act specifically allows states to impose taxes on health care providers and use the revenue generated by the assessment for use as non-Federal Medicaid matching funds. As Medicaid enrollment grows and the program becomes a larger portion of total budgets, states increasingly have turned to taxes on hospitals, nursing homes and other health care providers to generate funds to pay for their Medicaid programs. Federal law establishes some mandates on the structure of these provider taxes. There are three major criteria that a Medicaid provider tax must meet to be acceptable to the Federal government.

1. The tax rate imposed upon providers may not exceed 5.5 percent. For many years this standard was 6.0 percent, but the Federal government modified it in 2006.

2. The tax must be "broad-based". This means that the tax must be applied to an entire provider group (for example, all the hospitals in a state).
3. If possible, the tax must create winners and losers. States may not establish a provider tax that is structured to minimize or eliminate financial loss by providers.

Michigan

Since fiscal year (FY) 2001-02, the State of Michigan has made use of targeted tax programs for medical providers, known as Quality Assurance Assessment Programs (QAAPs), to fund increases in Medicaid reimbursement and generate General Fund/General Purpose (GF/GP) savings. The State currently makes use of QAAPs to enhance Medicaid reimbursement to Medicaid health maintenance organizations (HMOs), nursing homes, hospitals, and Community Mental Health (CMH) agencies.

The QAAP is assessed on all net patient revenue, before deduction of expenses, less Medicare net revenue. Medicare net revenue includes Medicare payments and amounts collected for coinsurance and deductibles. The QAAP is set at a rate that generates funds not more than the maximum allowable under the federal matching requirements.

Consistent with historical accounting for the Hospital, in this appraisal provider taxes are treated as a net tax/benefit calculation as part of our revenue analysis and forecast for the subject going concern. Therefore, provider taxes are not forecast as an expense.

Property Taxes

The property tax expense is discussed in the subject property description section of the report.

Reserves for Replacement

Reserves for replacing short-lived improvements and personal property (furniture, fixtures and equipment) have been established in order to preserve the earning potential of the going concern during its remaining economic life. Replacements must be made on an infrequent but consistent basis for the going concern and underlying assets to remain useful and economically viable during their economic lives. Examples of such replacements include HVAC equipment and roof covers, acquiring new medical equipment, renovation or remodeling projects, resurfacing the parking lot, etc. For accounting purposes these capital improvements are depreciated rather than expensed. This concept of replacement or upgrade of building subsystems is also known as recapitalization.

Hospitals, and particularly those that are not reimbursed on a cost basis, walk a fine line on capital improvement spending. By spending too little a hospital risks falling behind the curve on healthcare service delivery, having trouble attracting physicians, losing appeal and market share, and operating inefficiently. However, a hospital risks being less profitable or even unprofitable if it spends more than can be justified based upon medical case demand.

With respect to the personal property utilized in a hospital going concern, it is common for operators to lease some or even much of that equipment rather than to acquire it outright. Often, it is acquired via a capital lease, whereby the lessee acquires the capital asset or the right to use it for most or all its economic life via a lease agreement. A capital lease is basically considered a form of financing used to acquire the capital asset. For forecasting purposes, if the expense forecast includes FF&E lease costs, then it would be double counting to account for that FF&E's replacement as a reserve for replacement item.

Our analysis includes a reserve for replacement forecast for short-lived assets only. Effectively, reserve for replacement, as forecast, is closely associated with depreciation expense for short-lived assets.

Reflecting the anticipated replacement costs and useful lives of the short-lived improvements and personal property, with consideration to equipment leasing expense included in the “other operating” expense forecast, we have forecast the replacement allowance at 2.0 percent of net patient revenue.

Summary for Operating Expense Forecast

Operating Expense Forecast					
Inflation Adjusted to Period Ending 6-30-2020					
Period Ending >>>	Actual FYE 12/31/2017	Actual FYE 12/31/2018	4 Months Annualized 12/31/2019	Operator's Budget for 12/31/2019	As Completed Forecast 6/30/2020
Salaries & Wages	\$ 46,991,982	\$ 44,541,242	\$ 39,575,598	\$ 36,586,938	\$ 39,501,821
Payroll Taxes & Benefits	\$ 18,577,979	\$ 7,010,570	\$ 14,569,572	\$ 14,881,307	\$ 11,613,535
Supplies	\$ 24,216,161	\$ 22,512,716	\$ 18,713,587	\$ 22,164,212	\$ 21,264,053
Amount Per Equivalent Discharge	1,614	1,666	1,499	1,620	1,625
Amount Per Equivalent Patient Day	486	515	439	523	486
Purchased Services	\$ 10,228,989	\$ 9,225,203	\$ 5,942,010	\$ 7,454,224	\$ 7,758,487
Amount Per Equivalent Discharge	682	683	476	545	593
Amount Per Equivalent Patient Day	205	211	139	176	177
Professional Fees	\$ 13,112,016	\$ 10,179,874	\$ 7,690,273	\$ 11,968,698	\$ 10,128,227
Amount Per Equivalent Discharge	874	753	616	875	774
Amount Per Equivalent Patient Day	263	233	180	282	232
Other Operating	\$ 1,928,247	\$ 1,961,595	\$ 4,293,918	\$ 1,702,468	\$ 2,447,312
Amount Per Equivalent Discharge	129	145	344	124	187
Amount Per Equivalent Patient Day	39	45	101	40	56
Maintenance & Utilities	\$ 1,837,667	\$ 1,483,584	\$ 1,589,098	\$ 1,432,657	\$ 1,565,318
Square Feet of Building Area	267,474	267,474	267,474	267,474	267,474
Amount Per Square Foot	\$ 6.87	\$ 5.55	\$ 5.94	\$ 5.36	\$ 5.85
Insurance	\$ 531,951	\$ 450,610	\$ 900,990	\$ 570,367	\$ 539,912
Amount Per Equivalent Discharge	35	33	72	42	41
Amount Per Equivalent Patient Day	11	10	21	13	12
Central Office / Mgmt *	\$ -	\$ -	\$ -	\$ -	\$ 1,536,010
Net Patient Revenue	101,328,480	99,345,809	93,479,148	95,702,454	102,400,638
Central Office / Management Ratio	0.0%	0.0%	0.0%	0.0%	1.5%
Property Taxes	\$ 48,897	\$ 62,486	\$ -	\$ 46,906	\$ 603,351
Square Feet of Building Area	267,474	267,474	267,474	267,474	267,474
Amount Per Square Foot	\$ 0.18	\$ 0.23	\$ -	\$ 0.18	\$ 2.26

* Historical Bad Debt and Central Office / Management expenses are actual rather than inflation-adjusted.
Amounts per Equivalent Discharge and Equivalent Patient Day are rounded to the nearest dollar.

Stabilized Net Operating Income Forecast

The use of a stabilized forecast (as opposed to historical figures) is very important because there can be considerable variation in year-to-year cash flows resulting from changes in management, competition, reimbursement, etc. The operating performance of a hospital going concern has inherent variability and uncertainty and is impacted by the actions and effectiveness of management. Furthermore, it can be influenced significantly by the unforeseeable actions of competitors and the physicians that practice in the market service area.

As best as possible, the stabilized perspective considers many of the principal matters that are likely to influence future cash flow; better reflecting what a prospective buyer should expect during their near-term ownership of the going concern. The forecast is meant to represent a stabilized perspective subject to the “for-profit” and “competent management” limiting conditions. Despite the process and analyses performed, we

acknowledge that it is often difficult to forecast the cash flow of a hospital going concern with a high degree of certainty.

Net Operating Income Forecast		As Completed Forecast 6/30/2020
Revenue	Period Ending >>>	
<u>Net Patient Revenue</u>		
Hospital Inpatient Services		\$ 26,347,884
Hospital Outpatient Services		83,169,447
IP Charity		(350,000)
OP Charity		(2,500,000)
Bad Debt		(4,266,693)
Total Net Patient Revenue		\$ 102,400,638
<u>Other Revenue</u>		
Other Operating Revenue (Hospital)		\$ 4,706,843
Total Other Revenue		\$ 4,706,843
Total Operating Revenue		\$ 107,107,480
<u>Operating Expenses</u>		
Salaries & Wages		\$ 39,501,821
Payroll Taxes & Emp. Benefits		11,613,535
Supplies		21,264,053
Purchased Services		7,758,487
Professional Fees		10,128,227
Other Operating		2,447,312
Maintenance & Utilities		1,565,318
Insurance		539,912
Central Office / Mgmt. @ 1.5% of Net Patient Rev.		1,536,010
Property Taxes		603,351
Replacement Reserves @ 2.0% of Net Patient Rev.		2,048,013
Total Operating Expense		\$ 99,006,038
Net Operating Income		\$ 8,101,443
Net Operating Income Margin		7.6%

The annual not-for-profit health system “median reports” from Moody’s, Standard & Poor’s and Fitch were released in Q3 of 2017, reflecting 2016 data. These reports analyze the median financial and operating performance for the rating agencies’ respective portfolios of health system clients. Those reports suggest an average operating EBITDA margin (akin to NOI margin, only without a reduction for replacement reserves, and not necessarily with a reduction for central office expense) of 9.6 percent. Importantly, this EBITDA is substantially comprised of providers paid by prospective payment – no cost settlement.

Direct Income Capitalization Process

Capitalization is simply the conversion of income to value. The direct capitalization method converts a single year's income expectancy into a value indication. Yield and value change are implied, but not specifically identified. This method does not distinguish between the return on and the return of capital.

Capitalization rates reflect current market rates of return on similar property investments. These rates incorporate the following.

1. A return on the equity investment
2. Debt service
3. Principal build-up
4. Anticipated changes in income and value
5. Recapture of depreciating components of the property
6. Physical quality of the property
7. Other economic factors

Direct capitalization may be based on several revenue and income sources that require respective multipliers and rates to convert to indications of value. Income sources typically include potential gross income, effective gross income, net operating income, EBITDA, equity income and mortgage income.

For this appraisal, the following direct capitalization techniques are applied.

Technique #1 -- Division of net operating income by income capitalization rate.

Technique #2 -- Multiplication of effective net revenue by an income factor.

The rates and multipliers derived for the comparable sales are based upon historical operating performance of the respective going concerns, not the operating expectations of the respective buyers. Reflecting the variables that often exist with a change in ownership of a hospital, and the level of uncertainty and unpredictability of changes that may be made by a new owner, we have avoided making predictions for future operating results to develop forward-looking capitalization rates. The development of capitalization rates based on future expectations of performance is reasonable for many less complicated types of property, but with a hospital, unless it is being appraised, a cursory look tends to lack the depth of analysis necessary to yield credible results. Reflecting these considerations, the capitalization rates are based upon trailing operations in periods that are as closely matched to the sale date as cost reporting data permits.

Technique #1 Analysis (Overall Capitalization Rate)

We are unaware of any investment surveys conducted for hospital going concerns. Our overall capitalization rate conclusion is formulated using three sets of analyses.

- (A) Analysis of trailing OARs indicated by the comparable sales
- (B) Development of a theoretical OAR for a hypothetical going concern based upon sales of leased hospital properties; using EBITDAR-to-rent coverage ratios and leased fee capitalization rates
- (C) Development of an average OAR applicable to a set of publicly traded hospital operating companies based upon EBITDA multiples of their enterprise values

(A) Trailing OARs for Comparable Sales

Overall capitalization rates for the comparable sales profiled in the sales comparison approach are summarized in the following table.

Summary of Comparable Sale Capitalization Rates						
<u>Sale</u>	<u>Hospital Name</u>	<u>Effective Year Built</u>	<u>Expense Margin</u>	<u>Adjusted Sale Price</u>	<u>Trailing NOI (aka EBITDAR)</u>	<u>Overall Cap. Rate</u>
1	Bedford Memorial Hospital	1970	92.6%	\$24,000,000	\$2,576,325	10.7%
2	Rockdale Medical Center	1994	101.6%	79,300,000	(2,326,000)	N/M
3	NW Health Physicians' Specialty	1994	90.0%	40,125,000	3,212,200	8.0%
4	Bartow Regional Medical Center	2000	86.2%	60,000,000	8,222,640	13.7%
5	La Porte Hospital & Starke Hospital	1972	87.9%	130,000,000	21,854,600	16.8%
6	Memorial University Medical Center	1987	94.1%	456,656,000	28,742,320	6.3%
7	Clearview Regional Medical Center	2010	86.1%	37,400,000	7,082,000	18.9%
8	Casa Grande Regional Med Ctr	1990	104.3%	93,200,000	(4,303,959)	N/M
	Averages	1990	92.9%	\$115,085,125	\$8,132,516	12.4%

The overall capitalization rates derived from the comparable sales fall within an extremely wide range. These OARs are based on historical operating performance, not the operating expectations of the respective buyers. Hospitals are very management intensive businesses and their net operating income can vary considerably from year to year even when market conditions and management are stable. Many hospitals that transfer ownership have a history of losing money or operating near the break-even point. The buyers of these going concerns typically believe that they can make the business more profitable by implementing their management expertise and business strategy. The changes that are necessary or that are perceived as necessary will vary from property to property and from operator to operator. Some efforts will be more successful than others. Not all unprofitable hospital going concerns will be made more profitable per a change in ownership. The risks inherent in the operation of a hospital going concern are high, and they increase in situations that require a turnaround. Many turnaround situations are based in part upon large capital investments being made in plant, equipment and the addition of additional medical services.

Given the widespread noted in the OARs, it is difficult to draw strong conclusions from the comparable sales. The data demonstrates that buyers place significant emphases on revenues, physical plant characteristics, and a host of intangible elements when purchasing hospital going concerns. Even with respect to the average OAR indicated by the comparables with positive cash flow, many of them are presumably expected to achieve significantly higher future earnings. These circumstances set a limitation on the reliability of those comparables as indicators.

(B) Leased Fee Investment Analysis

The availability of REIT sale-leaseback transactions for hospital properties is reasonably good, although most those deals are for IRFs, LTCHs and other specialty hospitals rather than short-term acute care facilities. An analysis of this data is useful in helping to support theoretical overall capitalization rates. REITs look to EBITDAR (earnings before interest, taxes, depreciation, amortization and rent) as a basis for setting rent and establishing value. EBITDAR is substantially equivalent to net operating income. The following capitalization rate analysis has been made with the data provided on a following page.

Theoretical Underpinnings for Overall Capitalization Rate Development Using EBITDAR-to-rent Coverage Ratios

Overall Going Concern and Leased Fee Capitalization Rate Comparisons

A comparison of EBITDAR-to-rent coverage and lease rates of return (aka leased fee capitalization rates) provides market support for overall capitalization rates of going concerns. Albeit it theoretical, the basis is strongly rooted in REIT market activity. The following formula can be applied.

$$\frac{\text{EBITDAR-to-Rent Coverage Rate}}{\text{Lease Rate of Return (leased fee cap rate)}} = \text{Going Concern Cap Rate}$$

- Lease return rates for mid-life hospitals acquired by REITs typically range from:

Low	=	9.0%
High	=	12.0%
Midpoint	=	10.5%

- Lease rates for hospital properties are typically established at EBITDAR-to-rent coverage ratios from:

-

Low	=	1.50
High	=	2.25
Midpoint	=	1.75

- Typical going concern capitalization rate (including normalized management, and capex) using midpoints of noted ranges:

EBITDAR-to-rent coverage	1.75
Leased fee capitalization rate or lease rate of return	10.5%
Indicated hospital going-concern capitalization rate	16.67%

The following table supplies market evidence supporting the theoretical capitalization rate underpinnings outlined. Importantly, the EBITDAR-to-rent coverage ratios noted are representative of properties with reasonably strong operating ratios. There is a strong relationship between overall rates and operating ratios. Hospital going concerns with low operating margins sell at lower capitalization rates. Sales of hospital going concerns with negative operating margins are common; thus, there are significant limitations to this theoretical OAR analysis when hospital businesses with lower operating margins are being evaluated.

Hospital Lease and Sale Data

Summary of Hospital Leases And Hospital Leased Fee Capitalization Rates

	Year(s) built	Annual Rent Annual Increases	Rent/Sq. Ft	EBITDAR-to-Rent Coverage & Lease Rate	Beds	Rent Per Bed	Comments
Medical Properties Trusts	Various Existing	\$27,000,000		1.6 9.0%	606 LTAC & IRFs	\$44,554	Portfolio of 8 LTACHs plus 8 IRFs located in mostly Western states. 12 properties leased and 4 mortgage at similar terms, all cross defaulted; 20 years, plus 3, 5-yr extensions
Select - Southeast LTACHs	2006-07	\$8,425,000	\$38.47	EBITDAR not considered, But 0.9:1	209	\$40,311	Sale-leaseback transaction; EBITDAR based on trailing 2010-11 figures; low-cost LATCH building
Healthcare Trust GA FA TX		Unknown		8.26%	LATCH		
Select Medical	2008	\$1,070,058	\$34.66	1.38, but not considered in setting the rent	42	\$25,478	Sale-leaseback transaction; EBITDAR based on trailing 2010 figures; low-cost LATCH building
Omaha NE		Unknown		8.76%	LTAC		
Global Rehab	2012	\$1,932,000	\$35.52	EBITDAR no considered	50	\$38,640	Lease rent based on construction cost (no intangibles in the lease); 15 year lease with 2, 5-yr extensions
Scottsdale AZ		2.0%/Year		10.25%	IRF		
Select Medical	2009	\$1,412,140	\$34.35	1.8, but not considered in setting the rent	52	\$27,157	Lease rent based on construction cost (no intangibles in the lease); 15 year lease with 5, 5-yr extensions
Omaha NE		3.0%/Year		9.15%	LTAC		
St. John's Mercy (IRF)	2007	\$2,962,359	\$26.69	Not considered in setting the rent	58	\$51,075	Lease rent based on construction cost (no intangibles in the lease). Excellent tenant credit
Chesterfield MO		2.0%		9.25%	IRF		
Greater Peoria Specialty Hospital (LTAC) Peoria IL	2009	\$1,884,393 10.0% every 5 years	\$33.44	1.73 in Yr. 3, Not Considered in Rent 10.00%	50 LTAC	\$37,688	Lease rent based on construction cost; first-year EBITDAR was negative \$1.8 mm.
Michigan Orthopedics Rehab Hospital (IRF) Mishawaka, Indiana	2010	\$1,225,000 2.0%	\$26.47	2.13 in Year three (1 st stabilized year) 8.75%	40 IRF	\$30,625	Based upon the projected development cost of \$14,000,000, the initial year base (minimum) rent reflects a return of 8.75 percent. (no intangibles in the lease)
Landmark Hospital of Joplin Joplin MO	2007	\$820,089 Yes, Unknown	\$30.76	Mature Lease 8.950%	30 LTAC	\$27,336	The leased fee interest sold in late 2009 at a 9.74% cap rate; lease set in 2007 based on construction costs; we not know with intangibles revert to landlord at termination.
Solara Muskogee OK	2006	\$997,000 Annual/Unknown	\$26.95	Unknown 9.29%	41 LTAC	\$24,317	The leased fee interest sold in 2010 at a 9.29% cap rate; lease set in 2006 based on construction costs; we not know with intangibles revert to landlord at termination.
Dallas LTAC Dallas TX	2007	\$2,598,000 2.5%	\$49.62	Mature Lease 9.74%	60 LTAC	\$43,300	Rent based on development cost. 30 beds expandable to 42 beds (rent \$820,089/yr); 2008-10 average EBITDAR
Select Rehab Denton TX	2008	\$1,364,000 2.5%	\$31.26	Unknown Lease preceded Sale 9.03%	48 IRF	\$28,417	Lease set in 2008 at construction cost. EBITDAR unknown
Alvarado Parkway Behavioral Institute La Mesa, California	1980	\$1,500,000 Yes, Unknown	\$40.49	1.77 12.0%	66 Psych	\$22,727	Annual rent is \$1,500,000 with annual increases; 1980 construction, psych hospital
Texas Regional Sunnyvale Sunnyvale TX	2008	\$5,799,750 6.0% each 5th yr.	\$49.27	Unknown Lease preceded Sale 9.25%	70 Acute	\$82,854	Lease set in 2008 at construction cost. EBITDAR unknown; 25 year term, & 2, 5-yr. extensions

(C) Implied OAR for a Set of Publicly Traded Hospitals

Our development of an average OAR applicable to a set of publicly traded hospital operating companies based upon EBITDA multiples of their enterprise values utilizes data supplied by Cain Brothers in their monthly publication titled Industry Insights. Cain Brothers is an investment banking firm that focuses extensively on the medical services industry. Enterprise value is the market cap of the company, minus the cash, plus the debt.

EBITDA is Earnings Before (add back) Interest, Taxes, Depreciation and Amortization. Earnings represent the net income presented in the statement of operations under GAAP. EBITDA is essentially the income that a company has free for interest payments. EBITDA is made without recognition of capital expenditures (reserves for replacement of short-lived improvements and FF&E). Rent expense for tangible property is accounted for in EBITDA. With some caveats, EBITDA represents an equivalent calculation of net operating income for a going concern. The caveats are analyzed following the table below.

EBITDA Multiples for Public Hospital Companies				
Company	EBITDA Multiples of Enterprise Value		EBITDA Margins	
	CY 2018 E	CY 2019 E	CY 2018 E	CY 2019 E
HCA Healthcare	9.5	8.8	18.9%	19.3%
Tenet Healthcare	7.4	7.3	13.5%	13.7%
Universal Health Services	9.4	9.0	16.0%	16.7%
Community Health Systems	8.8	9.1	11.4%	12.1%
Quorum Health	8.5	7.7	8.2%	9.1%
Mean	8.7	8.4	13.8%	14.3%
Median	8.8	8.8	11.4%	12.5%
Data Source: Cain Brothers, Industry Insights, 2-8-19				
Enterprise value is equal to equity value plus debt, less cash and investments.				
EBITDA projections are calendarized and are Wall Street consensus estimates.				

In principle, the conversion of these EBITDA multiples to overall capitalization rates (OARs) is simply the reciprocal; an 8.0 multiplier is a 12.5% capitalization rate ($1 / 8 = .125$). However, as noted, there are two matters which complicate the conversion process: rent expenses and reserves for replacement.

Rent Expense

Many hospitals lease some space for ancillary or support services. Our forecasts may include rent expenses (real or imputed) for ancillary or support properties that are occupied by the hospital, but not for the core real estate asset. In contrast, the public companies cited, in some instances, may incur a lease expense for the core real estate asset at some of their hospital locations. Per our fee simple appraisal of the subject's core hospital real estate asset, the forecast net operating income includes amounts that provide a return on and of those assets. For comparison purposes, the EBITDA figures for the public hospitals could be lower than the subject NOI forecast due to the rent expense for core real estate assets.

For this analysis, we do not have the data necessary to make an adjustment for the rental expense matter. We are therefore left to note that, with respect to the rental expense matter, the converted OARs may be skewed somewhat in relation to an OAR applicable to the subject going concern.

Reserves for Replacement

Our appraisal forecast for net operating income includes a reserve-for-replacement allowance. As previously mentioned, EBITDA is made without recognition of capital expenditures (reserves for replacement of short-lived improvements and FF&E) needed

to sustain the earnings ability of the going concern. Reserves for replacement are a critical part of a hospital's ongoing operations and a focal point in the budgeting process.

For purposes of consistency in the analysis, the EBITDA multiples noted in the Industry Insights publication must be adjusted for reserves to produce a multiplier or capitalization rate applicable to the net operating income forecast developed in this appraisal. The conversion process requires the use of an operating expense ratio or its converse indication, the operating profit margin (i.e., EBITDA margin). In addition to the EBITDA multiples, the previous table identifies the corresponding EBITDA margins.

Using the median EBITDA multiples and margins noted for the public hospital companies and adjusting them for replacement reserves at a rate of 2.0 percent of revenues, the following OAR indications have been determined.

Conversion of EBITDA Multiples to OARs		
	CY 2018 E	CY 2019 E
Median EBITDA Multiples for Data Set (a)	8.80	8.80
EBITDA for Conversion (b)	\$1.00	\$1.00
Enterprise Value (c) = (a x b)	\$8.80	\$8.80
Median EBITDA Margin (d)	11.4%	12.5%
Implied Revenue at Expense Ratio (e) = (b / d)	\$8.80	\$8.00
Reserves Percentage of Revenue (f)	2.0%	2.0%
Operating Margin Adjusted for Reserves (g) = (d - f)	9.4%	10.5%
Adjusted EBITDA (h) = (g x e)	\$0.82	\$0.84
Adjusted EBITDA Multiple (i) = (c / h)	10.68	10.48
Implied OAR on Adjusted EBITDA Multiple (j) = (1 / i)	9.4%	9.5%

Implied OAR Conclusion for Public Traded Hospital Companies

As the implied OARs are from publicly traded companies, it is important to point out that they do not correlate directly to an asset sale of a privately held one-off hospital.

These public companies may have access to less costly capital by raising equity through share offerings that do not necessarily require payment of dividends. Moreover, the enterprise value (particularly the equity value) likely includes a "portfolio premium." In contrast, there could be various types of liabilities that the public companies maintain, some of which may serve to diminish the value of their equity. Our appraisal of the subject property reflects the assumption of an asset sale, whereby, aside from working capital, financial and other liabilities are specifically excluded from consideration.

In business valuations, a common premise made is that, all things otherwise being equal, a private company has less value than a public company due to its lack of liquidity. Given two identical business interests, a higher price will be paid by investors in the market for the business interest that can be converted to cash most rapidly, without risk of loss in value. Interests in private business entities are less liquid than those in public companies as there is no ready market for the private one. Privately held companies require extended periods of time to sell because they must be assembled, intermediaries must be engaged, qualified buyers must be found, and sales must be negotiated and closed. Such interests are illiquid by their very nature. Even as an asset sale, hospitals tend to be particularly illiquid due to certificate of need laws, multiple licenses and certifications being transferred, the extensive amount of due diligence warranted, transaction oversight by regulatory agencies, etc. Therefore, the greater value of the publicly traded company effectively translates to a lower implied OAR than would be applicable to a privately held going concern.

Considering the private vs. public value considerations, we are left to conclude that the implied OARs should serve as a low benchmark for asset-based valuations of privately held hospitals.

Key Points for Consideration in OAR Selection

Various issues relating to the subject property and the marketplace are given consideration in selecting the overall capitalization rate. Among them are physical qualities of the tangible property, the relationship of historical and forecast performance, market service area trends, property location, changes in the competitive landscape, and reimbursement trends. The following issues are specifically noted.

Lower-than-average overall capitalization rate:

- Sole community hospital status helps to ensure better profitability than hospitals paid solely on a PPS basis
- Going concern operates clinics with Rural Health Clinic and provider-based status, which provides cost-based reimbursement for Medicare and helps to ensure better profitability
- There is no expectation of any meaningful, near-term change in the supply of healthcare services for the market service area
- Modest dependency on Medicaid reimbursement – economic and budget issues at the state level, along with swings in the prevailing political ideology of elected state officials, can contribute to uncertainty about the stability of Medicaid-sourced revenues
- The contributory value of the tangible assets is a reasonably high percentage of the going concern value

Higher-than-average overall capitalization rate:

- Higher outpatient to inpatient business ratio – inpatient revenues are less vulnerable to competitive pressure than outpatient type
- Forecast profitability is above historical profitability
- Operator has limited integration with primary care physicians and therefore has limited ability to influence referral activity

Overall capitalization rate in the middle of the range:

- Typical physical plant qualities
- Mid-range operating margin

Overall Capitalization Rate Conclusion

Due to the specific and effectively unique circumstances which surround sales of hospital going concerns, we are unable to draw significant conclusions about the relationship between OARs and revenue sources (Medicare, Medicaid, commercial, etc.). Presumably, the impact of payer mix is substantially accounted for in the net revenue differences for respective payers. There is evidence of properties with lower effective ages commanding higher unit prices but, again, the OAR relationship is more difficult to discern. Prices paid, and the trailing rates of return produced at those prices are influenced significantly by buyer motivations. Opportunities for efficiency, service area expansion, and physician practice accommodation are some of the factors that can enhance one buyer's motivation over another's.

