***In Re*: Termination of Affiliation among Huggins Hospital, Monadnock Community Hospital, and Catholic Medical Center**

JOINT NOTICE TO THE DIRECTOR OF CHARITABLE TRUSTS PURSUANT TO NEW HAMPSHIRE RSA 7:19-b

This Joint Notice is submitted to the New Hampshire Attorney General, Director of Charitable Trusts, pursuant to New Hampshire RSA ("*NHRSA*") 7:19-b(III) by **Huggins Hospital**, a New Hampshire voluntary corporation ("*Huggins*"), and **Monadnock Community Hospital**, a New Hampshire voluntary corporation ("*MCH*"), in connection with their proposed withdrawal from and dissolution of GraniteOne Health, a New Hampshire voluntary corporation ("*GOH*") (the "*Affiliation Dissolution*"). Consistent with the decision of the Director of Charitable Trusts (the "*Director*") dated November 3, 2016, taking no action to prohibit the Parties from proceeding with the affiliation subject to certain conditions, GOH was created in December, 2016, as a New Hampshire voluntary corporation, supporting organization to serve as the sole corporate member of Huggins and MCH and as a comember of **Catholic Medical Center**, a New Hampshire voluntary corporation ("*CMC*") to implement the affiliation of Huggins, MCH and CMC, effective January 1, 2017 (the "*Affiliation*"). (Huggins, MCH and CMC sometimes are referred to singularly as a "*Party*" and collectively as the "*Parties*"). **CMC Healthcare System,** a New Hampshire voluntary corporation ("*CMCHS*") was prior to the creation of GOH, the sole corporate member of CMC and continued as a comember of CMC together with GOH after the Affiliation. In providing his "no objection" to the Affiliation, the Director noted that the Affiliation did not constitute a change of control of CMC since CMC effectively controlled GOH. Accordingly, while the Affiliation Dissolution also does not result in a change of control for CMC, CMC is joining in this notice to provide information to the Director.

The Parties' Affiliation Agreement dated June 29, 2016, and the Second Amendment dated as of May 13, 2022 (together the "*Affiliation Agreement*") are attached as Exhibits I and II. The Affiliation Agreement governs the creation, powers and

operation of GOH, granting GOH reserved powers to ratify certain actions of the Parties and their respective subsidiaries, and to appoint representatives to Huggins' and MCH's Boards of Trustees. GOH's rights do not include any authority to mandate any action by any of the three Parties. The Parties have each decided to invoke their rights under the Affiliation Agreement to withdraw from GOH without cause (see section 13 of the Affiliation Agreement at Exhibit I) and intend to dissolve GOH by agreement.

By letter dated November 3, 2022, the Parties set forth their reasons for how the withdrawals from and dissolution of GOH did not constitute an "acquisition transaction" under RSA 7:19-b. In response, the Director by letter dated November 17, 2022 did not agree and provided the Director's reasoning for how the transaction falls within RSA 7:19-b. While the Parties reserve their right to assert their position in any future proceedings, they are filing this Notice in the spirit of cooperation with the Division of Charitable Trusts and request a no action letter confirming that the Parties will not be prohibited by the Division of Charitable Trusts from proceeding with their withdrawals from and dissolution of GOH.

A. PARTIES TO THE AFFILIATION (NH RSA 7:19-b(III))

1. Huggins Hospital.

Huggins is a charitable organization established by statute in 1907 and operates an acute care, twenty-five (25) bed, Critical Access Hospital ("*CAH*") located in Wolfeboro, New Hampshire. Huggins focuses on primary care and secondary acute care services, as limited by federal regulations, and provides inpatient, outpatient, emergency care, ambulatory care, primary care and some specialty care services. Huggins serves the region's year-round population of approximately thirty thousand (30,000) residents and approximately one hundred twenty thousand (120,000) seasonal residents in the communities of Alton, Brookfield, Effingham, Freedom, Madison, Moultonborough, New Durham, Ossipee, Sanbornville, Sandwich, Tamworth, Tuftonboro, Wolfeboro and surrounding towns.