Capitalization rates for hospital going concerns, which encompass real estate, personal property and intangible components of value, have historically been greater than those for commercial real estate (often in the 6.0 to 10.0 percent range). Nursing homes, which often transact in the 12.0 to 15.0 percent OAR range, are going concerns with some similarities to hospitals. However, the cash flows from hospitals are inherently riskier than those from nursing homes for a variety of reasons:

- hospitals generally have higher ratios of FF&E cost/value
- they require greater capital investment to remain competitive
- they are more management intensive and require greater expertise
- they are more dependent upon operating scale for efficiency, purchasing power and leverage in payer negotiations

In recent years, healthcare reform has proven to be a motivation for consolidation and strategic acquisition. Buyers have been more aggressive, and capitalization rates below those common to nursing home sales are being observed. At this point in time, we believe capitalization rates in the range of 10 to 18 percent represent a baseline measure from which to evaluate hospital going concerns operating on a stabilized (reasonably optimal and profitable) basis.

A significant risk for any hospital is its ability to align itself with the physicians that practice there – to align the interests of the hospital with those of the physicians to attract and retain staff. This issue has gained importance with healthcare reform due to bigger volumes of business and the movement toward bundled payment. Physician alignment is going to be very important to the future success of the subject hospital. Larger, more sophisticated organizations have an advantage in this arena, which is one of various reasons that smaller hospitals are choosing to merge or be acquired by larger hospitals or systems.

I have selected an overall capitalization rate of 14.5 percent for the “as completed” valuation. The market value indication for the going concern of Dickinson County Memorial Hospital is summarized as follows.

OAR-based Direct Capitalization Value Indication	
	As Completed
Forecast Net Operating Income	\$ 8,101,443
Overall Capitalization Rate	14.5%
Preliminary Going Concern Value	\$ 55,872,020
Going Concern Value (rounded)	\$ 55,900,000

Technique #2 Analysis (Effective Net Revenue Multiplier)

Hospitals are frequently priced on multiples of net revenue. In an industry where many properties either do not have a history of profitable operations, or which experience wide variances in cash flow from year to year, the use of a more simplistic technique to express value via income capitalization is commonplace. As with overall capitalization rates, there can be wide variances in the effective net revenue multiples observed with sales of going concerns. Intuitively, hospitals that have histories of losing money, have aged physical plants with significant capital improvement needs, or otherwise have higher operating risks should sell at lower multiples than those with the opposite characteristics. All the considerations that should impact the ENRM applicable to the subject property are discussed in the overall capitalization rate (OAR) analysis.

The following table summarizes the ENRMs for the comparable sales.

Summary of Effective Net Revenue Multiples		
<u>Sale</u>	<u>Hospital Name</u>	<u>ENRM</u>
1	Bedford Memorial Hospital	0.69
2	Rockdale Medical Center	0.56
3	NW Health Physicians' Specialty	1.25
4	Bartow Regional Medical Center	1.00
5	La Porte Hospital & Starke Hospital	0.72
6	Memorial University Medical Center	0.94
7	Clearview Regional Medical Center	0.73
8	Casa Grande Regional Med Ctr	0.93
	Mean	0.85
	Median	0.83

I have selected an ENRM of 0.50 for the “as completed” valuation. The market value indication for the going concern of Dickinson County Memorial Hospital is summarized as follows.

ENRM-based Direct Capitalization Value Indication	
	<u>As Completed</u>
Forecast Effective Net Revenue	\$ 107,107,480
Effective Net Revenue Multiplier	0.50
Preliminary Going Concern Value	\$ 53,553,740
Going Concern Value (rounded)	\$ 53,600,000

Income Approach Value Conclusion

We have elected to weight the OAR and ENRM indications of value equally in adopting our conclusion of value by the income capitalization approach.

Income Capitalization Approach Conclusion of Value	
	<u>As Completed</u>
OAR-based Indication of Value	\$ 55,900,000
ENRM-based Indication of Value	53,600,000
Value Conclusion by Income Capitalization	\$ 55,000,000
Value per Equivalent Discharge	\$ 4,203
Value per Equivalent Patient Day	1,258
Value per Staffed Acute Hospital Bed	1,122,449
Value per Total Licensed Acute Hospital Bed	1,122,449

Direct Sales Comparison Approach

The market value of a hospital going concern is influenced materially by its ability to generate revenues and earnings. What's more, hospital going concerns are complex businesses that have many value influences, some of which include:

- Market relationships between facilities and/or health systems
- Managed care competition and the relationship of MCOs with hospitals and health systems
- Economies of scale for specific buyers and sellers
- Physician relationships and the impact of new healthcare facilities that have physician ownership interests
- The effectiveness of historical management
- Service line specialties
- Inpatient and outpatient revenue relationships
- Profitability relationships for specific payers
- Unrealized business opportunities

These implicit considerations are usually too numerous and complex to develop a meaningful narrative analysis for comparison. Given these considerations, the sales comparison approach cannot be applied judiciously to a hospital going concern appraisal without considerable evaluation of income capitalization approach variables.

Hospital merger and acquisition activity has been very active in recent years. Many of the transactions involve mergers or include multiple facilities. Often, buyers are seeking to consolidate beds and services within their respective markets or increase market share. Some for-profit companies are actively expanding in niche markets, such as rural hospitals and specialty hospitals. Generally, weaker facilities are targets for buyers that seek consolidation.

Our analyses of the sales of hospital going concerns are limited to a cursory comparison using various unit price measures. This broad-based approach is simply a test of reasonableness for the unit prices yielded by the income approach indication(s) of value.

The sales applied to this analysis were researched via a variety of possible sources:

- Reviews of stories published in trade journals, newspapers or business journals
- Interviews with hospital administrators or corporate management
- Public records
- SEC filings
- Medicare claims data (MedPAR and OPPS) sourced via American Hospital Directory
- Medicare and/or Medicaid cost reports
- Actual operating and physical data collected by appraising properties

Comparable Sales Data

Descriptions and comparative analyses of the market data selected for this appraisal are presented on the following pages.

Sale One
Bedford Memorial Hospital
1613 Oakwood Street
Bedford, VA 24523

Sale Date	July 1, 2014
Licensed & Staffed Beds	50 / 50
Total Price	\$24,000,000
Financing	Cash to seller
Seller	Carilion Clinic
Buyer	Centra Health
Confirmation	Public disclosures; American Hospital Directory
Cash Equivalent Price	\$24,000,000

Property Data

Land Area (Acres)	49.24
Gross Building Area (SF)	124,296
All Years Built	1954/1964/1974/1980/1986/1993/1997
Building Description	One- to three-story buildings, masonry facade
Overall Building Condition	Average

Operating Data

Occupancy (Licensed Beds)	23.3%
Medicare Mix (Hospital Bed Discharges)	68.1%
Medicaid Mix (Hospital Bed Discharges)	3.5%
Total Discharges (Hospital & SNF/NF)	1,500
Equivalent Discharges	3,497
OP Revenue as % Total Patient Revenue	57.1%
Net Revenue	\$34,865,569
Operating Expenses before Cap-X	\$31,591,933
Reserves @ 2% of Net Revenue	\$697,311
EBITDAR (no reserves deducted)	\$3,273,636
Expense Margin (no reserves deducted)	90.6%
Adjusted EBITDAR (reserves deducted)	\$2,576,325
Adjusted Expense Margin (reserves ded.)	92.6%

Price Indicators

Price per Staffed Bed	\$480,000
Price per Square Foot	\$193
Effective Net Revenue Multiplier	0.69
Overall Capitalization Rate	10.7%
Price per Discharge	\$16,000
Price per Equivalent Discharge	\$6,864

Comments

Bedford Memorial Hospital is in a rural/suburban area of south-central Virginia, between Lynchburg and Roanoke. Bedford County is part of the Lynchburg Metropolitan Statistical Area. The population of the city of Bedford is near 6,000, while the population of Bedford County is near 70,000.

Bedford Memorial Hospital Bedford, VA

Bedford Memorial Hospital is the only hospital in Bedford County. Lynchburg is the nearest community with another hospital, and that facility is over 20 miles away.

Bedford Memorial Hospital includes the 50-bed hospital and a 111-bed nursing facility known as Oakwood Health and Rehabilitation Center. The nursing home operated at a 90.2 percent occupancy rate in FY 2013. The SNF Medicare and private pay mixes during that period were 22.7 percent and 21.7 percent, respectively.

The buyer in this transaction owned a 50 percent interest in the hospital. The acquisition is for the other 50 percent interest that was owned by Carilion Clinic, a Roanoke, Virginia-based not-for-profit health care organization that owns and operates multiple hospitals in the western part of Virginia. Carilion Clinic and Centra Health had owned and operated the hospital in a 50-50 joint venture since 2001. The purchase price was \$12 million for a 50 percent interest; the \$24 million price used is a 100 percent interest equivalent amount.

Centra Health is a Lynchburg-based health system. Upon completing the transaction, Centra indicated that it would begin making investments in both facilities and staff at the hospital, including spending \$1.5 million to \$2 million in capital per year for the next three to five years to upgrade and grow the hospital. They plan to make updates to the emergency department and the long-term care facility, other modifications to the building infrastructure, add more advanced medical equipment, improve technology, and make cosmetic changes. In addition, the recruitment of new physicians would be ramped up.

The financial information was obtained from the Medicare Cost Report. The financials are from October 1, 2012 through September 30, 2013.



Sale Two
Rockdale Medical Center
1412 Milstead Ave
Conyers GA 30012

Sale Date	October 1, 2017
Licensed & Staffed Beds	141 /141
Total Price	\$79,300,000
Seller	Rockdale Hospital, LLC ("LifePoint Health")
Buyer	Piedmont Rockdale Hospital, Inc. ("Piedmont Healthcare")
Confirmation	Public disclosures, form 10-Q

Property Data

Land Area (Acres)	27.64
Gross Building Area (SF)	596,765
All Years Built	1978, 1988, 1997, 2001, 2004, 2005, 2007
Building Description	One to three-story buildings
Overall Building Condition	Average/good

Operating Data

Occupancy (Licensed Beds)	70.0%
Medicare Mix (Hospital Bed Discharges)	41.5%
Medicaid Mix (Hospital Bed Discharges)	24.0%
Total Discharges (Hospital & SNF/NF)	8,832
Equivalent Discharges	20,073
OP Revenue as % Total Patient Revenue	56.0%
Net Revenue	\$141,300,000
Operating Expenses Before Cap-X	\$140,800,000
Reserves @ 2% of Net Revenue	\$ 2,826,000
EBITDAR (no reserves deducted)	\$ 500,000)
Expense Margin (no reserves deducted)	99.6%
Adjusted EBITDAR (reserves deducted)	(\$ 2,326,000)
Adjusted Expense Margin (reserves deducted)	101.6%

Price Indicators

Price per Staffed Bed	\$562,411
Price per Square Foot	\$133
Effective Net Revenue Multiplier	0.57
Overall Capitalization Rate	N/M
Price per Discharge	\$8,979
Price per Equivalent Discharge	\$3,951

Comments

Rockdale Medical Center is in north-central Georgia, 20 miles east of Atlanta. Conyers is located along Interstate 20, which runs from Atlanta to Augusta, Georgia. Conyers is the only city in Rockdale County. The city population is near 15,000. The formerly separate town Milstead is now part of Conyers.

Rockdale Medical Center is the only hospital in Rockdale County. The only other hospital within 10 miles is the 90-bed Dekalb Medical Hillandale facility located in Lithonia, GA.

Rockdale Medical Center Conyers, GA

The facility consists of two main buildings that are connected. There is a two-level parking garage that is not included in the building area. There is one off-campus medical clinic included with the property.

The seller of Rockdale Medical Center is LifePoint Health. LifePoint operates more than 70 hospital campuses and regional health systems, as well as physician practices, outpatient centers and post-acute service providers in 22 states.

The buyer is Piedmont Healthcare. Rockdale is the eighth hospital to join the Atlanta-based health care system. Piedmont has had a clinical affiliation with Rockdale for nearly three years before the sale. It enabled Rockdale to open a heart and vascular center and interventional cardiology program in partnership with Piedmont Heart.



Sale Three
Physicians Specialty Hospital
3873 North Parkview Drive
Fayetteville AR 72703

Sale Date	April 1, 2016 (see comments)
Licensed & Staffed Beds	20 / 20
Total Price	\$40,125,000
Financing	Cash to Seller
Seller	Physicians Specialty Hospital, LLP, etal
Buyer	Community Health Systems, Inc., etal
Confirmation	Public disclosures, form 10-K
Cash Equivalent Price	\$40,125,000

Property Data

Land Area (Acres)	1.43
Gross Building Area (SF)	55,740
All Years Built	1994
Building Description	Two and three-story, brick envelope
Overall Building Condition	Average

Operating Data

Occupancy (Licensed Beds)	23.1%
Medicare Mix (Hospital Bed Discharges)	28.4%
Medicaid Mix (Hospital Bed Discharges)	1.6%
Total Discharges (Hospital & SNF/NF)	1,131
Equivalent Discharges	2,856
OP Revenue as % Total Patient Revenue	60.4%
Net Revenue	\$32,090,000
Operating Expenses Before Cap-X	\$28,236,000
Reserves @ 2% of Net Revenue	\$ 641,800
EBITDAR (no reserves deducted)	\$ 3,854,000
Expense Margin (no reserves deducted)	88.0%
Adjusted EBITDAR (reserves deducted)	\$ 3,212,200
Adjusted Expense Margin (reserves deducted)	90.0%

Price Indicators

Price per Staffed Bed	\$2,006,250
Price per Square Foot	\$720
Effective Net Revenue Multiplier	1.25
Overall Capitalization Rate	8.0%
Price per Discharge	\$35,477
Price per Equivalent Discharge	\$14,049

Comments

Fayetteville is in the northwest corner of the state, 30 miles east of the Oklahoma border and 20 miles south of the Missouri border, in Washington County. The city has a population of about 85,000. It is part of the Fayetteville-Springdale-Rogers Metropolitan Area, which has a total population of near 460,000 residents. Washington Regional Medical Center serves as the major acute care hospital in the area and is located just over a mile away from the subject.

The sale profiled represents the combination of two separate transactions – one for the real estate and one for the going concern and its leasehold interest in the real estate. The seller in both transactions is the same entity. There was a time span of roughly three years between the two transaction dates. The most recent transaction date is used in the sale profile.

The first transaction is the sale of the real estate. On June 27, 2013, NWA Surgeon Investors Properties, LLC (“NWASIP”) sold the real estate to HC-3873 N. Parkview Drive, LLC, a subsidiary of Carter Validus Mission Critical REIT. The price was \$22,625,000. The property was leased to Physicians Specialty Hospital, LLC (“PSH”), which is believed to be a closely related entity of NWASIP. The lease had a remaining term of approximately 10 years, three five-year renewal options, and 2.0% fixed annual escalator. The year one NNN rent at the time of sale was approximately \$1,923,000, yielding an 8.5% OAR. Other unit prices were \$1,131,250 per bed and \$405.90 per square foot.

The second transaction is the majority interest sale of the going concern and its leasehold interest. On April 1, 2016, Community Health Systems, Inc. (“CHS”) purchased an 80% interest in Physicians Specialty Hospital, LLC. The total consideration was \$14,000,000. That price has been adjusted to a 100% interest equivalent of \$17,500,000. CHS is one of the largest for-profit hospital operators in the United States, focusing on hospitals located outside of major metropolitan areas. In this region, CHS operates as Northwest Health. PSH became the fourth hospital in that system. The minority interest holder and seller of the majority interest in PSH is a group of physicians. The hospital experiences a relatively high Medicare CMI – near 2.3.

The hospital features five operating rooms, one procedure room, a full-scale emergency department, and in-house diagnostic lab and radiology departments. The building was constructed in 1994 and converted to an inpatient specialty surgical hospital in 2009. In addition to the 1.429-acre hospital site, there is a 1.05-acre parcel located across the street that is controlled by ground lease. That property is used for parking.



Sale Four
Bartow Regional Medical Center
2200 Osprey Boulevard
Bartow FL 33830

Sale Date	December 31, 2015
Licensed & Staffed Beds	72 / 72
Total Price	\$60,000,000
Financing	Cash to seller
Seller	Bartow HMA, LLC (a subsidiary of Community Health Systems, Inc.)
Buyer	Bartow Regional Medical Center, Inc. (a subsidiary of BayCare Health System, Inc.)
Confirmation	Form 10-Q, public disclosures
Cash Equivalent Price	\$60,000,000

Property Data

Land Area (Acres)	35
Gross Building Area (SF)	156,417
All Years Built	1999, 2001, 2002
Building Description	One and two-story buildings
Overall Building Condition	Good

Operating Data

Occupancy (Licensed Beds)	53.0%
Medicare Mix (Hospital Bed Discharges)	59.1%
Medicaid Mix (Hospital Bed Discharges)	12.1%
Total Discharges (Hospital & SNF/NF)	3,081
Equivalent Discharges	6,446
OP Revenue as % Total Patient Revenue	52.2%
Net Revenue	\$59,768,000
Operating Expenses Before Cap-X	\$50,350,000
Reserves @ 2% of Net Revenue	\$ 1,195,360
EBITDAR (no reserves deducted)	\$ 9,418,000
Expense Margin (no reserves deducted)	84.2%
Adjusted EBITDAR (reserves deducted)	\$ 8,222,640
Adjusted Expense Margin (reserves deducted)	86.2%

Price Indicators

Price per Staffed Bed	\$833,000
Price per Square Foot	\$384
Effective Net Revenue Multiplier	1.0
Overall Capitalization Rate	13.7%
Price per Discharge	\$19,474
Price per Equivalent Discharge	\$9,309

Comments

Bartow Regional Medical Center ("BRMC") is in the central portion of the state. Bartow is located along Highway 98, 35 miles east of Tampa and 50 miles southwest of Orlando. The population in Bartow is 19,500 and the population in Polk County is 650,000. Bartow is part of the Lakeland Metropolitan Statistical Area.

BRMC serves South Lakeland, Bartow, Ft. Meade, Mulberry, rural south Polk County and northern Hardee County. There are three other hospitals within 20 miles of Bartow: Lake Wales Medical Center, Lakeland Regional Medical Center, and Winter Haven Hospital. They have a combined total of about 1,520 beds.

There are three separate buildings on the Bartow Regional Medical Center campus. The main hospital building is 112,840 square feet, built in 1999. The other buildings are medical office and outpatient type, 2001 and 2002.

The seller of Bartow Regional Medical Center is Community Health Systems, Inc. ("CHS"), one of the largest publicly traded hospital companies in the United States. With the sale, CHS still operated 25 hospitals in Florida.

The buyer is a subsidiary of BayCare Health System, Inc. They are a nonprofit organization based in Clearwater, Florida. They own and operate 14 hospitals, all in Florida. They had just under \$3 billion in operating revenue in 2014. They bought another Polk county Hospital, Winter Haven Hospital, in 2013.



Sale Five

La Porte Hospital
1007 Lincolnway
La Porte, IN 46350

Starke Hospital
102 E Culver Road
Knox, IN 46534

Sale Date	March 1, 2016
Licensed & Staffed Beds	280 / 182 (includes leasehold)
Total Price	\$130,000,000
Financing	Cash to seller
Seller	Laporte Regional Health System, Inc. (Indiana University Health)
Buyer	Laporte Hospital Company, LLC (Community Health Systems, Inc.)
Confirmation	Public disclosures, form 10-K, AHD
Cash Equivalent Price	\$130,000,000

Property Data

Land Area (Acres)	25.2 (excludes leasehold)
Gross Building Area (SF)	429,719 (excludes leasehold)
All Years Built	1945, 1954, 1970, 1972, 1980, 1987, 1994, 1996, 2009
Building Description	One to seven-story masonry
Overall Building Condition	Average

Operating Data

Occupancy (Licensed Beds)	16.5%
Medicare Mix (Hospital Bed Discharges)	53.0%
Medicaid Mix (Hospital Bed Discharges)	27.4%
Total Discharges (Hospital & SNF/NF)	4,806
Equivalent Discharges	12,451
OP Revenue as % Total Patient Revenue	61.4%
Net Revenue	\$181,270,900
Operating Expenses Before Cap-X	\$155,790,900
Reserves @ 2% of Net Revenue	\$ 3,625,400
EBITDAR (no reserves deducted)	\$ 25,480,000
Expense Margin (no reserves deducted)	85.9%
Adjusted EBITDAR (reserves deducted)	\$ 21,854,600
Adjusted Expense Margin (reserves deducted)	87.9%

Price Indicators

Price per Staffed Bed	\$714,286
Price per Square Foot	\$303
Effective Net Revenue Multiplier	0.72
Overall Capitalization Rate	16.8%
Price per Discharge	\$27,050
Price per Equivalent Discharge	\$10,441

Comments

This sale includes the operations of two hospitals – La Porte Hospital and Starke Hospital. The La Porte Hospital property included most of the real estate utilized by that facility. The Starke Hospital did not include the real estate utilized by that facility – it represents a leasehold interest acquired.

La Porte Hospital is in northwest Indiana in the city of La Porte, which is 25 miles east of South Bend. The population of La Porte is about 22,000, while the population of La Porte County is about 113,000. La Porte Hospital is one of two principal hospitals in the region. The other is Franciscan Health - Michigan City, a 310-bed facility located 13 miles from La Porte Hospital.

Starke Memorial Hospital is in Knox, which is approximately 53 miles southwest of South Bend and 25 miles from La Porte.

The seller is IU Health, a major medical network that works in partnership with the Indiana University School of Medicine. IU Health controls multiple hospitals in Indiana. IU Health retained a 20 percent stake in the hospital while transferring 80 percent to the cash buyer, Community Health Systems, Inc (CHS). CHS is a Fortune 500 company and one of the largest providers. At the time sale it operated almost 200 hospitals in the United States.

The 3/1/16 sale was an 80% interest sale for \$104,000,000. The price used reflects a 100% interest ($\$104,000,000/0.80$). As a part of the sale, CHS pledged to build a new replacement hospital in La Porte. The replacement hospital broke ground in August 2018. Prior to breaking ground for the new hospital, CHS purchased the remaining 20% interest in the hospital from IU Health, for an undisclosed amount.

The lease for Starke Memorial Hospital expires in September 2026 and is subject to one ten-year renewal term. The lease also provides the lessee with a right of first refusal to purchase the hospital.

Financials used to profile the sale represent FY 2015 data per Medicare cost reports.

La Porte Hospital



Starke Hospital



Dickinson County Memorial Hospital

Sale Six
Memorial Health University Medical Center
4700 Waters Avenue
Savannah GA 31404

Sale Date	February 1, 2018
Licensed & Staffed Beds	512 / 496
Total Price	\$456,656,000
Financing	Cash to seller
Seller	Chatham County Hospital Authority, etal
Buyer	Savannah Health Services, LLC (a subsidiary of HCA Healthcare, Inc.)
Confirmation	Asset purchase agreement, public disclosures, American Hospital Directory
Cash Equivalent Price	\$456,656,000

Property Data

Land Area (Acres)	148.3
Gross Building Area (SF)	1,340,000
All Years Built	1954, 1980, 1985, 1987, 1988, 1990, 1993, 1996, 2001, 2003, 2016
Building Description	One to five story buildings
Overall Building Condition	Average/good

Operating Data

Occupancy (Licensed Beds)	81.7%
Medicare Mix (Hospital Bed Discharges)	33.6%
Medicaid Mix (Hospital Bed Discharges)	11.2%
Total Discharges (Hospital & SNF/NF)	26,125
Equivalent Discharges	41,840
OP Revenue as % Total Patient Revenue	37.6%
Net Revenue	\$488,234,000
Operating Expenses Before Cap-X	\$449,727,000
Reserves @ 2% of Net Revenue	\$ 9,764,680
EBITDAR (no reserves deducted)	\$ 38,507,000
Expense Margin (no reserves deducted)	92.1%
Adjusted EBITDAR (reserves deducted)	\$ 28,742,320
Adjusted Expense Margin (reserves deducted)	94.1%

Price Indicators

Price per Staffed Bed	\$920,677
Price per Square Foot	\$341
Effective Net Revenue Multiplier	0.94
Overall Capitalization Rate	6.3%
Price per Discharge	\$17,480
Price per Equivalent Discharge	\$10,914

Memorial Health University Medical Center Savannah GA

Comments

Memorial Health University Medical Center is on the eastern edge of Georgia in the city of Savannah. The population of Savannah is near 147,000, while the population of Chatham county is near 287,000. Savannah is the oldest city in Georgia and the county seat of Chatham county. Savannah is 120 miles north of Jacksonville, FL and 80 miles southwest of Charleston, SC. There are two other large hospitals in Savannah. Candler Hospital, with 267 beds, is a half mile from Memorial. Saint Joseph's Hospital, with 247 beds, is five miles away.

The base purchase price for the deal is \$456.7 million. The buyer has agreed to spend another \$280 million over the next ten years in capital expenditures and improvements, \$60+/- million of which will be allocated to the construction of a new, freestanding Children's Hospital in the space currently occupied by a former 50-bed rehabilitation building. According to the certificate of need progress report, as of 7/18/2018, the project was five percent complete.

The seller of Memorial Health is a combination of entities: Chatham County Hospital Authority; Memorial Medical Center, Inc., Memorial Health University Medical Center, Inc., Provident Health Services, Inc., and Savannah Midtown Properties, Inc. In pursuit of a merger or sale, the Hospital utilized a third-party solicitor that engaged with 17 potential partners. Seven of those potential partners submitted proposals, and two of them submitted letters of interest.

Memorial Health is an acute care urban safety net tertiary care trauma center. The Hospital is a Level I trauma center, operates a children's hospital, and is the Savannah Campus for Mercer University School of Medicine. The Hospital's service area encompasses a 35-county area in southeast Georgia and southern South Carolina. The sale includes substantially all the assets of Memorial and Chatham County Hospital Authority, and affiliates of Memorial.

The real estate included in the sale included all the real property assets of the going concern. There were several modestly priced homes and vacant residential lots included in the sale. Those properties are located around the hospital campus. Healthcare buildings represent about 95% of the building area noted. Parking garages on the campus are not included in the building area noted.

The buyer is Savannah Health Services, LLC, an indirect wholly owned subsidiary of HCA Healthcare, Inc. HCA is a publicly traded for-profit healthcare provider based in Nashville, TN. HCA operates 170 hospitals, 71 urgent care facilities, and 830 physician clinics. HCA, or its affiliates, own and operate several other hospitals in Georgia. Financial data for the sale reflects FY 2016 operations.

**Memorial Health University Medical Center
Savannah GA**



Sale Seven
Clearview Regional Medical Center
2151 West Spring St.
Monroe GA 30655

Sale Date	March 30, 2018
Licensed & Staffed Beds	77 / 76
Total Price	\$37,400,000
Seller	Monroe HMA, LLC ("Quorum Health Corporation")
Buyer	Piedmont Walton Hospital, Inc. ("Piedmont Healthcare, Inc.")
Confirmation	Assessor info, public disclosures
Property Data	
Land Area (Acres)	78.27
Gross Building Area (SF)	202,024
All Years Built	1196, 2011, 2014, 2016
Building Description	One story main hospital with two attached medical office buildings
Overall Building Condition	Good
Operating Data	
Occupancy (Licensed Beds)	32.0%
Medicare Mix (Hospital Bed Discharges)	45.4%
Medicaid Mix (Hospital Bed Discharges)	9.3%
Total Discharges (Hospital & SNF/NF)	2,669
Equivalent Discharges	8,897
OP Revenue as % Total Patient Revenue	70.0%
Net Revenue	\$50,900,000
Operating Expenses Before Cap-X	\$42,800,000
Reserves @ 2% of Net Revenue	\$ 1,018,000
EBITDAR (no reserves deducted)	\$ 8,100,000
Expense Margin (no reserves deducted)	84.1%
Adjusted EBITDAR (reserves deducted)	\$ 7,082,000
Adjusted Expense Margin (reserves deducted)	86.1%
Price Indicators	
Price per Staffed Bed	\$492,105
Price per Square Foot	\$185
Effective Net Revenue Multiplier	0.73
Overall Capitalization Rate	18.9%
Price per Discharge	\$14,013
Price per Equivalent Discharge	\$4,204

Comments

Clearview Regional Medical Center, renamed to Piedmont Walton, is about 40 miles east of Atlanta, within the Atlanta metropolitan area. The population of Monroe is around 13,000, while the population of Walton county is near 83,000. Clearview Regional Medical Center is the only acute care hospital in Walton County.

In addition to the hospital campus property, the sale included an off-campus clinic building and a separate vacant parcel of land.

Clearview Regional Medical Center Monroe GA

The seller is Quorum Health Corporation, a spin-off of Community Health Systems created in 2016 to help reduce the debt burden experienced by CHS. Quorum operates 28 hospitals and 15 outpatient centers in 14 different states. Quorum is a for-profit, publicly traded company under the ticker symbol QHC.

The buyer is Piedmont Healthcare, a not-for-profit community health system that operates in Atlanta and surrounding north Georgia. Piedmont operates 11 hospitals and over 100 physician and specialty offices.



Sale Eight
Casa Grande Regional Med Ctr
1800 E. Florence Blvd.
Casa Grande, AZ 85122

Sale Date	June 6, 2014
Licensed & Staffed Beds	177 / 174
Total Price	\$93,200,000
Financing	No cash exchanged
Seller	Casa Grande Com. Hospital, etal
Buyer	Banner Health
Confirmation	Public disclosures; American Hospital Directory
Cash Equivalent Price	\$93,200,000

Property Data

Land Area (Acres)	48.57
Gross Building Area (SF)	N/A
All Years Built	1990
Building Description	One- and two-story buildings
Overall Building Condition	Average

Operating Data

Occupancy (Licensed Beds)	49.4%
Medicare Mix (Hospital Bed Discharges)	29.3%
Medicaid Mix (Hospital Bed Discharges)	33.5%
Total Discharges (Hospital & SNF/NF)	7,724
Equivalent Discharges	15,265
OP Revenue as % Total Patient Revenue	49.4%
Net Revenue	\$100,251,803
Operating Expenses before Cap-X	\$102,550,726
Reserves @ 2% of Net Revenue	\$2,005,036
EBITDAR (no reserves deducted)	-\$2,298,923
Expense Margin (no reserves deducted)	102.3%
Adjusted EBITDAR (reserves deducted)	-\$4,303,959
Adjusted Expense Margin (reserves ded.)	104.3%

Price Indicators

Price per Staffed Bed	\$535,632
Price per Square Foot	N/A
Effective Net Revenue Multiplier	0.93
Overall Capitalization Rate	N/M
Price per Discharge	\$12,066
Price per Equivalent Discharge	\$6,106

Comments

Casa Grande Regional Med Ctr is in Pinal County, the third-most populous county in Arizona. Pinal County is one of the two counties that make up the Phoenix MSA. Casa Grande is located along Interstate Highway 10, approximately halfway between Phoenix and Tucson. The city serves as the retail center for western Pinal County. Most residents of the city commute to Phoenix or Tucson for employment. The population of Casa Grande is about 50,000.

Casa Grande Regional Med Ctr Casa Grande, AZ

Casa Grande Regional Med Ctr is the only hospital in Casa Grande. Roughly half of the inpatient discharges originate from Casa Grande. The Hospital also serves other communities of western Pinal County. The nearest competitor is the Hu Hu Kam Memorial Hospital, a 15-bed critical access facility located in Sacaton, about 14 miles to the north. Hu Hu Kam serves the Gila River Indian Community.

Improvements in the sale include the hospital building, three MOB's, three medical condo units, an urgent care center, and a behavioral health inpatient facility. All the hospital's patient beds are in private rooms.

The Hospital experienced an \$18.3-million-dollar increase in bad debt/charity care from FY 2012 to FY 2013, primarily stemming from cuts to Medicaid. Coupled with a heavy debt load, that experience led to the Hospital being out of compliance with certain bond covenants. The Hospital did not have enough cash to make its mandatory bond sinking fund payment, resulting in an event of default. The bond covenant violations and operating results led management to seek a partner in better financial position. The seller sought Chapter 11 bankruptcy protection on February 4, 2014. The plan of reorganization included the sale of substantially all the assets to Banner Health. Banner Health operates 12 general acute care hospitals in Arizona (prior to this transaction).

The purchase price reflects an aggregate purchase price equal to (1) all allowed claims against the seller parties (not to exceed \$87 million), plus (2) debtor in possession financing provided by Banner to finance operations between the signing of the LOI in December 2013 and the close of the transaction (\$6.2 million). The \$87 million amount was anticipated to pay all creditors in full.

The financial information profiled was obtained from the Medicare Cost Report. The financials are for FY 2013; from July 1, 2012 through June 30, 2013. The FY 2012 adjusted EBITDAR was approximately \$9,162,000, which yields an OAR of 9.8% on the price paid.



Summary of Comparable Sale Transactions										
	Sale One	Sale Two	Sale Three	Sale Four	Sale Five	Sale Six	Sale Seven	Sale Eight	Averages	Subject
Hospital Name	Bedford Memorial Hospital	Rockdale Medical Center	NW Health Physicians' Specialty	Bartow Regional Medical Center	La Porte Hospital & Starke Hospital	Memorial University Medical Center	Cleaview Regional Medical Center	Casa Grande Regional Med Ctr		Dickinson County Memorial Hospital
City and State	Bedford, VA	Conyers, GA	Fayetteville, AR	Bartow, FL	La Porte & Knox, IN	Savannah, GA	Monroe, GA	Casa Grande, AZ		Iron Mountain, MI
Sale Information										
Sale Date / Effective Date of Appraisal	7/1/2014	10/1/2017	4/1/2016	12/31/2015	3/1/2016	2/1/2018	3/30/2018	6/6/2014	As Completed Perspective	
Seller	Carlilion Clinic	Rockdale Hospital, LLC	Physicians Specialty Hospital, LLP, et al	Bartow HMA, LLC	Indiana University Health	Chatham County Hospital District, et al	Monroe HMA, LLC	Casa Grande Com. Hospital, et al		6/26/2019
Buyer	Centra Health	Piedmont Rockdale Hospital, Inc.	Community Health Systems, Inc., et al	Bartow Regional Medical Center, Inc.	Community Health Systems, Inc.	Savannah Health Services, LLC	Piedmont Walton Hospital, Inc.	Banner Health		
Licensed Hospital Beds (no SNF/NF)	50	141	20	72	280	512	77	177	166	49
Staffed Hospital Beds (no SNF/NF)	50	141	20	72	182	496	76	174	151	49
Total Price	\$24,000,000	\$79,300,000	\$40,125,000	\$60,000,000	\$130,000,000	\$456,656,000	\$37,400,000	\$93,200,000	\$115,085,125	\$55,000,000
Financing	Cash to seller	Cash to Seller	Cash to Seller	Cash to Seller	Cash to Seller	Cash to Seller	Cash to Seller	No cash exchanged		
Cash Equivalent Price	\$24,000,000	\$79,300,000	\$40,125,000	\$60,000,000	\$130,000,000	\$456,656,000	\$37,400,000	\$93,200,000	\$115,085,125	
Property Data										
Land Area (Acres)	49.24	27.64	1.43	35.00	25.20	148.30	78.27	48.57	51.71	43.02
Gross Building Area (SF)	124,296	596,765	55,740	156,417	429,719	1,340,000	202,024	N/A	414,994	267,474
Effective Year Built (not effective age)	1970	1994	1994	2000	1972	1987	2010	1990	1990	1995
Overall Building Condition	Average	Good	Good	Good	Average	Avg/good	Good	Average		Average
Operating Data										Forecast
Occupancy (Lic. Hospital Beds)	23.3%	70.0%	23.1%	53.0%	16.5%	81.7%	32.0%	49.4%	43.6%	47.5%
Medicare Mix (Hosp. Discharges)	68.1%	41.5%	28.4%	59.1%	53.0%	33.6%	45.4%	29.3%	44.8%	57.8%
Medicaid Mx (Hosp. Discharges)	3.5%	24.0%	1.6%	12.1%	27.4%	11.2%	9.3%	33.5%	15.3%	12.3%
Total Discharges (Hosp. & SNF)	1,500	8,832	1,131	3,081	4,806	26,125	2,669	7,724	6,984	2,545
OP Rev. as % Total Patient Rev.	57.1%	56.0%	60.4%	52.2%	61.4%	37.6%	70.0%	49.4%	55.5%	75.6%
Equivalent Discharges	3,497	20,073	2,856	6,446	12,451	41,840	8,897	15,265	13,915	13,086
Net Revenue	\$34,865,569	\$141,300,000	\$32,090,000	\$59,768,000	\$181,270,900	\$488,234,000	\$50,900,000	\$100,251,803	\$136,085,034	\$107,107,480
Operating Expenses after Cap-X	32,289,244	143,626,000	28,877,800	51,545,360	159,416,300	459,491,680	43,818,000	104,555,762	127,952,518	99,006,038
Adjusted EBITDAR	\$2,576,325	-\$2,326,000	\$3,212,200	\$8,222,640	\$21,854,600	\$28,742,320	\$7,082,000	-\$4,303,959	\$8,132,516	\$8,101,443
Expense Margin	92.6%	101.6%	90.0%	86.2%	87.9%	94.1%	86.1%	104.3%	92.9%	92.4%
Price Indicators										
Price per Staffed Hospital Bed	\$480,000	\$562,411	\$2,006,250	\$833,333	\$714,286	\$920,677	\$492,105	\$535,632	\$818,087	\$1,122,449
Price per Square Foot	\$193	\$133	\$720	\$384	\$303	\$341	\$185	N/A	\$323	\$206
Effective Net Revenue Multiplier	0.69	0.56	1.25	1.00	0.72	0.94	0.73	0.93	0.85	0.51
Overall Capitalization Rate	10.7%	N/M	8.0%	13.7%	16.8%	6.3%	18.9%	N/M	12.4%	14.7%
Price per Discharge	\$16,000	\$9,979	\$35,477	\$19,474	\$27,050	\$17,480	\$14,013	\$12,066	\$18,817	\$21,611
Price per Equivalent Discharge	\$6,864	\$3,951	\$14,049	\$9,309	\$10,441	\$10,914	\$4,204	\$6,106	\$8,230	\$4,203



Analysis of Sales Data

In the following table the subject forecasts and the unit price measures derived from the income approach indication of market value for the subject going concern are compared to the average, median, low and high measures indicated by the comparable sales.

The unit price measures for the comparable sales tend to vary widely. In the current market, buyers are placing greater emphasis on non-financial considerations and less on more objective measures of financial performance and asset age. Strategic considerations, such as the opportunity to eliminate a competitor, bring efficiencies to a health system, or gain leverage with payers for rate negotiations are important. Facilities with more stable market share and a stronger, stable medical staff are viewed more favorably than those which lack these characteristics. In an environment of increasing physician shortages and aggressive employment of physicians by larger systems, the ability to secure a hospital's revenue stream with a strong and stable medical staff is a key valuation driver. The level of competition in a market is also important, as the potential to lose market share is greater in ones with too many physicians or providers. The demographics of the market service area, which impact trends in payer mix and future profitability, are another variable which influences pricing.

Comparison of Subject Forecasts and Income Approach Conclusions to Comparable Sales					
Element of Comparison	Lowest Figure of Comp. Sales	Highest Figure of Comp. Sales	Comparable Sales Median	Comparable Sales Average	Subject
Operating Data					
Occupancy	16.5%	81.7%	40.7%	43.6%	47.5%
Medicare Mix (Discharges)	28.4%	68.1%	43.5%	44.8%	57.8%
Medicaid Mix (Discharges)	1.6%	33.5%	11.7%	15.3%	12.3%
Total Discharges	1,131	26,125	3,944	6,984	2,545
OP Revenue as % Total Gross	37.6%	70.0%	56.6%	55.5%	75.6%
Equivalent Discharges	2,856	41,840	10,674	13,915	13,086
Net Revenue	\$32,090,000	\$488,234,000	\$80,009,902	\$136,085,034	\$107,107,480
EBITDAR	-\$4,303,959	\$28,742,320	\$5,147,100	\$8,132,516	\$8,101,443
Expense Margin	86.1%	104.3%	91.3%	92.9%	92.4%
Price Indicators					
Price per Staffed Bed	\$480,000	\$2,006,250	\$638,349	\$818,087	\$1,122,449
Price per Square Foot	\$133	\$720	\$303	\$323	\$206
Effective Net Revenue Multiplier	0.56	1.25	0.83	0.85	0.51
Overall Capitalization Rate	6.3%	18.9%	12.2%	12.4%	14.7%
Price per Discharge	\$8,979	\$35,477	\$16,740	\$18,817	\$21,611
Price per Equivalent Discharge	\$3,951	\$14,049	\$8,086	\$8,230	\$4,203

The price indicators for the subject are derived utilizing the total concluded value. Therefore, if any adjustments are made to the capitalized value for extraordinary items or considerations, the OAR will differ from the rate applied in the income approach.

The income approach indication of market value of the subject going concern produces a value indicator that is:

- 137.2 percent of the average price per staffed bed
 - 63.8 percent of the average price per square foot
 - Below the low end of the net revenue multiplier range
 - 114.8 percent of the average price per discharge
 - 51.1 percent of the price per equivalent discharge
- The low ratio of beds to revenues and the high ratio of OP to IP revenues contribute to the higher price per staffed bed and price per discharge
 - The subject has a relatively large amount of building area, which contributes to the

lower price per square foot

- The conversion of outpatient revenues into an equivalent discharge is an imperfect process. Although the outpatient business typically has a better operating margin than inpatient business, the asset cost to produce the inpatient component is much higher. Reflecting these considerations, the contributory value of an equivalent outpatient discharge is lower than an inpatient discharge. The subject going concern has a high ratio of outpatient to total patient revenues.

Public Hospital Units of Value

Because the hospital acquisition market is substantially comprised of sales of struggling facilities, we have elected to provide a supplemental analysis for publicly traded hospital operating companies. This summary analysis identifies certain unit values based upon the enterprise value for the respective corporations analyzed. Those figures are compared to the unit values indicated for the subject property per the income approach.

As discussed in the implied OAR analysis in the income approach, there are various matters that complicate the comparison process, such as rental expenses for core assets, access to capital, unique assets and liabilities, liquidity of the interests, etc. These considerations are too broad and complex to distill into truly meaningful comparative analyses.

Enterprise Value per Unit Indications for for Public Hospital Operating Companies			
Company	\$ Amount per		
	Licensed Bed	Discharge	Equivalent Discharge
HCA Healthcare	1,786,318	42,077	24,650
Tenet Healthcare	1,053,788	27,597	15,341
Universal Health Services	557,547	21,079	N/A
Community Health Systems	781,829	22,716	10,541
Quorum Health	496,928	17,434	7,036
Unit Means for Dataset	935,282	26,181	14,392
Subject Property Conclusions	1,122,449	21,611	4,203
Subject %s of Dataset Means	120%	83%	29%
Data Sources: Enterprise value -- Cain Brothers, Industry Insights, 2-8-19 Beds, discharges & equivalent discharges -- 10-K filings. Discharges and equivalent discharges are 2018 totals. Set-up bed capacities are unknown -- licensed bed capacities are reported.			
Enterprise value is equal to equity value plus debt, less cash and investments.			

This analysis is probably best thought of as a measurement exercise to illustrate relative value, whereby the dataset averages should be reasonably indicative of the middle segment of hospitals nationwide. However, it must be recognized that there are differences in the liquidity of interests in private business entities than those in public companies. Given two identical business interests, a higher price will be paid by investors in the market for the business interest that can be converted to cash most rapidly.

In this case, the unit value indications for the subject going concern one that considerably lower than the means for the dataset, and two that are reasonably close to the means. The subject has a higher ratio of outpatient income, which contributes significantly to the lower equivalent discharge indicator. Intuitively, given the historical and forecast profitability of the going concern, the effective age of the real property assets, the IP/OP revenue relationships, and the intangible assets that have been developed and are in place, the market served and state reimbursement policies, the unit value relationships

seem reasonable and supportive of the income approach indication of value, but there are enough differences to draw a strong conclusion.

Conclusion

Overall, while the process of validating the income capitalization approach with comparable sale indicators has significant limitations, we believe the sales data supports the value conclusion indicated by the income approach. The sales comparison approach provides evidence that while the forecast profitability exceeds historical profitability, the overall valuation is not aggressive in relation to the comparable sales.

Reconciliation and Final Conclusion of Market Value

Cost Approach

The cost approach is most effective when the improvements are new, or nearly new, and are fully utilized for their designed purpose. The subject property improvements are predominately middle aged. While the applicability of the cost approach is reduced somewhat by the limitations that exist in developing an accurate estimate of accrued depreciation for the real estate, we nevertheless believe it remains sufficiently well supported to establish the value in place for the real property component of the going concern market value conclusion.

The improvement cost estimates are principally based on actual and budgeted construction costs of other hospitals and medical office buildings. Accrued depreciation is estimated in an age-life method. This appraisal utilizes the depreciated book value of the personal property as the basis for its value in place, adjusted for budgeted amounts per the proposed expansion and renovation project; however, this figure is discounted for perceived external obsolescence.

We believe the cost approach offers a meaningful measure of value for the tangible assets of the going concern. Because we have not made a specific addition for intangible components, it does not provide an indication of value for the going concern. Instead, as applied (without an intangible asset addition), the cost approach provides a good basis for allocating the market value of the going concern to real property, personal property and intangible assets.

Income Capitalization Approach

The income capitalization approach offers the potential to provide a reliable measure of value in the appraisal of many hospital going concerns. The reliability is enhanced when the operating history is reasonably consistent, and the historical operating margins have been positive. The reliability is reduced when the business is experiencing operating losses, declining market share, unusual turnover of professional staff, ineffective management, reputation problems tied to services provided, or other issues that are contributing to operating losses and bleaker prospects. Beyond those considerations, nonprofits are mission-driven to provide charity care and they are often operated less efficiently than for-profits, both of which drive up expense margins. Therefore, per our "for profit" assumption for operations, cash flow forecasts for nonprofit hospitals often require line item expense amounts (in total and on a unit basis) that are well below their historical levels. Such variances lend to a greater amount of speculation in the NOI forecast.

Healthcare facility cash flows can vary considerably from one year to the next, making historical-based forecasts quite difficult. Nevertheless, we believe there is enough information available to develop reasonable revenue and expense forecasts. As best as possible and with adjustments deemed reasonable and appropriate, the revenue and expense forecasts are tied to the historical results of the subject and those for comparable hospitals. Additional consideration may be given to national, statewide, or sector-based expense and utilization data. In this case, the forecasts reflect greater profitability than has been achieved in the recent past, but many of the staffing and operational changes necessary to achieve better profitability have already been undertaken or are being implemented and evaluated. Additionally, the historical basis of operation is nonprofit, whereas our forecast may reflect certain operational differences inherent in a for-profit enterprise. The disparity between historical and forecast profitability serves to diminish the reliability of the income approach in this appraisal. Despite that acknowledgement, the

difficulty in producing a more definitive sales comparison conclusion (one that is not income based) leads us to rely significantly upon the income approach indication of value.

Sales Comparison Approach

The sales comparison approach reflects prices paid for other hospital going concerns. The most meaningful units of comparison derived in the analysis are the capitalization rates (overall capitalization rate and effective net revenue multiplier), which are applied in the income capitalization approach. Because market specific and operating variables drive the profitability of a hospital operation, the use of more traditional unit measures of comparison (e.g., price-per-bed or price-per-square foot) generally lends to an inconclusive or even misleading analysis. Service volume-based unit measures, such as the equivalent price-per-discharge, are more meaningful and are given consideration, but they also have their limitations for comparative analyses.

Based upon these considerations, the sales comparison approach is most useful to frame the indication(s) of value by income capitalization. Effectively, the application of the sales comparison approach is one of economic comparison, with no dependable physical unit comparison. In this appraisal, the sales comparison approach has solely been used as a test of reasonableness for the income capitalization approach indication(s) of value. Even within the stated confines of its application, the sales comparison approach does not fully affirm the income capitalization approach value conclusion(s). This is due in part to the fact that the prices paid for some comparables are rooted more in business opportunity than historical operating performance.

Conclusion

In conclusion, we have adopted the income capitalization approach value indication as our opinion of market value. The going concern value conclusion is summarized as follows.

As Completed	\$55,000,000

Allocation of Market Value

In order to fulfill the client's needs and meet the Interagency Appraisal and Evaluation Guidelines (OCC, FDIC, FRB, OTS & NCUA), our opinion of market value is allocated between tangible and intangible assets. The tangible assets are allocated between real property and personal property.

While the continuation of the subject going concern is probable, the allocation of value would most likely be invalid if the going concern were to discontinue operations. The Dictionary of Real Estate Appraisal defines two important concepts that are essential to the market value of a going concern: "going-concern value" and "value in place."

Going-concern value is defined as: "the value created by a proven property operation; considered as a separate entity to be valued with a specific business establishment."

Value in place is defined as: "the amount a prudent purchaser would pay for an item (e.g., equipment and fixtures in place) determined by the use the item contributes to the whole."

Accordingly, it is important to realize that the allocation of value reported in this appraisal is meaningful only if the going concern continues operating with all the assets in place. The market value of the going concern, and thus the contributory values in place for the respective asset classes that comprise the going concern, are dependent on the assemblage of all the assets being appraised. If one asset class is removed from the going concern, the remaining assets will likely be worth less than their estimated contributory values in place to the whole enterprise. Likewise, if the subject going concern discontinued operations, the liquidation values of the respective assets are likely to be worth less than their estimated contributory values in place as a part of the whole enterprise. The appraisal assumes the continuation of the going concern.

The intangible value of a hospital going concern encompasses its licenses and certificate of need (if applicable); Medicaid and Medicare certifications; contracts with commercial payers; physician and other professional service contracts; assembled workforce; working capital; computer software; as well as in-place management, staff and patients. In this appraisal, the going concern is forecast to operate at a level that produces monetary value greater than the value (depreciated replacement cost) of the tangible assets, as indicated by the cost approach. We do not make any addition for intangible components in the cost approach; thus, it is our opinion that the value greater than the cost approach indication represents the value in place of the intangible assets.

As discussed in the assumptions section of the appraisal, working capital is an acknowledged intangible asset in hospital acquisitions. The buyer and seller agree to an amount of net working capital needed for the business to operate post-closing without requiring a capital infusion by the new owner. Our allocation of value(s) in place for the intangible assets includes a breakout estimate for normalized working capital. We have elected to estimate the normalized amount as a ratio (4.0%) of the forecast total operating revenue. Our adopted ratio reflects the amounts and ratios observed in hospital sale transactions and in balance sheet data for many hospitals. Our normalized working capital estimate is NOT tied to the operator's actual working capital as of the effective date of the appraisal.

Using the cost approach value indications for real and personal property, and the reconciled value conclusion for the going concern, the following allocation of market value is made.

Allocation of Market Value Conclusion for the Going Concern		
	As Completed	
Opinion of Market Value		\$ 55,000,000
Tangible Assets		
Real Property		
Land	\$ 1,690,000	
Improvements	40,050,000	
Total Real Property		\$ 41,740,000
Personal Property (FF&E)		\$ 7,702,900
Total Tangible Assets		\$ 49,442,900
Intangible Assets		
Working Capital (normalized)		\$ 4,300,000
Other		1,257,100
Total Intangible Assets		\$ 5,557,100
Allocated values represent contributory values in place under the going concern valuation premise.		

Certification

We certify that, to the best of our knowledge and belief:

1. The statements of fact contained in this report are true and correct.
2. The reported analyses, opinions and conclusions are limited only by the reported assumptions and limiting conditions, and are our personal, impartial, and unbiased professional analyses, opinions, and conclusions.
3. We have no present or prospective interest in the property that is the subject of this report and no personal interest with respect to the parties involved.
4. Victor D. Cremeens, MAI has not provided appraisal or other services pertaining to the subject property during the last three years. Victor D. Cremeens, MAI does not have any current or prospective interest in the subject property or the parties involved.
5. We have no bias with respect to the property that is the subject of this report or to the parties involved with this assignment.
6. Our engagement in this assignment was not contingent upon developing or reporting predetermined results.
7. Our compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this appraisal.
8. Our analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice as well as applicable state appraisal regulations.
9. The reported analyses, opinions and conclusions were developed, and this report has been prepared, in conformity with the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.
10. The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.
11. The subject facility was inspected by Victor D. Cremeens, MAI on June 26, 2019.
12. No one provided significant real property appraisal assistance, personal property appraisal assistance, or business valuation assistance to the persons signing this report.
13. We have experience in appraising properties like the subject and are in compliance with the Competency Rule of USPAP.
14. As of the date of this report, Victor D. Cremeens, MAI, has completed the continuing education program for Designated Members of the Appraisal Institute.
15. Appraisers are required to be licensed and are regulated by the Michigan Department of Consumer and Industry Services, P.O. Box 30018, Lansing, Michigan, 48909.



Victor D. Cremeens, MAI
Managing Director
Michigan Certified General Real Estate Appraiser
1201073126

Assumptions and Limiting Conditions

This appraisal and any other work product related to this engagement are limited by the following standard assumptions, except as otherwise noted in the report:

1. The title is marketable and free and clear of all liens, encumbrances, encroachments, easements and restrictions. The property is under responsible ownership and competent management and is available for its highest and best use.
2. There are no existing judgments or pending or threatened litigation that could affect the value of the property.
3. There are no hidden or undisclosed conditions of the land or of the improvements that would render the property more or less valuable. Furthermore, there is no asbestos in the property.
4. The revenue stamps placed on any deed referenced herein to indicate the sale price are in correct relation to the actual dollar amount of the transaction.
5. The property is in compliance with all applicable building, environmental, zoning, and other federal, state and local laws, regulations and codes.
6. The information furnished by others is believed to be reliable, but no warranty is given for its accuracy.

This appraisal and any other work product related to this engagement are subject to the following limiting conditions, except as otherwise noted in the report:

1. An appraisal is inherently subjective and represents our opinion as to the value of the property appraised.
2. The conclusions stated in our appraisal apply only as of the effective date of the appraisal, and no representation is made as to the effect of subsequent events.
3. No changes in any federal, state or local laws, regulations or codes (including, without limitation, the Internal Revenue Code) are anticipated.
4. No environmental impact studies were either requested or made in conjunction with this appraisal, and we reserve the right to revise or rescind any of the value opinions based upon any subsequent environmental impact studies. If any environmental impact statement is required by law, the appraisal assumes that such statement will be favorable and will be approved by the appropriate regulatory bodies.
5. Unless otherwise agreed to in writing, we are not required to give testimony, respond to any subpoena or attend any court, governmental or other hearing with reference to the property without compensation relative to such additional employment.
6. We have made no survey of the property and assume no responsibility in connection with such matters. Any sketch or survey of the property included in this report is for illustrative purposes only and should not be considered to be scaled accurately for size. The appraisal covers the property as described in this report, and the areas and dimensions set forth are assumed to be correct.
7. No opinion is expressed as to the value of subsurface oil, gas or mineral rights, if any, and we have assumed that the property is not subject to surface entry for the exploration or removal of such materials, unless otherwise noted in our appraisal.
8. We accept no responsibility for considerations requiring expertise in other fields. Such considerations include, but are not limited to, legal descriptions and other legal matters such as legal title, geologic considerations such as soils and seismic stability; and civil, mechanical, electrical, structural and other engineering and environmental matters. Such considerations may also include determinations of compliance with zoning and other federal, state, and local laws, regulations and codes.
9. The distribution of the total valuation in the report between land and improvements applies only under the reported highest and best use of the property. The allocations of value for land and improvements must not be used in conjunction with any other appraisal and are invalid if so

- used. The appraisal report shall be considered only in its entirety. No part of the appraisal report shall be utilized separately or out of context.
10. Neither all nor any part of the contents of this report (especially any conclusions as to value, the identity of the appraisers, or any reference to the Appraisal Institute) shall be disseminated through advertising media, public relations media, news media or any other means of communication (including without limitation prospectuses, private offering memoranda and other offering material provided to prospective investors) without the prior written consent of the persons signing the report.
 11. Information, estimates and opinions contained in the report and obtained from third-party sources are assumed to be reliable and have not been independently verified.
 12. Any income and expense estimates contained in the appraisal report are used only for the purpose of estimating value and do not constitute predictions of future operating results.
 13. If the property is subject to one or more leases, any estimate of residual value contained in the appraisal may be particularly affected by significant changes in the condition of the economy, of the real estate industry, or of the appraised property at the time these leases expire or otherwise terminate.
 14. Unless otherwise stated in the report, no consideration has been given to personal property located on the premises or to the cost of moving or relocating such personal property; only the real property has been considered.
 15. The current purchasing power of the dollar is the basis for the values stated in the appraisal; we have assumed that no extreme fluctuations in economic cycles will occur.
 16. The values found herein are subject to these and to any other assumptions or conditions set forth in the body of this report, but which may have been omitted from this list of Assumptions and Limiting Conditions.
 17. The analyses contained in the report necessarily incorporate numerous estimates and assumptions regarding property performance, general and local business and economic conditions, the absence of material changes in the competitive environment and other matters. Some estimates or assumptions, however, inevitably will not materialize, and unanticipated events and circumstances may occur; therefore, actual results achieved during the period covered by our analysis will vary from our estimates, and the variations may be material.
 18. The Americans with Disabilities Act (ADA) became effective January 26, 1992. We have not made a specific survey or analysis of the property to determine whether the physical aspects of the improvements meet the ADA accessibility guidelines. We claim no expertise in ADA issues, and render no opinion regarding compliance of the subject with ADA regulations. Inasmuch as compliance matches each owner's financial ability with the cost to cure the non-conforming physical characteristics of a property, a specific study of both the owner's financial ability and the cost to cure any deficiencies would be needed for the Department of Justice to determine compliance.
 19. The appraisal report is prepared for the exclusive benefit of the Client, its subsidiaries and/or affiliates. It may not be used or relied upon by any other party. All parties who use or rely upon any information in the report without our written consent do so at their own risk.
 20. No studies have been provided to us indicating the presence or absence of hazardous materials on the subject property or in the improvements, and our valuation is predicated upon the assumption that the subject property is free and clear of any environment hazards including, without limitation, hazardous wastes, toxic substances and mold. No representations or warranties are made regarding the environmental condition of the subject property. Integra – Healthcare & Senior Housing, Integra Realty Resources, Inc., Integra Strategic Ventures, Inc. and/or any of their respective officers, owners, managers, directors, agents, subcontractors or employees (the "Integra Parties"), shall not be responsible for any such environmental conditions that do exist or for any engineering or testing that might be required to discover whether such conditions exist. Because we are not experts in the field of environmental conditions, the appraisal report cannot be considered as an environmental assessment of the subject property.

21. The persons signing the report may have reviewed available flood maps and may have noted in the appraisal report whether the subject property is in an identified Special Flood Hazard Area. We are not qualified to detect such areas and therefore do not guarantee such determinations. The presence of flood plain areas and/or wetlands may affect the value of the property, and the value conclusion is predicated on the assumption that wetlands are non-existent or minimal.
22. Integra – Healthcare & Senior Housing is not a building or environmental inspector. Integra – Healthcare & Senior Housing does not guarantee that the subject property is free of defects or environmental problems. Mold may be present in the subject property and a professional inspection is recommended.
23. The appraisal report and value conclusions for an appraisal assume the satisfactory completion of construction, repairs or alterations in a workmanlike manner.
24. It is expressly acknowledged that in any action which may be brought against any of the Integra Parties, arising out of, relating to, or in any way pertaining to this engagement, the appraisal reports, and/or any other related work product, the Integra Parties shall not be responsible or liable for any incidental or consequential damages or losses, unless the appraisal was fraudulent or prepared with intentional misconduct. It is further acknowledged that the collective liability of the Integra Parties in any such action shall not exceed the fees paid for the preparation of the appraisal report unless the appraisal was fraudulent or prepared with intentional misconduct. Finally, it is acknowledged that the fees charged herein are in reliance upon the foregoing limitations of liability.
25. Integra – Healthcare & Senior Housing, an independently owned and operated company, has prepared the appraisal for the specific intended use stated elsewhere in the report. The use of the appraisal report by anyone other than the Client is prohibited except as otherwise provided. Accordingly, the appraisal report is addressed to and shall be solely for the Client's use and benefit unless we provide our prior written consent. We expressly reserve the unrestricted right to withhold our consent to your disclosure of the appraisal report or any other work product related to the engagement (or any part thereof including, without limitation, conclusions of value and our identity), to any third parties. Stated again for clarification, unless our prior written consent is obtained, no third party may rely on the appraisal report (even if their reliance was foreseeable).
26. The conclusions of this report are estimates based on known current trends and reasonably foreseeable future occurrences. These estimates are based partly on property information, data obtained in public records, interviews, existing trends, buyer-seller decision criteria in the current market, and research conducted by third parties, and such data are not always completely reliable. The Integra Parties are not responsible for these and other future occurrences that could not have reasonably been foreseen on the effective date of this assignment. Furthermore, it is inevitable that some assumptions will not materialize and that unanticipated events may occur that will likely affect actual performance. While we are of the opinion that our findings are reasonable based on current market conditions, we do not represent that these estimates will be achieved, as they are subject to considerable risk and uncertainty. Moreover, we assume competent and effective management and marketing for the duration of the projected holding period of this property.
27. All prospective value opinions presented in this report are estimates and forecasts which are prospective in nature and are subject to considerable risk and uncertainty. In addition to the contingencies noted in the preceding paragraph, several events may occur that could substantially alter the outcome of our estimates such as, but not limited to changes in the economy, interest rates, and capitalization rates, behavior of consumers, investors and lenders, fire and other physical destruction, changes in title or conveyances of easements and deed restrictions, etc. It is assumed that conditions reasonably foreseeable at the present time are consistent or similar with the future.

Exhibit A
Engagement Letter



DATE OF PROPOSAL
May 14, 2019

PARTIES TO THE ENGAGEMENT

Client:

Dickinson County Health System
Margaret Minerick, Chairperson
1721 South Stephenson Avenue
Iron Mountain, MI 49801

Appraiser:

Integra Realty Resources – Healthcare & Senior Housing
Victor Cremeens, MAI
16759 Main Street, Suite 209
St. Louis, Missouri 63040
(636) 821-5311
vcremeens@irr.com

Appraiser hereby proposes to complete an appraisal assignment as follows:

PROPERTY TYPE AND IDENTIFICATION

The subject property is an existing health system whose principal health care service center is an acute care hospital located in Iron Mountain, Michigan.

- Dickinson Memorial Hospital
1721 South Stephenson Avenue
Iron Mountain, MI 49801
Assessment Parcel ID: 051-14-813-10

INTEREST VALUED

The appraisal will provide an opinion of the "as is" market value for the hospital going concern, including applicable interests in real property, personal property (FF&E), and intangible assets. The value conclusion will be allocated (values in place) among the real, personal, and intangible assets.

The value of the FF&E used in for the asset allocation process will be based upon the current depreciated book value of those assets.

Our allocation of value in place for the intangible assets will include a breakout estimate for normalized working capital. This estimate will NOT be tied to the operator's actual working capital as of the effective date of the appraisal.

This appraisal will reflect the conditions inherent in an asset sale. In an asset sale, the seller retains possession of the legal entity and the buyer purchases individual assets of the company. Only those tangible and intangible assets and liabilities specifically listed in the purchase agreement are transferred.

INTENDED USERS

The intended users of the appraisal are:

- Dickinson County Healthcare System Board of Trustees
- Dickinson County Commission
- United States Department of Agriculture
- Venable LLP
- Other parties the Client may designate for purposes of securing financing for the hospital

INTENDED USE

To assist the intended users with effort to restructure existing debt, including a USDA-RD CF Loan Application.

TYPE OF VALUE

Market value is defined in accordance with Federal Reserve System 12 CFR Part 225, Federal Deposit Insurance Corporation (12 CFR Part 323), The Office of the Comptroller of Currency (12 CFR Part 34). "Market Value" is defined as follows:

Regulatory Definition: The most probable price which a property should bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller each acting prudently and knowledgeably, and assuming the price is not affected by undue stimulus. Implicit in this definition is the consummation of a sale as of a specified date and the passing of title from seller to buyer under conditions whereby:

- Buyer and seller are typically motivated;
- Both parties are well-informed or well-advised and each is acting in what they consider their own best interests;
- A reasonable time is allowed for exposure in the open market;
- Payment is made in terms of cash in U.S. dollars or in terms of financial arrangements comparable thereto; and
- The price represents a normal consideration for the property sold unaffected by special or creative financing, or sales concessions granted by anyone associated with the sale.

DATE OF VALUE

The appraisal will value the subject property as of the date of inspection (as is).

HYPOTHETICAL CONDITIONS, EXTRAORDINARY ASSUMPTIONS

The Appraiser does not anticipate the need to make hypothetical conditions or extraordinary assumptions to complete the appraisal. If hypothetical conditions or extraordinary assumptions become necessary to produce credible appraisal results, Appraiser will notify Client prior to delivering the appraisal report.

APPLICABLE REQUIREMENTS OTHER THAN THE UNIFORM STANDARDS OF PROFESSIONAL APPRAISAL PRACTICE (USPAP)

The Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.

ANTICIPATED SCOPE OF WORK

- Inspection of the subject property
- Analysis of sales history and/or pending transactions
- Regional and neighborhood analyses
- Description and physical/functional analyses of the real property being appraised
- Review of real estate taxation and government land use restrictions
- Description of the operator's business, including licensure, certifications, physician matters, business plans, etc.

- Inpatient and outpatient competitive market analysis
- Highest and best use analysis
- Cost approach
- Sales comparison approach
- Income capitalization approach
- Reconciliation of a final opinion of value(s)
- Allocation of the final opinion(s) of value into contributory values in place for the assets

REPORTING OPTION PER USPAP

Appraisal Report

ADDITIONAL DOCUMENTATION

To the best of their ability, Client agrees to provide Appraiser with the documentation needed to produce a credible appraisal report. Such documentation will be provided as soon as possible after engaging the Appraiser to perform the appraisal assignment. Failure to provide the requested documents in a timely manner may delay the delivery of the appraisal.

Information needed to perform the appraisal is listed in a separate document. The Appraiser may discover the need for additional information during the course of appraising the property. Upon such discovery, a request for that information will be made promptly.

DELIVERY DATE

60 days following Appraiser's receipt of signed engagement letter; subject to timely receipt of the information requested from the Client and/or property owner and/or operator of the business.

DELIVERY METHOD

Overnight private courier and/or PDF email.

PAYMENT TO APPRAISER

\$35,000

This fee includes all our travel and production expenses associated with completing the appraisal and delivering the appraisal report.

PAYMENT DUE DATE

Client will pay a retainer of \$17,250 prior to the appraiser visiting the site. Appraiser shall invoice Client for the remaining fee upon delivery of the appraisal report. The fee is not subject to any valuation outcome and must be paid regardless of any value conclusion. Appraiser's invoices are considered due upon receipt by Client and shall be deemed delinquent if not paid within 30 days of the date of Appraiser's invoice.

WHEN APPRAISER'S OBLIGATIONS ARE COMPLETE

Appraiser's obligations pursuant to this Agreement are complete when the Appraisal Report in the form specified in this Agreement is delivered to Client pursuant to this Agreement. Appraiser agrees to be responsive to Client's legitimate inquiries regarding the contents of the report after delivery.

Should Client request the Appraiser to be available in person for any meetings with the Client and other parties, Client agrees to pay Appraiser's actual, reasonable travel expense and Appraiser's time travelling and attending the meeting(s). The fee for any additional involvement of the Appraiser will be based on an hourly rate of \$350.00 for James Tellatin, and \$250 per hour for Victor Cremeens.

CONFIDENTIALITY

Appraiser shall not provide a copy of the written Appraisal Report or disclose the results of the appraisal prepared in accordance with this Agreement to any party other than Client, unless Client authorizes, except as stipulated in the Confidentiality Section of the Ethics Rule of the Uniform Standards of Professional Appraisal Practice (USPAP).

USE OF EMPLOYEES

Appraiser will use employees at Appraiser's discretion to complete the assignment, unless otherwise agreed by the parties. Notwithstanding, Appraiser shall sign the written Appraisal Report and take full responsibility for the services provided per this Agreement.

SERVICES NOT PROVIDED

The fees set forth in this Agreement apply to the appraisal services rendered by Appraiser as set forth in this Agreement. Unless otherwise specified herein, Appraiser's services for which the fees in this Agreement apply shall not include meetings with persons other than Client or Client's agents or professional advisors; Appraiser's deposition(s) or testimony before judicial, arbitration or administrative tribunals; or any preparation associated with such depositions or testimony. The fee for any additional involvement of the Appraiser will be based on an hourly rate of \$350.00 for James Tellatin, and \$250 for Victor Cremeens, plus travel expenses for appearances in depositions, trials, hearings and meetings.

TESTIMONY AT COURT OR OTHER PROCEEDINGS

Unless otherwise stated in this Agreement, Client agrees that Appraiser's assignment pursuant to this Agreement shall not include Appraiser's participation in or preparation for, whether voluntarily or pursuant to subpoena, any oral or written discovery; sworn testimony in a judicial, arbitration or administrative proceeding; or attendance at any judicial, arbitration or administrative proceeding relating to this assignment.

Should the Appraiser be required to be deposed and/or testify in a judicial, arbitration or administrative proceeding relating to this assignment at some future date, the Appraiser will require a 30-day notice in order to be available for such proceedings.

CHANGES TO AGREEMENT

Any changes to the assignment as outlined in this Agreement shall necessitate a new Agreement. The identity of the Client, intended users, or intended use; the date of value; type of value; or property appraised cannot be changed without a new Agreement.

CANCELLATION

Client may cancel this Agreement at any time prior to Appraiser's delivery of the Appraisal Report upon written notification to Appraiser. Client shall pay Appraiser for work completed on assignment prior to Appraiser's receipt of written cancellation notice, unless otherwise agreed upon by Appraiser and Client in writing. Compensation for partially completed work will be based proportionately upon the work completed at the time of cancellation to the total work required to complete the assignment in full.

GOVERNING LAW AND JURISDICTION

This Agreement shall be governed by the law of the state in which Appraiser's office as specified in this Agreement is located, exclusive of that state's choice of law rules. The parties agree that any legal proceeding brought by either party to interpret or enforce this Agreement, or to enforce an arbitration award entered pursuant to this Agreement, shall be brought in a state or federal court having jurisdiction over the location of Appraiser's office as specified in this Agreement, and the parties hereby waive any objections to the personal jurisdiction of said court.

APPRAISER INDEPENDENCE

Appraiser cannot agree to provide a value opinion that is contingent on a predetermined amount. Appraiser cannot guarantee the outcome of the assignment in advance. Appraiser cannot ensure that the opinion of value developed as a result of this Assignment will serve to facilitate any specific objective of Client or others or advance any particular cause. Appraiser's opinion of value will be developed competently and with independence, impartiality and objectivity.

NOTICES

Any notice or request required or permitted to be given to any party shall be given in writing and shall be delivered to the receiving party by: a) registered or certified mail, postage prepaid; (b) overnight courier, such as Federal Express, United Parcel Service or equivalent; or (c) hand delivery. The address for delivery of any notice shall be the address for the party as specified in this Agreement or at such other address as party may designate by written notice to the other party in conformance with this paragraph.

Unless otherwise specified herein, notice shall be effective the date it is postmarked or given to a third party for delivery to the receiving party, whether or not the receiving party signs for or accepts delivery of such notice.

NO THIRD-PARTY BENEFICIARIES

Nothing in this Agreement shall create a contractual relationship between Appraiser or Client and any third party, or any cause of action in favor of any third party. This Agreement shall not be construed to render any person or entity a third-party beneficiary of this Agreement, including, but not limited to, any third parties identified herein.

MEDIATION & ARBITRATION

In the event of a dispute concerning the subject matter of this Agreement, the parties shall in good faith attempt to resolve such dispute by negotiation between the parties' principals, or, if such negotiation is unsuccessful, by mediation conducted by a third-party mediator. If such mediation results in an impasse, the parties shall submit their dispute to binding arbitration. Such mediation or, if necessary, binding arbitration shall be conducted pursuant to the mediation procedures or the commercial arbitration rules of the American Arbitration Association. The parties shall share equally the costs of any mediation. In the event of binding arbitration, the arbitrators shall, in addition to any relief appropriate to be awarded to the prevailing party, enter an award in favor of the prevailing party for that party's costs of the arbitration, including the party's reasonable attorneys' fees and arbitration expenses incurred in prosecuting or defending the arbitration proceeding. Subject to the right of the prevailing party to recover its share of the costs of the arbitration services pursuant to the arbitrator's award, the costs of the arbitration services shall be borne equally by the parties. If the prevailing party seeks judicial confirmation of any arbitration award entered pursuant to this Agreement, the court shall, in addition to any other appropriate relief, enter an award to the prevailing party in such confirmation proceeding for its reasonable attorneys' fees and litigation expenses incurred in confirming or successfully opposing the confirmation of such an award.

SPECIAL OR CONSEQUENTIAL DAMAGES

Neither party shall under any circumstances be liable to the other party for special, exemplary, punitive or consequential damages, including, without limitation, loss of profits or damages proximately caused by loss of use of any property, whether arising from either party's negligence, breach of the Agreement or otherwise, whether or not a party was advised, or knew, of the possibility of such damages, or such possibility was foreseeable by that party. In no event shall Appraiser be liable to Client for any amounts that exceed the fees and costs paid by Client to Appraiser pursuant to this Agreement.

ASSIGNMENT

Neither party may assign this Agreement to a third party without the express written consent of the other party, which the non-assigning party may withhold in its sole discretion. In the event this Agreement is assigned by mutual consent of the parties, it shall become binding on the assigning party's permitted assigns.

SEVERABILITY

In the event any provision of this Agreement shall be determined to be void or unenforceable by any court of competent jurisdiction, then such determination shall not affect any other provision of this Agreement and all such other provisions shall remain in full force and effect.

CLIENT'S REPRESENTATIONS AND WARRANTIES

Client represents and warrants to Appraiser that (1) Client has all right, power and authority to enter into this Agreement; (2) Client's duties and obligations under this Agreement do not conflict with any other duties or obligations assumed by Client under any agreement between Client and any other party; and (3) Client has not engaged Appraiser, nor will Client use Appraiser's Appraisal Report, for any purposes that violate any federal, state or local law, regulation or ordinance or common law.

EXTENT OF AGREEMENT

This Agreement represents the entire and integrated agreement between the Client and Appraiser and supersedes all prior negotiations, representations or agreements, either written or oral. This Agreement may be amended only by a written instrument signed by both Client and Appraiser.

EXPIRATION OF AGREEMENT

This Agreement is valid only if signed by both Appraiser and Client within five days of the Date of Agreement specified.

By Appraiser:



Victor D. Cremeens, MAI

May 14, 2019

By Client:



(Signature)

for: Margaret Minerick, Chairperson

5/30/19
(Date)

Exhibit B
Legal Description

LEGAL DESCRIPTION

Main Hospital Campus

Parcels: 051-000-257-00 & 051-000-251-01

PARCEL A:

A parcel of land located in the Southwest Quarter of the Southwest Quarter (SW $\frac{1}{4}$ xSW $\frac{1}{4}$) of Section Thirty-two (32), Township Forty (40) North, Range Thirty (30) West, more particularly described by metes and bounds as follows:

Commencing at the Southwest corner of Section 32, T40N, R30W; thence running North along the West line of Section 32 for a distance of 214.53 feet to a point on the North right of way line of U.S. Highway No. 2 and 141 and the Point of Beginning of the parcel to be described; thence continuing to run North along the West line of Section 32 for a distance of 1124.95 feet to a concrete monument marking the occupied Northwest Corner of the SW $\frac{1}{4}$ xSW $\frac{1}{4}$;

thence running North 88°44'54" East along the North line of the SW $\frac{1}{4}$ xSW $\frac{1}{4}$ for a distance of 1314.43 feet to a capped iron bar marking the Northeast corner of the SW $\frac{1}{4}$ xSW $\frac{1}{4}$; thence running South 00°16'49" East for a distance of 599.98 feet; thence running West for a distance of 89.73 feet to an existing concrete monument; thence running South 12°07' East for a distance of 269.51 feet to an existing monument; thence running South 72°30' West along the Northerly line of U.S. Highway No. 2 and 141 for a distance of 117.30 feet to the Point of Curve of a 11294 foot radius curve concave to the right; thence running in a Southwesterly direction along the arc of said curve for a distance of 663.21 feet (long chord bears South 74°32'26" West, 663.12 feet) to Point of Tangent; thence running South 76°13'22" West for a distance of 107.24 feet to the Point of Curve of a 1835.08 foot radius curve concave to the right; thence running along the arc of said curve for a distance of 432.97 feet (long chord bears South 83°00'36" West, 431.97 feet) to the Point of Beginning.

PARCEL B:

All that part of the Southwest Quarter of the Southwest Quarter (SW $\frac{1}{4}$ xSW $\frac{1}{4}$) of Section 32, T40N, R30W., as conveyed to Hydraulic Power Company, a Wisconsin Corporation by instrument recorded in Liber 32 of Deeds, page 482 and Liber 32 of Deeds, page 485 and subsequently conveyed to Wisconsin Electric Power Company and more particularly described as follows: a strip, belt or parcel of land 100 feet in width extending across the W $\frac{1}{2}$ xSW $\frac{1}{4}$, Section 32, T40N, R30W, lying 50 feet on each side of the centerline of said strip as now located, being that same strip of land as shown on Survey by Robert F. Perkins, R.L.S., dated January 17, 1994.

Parcel: 051-104-812-00

A parcel of land located in the Southeast Quarter of the Southwest Quarter (SE 1/4 of the SW 1/4), Section Thirty-two (32), Township Forty (40) North, Range Thirty (30) West, in the City of Iron Mountain, Dickinson County, Michigan, more particularly described as follows:

Commencing at the Southwest of Section Thirty-two (32), Township Forty (40) North, Range Thirty (30) West; thence North 88 deg. 21 min. 00 sec. East along the Township line between Sections Thirty-two (32) and Five (5) a distance of 1,495.36 feet; thence North 01 deg. 39 min. 00 sec. West a distance of 515.13 feet to a point on the Northerly right of way of line of a variable width right of way of U.S. Highway 2 and the point of beginning; thence North 16 deg. 18 min. 21 sec. West a distance of 259.10 feet to a point on the Southerly side of a 66 foot right of way; thence Easterly on the South right of way, curved to the right on a chord North 76 deg. 49 min. 38 sec. East a distance of 81.93 feet; thence Easterly on the South right of way, curved to the right on a chord North 79 deg. 15 min. 18 sec. East a distance of 69.36 feet; thence Easterly on the South right of way, curved to the right on a chord South 82 deg. 58 min. 14 sec. East a distance of 77.54 feet; thence Easterly on the South right of way, curved to the right on a chord South 65 deg. 12 min. East a distance of 4.40 feet to a point of intersection with the West right of way of a 66 foot wide roadway; thence Southerly along right of way curved to the left on a chord South 08 deg. 53 min. West a distance of 59 feet; thence continuing along right of way South 01 deg. 52 min. East a distance of 174 feet to a point of intersection with variable width right of way of U.S. Highway 2; thence Westerly continuing along said right of way South 77 deg. 14 min. West a distance of 128 feet; thence continuing along said right of way South 72 deg. 33 min. West a distance of 29 feet back to the point of beginning.

Property Address: 1771 S. Stephenson Avenue Iron Mountain, MI 49801

Tax Parcel Number: 22051-104-812-00 PARENT PARCEL; 22051-104-813-15

The Property Address shown herein is for informational purposes only.

1815 S Stephenson Ave.

EXHIBIT A

Land in the City of Iron Mountain, County of Dickinson and State of Michigan, described as follows:

Lot(s) Numbered Thirty (30) of the Plat of Carbis and Johnson Subdivision.

Commonly known as: 1815 S Stephenson Ave., Iron Mountain, Michigan 49801

Medical Office Building

Land in the City of Iron Mountain, County of Dickinson and State of Michigan, described as follows:

Unit Numbers 105, 110, 120, 200, 210, 220, 225, 235 and 240 of Dickinson Professional Office Building Condominium Dickinson County Condominium Subdivision Plan #7, according to the Master Deed recorded on August 15, 1996 in Liber 332 of Records on Pages 337-400, Dickinson County Register of Deeds, together with an undivided interest in the common and limited common elements as set forth in said Master Deed and Amendment thereto.

Podiatry Clinic

Parcel: 051-101-353-10

PARCEL A:

The West 50 feet of Lots Nine (9) and Ten (10) and the West 50 feet of the North 40 feet of Lot Eight (8) all in Block Six (6), according to the recorded Plat of Hamilton and Merryman's Second Addition, in the City of Iron Mountain, Dickinson County, Michigan.

AND;

The East 50 feet of the West 100 feet of Lots Nine (9) and Ten (10) and the East 50 feet of the West 100 feet of the North 40 feet of Lot Eight (8), Block Six (6), according to the recorded Plat of Hamilton and Merryman's Second Addition, in the City of Iron Mountain, Dickinson County, Michigan.

PARCEL B:

The North 40 feet of Lot Seven (7) and the South 10 feet of Lot Eight (8), including the West Half of the vacated 20 foot alley adjacent thereto, all in Block Six (6), according to the recorded Plat of Hamilton and Merryman's Second Addition, in the City of Iron Mountain, Dickinson County, Michigan.

AND;

The East 40 feet of Lots Nine (9) and Ten (10) and the East 40 feet of the North 40 feet of Lot Eight (8), all in Block Six (6), according to the recorded Plat of Hamilton and Merryman's Second Addition, in the City of Iron Mountain, Dickinson County, Michigan, including the West Half of the vacated 20 foot alley adjacent thereto, as set forth in Liber 512 of Records, on Page 202,

Property Address: 225 West H Street Iron Mountain, MI 49801

Tax Parcel Number: 22051-101-353-10

Medical Park MOB

Parcel: 051-000-300-01

All that portion of land situated in the Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4), Section Thirty-six (36), Township Forty (40) North, Range Thirty-one (31) West, in the City of Iron Mountain, Dickinson County, Michigan:

Commencing at a point described as the Northwest corner of the Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4), Section Thirty-six (36), Township Forty (40) North, Range Thirty-one (31) West, which point is the point of beginning of this description; thence South along the West line of said Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4) a distance of 1,320 feet to the Southwest corner of said Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4); thence East along the South line of the Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4) a distance of 400 feet to a point; thence North and parallel to the West line of the Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4) a distance of 1,320 feet to a point on the North line of said Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4); thence West along the North line of Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4) a distance of 400 feet to the point of beginning.

Less:

A parcel of land located in the Northeast Quarter of the Southwest Quarter (NE 1/4 of the SW 1/4), Section Thirty-six (36), Township Forty (40) North, Range Thirty-one (31) West, in the City of Iron Mountain, Dickinson County, Michigan, more particularly described as follows:

Durable Medical Equipment Building

Parcel: 051-101-806-00

That part of Lots numbered One (1) and Two (2) of Block Nine (9), according to the recorded Plat of Kimberly's First Addition, in the City of Iron Mountain, Dickinson County, Michigan, described as follows:

Starting at the Southeast corner of said Lot 1; thence due North on the East line of said Lot a distance of 46 feet 10 inches to a point, which point is the center of an existing brick wall approximately 1 foot thick (and which wall extends in an Easterly and Westerly direction); thence West from said point through the center line of said brick wall on a line which is parallel to the South line of said Lots 1 and 2 to the West line of said Lot 2; thence due South on the West line of said Lot 2 a distance of 46 feet 10 inches to the Southwest corner of said Lot 2; thence East on the South line of said Lots 1 and 2 to the Southeast corner of said Lot 1 to the point of beginning.

AND

Lots Eleven (11) and Twelve (12), Block Nine (9), according to the recorded Plat of Kimberly's First Addition, in the City of Iron Mountain, Dickinson County, Michigan.

EXCEPTING THEREFROM that part described as follows:

Starting at the Southeast corner of said Lot 12; thence due North on the East line of said Lot a distance of 100 feet to a point; thence West from said point on a line which is parallel to the South line of said Lots 11 and 12 to the West line of said Lot 11; thence due South on the West line of said Lot 11 a distance of 100 feet to the Southwest corner of said Lot 11; thence East on the South line of said Lots 11 and 12 to the Southeast corner of said Lot 12 and the place of beginning.

Home Health Building & Parking

Parcels: 051-100-521-00, 051-100-521-01, 051-100-522-00

The East Half (E 1/2) of Lots Three (3), Four (4), Five (5) and Six (6), Block Ten (10), according to the recorded Plat of Buell, Jenkins & Spies First Addition, in the City of Iron Mountain, Dickinson County, Michigan.

Property Address: 712 & 722 River Avenue Iron Mountain, MI 49801

Tax Parcel Number: 22051-100-521-00, 22051-100-521-01, 22051-100-522-00

Sleep Disorders Clinic

Parcel: 22052-850-003-00

That Leashold Interest of that parcel of land located in the Southwest Quarter of the Southeast Quarter (SW 1/4 of SE 1/4), Section One (1), Township Thirty-nine (39) North, Range Thirty-one (31) West, in the City of Kingsford, Dickinson County, Michigan, described as follows:

Commencing at a point where the South line of Breitung Avenue, intersects the West line of Carpenter Avenue (M-95); thence running Southwesterly along the West line of Carpenter Avenue (M-95) for a distance of 300.00 feet to the point of beginning of this parcel; thence continuing to run Southwesterly along the West line of Carpenter Avenue (M-95) for a distance of 295 feet more or less to a point where the West line of Carpenter Avenue intersects the North line of Sagola Avenue; thence West along the North line of Sagola Avenue for a distance of 157.9 feet to the East line of Parkway Street; thence running North 08 deg. 19 min. East, along the East line of Parkway Street for a distance of 296.4 feet to a point that is 300.00 feet South of the South line of Breitung Avenue as measured along the East line of Parkway Street; thence running East and parallel to the South line of Breitung Avenue for a distance of 149.75 feet to the point of beginning.

Property Address: 1100 S. Carpenter Avenue Kingsford, MI 49802

Tax Parcel Number: 22052-850-003-00

Florence Clinic

Parcel: 010-01750-0025

A parcel of land located in the Southwest Quarter of the Southwest Quarter (SW 1/4 of SW 1/4) of Section Twenty-one (21), Township Forty (40) North, Range Eighteen (18) East, Township of Florence, County of Florence, State of Wisconsin, more particularly described as follows:

Commencing at the Southwest corner of Section 21, T40N-R18E; thence running North 00 deg. 55 min. 45 sec. East along the West line of Section 21 for a distance of 1312.23 feet; thence running South 89 deg. 47 min. 29 sec. East for a distance of 425.00 feet to a found iron pipe; thence running South 12 deg. 55 min. 40 sec. West for a distance of 190.00 feet to a capped iron bar marking the point of beginning of the parcel to be described; thence running South 77 deg. 04 min. 20 sec. East for a distance of 129.00 feet to a capped iron bar; thence running South 12 deg. 55 min. 40 sec. West for a distance of 465.46 feet to a capped iron pipe located on the Northeasterly right of way line of U.S. Highway No. 2; thence running in a Northwesterly direction along said right of way line along the arc of a 855.77 foot radius curve concave to the right for a distance of 137.51 feet (Long chord bears North 56 deg. 58 min. 57 sec. West, 137.36 feet) to a found iron pipe; thence running North 12 deg. 55 min. 40 sec. East for a distance of 418.28 feet to the point of beginning.

EXCEPT that part conveyed to the Town of Florence in Volume 154 of Records at page 29.

Wausaukee Clinic

Parcel: 191-00611-013

All that part of the Southeast Quarter of the Southwest Quarter (SE 1/4-SW 1/4) of Section 36, Township 34 North, Range 20 East, Village of Wausaukee, Marinette County, Wisconsin described as follows:

Commencing at the South 1/4 corner of said Section 36; thence N89°59'40"W parallel with the north right of way line of STH "180", 1250.01 feet; thence N00°24'55"W parallel with the west line of Certified Survey Map #353, 862.98 feet to the intersection of the north right of way line of Kenny Drive (60 feet wide) and the easterly right of way line of US "141" (70 feet wide from centerline), said point also being the POINT OF BEGINNING; thence N5°21'48"E along the easterly right of way line of US "141", 201.02 feet; thence N89°35'05"E parallel with the north line of Kenny Drive, 179.76 feet; thence S00°24'55"E 200.00 feet, to the north right of way line of Kenny Drive; thence S89°35'05"W 200.00 feet to the POINT OF BEGINNING, except that portion, if any, now in use for public roadway purposes.

Exhibit C
Photographs of the Subject Facility

Subject Photographs – Main Hospital Exterior



Building Front



East Side of Building

Subject Photographs – Main Hospital Exterior



Emergency Department Entrance



West Side of Building

Subject Photographs – Main Hospital Interior



Main Lobby



Operating Room

Subject Photographs – Main Hospital Interior



Typical Hallway



MRI

Subject Photographs – Main Hospital Interior



Basement Level - Boilers



Cafe

Subject Photographs – Medical Office Building Exterior



South Side of Building



North Side of Building

Subject Photographs – Medical Office Building Interior



Exam Room



Pediatric Clinic

Subject Photographs – Hemlock Street Medical Park Exterior



East Side of Building



West Side of Building

Subject Photographs – Hemlock Street Medical Park Interior



Lobby



Exam Room

Subject Photographs – OB/GYN Clinic Exterior



Main Entrance



Handicap Accessible Entrance

Subject Photographs – OB/GYN Clinic Interior



Lobby and Registration Area



Procedure Room

Subject Photographs – 1707 Stephenson Clinic Exterior



East Side of Building



West Side of Building

Subject Photographs – 1707 Stephenson Clinic Interior



Exam Room



Wound Chamber Room

Subject Photographs – Podiatry Clinic Exterior



Front Side of Building



Rear of Building

Subject Photographs –Podiatry Clinic Interior



Lobby and Waiting Area



Exam Room

Subject Photographs – Sleep Disorders Clinic Exterior



Front of Building



Rear of Building

Subject Photographs – Sleep Disorders Clinic Interior



Exam Room



Lobby

Subject Photographs – Home Health Exterior



Front of Building



Rear of Building

Subject Photographs – Home Health Interior



Office Area



Meeting Room

Subject Photographs – Florence Clinic Exterior



Front of Building



Rear of Building

Subject Photographs – Florence Clinic Interior



Physical Therapy Room



Exam Room

Subject Photographs – Wausaukee Clinic Exterior



Front of Building



Rear of Building

Subject Photographs – Wausaukee Clinic Interior



Storage

Exhibit D
Site and Improvement Description Exhibits

PARCEL IDENTIFICATION (MAIN HOPITAL CAMPUS)

PARCELS INCLUDED IN OUTLINE:

051-000-257-00, 051-000-257-10, 051-502-001-00, 051-502-002-00, 051-502-003-00, 051-502-002-50, 051-502-004-00, 051-502-004-50
051-502-005-00, 051-502-006-00, 051-502-007-00, 051-502-008-00, 051-502-009-00, 051-502-010-00, 051-502-011-00, 051-502-012-00
051-502-013-00, 051-502-016-00, 051-502-016-10, 051-502-018-00, 051-104-813-10, 051-104-812-00



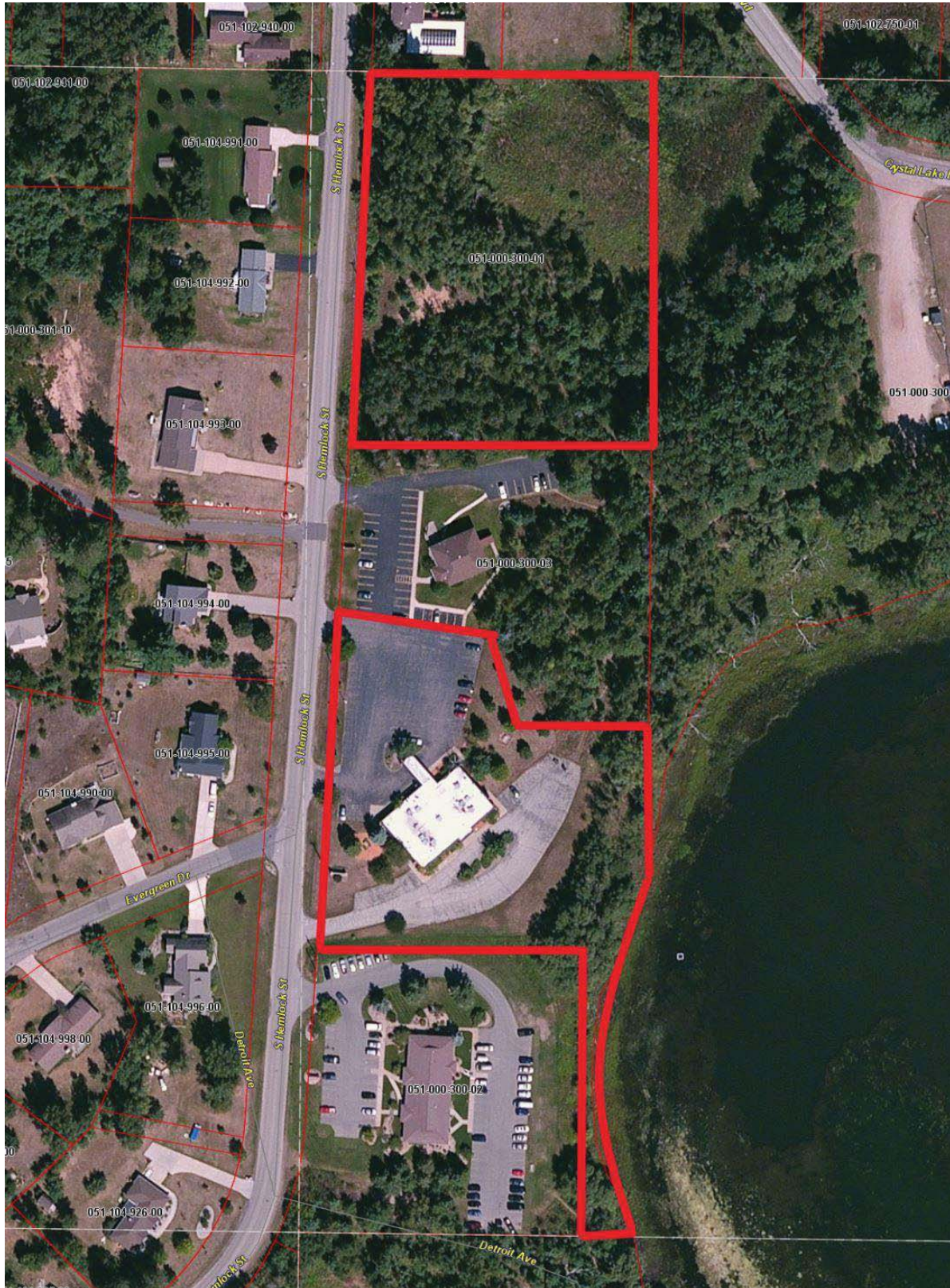
PARCEL IDENTIFICATION (MEDICAL PARK MOB & VACANT LAND)

N↑

PARCELS INCLUDED IN OUTLINE:

051-000-300-01

Note: Although physically separated, the MOB & vacant land are assessed as one parcel.



PARCEL IDENTIFICATION (HOME HEALTH & DURABLE MEDICAL EQUIPMENT)

N↑

PARCELS INCLUDED IN OUTLINE:

- 051-100-522-00
- 051-100-521-10
- 051-100-051-00
- 051-101-806-00



PARCEL IDENTIFICATION (SLEEP DISORDER CLINIC)

N↑

PARCELS INCLUDED IN OUTLINE:

052-001-107-00



←
Z

051-101-353-10



PARCEL IDENTIFICATION (WAUSAUKEE, WI CLINIC)

N↑

PARCELS INCLUDED IN OUTLINE:

191-00611.013



PARCEL IDENTIFICATION (FLORENCE, WI CLINIC)

N↑

PARCELS INCLUDED IN OUTLINE

010-01750-0025

Note: The mapping is shown incorrectly by the assessment map.



← Z

← Z



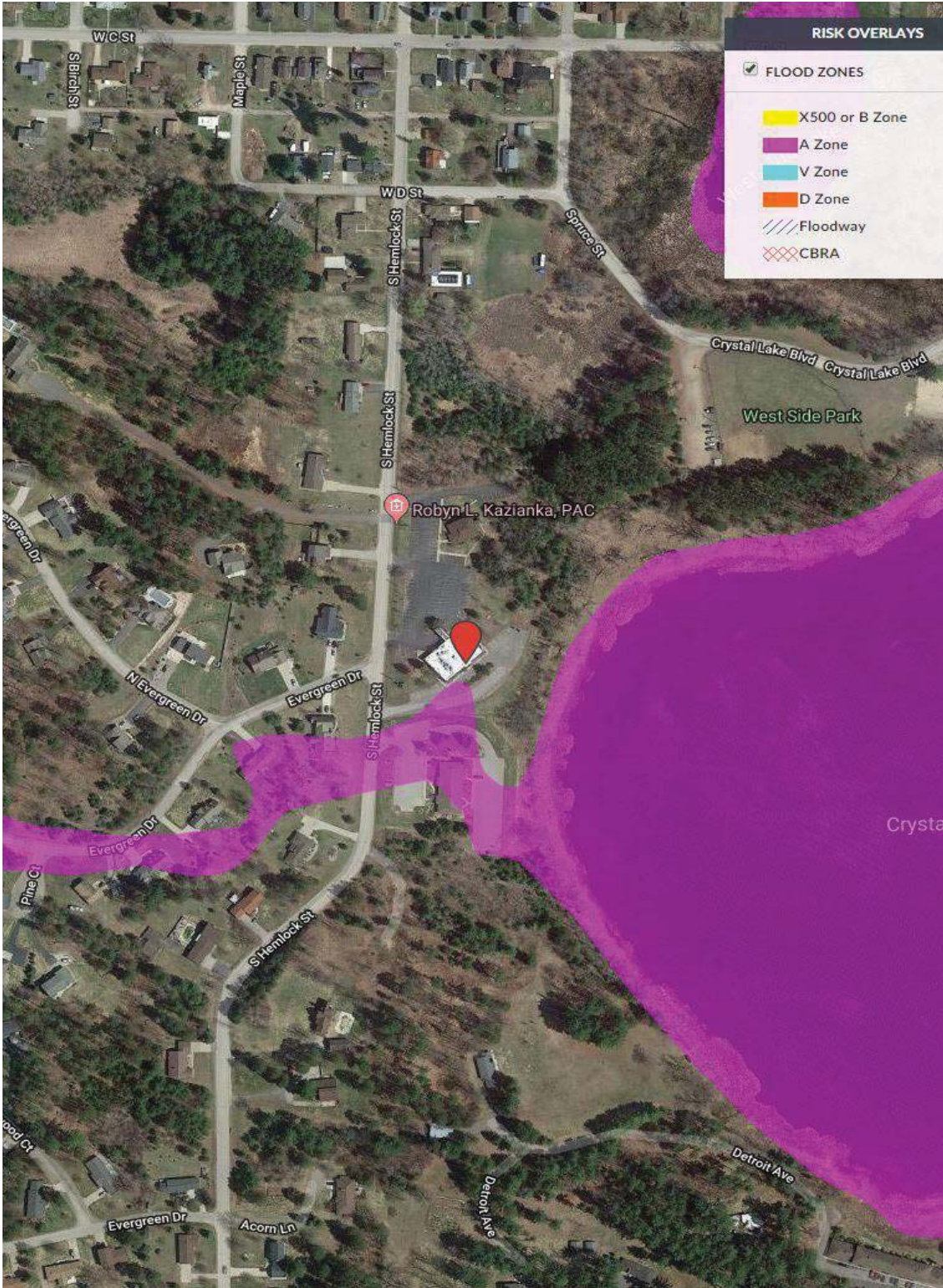
FLOOD PLAIN MAP (MAIN HOSPITAL)

N↑

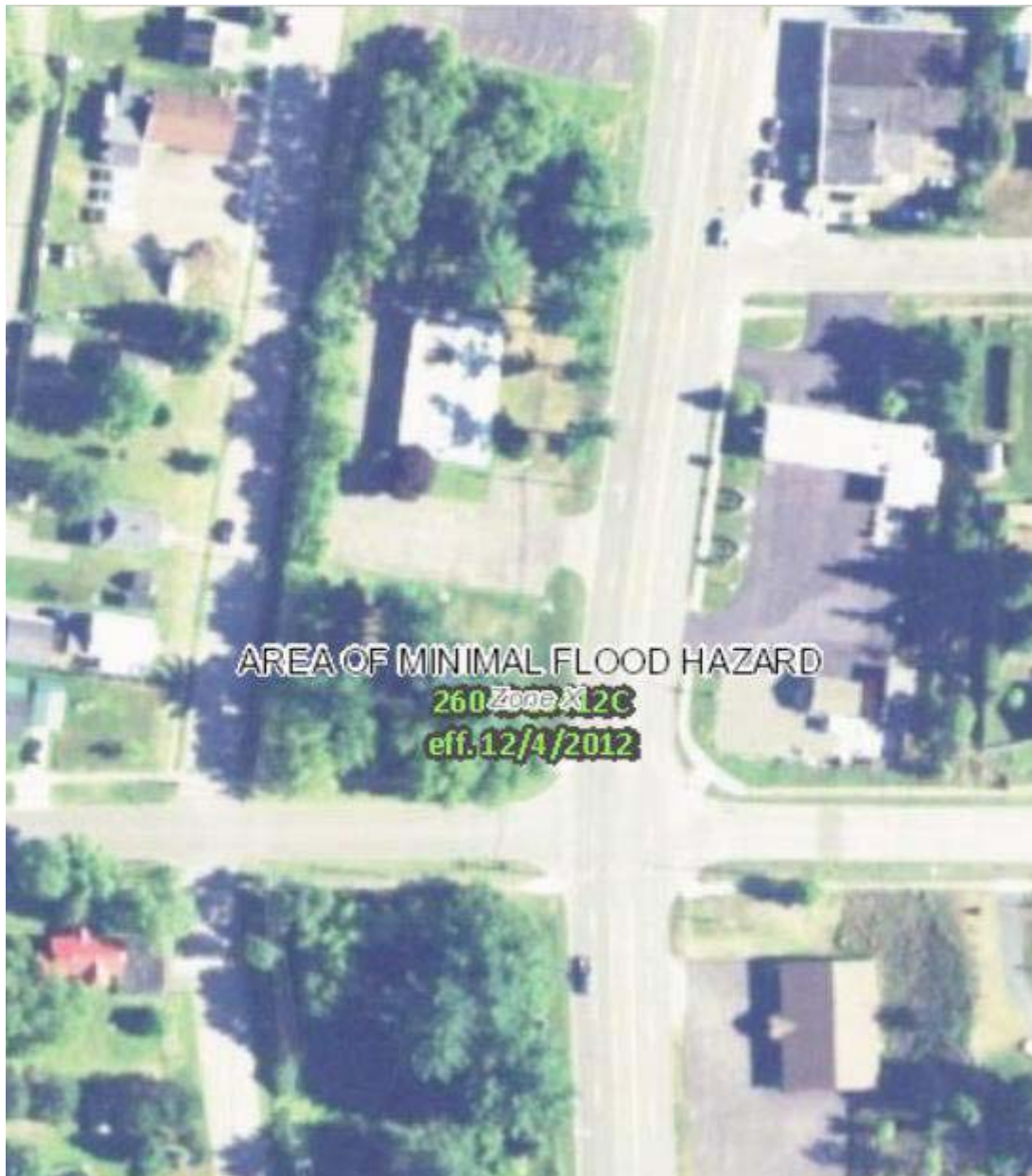




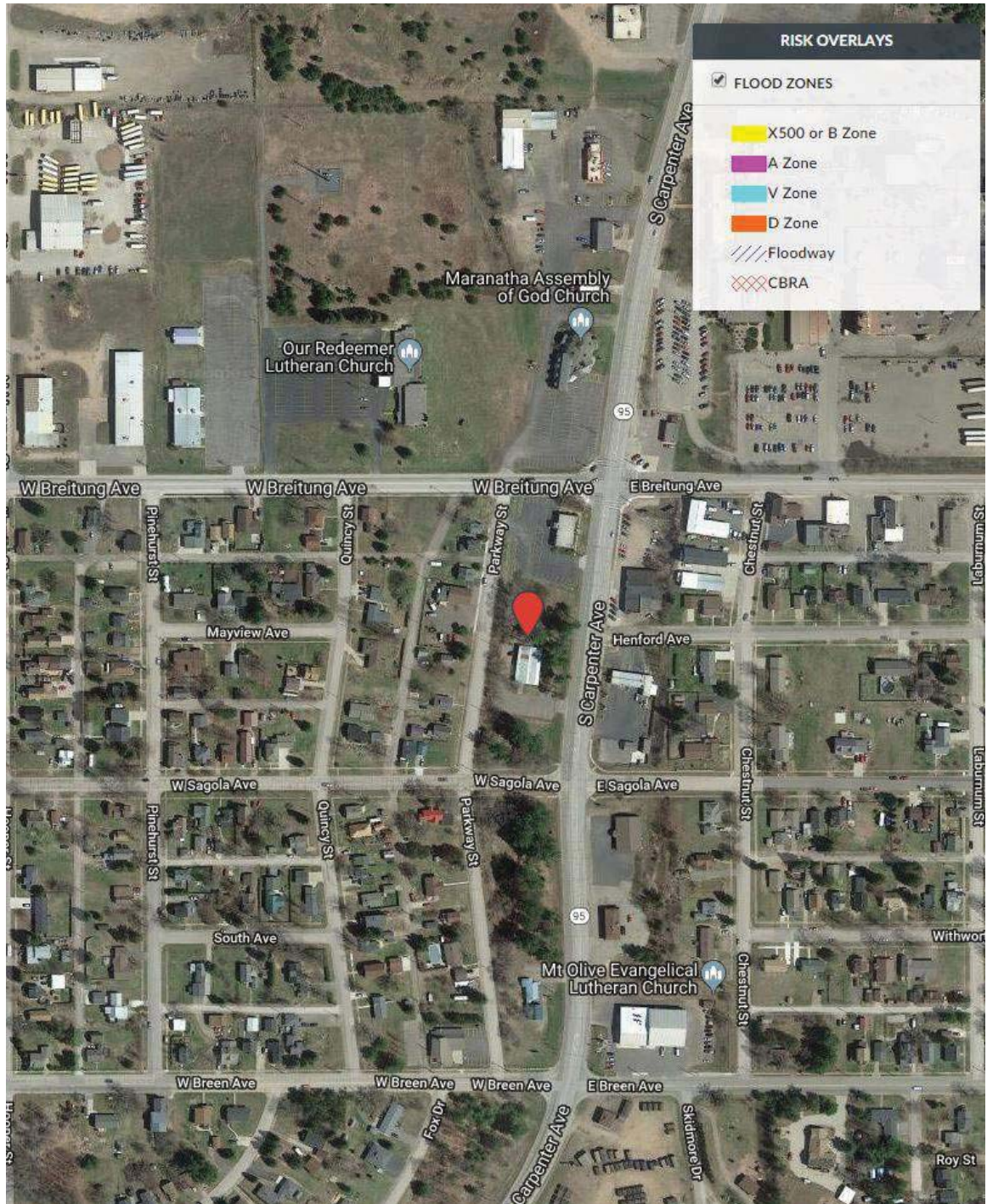
FLOOD PLAIN MAP (MEDICAL PARK MOB)



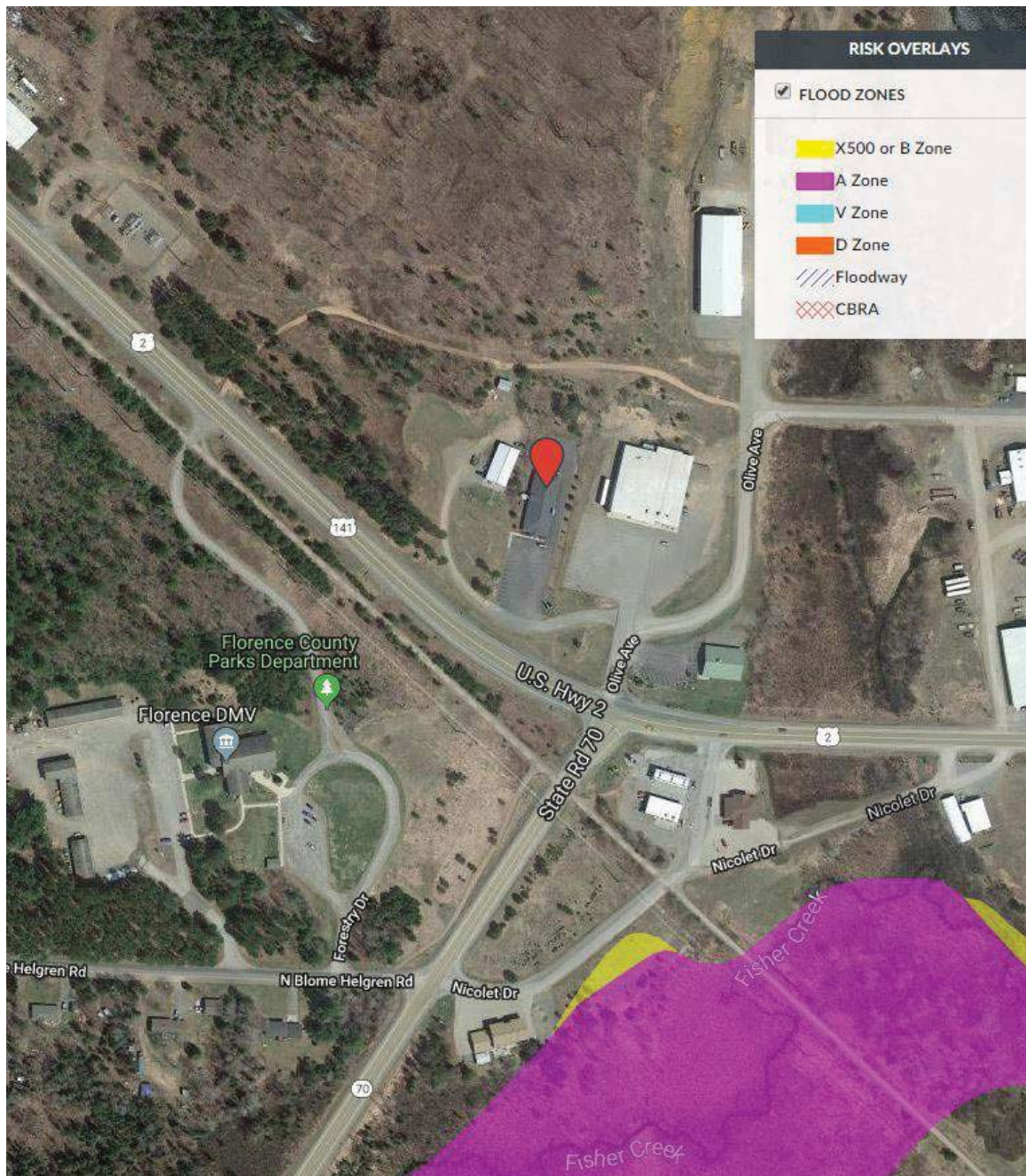
FLOOD PLAIN MAP (SLEEP DISORDERS CENTER)



FLOOD PLAIN MAP (SLEEP DISORDER CLINIC)



FLOOD PLAIN MAP (FLORENCE, WI CLINIC)



FLOOD PLAIN MAP (WAUSAUKEE, WI CLINIC)



N↑



	RESIDENTIAL - 1
	RESIDENTIAL - 2
	RESIDENTIAL - 3
	BUSINESS - 1
	BUSINESS - 2
	OFFICE SERVICE
	INDUSTRIAL - 1
	INDUSTRIAL - 2

*MAIN HOSPITAL PARCEL IS ZONED +/- 90% OS – OFFICE SERVICE AND +/- 10% IS ZONED B2 - BUSINESS

ZONING REGULATIONS (MAIN HOSPITAL PARCEL)

DIVISION 5. - O-S OFFICE SERVICE DISTRICT



Sec. 74-271. - Purpose.



It is the purpose of the O-S district to permit the integration of office, personal service and limited business uses. This district is specifically designed for applications where existing residential uses are experiencing redevelopment pressures. Among the purposes of the O-S district is the development of various office uses performing administrative, professional and personal services, and very limited commercial ventures.

(Ord. of 5-1-95, § 8-10-1)

Sec. 74-272. - Uses permitted by right.



In an O-S office service district, no building or land shall be used and no building erected except for one or more of the following specified uses, unless otherwise provided in this chapter:

- (1) Office establishments which perform services on the premises.
 - a. Financial institutions.
 - b. Insurance offices.
 - c. Real estate offices.
 - d. Offices for attorneys, accountants, architects, engineers and similar professionals.
 - e. Photographic studios.
 - f. Other office establishments similar to and compatible with such uses.
- (2) Professional service establishments, medical offices and clinics providing human health care on an outpatient basis.
- (3) Miscellaneous business service establishments.
 - a. Consumer credit reporting agencies.
 - b. Mailing list and stenographic services.
 - c. Business management consulting services.
 - d. Duplicating services.
 - e. Other establishments similar to and compatible with such uses.
- (4) Governmental offices and libraries.
- (5) Churches and related facilities.
- (6) Offices of nonprofit organizations, such as professional membership organizations, labor unions, civic, social and fraternal associations and political organizations.
- (7) Mortuaries and funeral homes, subject to the following restrictions:
 - a. Sufficient off-street automobile parking and assembly area shall be provided for vehicles to be used in funeral processions. The assembly area shall be provided in addition to the otherwise required off-street parking area.
 - b. Loading and unloading areas used by ambulances, hearses or other such service vehicles shall be obscured from view with an opaque fence or wall not less than six feet in height.
- (8) Hospitals.
- (9) Nursing or convalescent homes.



Sec. 74-311. - Purpose.

It is the purpose of the B-2 district to provide a district and area within the city where a wide range of commercial and business facilities can be centralized to most efficiently and effectively serve the community. These regulations are intended to ensure harmonious relationships with surrounding land uses and in particular have minimal impact on surrounding residential neighborhoods.

(Ord. of 5-1-95, § 8-12-1)

Sec. 74-312. - Uses permitted by right.

In a B-2 general business district, no building or land shall be used and no building erected except for one or more of the following specified uses, unless otherwise provided in this chapter:

- (1) All uses permitted by right in the B-1 neighborhood business district, except single-family residences and duplexes. Residential occupancy is permitted above the ground floor. Residential occupancy is only permitted on the ground floor if required to comply with barrier-free access requirements under state or federal law, but no greater occupancy shall be allowed than that required to comply.
- (2) General retail establishments whose principal activity is the sale of new merchandise to the public, including but not limited to household appliance stores, furniture stores, office supply stores, gift stores, hardware stores, banks, restaurants, cocktail lounges, supermarkets, bakeries, delicatessens, variety stores and other retail establishments similar to and compatible with such uses, except those in which the required repair and service facilities occupy more than 50 percent of the total floor area.
- (3) Personal service establishments and studios, such as beauty shops and barbershops, dressmakers, tailors, upholsterers, offices of lawyers, doctors or dentists, photo shops and similar service establishments.
- (4) Theaters, excepting outdoor or drive-in theaters.
- (5) Automobile service stations, automobile repair garages, automatic and self-service carwash establishments and tire shops.
- (6) Art or antique shops, secondhand stores and pawnshops.
- (7) Amusement enterprises, including billiard or pool halls, bowling alleys, dancehalls, nightclubs, skating rinks and the like, if conducted wholly within an enclosed building.
- (8) Hotels, motels, motor hotels, and bed and breakfast operations.
- (9) Printing, publishing, photographic reproduction, blueprinting and related trades and arts.
- (10) Other retail or service uses similar to such uses.

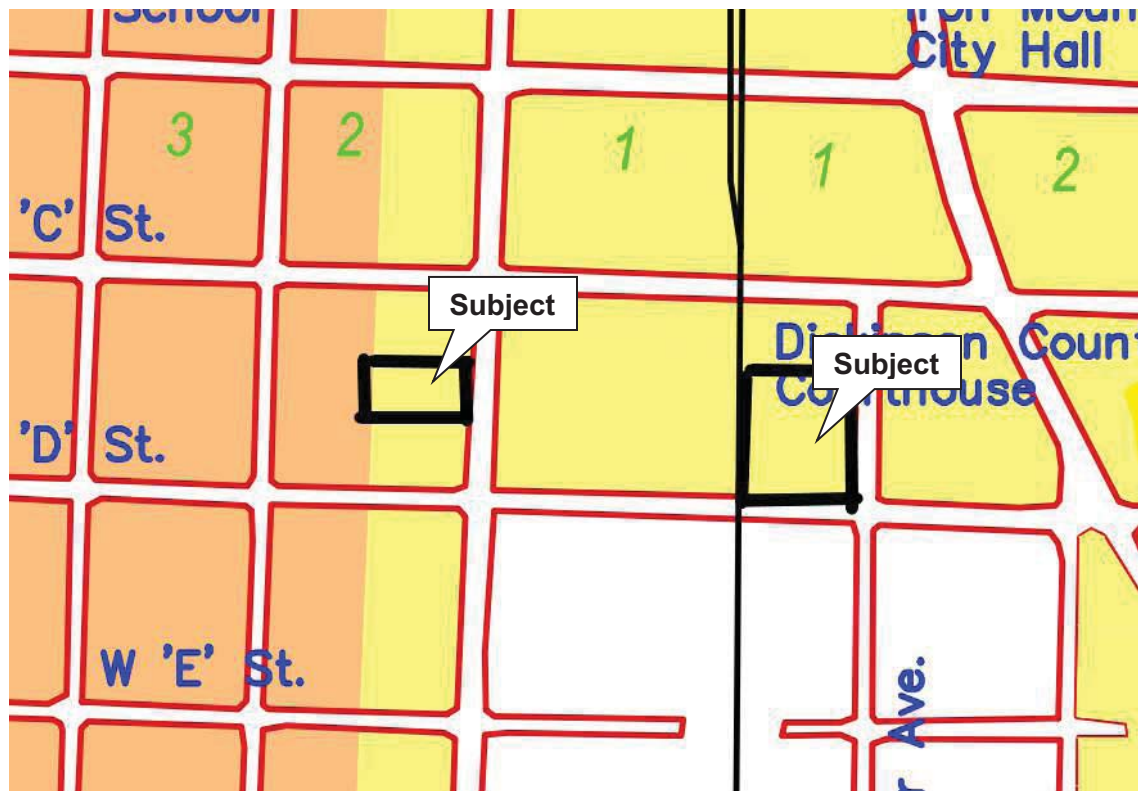
(Ord. of 5-1-95, § 8-12-2)

Sec. 74-313. - Permitted accessory uses.

The following are permitted accessory uses in the B-2 district:

- (1) Any use customarily incidental to the permitted principal use.
- (2) Signs, subject to the regulations in article VII of this chapter.
- (3) Off-street parking as required in article VI of this chapter.

ZONING MAP (HOME HEALTH & EQUIPMENT BUILDINGS)



LEGEND

	RESIDENTIAL - 1
	RESIDENTIAL - 2
	RESIDENTIAL - 3
	BUSINESS - 1
	BUSINESS - 2
	OFFICE SERVICE
	INDUSTRIAL - 1
	INDUSTRIAL - 2

****BOTH PARCELS ARE ZONED B2 - BUSINESS**

ZONING REGULATIONS (HOME HEALTH & EQUIPMENT BUILDINGS)

DIVISION 7. - B-2 GENERAL BUSINESS DISTRICT



Sec. 74-311. - Purpose.



It is the purpose of the B-2 district to provide a district and area within the city where a wide range of commercial and business facilities can be centralized to most efficiently and effectively serve the community. These regulations are intended to ensure harmonious relationships with surrounding land uses and in particular have minimal impact on surrounding residential neighborhoods.

(Ord. of 5-1-95, § 8-12-1)

Sec. 74-312. - Uses permitted by right.



In a B-2 general business district, no building or land shall be used and no building erected except for one or more of the following specified uses, unless otherwise provided in this chapter:

- (1) All uses permitted by right in the B-1 neighborhood business district, except single-family residences and duplexes. Residential occupancy is permitted above the ground floor. Residential occupancy is only permitted on the ground floor if required to comply with barrier-free access requirements under state or federal law, but no greater occupancy shall be allowed than that required to comply.
- (2) General retail establishments whose principal activity is the sale of new merchandise to the public, including but not limited to household appliance stores, furniture stores, office supply stores, gift stores, hardware stores, banks, restaurants, cocktail lounges, supermarkets, bakeries, delicatessens, variety stores and other retail establishments similar to and compatible with such uses, except those in which the required repair and service facilities occupy more than 50 percent of the total floor area.
- (3) Personal service establishments and studios, such as beauty shops and barbershops, dressmakers, tailors, upholsterers, offices of lawyers, doctors or dentists, photo shops and similar service establishments.
- (4) Theaters, excepting outdoor or drive-in theaters.
- (5) Automobile service stations, automobile repair garages, automatic and self-service carwash establishments and tire shops.
- (6) Art or antique shops, secondhand stores and pawnshops.
- (7) Amusement enterprises, including billiard or pool halls, bowling alleys, dancehalls, nightclubs, skating rinks and the like, if conducted wholly within an enclosed building.
- (8) Hotels, motels, motor hotels, and bed and breakfast operations.
- (9) Printing, publishing, photographic reproduction, blueprinting and related trades and arts.
- (10) Other retail or service uses similar to such uses.

(Ord. of 5-1-95, § 8-12-2)

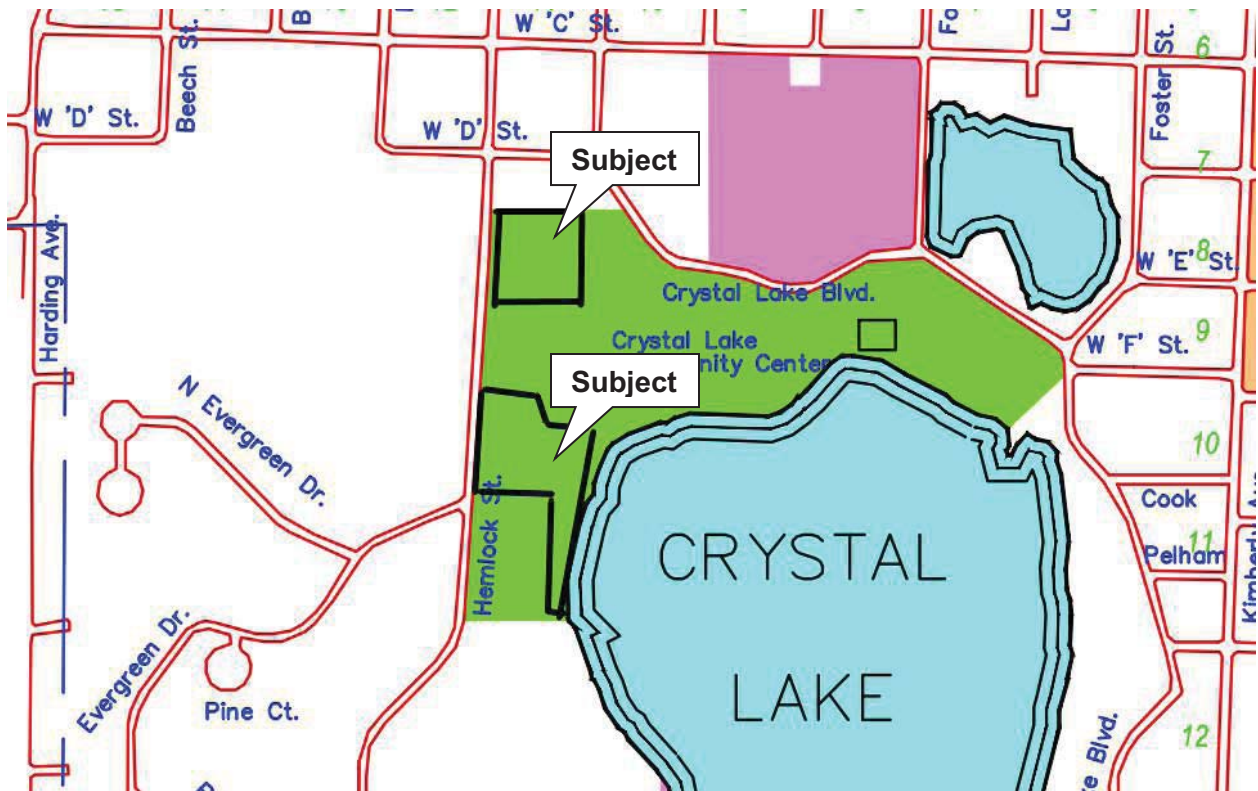
Sec. 74-313. - Permitted accessory uses.



The following are permitted accessory uses in the B-2 district:

- (1) Any use customarily incidental to the permitted principal use.
- (2) Signs, subject to the regulations in article VII of this chapter.
- (3) Off-street parking as required in article VI of this chapter.

ZONING MAP (MEDICAL PARK MOB)



LEGEND

	RESIDENTIAL - 1
	RESIDENTIAL - 2
	RESIDENTIAL - 3
	BUSINESS - 1
	BUSINESS - 2
	OFFICE SERVICE
	INDUSTRIAL - 1
	INDUSTRIAL - 2

**PARCEL ZONED OS – OFFICE SERVICE

ZONING REGULATIONS (UROLOGY CLINIC)

DIVISION 5. - O-S OFFICE SERVICE DISTRICT



Sec. 74-271. - Purpose.



It is the purpose of the O-S district to permit the integration of office, personal service and limited business uses. This district is specifically designed for applications where existing residential uses are experiencing redevelopment pressures. Among the purposes of the O-S district is the development of various office uses performing administrative, professional and personal services, and very limited commercial ventures.

(Ord. of 5-1-95, § 8-10-1)

Sec. 74-272. - Uses permitted by right.



In an O-S office service district, no building or land shall be used and no building erected except for one or more of the following specified uses, unless otherwise provided in this chapter:

- (1) Office establishments which perform services on the premises.
 - a. Financial institutions.
 - b. Insurance offices.
 - c. Real estate offices.
 - d. Offices for attorneys, accountants, architects, engineers and similar professionals.
 - e. Photographic studios.
 - f. Other office establishments similar to and compatible with such uses.
- (2) Professional service establishments, medical offices and clinics providing human health care on an outpatient basis.
- (3) Miscellaneous business service establishments.
 - a. Consumer credit reporting agencies.
 - b. Mailing list and stenographic services.
 - c. Business management consulting services.
 - d. Duplicating services.
 - e. Other establishments similar to and compatible with such uses.
- (4) Governmental offices and libraries.
- (5) Churches and related facilities.
- (6) Offices of nonprofit organizations, such as professional membership organizations, labor unions, civic, social and fraternal associations and political organizations.
- (7) Mortuaries and funeral homes, subject to the following restrictions:
 - a. Sufficient off-street automobile parking and assembly area shall be provided for vehicles to be used in funeral processions. The assembly area shall be provided in addition to the otherwise required off-street parking area.
 - b. Loading and unloading areas used by ambulances, hearses or other such service vehicles shall be obscured from view with an opaque fence or wall not less than six feet in height.
- (8) Hospitals.
- (9) Nursing or convalescent homes.

ZONING MAP (PODIATRY CLINIC)



LEGEND

	RESIDENTIAL - 1
	RESIDENTIAL - 2
	RESIDENTIAL - 3
	BUSINESS - 1
	BUSINESS - 2
	OFFICE SERVICE
	INDUSTRIAL - 1
	INDUSTRIAL - 2

**PARCEL ZONED B2 - BUSINESS

ZONING REGULATIONS (PODIATRY CLINIC)

DIVISION 7. - B-2 GENERAL BUSINESS DISTRICT



Sec. 74-311. - Purpose.



It is the purpose of the B-2 district to provide a district and area within the city where a wide range of commercial and business facilities can be centralized to most efficiently and effectively serve the community. These regulations are intended to ensure harmonious relationships with surrounding land uses and in particular have minimal impact on surrounding residential neighborhoods.

(Ord. of 5-1-95, § 8-12-1)

Sec. 74-312. - Uses permitted by right.



In a B-2 general business district, no building or land shall be used and no building erected except for one or more of the following specified uses, unless otherwise provided in this chapter:

- (1) All uses permitted by right in the B-1 neighborhood business district, except single-family residences and duplexes. Residential occupancy is permitted above the ground floor. Residential occupancy is only permitted on the ground floor if required to comply with barrier-free access requirements under state or federal law, but no greater occupancy shall be allowed than that required to comply.
- (2) General retail establishments whose principal activity is the sale of new merchandise to the public, including but not limited to household appliance stores, furniture stores, office supply stores, gift stores, hardware stores, banks, restaurants, cocktail lounges, supermarkets, bakeries, delicatessens, variety stores and other retail establishments similar to and compatible with such uses, except those in which the required repair and service facilities occupy more than 50 percent of the total floor area.
- (3) Personal service establishments and studios, such as beauty shops and barbershops, dressmakers, tailors, upholsterers, offices of lawyers, doctors or dentists, photo shops and similar service establishments.
- (4) Theaters, excepting outdoor or drive-in theaters.
- (5) Automobile service stations, automobile repair garages, automatic and self-service carwash establishments and tire shops.
- (6) Art or antique shops, secondhand stores and pawnshops.
- (7) Amusement enterprises, including billiard or pool halls, bowling alleys, dancehalls, nightclubs, skating rinks and the like, if conducted wholly within an enclosed building.
- (8) Hotels, motels, motor hotels, and bed and breakfast operations.
- (9) Printing, publishing, photographic reproduction, blueprinting and related trades and arts.
- (10) Other retail or service uses similar to such uses.

(Ord. of 5-1-95, § 8-12-2)

Sec. 74-313. - Permitted accessory uses.



The following are permitted accessory uses in the B-2 district:

- (1) Any use customarily incidental to the permitted principal use.
- (2) Signs, subject to the regulations in article VII of this chapter.
- (3) Off-street parking as required in article VI of this chapter.

ZONING MAP (SLEEP DISORDER CLINIC)

*NO ZONING MAP WAS AVAILABLE FOR REVIEW IN KINGSFORD, MI

*THE APPRAISERS SPOKE TO THE ZONING OFFICE ON 6-27-2019 AND IT WAS CONFIRMED THE PARCEL IS ZONED B2- BUSINESS DISTRICT

DIVISION 7. - B-2 GENERAL BUSINESS DISTRICT



Sec. 44-241. - Intent.



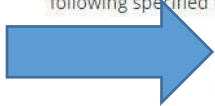
The B-2 general business district is designed to provide sites for more diversified business types than are found in B-1 and O-S districts and are frequently located so as to serve passerby traffic.

(Ord. No. 142, § 900, 5-21-1973)

Sec. 44-242. - Principal uses permitted.



No building or land shall be used and no building shall be erected in the B-2 general business district except for one or more of the following specified uses:



- All principal uses permitted and all uses subject to conditions as regulated in the O-S and B-1 districts, except as may be modified in this division.
- (2) Establishments renting equipment, tools and household articles.
- (3) Automobile dealer showrooms and sales lots for new and used automobiles.
- (4) Vehicle repair garage.
- (5) Automobile car wash.
- (6) Bus passenger stations.
- (7) Wholesale uses, freezer plants (lockers) and enclosed storage.
- (8) Bottling works and food packaging.
- (9) Governmental offices or other governmental uses; public utility offices, exchanges, transformer stations, pump stations, and service yards, but not including outdoor storage.
- (10) Greenhouses, florists, and plant material sales.
- (11) Bowling alleys, pool halls and/or billiard parlors.
- (12) Other uses which are similar to the above uses.

Sec. 44-221. - Intent.

The B-1 community business district is designed to meet the general shopping and service need of persons residing in residential areas of the city as well as trade area residents.

(Ord. No. 142, § 800, 5-21-1973)

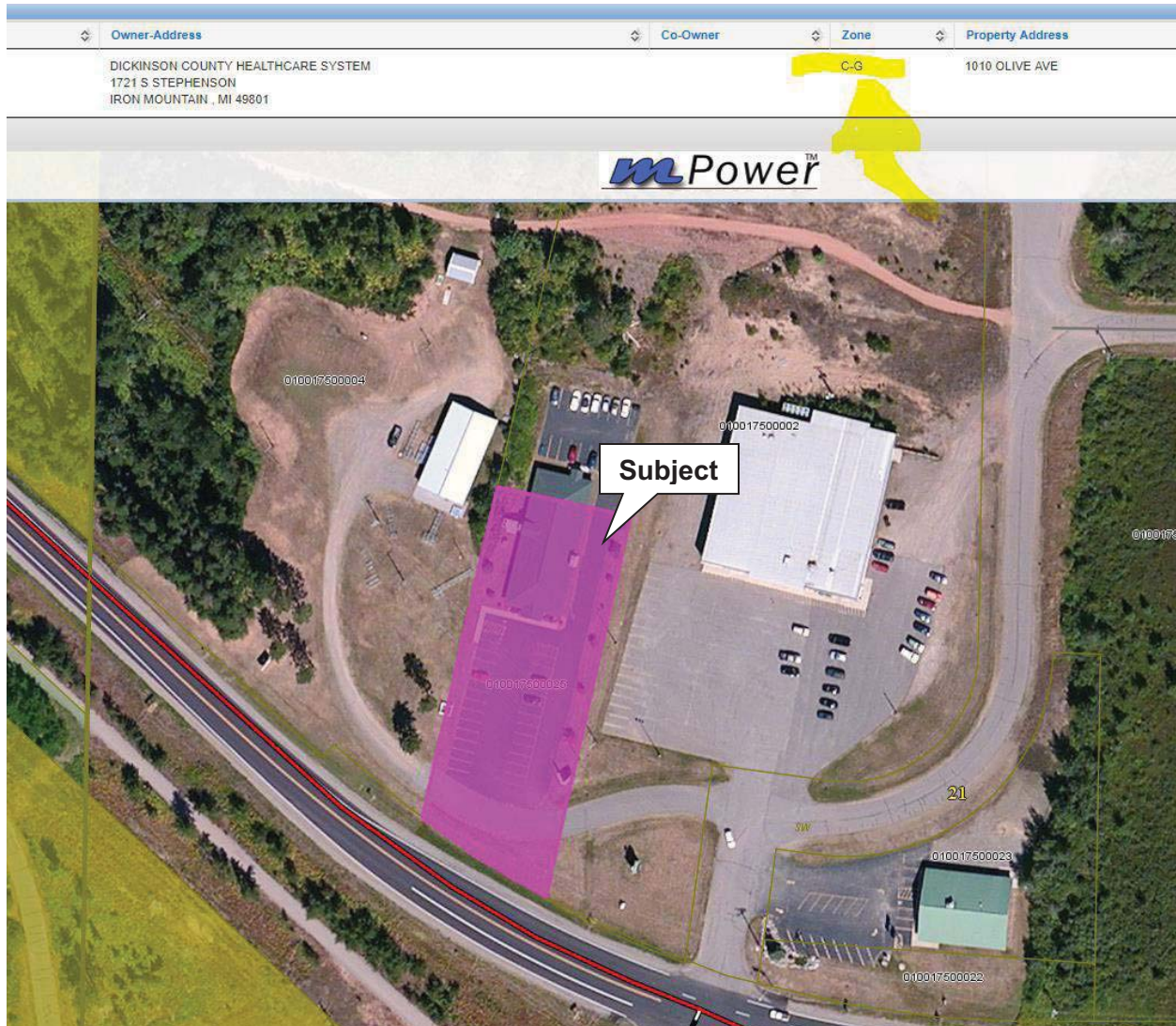
Sec. 44-222. - Principal uses permitted.

No building or land shall be used and no building shall be erected in the B-1 community business district except for one or more of the following specified uses:

- 
- (1) Generally recognized retail businesses which supply commodities on the premises, such as but not limited to: groceries, meats, dairy products, baked goods, or other foods, drugs, dry goods, clothing and notions, or hardware.
 - (2) Personal service establishments which perform services, on the premises, such as but not limited to: repair shops (watches, radio, television, shoe and etc.), tailor shops, beauty parlors or barbershops, photographic studios, and self-service laundries and dry cleaners.
 - (3) Dry cleaning establishments, or pickup stations, dealing directly with the consumer.
 - (4) Business establishments which perform services on the premises, such as but not limited to: banks, loan companies, insurance offices, and real estate offices.
 - (5) Professional services, including the following: offices of doctors, dentists, osteopaths, and similar or allied professions.
 - (6) All retail businesses, service establishments or processing uses as follows:
 - a. Any retail business the principal activity of which is the sale of merchandise in an enclosed building.
 - b. Any service establishment of an office, showroom, or workshop nature of an electrician, decorator, dressmaker, tailor, baker, painter, upholsterer, or an establishment doing radio or home appliance repair, photographic reproduction, and similar service establishments that require a retail adjunct.
 - c. Private clubs, fraternal organizations, and lodge halls.
 - d. Restaurants, taverns, or other places serving food or beverage, except those having the character of a drive-in.
 - e. Theaters, assembly halls, concert halls or similar places of assembly.
 - f. Business schools and colleges, or private schools operated for profit.
 - g. Motels, motor inns, and tourist lodging facilities, provided that the use has direct access to a major or secondary thoroughfare.
 - h. Other uses similar to the above uses.
 - (7) Dwelling units, provided they are efficiency, one-bedroom or two-bedroom units.

ZONING MAP (FLORENCE, WI CLINIC)



****PARCEL IS ZONED C-G – GENERAL COMMERCIAL ZONE**

ZONING REGULATIONS (FLORENCE, WI CLINIC)

3.31 C-1 GENERAL COMMERCIAL DISTRICT

3.31.1 PURPOSE

This District provides for uses found in small commercial areas as located throughout the county.

3.31.2 LOT SIZE REGULATIONS

- A. Minimum area: 10,000 sq. ft. except
- B. Minimum width: 50 feet

3.31.3 HEIGHT REGULATIONS

- A. Maximum height: 35 feet
- B. One additional foot of extra height may be permitted provided, one additional foot of side or rear yard for each additional foot of extra height is also established up to a maximum height of 60 feet unless the Planning and Zoning Committee approves a greater height.

3.31.4 YARD AND SETBACK REGULATIONS

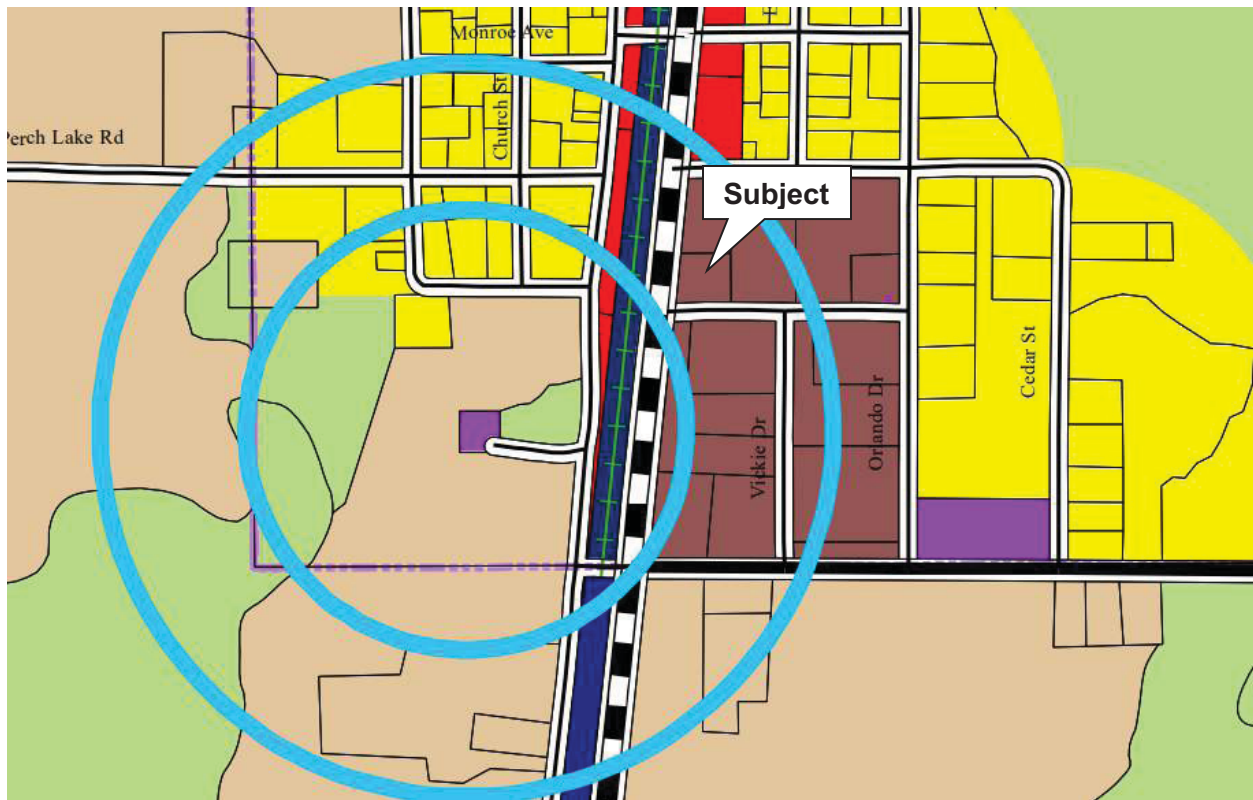
- A. Minimum front yard: See Section 2.6 (Highway Setback)
- B. Minimum side yard: None except same as adjoining O, R, A, & M Districts
- C. Minimum rear yard: 20 feet
- D. Minimum water setback: 75 feet

3.31.5 PERMITTED USES

- A. Auto service stations
- B. Banks and similar services
- C. Business and professional offices and studios
- D. Dental and medical clinics
- E. Dwelling, single-family, only as accessory to a principal use
- F. Funeral homes
- G. Garages for storage of vehicles used in conjunction with a permitted use
- H. Hotels
- I. Laundromats
- J. New car sales
- K. Restaurant
- L. Retail stores and shops offering convenience goods and services



ZONING MAP (WAUSAUKEE, WI CLINIC)



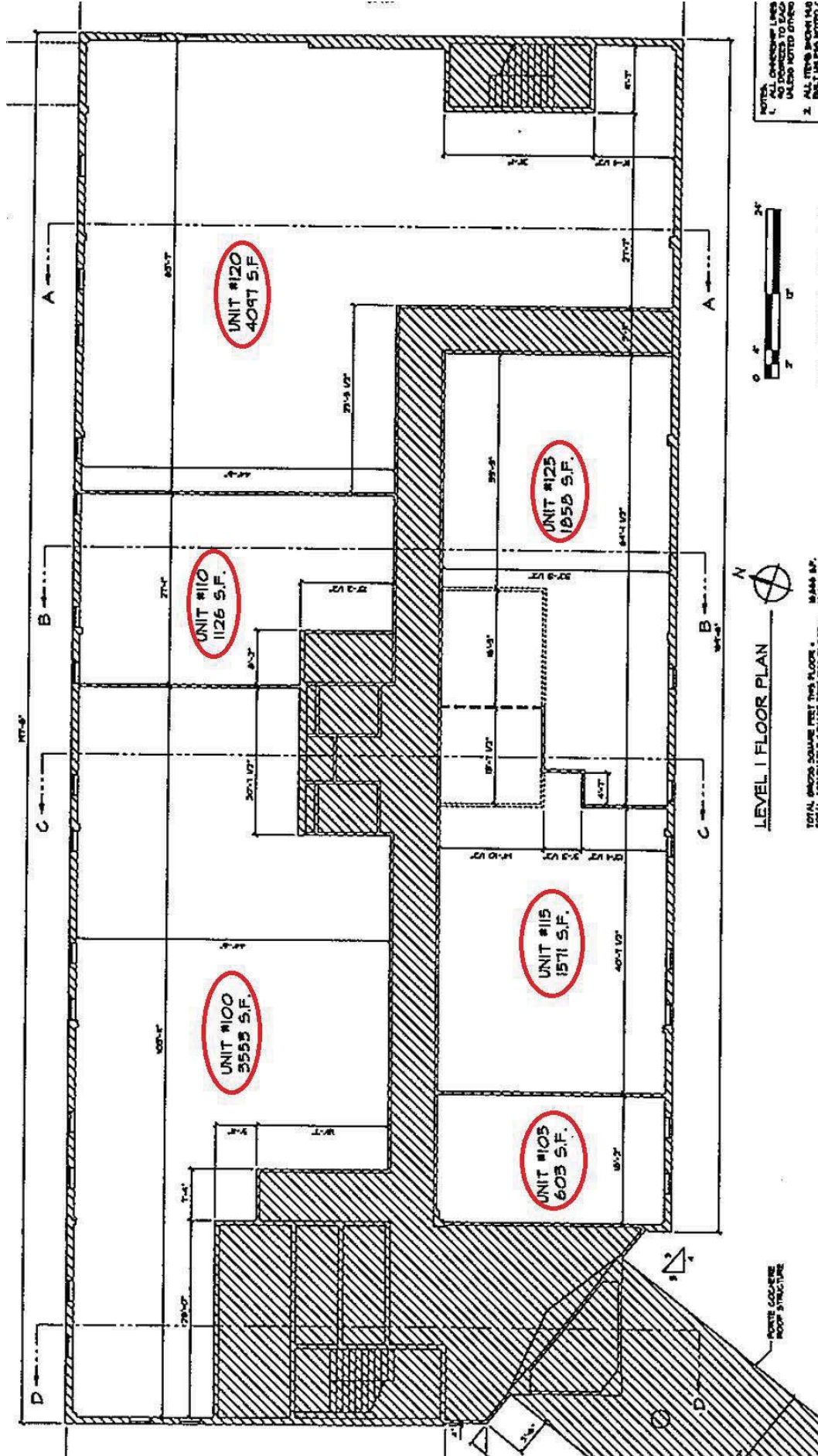
*PARCEL IS ZONED B-2 – HIGHWAY COMMERCIAL

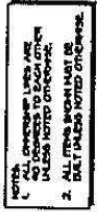
ZONING REGULATIONS (WAUSAUKEE, WI CLINIC)

Sec. 13-1-46 B-2 Highway Commercial District.

- (a) **Purpose.** The B-2 Highway Commercial District is intended to provide for the orderly and attractive grouping at appropriate locations along principal highway routes, of those businesses and customer services which are logically related to and dependent upon highway traffic, or which are specifically designated to serve the needs of such traffic.
- (b) **Permitted Uses.** The following are specific permitted uses in the B-2 District:
 - (1) Retirement homes.
 - (2) Lodges and fraternal uses.
 - (3) Governmental, cultural, and public buildings or uses, such as fire and police stations, community centers, libraries, public emergency shelters, parks, playgrounds and museums.
- (c) **Conditional Uses.** The following are specific conditional uses in this District:
 - (1) Amusement activities.
 - (2) Automobile and truck retail services.
 - (3) Automobile repair and fuel services.
 - (4) Bars and taverns.
 - (5) Gasoline service stations.
 - (6) Gift, novelty and souvenir sales.
 - (7) Hotels, motels and tourist courts.
 - (8) Night clubs and dance halls.
 - (9) Restaurants.
 - (10) Sales, service and installation of tires, batteries and accessories.
 - (11) Residential dwelling units.
 - (12) Animal hospital, shelters and kennels.
 - (13) Clinics.
 - (14) Public assembly uses.
 - (15) Commercial recreation facilities.
 - (16) Off-season storage facilities.
 - (17) Lodges and fraternal buildings.
 - (18) Nursing homes.
 - (19) Nursery and day care centers.
 - (20) Retirement homes.
 - (21) Drive-in food and beverage establishments.
 - (22) Drive-banks.
 - (23) Drive-in theaters.
 - (24) Vehicle sales and service.
 - (25) Public parking lots.
 - (26) Sewage disposal plants.
 - (27) Utilities.
 - (28) Mobile home sales.
 - (29) Log stacks are a conditional accessory use in the B-2 District, provided that they are located a minimum of sixty (60) from the center of adjacent public road right-of-ways.
 - (30) Farm implement sales.
 - (31) Other uses listed as either permitted or conditional uses in Section 13-1-45.
 - (32) Other uses similar to or customarily incidental to any of the above uses.

FLOOR PLANS – DICKINSON MEDICAL OFFICE BUILDING (aka DICKINSON PROFESSIONAL OFFICE BUILDING CONDOMINIUM)

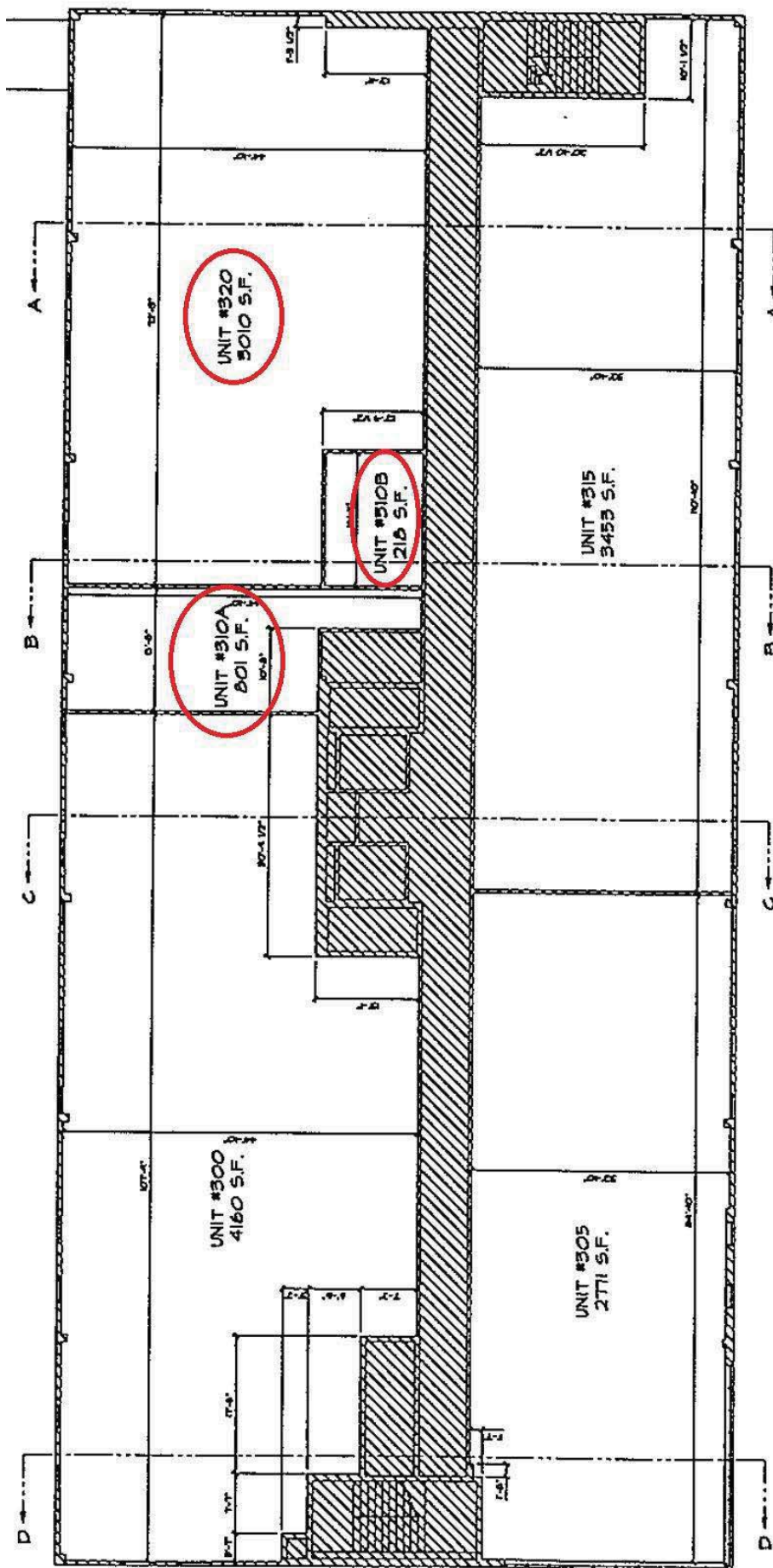




FLOOR PLAN

LEVEL 2 FLOOR PLAN

TOTAL GROSS SQUARE FEET THIS FLOOR *	9,870
TOTAL AVAILABLE SQUARE FEET THIS FLOOR *	13,444



NOTES:
 1. ALL DIMENSIONS ARE IN FEET AND INCHES UNLESS NOTED OTHERWISE.
 2. ALL DIMENSIONS ARE APPROXIMATE.



FLOOR PLAN



LEVEL 3 FLOOR PLAN

TOTAL GROSS SQUARE FEET THIS FLOOR: 14,321 S.F.
 TOTAL ADJUSTABLE SQUARE FEET THIS FLOOR: 14,321 S.F.

Exhibit E

Qualifications

Victor D. Cremeens, MAI

St. Louis, Missouri



16759 Main Street, Suite 209
St. Louis, Missouri 63040
Office Phone: (636) 530-0009
Direct: (636) 821-5311
Fax: (636) 530-0046
Email: vcremeens@irr.com

Employment

Mr. Cremeens serves as Managing Director – Hospital Valuation, of Integra Realty Resources (“IRR”). Effective March 2018 Tellatin, Inc., a pioneer in the appraisal of healthcare and senior housing properties, partnered with IRR to lead the organization’s Healthcare and Senior Housing practice group. With IRR and Tellatin, Inc., Mr. Cremeens has exclusively appraised healthcare and senior housing properties since 2000. Prior to specializing in the healthcare and senior housing field, he appraised general commercial real estate for a period of 15 years.

Experience

Mr. Cremeens specialized in the appraisal of general commercial real estate between 1985 and mid-2000. His appraisal assignments included a broad variety of property types, including: retail, office, industrial, hotel, special-purpose, agricultural, and land-in-transition properties. He has completed multiple subdivision analyses and condemnation appraisal assignments.

Mr. Cremeens has served as Managing Director for hospital valuation services since mid-2009. He has performed more than 125 hospital valuation assignments. Those appraisals are a mix of real-estate-only and going concern valuations. Clients include traditional and agency lenders (USDA and HUD programs), operators, assessors, and consultants.

State Licensure

Mr. Cremeens is currently licensed as a general real estate appraiser in Missouri, Texas, Ohio, Michigan, Colorado, Indiana, Minnesota and Illinois.

Education and Professional Accreditation

Mr. Cremeens earned a Bachelor of Science degree in Business Administration from the University of Missouri - Columbia. His areas of emphasis for the BSBA degree were finance and real estate. He holds the MAI designation from the Appraisal Institute.

**L

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING

N440911

CERTIFIED GENERAL APPRAISER
LICENSE

VICTOR DUANE CREMEENS

LICENSE NO.
1201073126

EXPIRATION DATE
07/31/2020

AUDIT NO
3348100

THIS DOCUMENT IS DULY ISSUED
UNDER THE LAWS OF THE STATE
OF MICHIGAN

ICENSE

About IRR

Integra Realty Resources, Inc. (IRR) provides world-class commercial real estate valuation, counseling, and advisory services. Routinely ranked among leading property valuation and consulting firms, we are now the largest independent firm in our industry in the United States, with local offices coast to coast and in the Caribbean.

IRR offices are led by MAI-designated Senior Managing Directors, industry leaders who have over 25 years, on average, of commercial real estate experience in their local markets. This experience, coupled with our understanding of how national trends affect the local markets, empowers our clients with the unique knowledge, access, and historical perspective they need to make the most informed decisions.

Many of the nation's top financial institutions, developers, corporations, law firms, and government agencies rely on our professional real estate opinions to best understand the value, use, and feasibility of real estate in their market.

Local Expertise...Nationally!

irr.com

LEGAL SERVICES AGREEMENT

This Agreement made this 19th day of July, 2019 between Dickinson County Healthcare System (DCHS), hereinafter referred to as "Owners," and Bart T. Stupak attorney at law, of Venable LLP as "Attorney":

WHEREAS, the Attorney agrees to perform all legal services necessary to the organization, financing, construction, and initial operation of a USDA Rural Development Community Facility Loan:

WITNESSETH:

That for and in consideration of the mutual covenants and promises between the parties hereto, it is hereby agreed:

SECTION A - LEGAL SERVICES

That the attorney will perform such services as are necessary to accomplish the above recited objectives including, but not limited to, the following:

1. Preparation and filing of petition for incorporation and supervision and assistance in the taking of such other actions as may be necessary or incidental to cause the Owners to become duly organized and incorporated and to be authorized to undertake the proposed project.
2. Furnish advice and assistance to the owner/governing body of the duly incorporated association in connection with (a) the notice for and conduct of meetings; (b) the preparation of minutes of meetings; (c) the preparation and enactment of such resolutions as may be necessary in connection with the authorization, financing, construction and initial operation of the facility/project; (d) the preparation of such affidavits, publication notices, ballots, reports, certifications, and other instruments and advice as may be needed in the conduct of such millage elections as may be necessary; (e) the preparation and completion of such debt instruments or other obligations as may be necessary to finance the facility/project; (f) the completion and execution of documents for obtaining a loan made or insured or a grant made by the United States of America, U. S. Department of Agriculture (USDA), (g) entering into construction contracts; (h) preparation and adoption of By-Laws, Rules and Regulations, and the rate schedules; (i) such other corporate action as may be necessary in connection with the financing, construction, and initial operation of the facility/project.
3. Review of purchase contracts, architectural contracts, construction contracts, bid-letting procedure, and surety and contractual bonds in connection therewith.

4. Preparation, where necessary of titles, financing statements and review of deeds, rendering title opinions with reference thereto; and providing for the recording thereof.
5. Obtain necessary permits and certificates from county and municipal bodies, from state regulatory agencies, and from other public or private sources with respect to the approval of the facility, the construction and operation thereof, and the like.
7. Cooperate with the architect employed by Owners in connection with preparation of tract sheets, easements, and other necessary title documents, construction contracts, water supply contracts, health permits, crossing permits, and other instruments.
8. Preparation and approval of those documents pertaining to the issuance of the Owner's obligations. Preparation of opinions of counsel as required by Owners or the USDA. When applicable, secure assistance of and cooperate with recognized bond counsel in the preparation of the documents necessary for the financing aspects of the facility/project. Where bond counsel is retained, the Attorney will not be responsible for the preparation and approval of those documents pertaining to the issuance of the Owner's obligations.

SECTION B - COMPENSATION

1. Owners will pay to the Attorney for professional services rendered in accordance herewith, fees as follows:
 - (a) Hourly rate of \$895 plus expenses; not to exceed \$125,000.00;
 - or
 - (b) Lump sum fee of \$_____.
2. Additional compensation, in excess of the maximum agreed on above, may be increased by amendment to this agreement only when there is sufficient documentation for the increase and approved by USDA Rural Development.

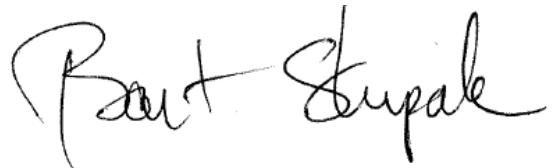
Said fees to be payable in the following manner and at the following times:

At the time of closing on the USDA Loan.

SECTION C - OTHER PROVISIONS

1. That upon organization and incorporation the association shall by appropriate resolution adopt and ratify this Agreement, that the association shall be substituted for the individual Owners as a party to this Agreement, and that the Owners as individuals shall thereupon be relieved of all personal liability existing or arising from this Agreement.
2. That upon organization and incorporation should the association fail or refuse to adopt and ratify this Agreement by appropriate resolution within 10 days from the date of the commencement of its legal existence, this Agreement shall terminate and Owners shall be liable to the Attorney for Payment of \$125,000.00, which sum represents payment in full for the organization and incorporation of the association for all other legal services rendered to Owners under the terms of this Agreement to the date of said termination.

Attorney:

A handwritten signature in black ink that reads "Bart Stupak". The signature is written in a cursive, flowing style.

Bart Stupak

Phone No: 202-344-4226

Email Address: bstupak@venable.com

Owners:

Dickinson County Healthcare System

Jerry Worden, Interim CFO

USDA RURAL DEVELOPMENT:

DICKINSON COUNTY HEALTHCARE SYSTEM
BOARD OF TRUSTEES
MARGARET MINERICK, CHAIRMAN
NOTICE OF PUBLIC HEARING FOR
A COMMUNITY FACILITIES DIRECT LOAN
PER FEDERAL CATALOG NUMBER 10.766
July 25, 2019
5:00 PM

NOTICE is hereby given that Dickinson County Healthcare System will conduct a Public Hearing on July 25, 2019, at 5:00 PM in Conference Room E, 1721 S. Stephenson Avenue, Iron Mountain, Michigan, for the purposes of affording citizens an opportunity to hear and present comments on the pre-application for a Community Facilities Direct Loan per Federal Catalog Number 10.766.

The Dickinson County Healthcare System proposes to request \$24,808,000.00 for the following purposes:

- \$10,035,000.00 for refinancing of a term loan with Fifth Third Bank, N.A.
- Financing of Capital Assets
 - \$786,700.00 for facilities improvement projects
 - \$3,087,927.00 for replacement of the Linear Accelerator (cancer center)
 - \$610,165.00 for replacement of the CT Unit
 - \$657,703.00 for replacement of the SPECT CT Unit
 - \$1,546,350.00 for replacement of the MRI Unit
 - \$3,353,290.00 for upgrading Information Technology systems
 - \$4,330,797.00 for upgrading other essential equipment
 - \$400,068.00 for payment of financing fees

The exact dollar amounts for the contemplated disbursements are subject to revision depending on the timing of the payoff, work performed, and purchases.

The loan will have a final maturity in 25 years from an assumed January 1, 2020, date of issuance. If the loan were to be amortized monthly according to a level debt service schedule at an assumed rate of 3.50 percent (the rate currently in effect), the weighted average maturity (WAM) of the loan would be approximately 14.3 years. This figure compares favorable to the composite useful life of the Capital Assets financed and refinanced. The annual debt service on the loan would be approximately \$1,491,000.

Citizen views and comments on the proposed application are welcome.

EQUAL OPPORTUNITY AGREEMENT

This agreement, dated 07-25-2019 between
Dickinson County Healthcare System

(herein called "Recipient" whether one or more) and United States Department of Agriculture (USDA), pursuant to the rules and regulations of the Secretary of Labor (herein called the 'Secretary') issued under the authority of Executive Order 11246 as amended, witnesseth:

In consideration of financial assistance (whether by a loan, grant, loan guaranty, or other form of financial assistance) made or to be made by the USDA to Recipient, Recipient hereby agrees, if the cash cost of construction work performed by Recipient or a construction contract financed with such financial assistance exceeds \$10,000 - unless exempted by rules, regulations or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order 11246 of September 24, 1965.

1. To incorporate or cause to be incorporated into any contract for construction work, or modification thereof, subject to the relevant rules, regulations, and orders of the Secretary or of any prior authority that remain in effect, which is paid for in whole or in part with the aid of such financial assistance, the following "Equal Opportunity Clause":

During the performance of this contract, the contractor agrees as follows:

- (a) The contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex or national origin. The contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited, to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the USDA setting forth the provisions of this nondiscrimination clause.
- (b) The contractor will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.
- (c) The contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the USDA, advising the said labor union or workers' representative of the contractor's commitments under this agreement and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- (d) The contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of all rules, regulations and relevant orders of the Secretary of Labor.
- (e) The contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, rules, regulations, and orders, or pursuant thereto, and will permit access to his books, records, and accounts by the USDA Civil Rights Office, and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- (f) In the event of the contractor's noncompliance with the nondiscrimination clauses of this contract or with any of the said rules, regulations, or orders, this contract may be cancelled, terminated, or suspended in whole or in part and the contractor may be declared ineligible for further Government contracts or federally assisted construction contracts in accordance with procedures authorized in Executive Order No. 11246 of September 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation or order of the Secretary of Labor, or as otherwise provided by Law.
- (g) The contractor will include the provisions of paragraph 1 and paragraph (a) through (g) in every subcontract or purchase order, unless exempted by the rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontract or purchase order as the USDA may direct as a means of enforcing such provisions, including sanctions for noncompliance: ~~Provided, however,~~ that in the event the contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the USDA, the contractor may request the United States to enter into such litigation to protect the interest of the United States.

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collections is 0575-0018. The time required to complete this information collection is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

2. To be bound by the above equal opportunity clause with respect to its own employment practices when it participates in federally assisted construction work: Provided, that if the organization so participating is a State or local government, the above equal opportunity clause is not applicable to any agency, instrumentality or subdivision of such government which does not participate in work on or under the contract.
3. To notify all prospective contractors to file the required 'Compliance Statement', Form RD 400-6, with their bids.
4. Form AD-425, Instructions to Contractors, will accompany the notice of award of the contract. Bid conditions for all nonexempt federal and federally assisted construction contracts require inclusion of the appropriate "Hometown" or "Imposed" plan affirmative action and equal employment opportunity requirements. All bidders must comply with the bid conditions contained in the invitation to be considered responsible bidders and hence eligible for the award.
5. To assist and cooperate actively with USDA and the Secretary in obtaining the compliance of contractors and subcontractors with the equal opportunity clause and rules, regulations, and relevant orders of the Secretary, that will furnish USDA and the Secretary such information such as , but not limited to, Form AD-560, Certification of Nonsegregated Facilities, to submit the Monthly Employment Utilization Report, Form CC-257, as they may require for the supervision of such compliance, and that it will otherwise assist USDA in the discharge of USDA's primary responsibility for securing compliance.
6. To refrain from entering into any contract or contract modification subject to such Executive Order 11246 of September 24, 1965, with a contractor debarred from, or who has not demonstrated eligibility for, Government contracts and Federally assisted construction contracts pursuant to the Executive Order and will carry out such sanctions and penalties for violation of the equal opportunity clause as may be imposed upon contractors and subcontractors by USDA or the Secretary of Labor pursuant to Part II, Subpart D, of the Executive Order.
7. That if the recipient fails or refuses to comply with these undertakings, the USDA may take any or all of the following actions: Cancel, terminate, or suspend in whole or in part this grant (contract, loan, insurance, guarantee); refrain from extending any further assistance to the organization under the program with respect to which the failure or refund occurred until satisfactory assurance of future compliance has been received from such organization; and refer the case to the Department of Justice for appropriate legal proceedings.

Signed by the Recipient on the date first written above.

_____ \$712,000 Recipient (SEAL) Attest: _____ City Clerk	_____ (\$293,000) Recipient Dickinson County Healthcare System _____ Name of Recipient By _____ Mayor

USDA
Form RD 400-4
(Rev. 11-17)

ASSURANCE AGREEMENT
(Under Title VI, Civil Rights Act of 1964)

FORM APPROVED
OMB No. 0575-0018
OMB No. 0570-0062

The Dickinson County Healthcare System

(name of recipient)

1721 South Stephenson Avenue, Iron Mountain, Michigan 49801

(address)

As a condition of receipt of Federal financial assistance, you acknowledge and agree that you must comply (and require any subgrantees, subrecipients, contractors, successors, transferees, and assignees to comply) with applicable provisions of national laws and policies prohibiting discrimination, including but not limited to:

1. Title VI of the Civil Rights Act of 1964, as amended, which prohibits you from discriminating on the basis of race, color, or national origin (42 U.S.C. 2000d et seq.), and 7 CFR Part 15, 7 CFR 1901, Subpart E.

As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service) guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with Title VI, you must take reasonable steps to ensure that LEP persons have meaningful access to your programs [in accordance with USDA RD LEP Guidance for RD Funded (Assisted) Programs]. Meaningful access may entail providing language assistance services, including oral and written translation, where necessary. You are encouraged to consider the need for language services for LEP persons served or encountered both in developing your budgets and in conducting your programs and activities. For assistance and information regarding your LEP obligations, go to <http://www.lep.gov>;

2. Title IX of the Education Amendments of 1972, as amended, which prohibits you from discriminating on the basis of sex in education programs or activities (20 U.S.C. 1681 et seq.) [as implemented by 7 CFR Part 15, 7 CFR 1901, Subpart E];

3. The Age Discrimination Act of 1975, as amended, which prohibits you from discriminating on the basis of age (42 U.S.C. 6101 et seq.) [as implemented by 7 CFR Part 15, 7 CFR 1901, Subpart E];

4. Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits you from discriminating on the basis of disability (29 U.S.C. 794) [as implemented by 7 CFR Part 15, 7 CFR Part 15b, 7 CFR 1901, Subpart E];

5. Title VIII of the Civil Rights Act, which prohibits you from discriminating in the sale, rental, financing, and advertising of dwellings, or in the provision of services in connection therewith, on the basis of race, color, national origin, religion, disability, familial status, and sex (42 U.S.C. 3601 et seq.), as implemented by the Department of Housing and Urban Development at 24 CFR part 100. The prohibition on disability discrimination includes the requirement that new multifamily housing with four or more dwelling units, i.e., the public and common use areas and individual apartment units (all units in buildings with elevators and ground-floor units in buildings without elevators) be designed and constructed with certain accessible features, see 24 CFR Part 100.201; and

6. Titles II and III of the Americans with Disabilities Act, which prohibit you from discriminating on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing entities (42 U.S.C. §§ 12131-12189), as implemented by Department of Justice regulations at 28 C.F.R. parts 35 and 36, and 7 CFR Part 15, 7 CFR Part 15b, 7 CFR 1901, Subpart E.

You also acknowledge and agree that you must comply (and require any subgrantees, subrecipients, contractors, successors, transferees, and assignees to comply) with applicable provisions governing USDA Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service) access to records, accounts, documents, information, facilities, and staff:

1. You must cooperate with any compliance review or complaint investigation conducted by USDA Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service).
2. You must give USDA Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service) access to and the right to examine and copy records, accounts, and other documents and sources of information related to the grant and permit access to facilities, personnel, and other individuals and information as may be necessary, as required by Title VI, Title IX, Age, and Section 504 implementing regulations and other applicable laws or program guidance.
3. You must keep such records and submit to the responsible Department official or designee timely, complete, and accurate compliance reports at such times, and in such form and containing such information, as the responsible Department official or his designee may determine to be necessary to ascertain whether you have complied or are complying with relevant obligations.
4. You must comply with all other reporting, data collection, and evaluation requirements, as prescribed by law or detailed in program guidance.
5. Make available to users, participants, beneficiaries and other interested persons such information regarding the provisions of this agreement and the regulations, and in such manner as the Rural Development or the U.S. Department of Agriculture finds necessary to inform such persons of the protection assured them against discrimination.
6. If, during the past three years, you (the recipient) have been accused of discrimination on the grounds of race, color, national origin (including limited English proficiency), sex, age, disability, religion, or familial status, you must provide a list of all such proceedings, pending or completed, including outcome and copies of settlement agreements.
7. In the event any court or administrative agency makes a finding of discrimination on grounds of race, color, national origin (including limited English proficiency), sex, age, disability, religion, or familial status against you, or you settle a case or matter alleging such discrimination, you must forward a copy of the complaint and findings to USDA Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service), Office of Civil Rights.

The United States has the right to seek judicial enforcement of these obligations.

You also acknowledge and agree that you must comply (and require any subgrantees, subrecipients, contractors, successors, transferees, and assignees to comply) with applicable provisions of program-specific nondiscrimination policy requirements found at CFR Part 15, 7 CFR Part 15 b, 12 CFR Part 202, 7 CFR 1901, Subpart E., DR4300-003, DR4330-0300, DR4330-005.

Period of Obligation

In the case of any service, financial aid, covered employment, equipment, property, or structure provided, leased, or improved with federal assistance extended to the Recipient by Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service), this assurance obligates the Recipient for the period during which federal assistance is extended. In the case of any transfer of such service, financial aid, equipment, property, or structure, this assurance obligates the transferee for the period during which federal assistance is extended. If any personal property is so provided, this assurance obligates the Recipient for the period during which it retains ownership or possession of the property. In all other cases, this assurance obligates the Recipient for the period during which the federal assistance is extended to the Recipient by Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service).

Employment Practices

Where a primary objective of the federal assistance is to provide employment or where the Recipient's employment practices affect the delivery of services in programs or activities resulting from federal assistance extended by Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service), the Recipient agrees not to discriminate on the grounds of race, color, national origin, sex, age, or disability, in its employment practices. Such employment practices may include, but are not limited to, recruitment, advertising, hiring, layoff or termination, promotion, demotion, transfer, rates of pay, training and participation in upward mobility programs; or other forms of compensation and use of facilities.

Data Collection

The Recipient agrees to compile and maintain information pertaining to programs or activities developed as a result of the Recipient's receipt of federal assistance from Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service). Such information shall include, but is not limited to the following: (1) the manner in which services are or will be provided and related data necessary for determining whether any persons are or will be denied such services on the basis of prohibited discrimination; (2) the population eligible to be served by race, color, national origin, sex, age, and disability; (3) data regarding covered employment including use or planned use of bilingual public contact employees serving beneficiaries of the program where necessary to permit effective participation by beneficiaries unable to speak or understand English; (4) the location of existing or proposed facilities connected with the program and related information adequate for determining whether the location has or will have the effect of unnecessarily denying access to any person on the basis of prohibited discrimination; (5) the present or proposed membership by race, color, national origin, sex, age and disability in any planning or advisory body which is an integral part of the program; and (6) any additional written data determined by Rural Development (Rural Housing Service, Rural Business and Cooperative Service, and Rural Utilities Service) to be relevant to the obligation to assure compliance by recipients with laws cited in this assurance agreement.

Under penalty of perjury, the undersigned officials certify that they have read and understand their obligations as herein described, that the information submitted in conjunction with this Document is accurate and complete, and that the recipient is in compliance with the nondiscrimination requirements set out above.

Rights and remedies provided for under this agreement shall be cumulative.

In witness whereof, Dickinson County Healthcare System on this
(name of recipient)
date has caused this agreement to be executed by its duly authorized officers and its seal affixed hereto, or, if a natural person, has hereunto executed this agreement.

(S E A L)

Recipient

07-25-19

Date

Attest:

Sally L. Blom, Secretary

Title

Margaret Minerick, Chairperson

Title

UNITED STATES DEPARTMENT OF AGRICULTURE
RURAL DEVELOPMENT

APPLICANT CERTIFICATION
FEDERAL COLLECTION POLICIES FOR CONSUMER OR COMMERCIAL DEBTS

The Federal Government is authorized to check credit information about the applicant(s) including using the federal Credit Alert Interactive Voice Response System (CAIVRS) or its successors to check to see if the applicant(s) are delinquent or in default on a Federal debt.

The Federal Government is also authorized by law to take any or all of the following actions in the event your loan payments become delinquent or you default on your loan:

- Report your name and account information to a credit reporting agency, and the Credit Alert Interactive Voice Response System (CAIVRS).
- Assess interest and penalty charges for the period of time that payment is not made.
- Assess charges to cover additional administrative costs incurred by the government to service your account.
- Offset amounts to be paid to you from your Federal income tax refund.
- Offset amounts to be paid to you under other Federal Programs.
- Refer your account to a private collection agency to collect the amount due.
- Foreclose on any security you have given for the loan.
- Pursue legal action to collect through the courts.
- Report any written off debt to the Internal Revenue Service as taxable income.
- If you are a current or retired Federal employee, take action to offset your salary, or civil service retirement benefits.
- Debar or suspend you from doing business with the Federal Government either as a participant or principal throughout the executive branch of the Federal Government for the period of debarment or suspension.
- Refer any debt that is delinquent to the Treasury Offset Program (TOP) in accordance with the Debt Collection Improvement Act of 1996.
- Refer any eligible debt that is delinquent to the Treasury for cross servicing in accordance with the Debt Collection Improvement Act of 1996.
- Garnish your wages as allowed by the Debt Collection Improvement Act of 1996.

Any or all of these actions may be used to recover any debts owed when it is determined to be in the interest of the Government to do so.

CERTIFICATION: I/we have read and I/we understand the actions the Federal Government may take in the event that I/we fail to meet my/our scheduled payments in accordance with the terms and conditions of my/our agreement. I/we understand that the above list is not all inclusive and that the Federal Government may deem additional actions necessary to collect should I/we become delinquent.

	Dickinson (		\$712,000
(Signature-Individual(s))	(Date)	(Signature-Individual(s))	(Date)

	07-25-2019		(\$293,000)
(SEAL)	(Date)	(Name of Applicant)	
		(Signature of Authorized Entity Official)	
ATTEST:			(\$1,140,000)
		(Title of Authorized Entity Official)	
		1721 South Stephenson Avenue	
		(Address)	
(Signature of Attesting Official)		Iron Mountain, Michigan 49801	
Sally L. Blom, Secretary		(City, State, and Zip Code)	
(Title of Attesting Official)			

CERTIFICATION FOR CONTRACTS, GRANTS AND LOANS

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant or Federal loan, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant or loan.

2 If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant or loan, the undersigned shall complete and submit Standard Form - LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3 The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including contracts, subcontracts, and subgrants under grants and loans) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Margaret Minerick

(name)

1721 South

(date)

Chairperson

(title)

000

U.S. DEPARTMENT OF AGRICULTURE

Certification Regarding Debarment, Suspension, and Other Responsibility Matters - Primary Covered Transactions

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 7 CFR Part 3017, Section 3017.510, Participants' responsibilities. The regulations were published as Part IV of the January 30, 1989 Federal Register (pages 4722-4733). Copies of the regulations may be obtained by contacting the Department of Agriculture agency offering the proposed covered transaction.

(BEFORE COMPLETING CERTIFICATION, READ INSTRUCTIONS ON REVERSE)

- (1) The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
 - (b) have not within a three-year period preceding this proposal been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - (c) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
 - (d) have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.
- (2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Dickinson County Healthcare System

10.766 Community Facilities

Organization Name

PR/Award Number or Project Name

Margaret Minerick

Name(s) and Title(s) of Authorized Representative(s)

07/25/2019

Signature(s)

Date

Instructions for Certification

1. By signing and submitting this form, the prospective primary participant is providing the certification set out on the reverse side in accordance with these instructions.
2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out on this form. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.
3. The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.
4. The prospective primary participant shall provide immediate written notice to the department or agency to whom this proposal is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.
6. The prospective primary participant agrees by submitting this form that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.
7. The prospective primary participant further agrees by submitting this form that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

U.S. DEPARTMENT OF AGRICULTURE

**CERTIFICATION REGARDING
DRUG-FREE WORKPLACE REQUIREMENTS (GRANTS)
ALTERNATIVE I - FOR GRANTEEES OTHER THAN INDIVIDUALS**

This certification is required by the regulations implementing Sections 5151-5160, of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), 7 CFR Part 3017, Subpart F, Section 3017.600, Purpose. The January 31, 1989, regulations were amended and published as Part II of the MAY 25, 1990, Federal Register (pages 21681-21691). Copies of the regulations may be obtained by contacting the Department of Agriculture agency offering the grant.

(BEFORE COMPLETING CERTIFICATION, READ INSTRUCTIONS ON REVERSE)

Alternative I

- A. The grantee certifies that it will or will continue to provide a drug-free workplace by:
- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - (b) Establishing an ongoing drug-free awareness program to inform employees about --
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a):
 - (d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will --
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
 - (e) Notify the agency in writing, within 10 calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position, title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
 - (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

B. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant:

Place of Performance (Street address, city, county, State, zip code)

1721 South Stephenson Avenue

Iron Mountain, Dickinson County, Michigan 49801

Check ☒ if there are workplaces on file that are not identified here.

Dickinson County Healthcare System

10.766 Community Facilities Loan

Organization Name

Award Number or Project Name

Margaret Minerick, Chairperson

Name and Title of Authorized Representative

Signature

Date

Instructions for Certification

1. By signing and submitting this form, the grantee is providing the certification set out on pages 1 and 2.
2. The certification set out on pages 1 and 2 is a material representation of fact upon which reliance is placed when the agency awards the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.
3. Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If know, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.
4. Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).
5. If the workplace identified to the agency changes during the performance of the grant, the grantee shall inform the agency of the change(s), if it previously identified the workplaces in question (see paragraph three).
6. Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

``Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 CFR 1308.11 through 1308.15);

``Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

``Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

``Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including: (i) all ``direct charge" employees; (ii) all ``indirect charge" employees unless their impact or involvement is insignificant to the performance of the grant; and, (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if sued to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

CHARTER TOWNSHIP OF BREITUNG

www.breitungtwp.org

Office of the Superintendent

Steve Mulka

3851 Menominee Street PO Box 160
Quinnesec, Michigan 49876

Office: (906) 779-2055

Fax: (906) 779-2077

Email: superintendent@breitungtwp.org

July 17, 2019

USDA Rural Development
Hon. Jason Allen, Director
3001 Coolidge Road, Suite 200
East Lansing, MI 48823

Hon. Jason Allen,

I hope this letter finds you well. I am writing to you on behalf of the Charter Township of Breitung in Quinnesec, Michigan to express our support for the Dickinson County Healthcare System's request for a USDA Rural Development loan. The information provided to our Board of Trustees stated that the hospital was requesting a 25 million dollar loan to maintain and expand healthcare services in the south-central Upper Peninsula of Michigan and north-eastern Wisconsin.

Considering the fact that the closest comparable healthcare system and hospital providing comparable medical services to our residents is located more than 90 miles away, we believe that Dickinson County Healthcare System is not only crucial but also a critical need in our rural area.

Dickinson County Healthcare System has been providing safe, reliable and affordable healthcare for our residents for over 68 years and having that leave the area would not only affect the health of the local residents but the economic state of our entire county in a negative way. Dickinson County Healthcare System has prided itself on their small-town service style with big-city innovations and I'm sure if you asked any random resident on the street, they would agree that the hospital needs the support that the USDA Rural Development loan would provide.

Thank you for taking the time to read through this letter. If you have any questions or would like to discuss this matter further with me, please feel free to call or email me using the information listed above.



Steve Mulka
Superintendent

Dear Director Jason Allen,

On behalf of the Breitung Township Schools District, I am writing this letter of support for the DCHS's Board of Trustee's application to borrow \$25,000,000 from the USDA Rural Development Agency. There is a critical need to have access to quality, affordable health care in our rural area encompassing the south central Upper Peninsula of Michigan and northeastern Wisconsin. Not only has DCHS met the medical needs of our community for the past 68 years, it has been a driving economic force in our community. DCHS is one of our area's largest employers, builds a stronger community and helps attract families and perspective employees to the area.

The new Leadership team at DCHS has been working diligently to stabilize and improve the financial condition of our health care system. Being a recipient of a \$25,000,000 USDA Rural Development Agency Grant will help ensure the goal of stabilizing and restructuring DCHS's long-term financial obligations comes to fruition. It will also enable purchase critically needed medical equipment.

Since the closest health care system and hospital providing comparable medical services to our residence is over 90 miles away it is critically important to keep DCHS in our community as a viable option.

Thank you for your consideration in approving DCHS's Board of Trustee's application to borrow \$25,000,000 from the USDA Rural Development Agency.

Sincerely,

A handwritten signature in blue ink, appearing to read "Craig Allen", is written over the typed name.

Craig Allen, Superintendent
Breitung Township Schools

JACK BERGMAN
1ST DISTRICT, MICHIGAN

COMMITTEE ON ARMED SERVICES
COMMITTEE ON VETERANS' AFFAIRS

Congress of the United States
House of Representatives
Washington, DC 20515-2201

WASHINGTON, DC OFFICE
414 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4735

TRAVERSE CITY OFFICE
1396 DOUGLAS DRIVE, SUITE 22B
TRAVERSE CITY, MI 49696
(231) 944-7633

MARQUETTE OFFICE
1500 W. WASHINGTON STREET, SUITE 2
MARQUETTE, MI 49855
(906) 273-2227

July 1, 2019

Hon. Jason Allen, Director
USDA Rural Development
3001 Coolidge Road, Suite 200
East Lansing, MI 48823

Dear Mr. Allen,

I am writing on behalf of Dickinson County Healthcare System (DCHS), which is seeking a loan from the USDA Rural Development Community Facilities Program. DCHS has made drastic improvements to both its medical services and its financial operations and this loan would help DCHS provide more efficient and effective medical treatment to the people in the Upper Peninsula.

Due to the rural nature of the region, the Upper Peninsula faces challenges in terms of access to medical care. This loan would ultimately contribute to increasing access to affordable, quality health care. For instance, DCHS has planned to use half of the loan to stabilize and restructure its long-term financial obligations, and the other half to purchase needed medical equipment including a new MRI machine and LINAC device for radiation oncology therapy.

DCHS has played an important role by serving as the only 24-hour healthcare provider in the south-central Upper Peninsula. The healthcare system is one of the area's largest employers, with over 750 employees and an operating budget of 100 million dollars annually. DCHS is also poised to assist the Oscar Johnson Veteran Affairs Medical Facility in Dickinson County through the MISSION Act, which was signed into law in 2018. Expanding these services is especially important to Upper Peninsula Veterans, as the next closest VA facility with specialty services in Milwaukee, WI.

As USDA Rural Development continues its mission of bringing opportunity to rural communities across America, I urge your full consideration for Dickinson County Healthcare System's loan application. This hospital provides an invaluable service to the rural communities throughout the Upper Peninsula. Please do not hesitate to contact my office with questions if further information is required.

Sincerely,



Jack Bergman
Member of Congress



June 20, 2019

USDA Rural Development
Hon. Jason Allen, Director
3001 Coolidge Road, Suite 200
East Lansing, MI 48823

Dear Director Allen,

On behalf of the Board of Directors of the Dickinson Area Economic Development Alliance (the Alliance), we write today to share our support of Dickinson County Healthcare System's (DCHS) loan application to borrow \$25 million dollars from the USDA Rural Development Agency.

The Alliance works to improve the dialog between businesses, industry, education, government, and community organizations to increase awareness and better coordinate economic stimulation in the Dickinson County area.

We recognize not only the important economic impact that DCHS contributes to our area, but also the value of having a robust level of healthcare services in our community. Because the Alliance focuses on developing initiatives that support talent retention, attraction and growth, we know that having a well-functioning healthcare system in any community is a necessary asset in order to retain and attraction the workforce needed to serve our business community.

The financial progress made by DCHS in recent months is truly encouraging and the leadership has charted a path of stability in order to ensure the future of DCHS. The potential of securing long term funding through a USDA Rural Development loan, is a very important step and we hope that you will support the application through the process.

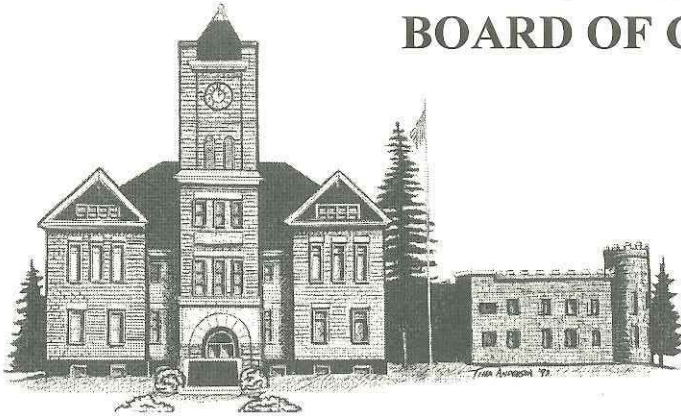
Please reach out to Lois Ellis, Alliance Executive Director at 906-360-4653 or lois.ellis@daeda.org if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Russ Kassin".

Russ Kassin, Chair

DICKINSON COUNTY BOARD OF COMMISSIONERS



Board Chairman: Henry Wender
Vice Chairman: Joe Stevens
Commissioners: John P. Degenauer, Jr.
Barb J. Kramer
Kevin Pirlot

Controller/Administrator: Brian Bousley
Administrative Assistant: Christy Paul

DICKINSON COUNTY RESOLUTION 2019-13

RESOLUTION IN SUPPORT OF THE DCHS BOARD OF TRUSTEES' LOAN APPLICATION TO BORROW \$25 MILLION DOLLARS FROM USDA RURAL DEVELOPMENT AGENCY

WHEREAS, The Dickinson County Healthcare System has been in operation for the past 68 years; and

WHEREAS, Dickinson County Healthcare System is critical in providing access to quality, affordable health care in the south-central Upper Peninsula of Michigan and northeastern Wisconsin; and

WHEREAS, the closest health care system and hospital providing comparable medical services to our residents of Dickinson County and northeastern Wisconsin is located more than 90 miles away; and

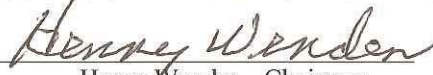
WHEREAS, the DCHS Board of Trustees and the internal leadership of DCHS have aggressively addressed the financial and medical needs for the benefits of our residents; and

WHEREAS, a portion of the proposed USDA \$25 million-dollar loan will be used to stabilize and restructure DCHS' long term financial obligations; and

WHEREAS, the remaining portion of the proposed USDA \$25 million-dollar loan will be used to purchase and upgrade critically needed medical equipment, new MRI and Linac for radiation oncology therapy.

NOW, THEREFORE, BE IT RESOLVED that, the Dickinson County Board of Commissioners does hereby support the DCHS Board of Trustees USDA Rural Development loan in the amount of \$25 million dollars.

DICKINSON COUNTY BOARD OF COMMISSIONERS


Henry Wender, Chairman


Joe Stevens, Commissioner


Kevin Pirlot, Commissioner

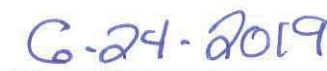

John Degenauer, Jr., Commissioner


Barbara Kramer, Commissioner

I, Dolly Cook, the duly appointed, qualified and acting Clerk of the County of Dickinson, Michigan, do hereby certify that the above extract from the minutes of a Regular meeting of the County Board of Commissioners of Dickinson County, Michigan held on June 24, 2019 is a true and correct excerpt of original minutes related to the matters set forth.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of the County of Dickinson, Michigan, this 24th day of June, 2019.


Dolly L. Cook, Clerk


Date

City of Iron Mountain

501 S. Stephenson Ave
Iron Mountain, MI 49801
Telephone: 906-774-8530
Fax: 906-774-3774

Email: clerktreasurer@cityofironmountain.com
Website: www.cityofironmountain.com

July 17, 2019

USDA Rural Development
Honorable Jason Allen, Director
3001 Coolidge Road, Suite 200
East Lansing, MI. 48823

Dear Director Allen,

The City of Iron Mountain supports the furtherance of business, industry, education, government, community organizations and the community as a whole; of which Dickinson County Health System (DCHS) has been providing medical care to the south central Upper Peninsula of Michigan and Northeastern Wisconsin since 1951.

We write today in support of a funding request by the Dickinson County Health care System (DCHS) to assist in the restructuring of its healthcare system and for other much needed upgrades in critical medical equipment. The financial progress made by DCHS in recent months is a visible sign of DCHS's efforts to ensure the continuing viability of our community's medical services. The securing of long-term funding through a USDA Rural Development loan would greatly aid DCHS's continued efforts to maintain and improve the medical services available in our area.

We proudly support DCHS for their past, present and future contributions to our community. On behalf of our City Council, residents, local stakeholders and patience we ask that you join us in supporting DCHS throughout the process of receiving a rural development loan.

Sincerely,



Isaac Micheau
Clerk/Treasurer

THE PROGRESSIVE CITY



CITY OF KINGSFORD

Phone: (906) 774-3526

305 S. Carpenter Avenue
Kingsford, MI 49802

Fax: (906) 774-7093

www.cityofkingsford.com

June 21, 2019

USDA Rural Development
Honorable Jason Allen, Director
3001 Coolidge Road, Suite 200
East Lansing, MI. 48823

Dear Honorable Jason Allen,

On behalf of the Kingsford City Council, we write today in support of a funding request by the Dickinson County Healthcare System (DCHS) to assist in the restructuring of its healthcare system and for other much needed upgrades in critical medical equipment. DCHS has been providing critical medical care to the south central Upper Peninsula of Michigan and Northeastern Wisconsin since 1951.

The City of Kingsford, which is located in DCHS's primary service area, was founded around the same pioneering spirit of those that settled this area in the late 1800s. Kingsford and the Dickinson County communities have survived over the years because of the strong work ethics passed down by our predecessors. This has allowed us to diversify and continue providing vibrant communities, which maintain strong industries, businesses, schools and neighborhoods. Maintaining a healthy and convenient medical facility is critical in continuing and maintaining this strong economic climate.

The new administration and board members of DCHS have shown decisive change during these past several months by taking on the challenges and tasks to progress the organization into a financially sound institution. We encourage this progress and support their leadership.

We ask that you take every consideration in supporting their financial request, so that they can continue to provide this much needed medical facility for the Dickinson County communities and the entire area.

Sincere Regards,

Anthony Erickson, Mayor

This Institution is an Equal Opportunity Provider, and Employer



108TH DISTRICT
STATE CAPITOL
P.O. BOX 30014
LANSING, MI 48909-7514
PHONE: (517) 373-0156
FAX: (517) 373-9370
beaulafave@house.mi.gov

MICHIGAN HOUSE OF REPRESENTATIVES

BEAU MATTHEW LAFAVE

STATE REPRESENTATIVE

COMMITTEES:
MILITARY, VETERANS AND
HOMELAND SECURITY, CHAIR
JUDICIARY, VICE CHAIR
AGRICULTURE
INSURANCE
OVERSIGHT
SELECT COMMITTEE ON REDUCING
CAR INSURANCE RATES

July 7, 2019

Mr. Jason Allen, Director
USDA Rural Development
3001 Coolidge Road, Suite 200
East Lansing, MI 48823

Dear Director Allen:

I am writing to indicate my support of the Dickinson County Healthcare System's (DCHS) loan application to borrow \$25 million dollars from the USDA Rural Development Agency.

As you know, access to quality, affordable rural healthcare is critical as rural residents face many different barriers for care with one of the major ones being proximity. The closest health care system and hospital providing comparable medical services to DCHS residents is located more than 90 miles away. Therefore, it is imperative that DCHS continue providing care for the residents of the Upper Peninsula of Michigan and northeastern Wisconsin as it has for the past 68 years.

The new leadership team at DCHS has been diligently working to put in place internal financial controls and processes to ensure continual improvement in DCHS budget and medical services. While the hospital has been able to report three quarters in the black and continues to effectively manage its finances, the \$25 million-dollar loan would play a key role in meeting those goals.

Approximately, one half of the \$25 million dollars would be used to stabilize and restructure the system's long-term financial obligations. This would help lower the health system's monthly financial obligations, thereby providing more efficient and effective medical treatment to patients. The other half of the loan would be used to purchase and upgrade critically needed medical equipment, including a new MRI and Linac for radiation oncology therapy.

I strongly support the healthcare system's plans to secure and utilize a USDA Rural Development loan as the trustee board continues to explore ways to most effectively provide quality and affordable healthcare to area residents. Please do not hesitate to contact me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Beau M. LaFave".

Beau Matthew LaFave
State Representative
108th House District



ED McBROOM

38TH DISTRICT

CAUCUS DEAN

P.O. BOX 30036

LANSING, MI 48909-7536

PHONE: (517) 373-7840

FAX: (517) 373-3932

senmcbroom@senate.michigan.gov

**THE SENATE
STATE OF MICHIGAN**

COMMITTEES:

CHAIR, NATURAL RESOURCES

CHAIR, OVERSIGHT

VICE CHAIR, ELECTIONS

VICE CHAIR, JCAR

ADVICE AND CONSENT

ENVIRONMENTAL QUALITY

TRANSPORTATION

June 21, 2019

Mr. Jason Allen, Director
USDA Rural Development
3001 Coolidge Road, Suite 200
East Lansing, MI 48823

Dear Director Allen:

I am writing to indicate my support of the Dickinson County Healthcare System's (DCHS) loan application to borrow \$25 million dollars from the USDA Rural Development Agency.

As you know, access to quality, affordable rural healthcare is critical as rural residents face many different barriers for care with one of the major ones being proximity. The closest health care system and hospital providing comparable medical services to DCHS residents is located more than 90 miles away. Therefore, it is imperative that DCHS continue providing care for the residents of the Upper Peninsula of Michigan and northeastern Wisconsin as it has for the past 68 years.

The new leadership team at DCHS has been diligently working to put in place internal financial controls and processes to ensure continual improvement in DCHS budget and medical services. While the hospital has been able to report three quarters in the black and continues to effectively manage its finances, the \$25 million-dollar loan would play a key role in meeting those goals.

Approximately, one half of the \$25 million dollars would be used to stabilize and restructure the system's long-term financial obligations. This would help lower the health system's monthly financial obligations, thereby providing more efficient and effective medical treatment to patients. The other half of the loan would be used to purchase and upgrade critically needed medical equipment, including a new MRI and Linac for radiation oncology therapy.

I strongly support the healthcare system's plans to secure and utilize a USDA Rural Development loan as the trustee board continues to explore ways to most effectively provide quality and affordable healthcare to area residents. Please do not hesitate to contact me with any questions.

Sincerely,

Sen. Ed McBroom
38th Senate District