Huggins is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "*Code*"), and is a public charity under section 509(a) of the Code. It is currently governed by a Board of Trustees composed of a minimum of eight (8) and a maximum of eighteen (18) trustees from three categories: (i) one quarter (1/4) of the total appointed by GOH, subject to the Trustee Criteria set forth in an exhibit to the Bylaws (ii) the presidents of Huggins and the Huggins Medical Staff, and (iii) the remaining trustees nominated and appointed by the sitting Board of Trustees, with GOH having the right to object to an individual nominee based on the Trustee Criteria. The current Huggins Articles of Agreement, Bylaws and annual consolidated financial statements for the year ended September 30, 2022 are attached as Appendices A-1, A-2 and A-3, respectively.

2. Monadnock Community Hospital.

MCH is a charitable organization formed in 1919 as The Peterborough Hospital and operates a twenty-five (25) bed, acute care CAH in Peterborough, New Hampshire providing inpatient, outpatient, emergency, ambulatory and certain specialty care services. Like Huggins, its services are limited by federal regulations applicable to CAHs. MCH also owns and operates a network of professional offices in Peterborough, and surrounding towns where physicians and other healthcare professionals provide a wide range of primary and behavioral health care services for people in the area. In addition to Peterborough, MCH's primary service area also includes the towns of Antrim, Bennington, Dublin, Francestown, Greenfield, Greenville, Hancock, Jaffrey, New Ipswich, Rindge, Sharon and Temple. The MCH service area has a total population of approximately forty thousand (40,000) people.

MCH is exempt from federal income taxation under section 501(c)(3), and is a public charity under section 509(a) of the Code. It is currently governed by a Board of Trustees composed of five (5) ex officio trustees with voting rights and thirteen (13) elected trustees (the Bylaws provide for nine (9) to sixteen (16) elected trustees). One quarter of the elected trustees are nominated and elected by GOH. The remaining elected trustees are nominated and elected by the sitting Board of Trustees, subject to

certain rights of GOH to object to a nominee for specified reasons. The current MCH Articles of Agreement, Bylaws and annual financial statements for the year ended September 30, 2022 are attached as Appendices A-4, A-5 and A-6, respectively.

3. Catholic Medical Center.

CMC is a charitable acute care three hundred thirty (330) bed full-service community hospital that currently staffs approximately two hundred sixty-five (265) beds. CMC provides full medical and surgical care with extensive subspecialties, inpatient and outpatient rehabilitation services, a 24-hour emergency department, outpatient behavioral health services, diagnostic imaging and the nationally ranked New England Heart and Vascular Institute. CMC also serves as a patient transfer center for other hospitals throughout the State. The CMC primary service area includes the towns and cities of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Londonderry, Manchester and New Boston.

CMC is exempt from taxation pursuant to section 501(c)(3) of the Code and is a public charity pursuant to section 509(a) of the Code. Being a Catholic affiliated healthcare system, CMC (and its ten (10) subsidiaries) are subsidiaries of CMCHS. CMCHS was established to be the public juridic person of diocesan right of the Roman Catholic Bishop of the Diocese of Manchester (the "*Bishop*"), meaning CMCHS is the corporate mechanism by which the Bishop oversees CMC to ensure its implementation of, and compliance with, the Ethical and Religious Directives for Catholic Health Care Services of the United States Conference of Catholic Bishops (the "*ERDs*"), the Code of Canon Law of the Roman Catholic Church and adherence to Catholic moral teaching. CMC is exempt from federal income taxes through its inclusion in The Official Catholic Directory and IRS Group Ruling held by the Diocese of Manchester. The current CMC Articles of Agreement, Bylaws and annual consolidated financial statements for the year ended September 30, 2022 are attached as Appendices A-7, A-8 and A-9, respectively. The CMCHS Articles of Agreement and Bylaws are attached as Appendices A-10 and A-11.

4. GraniteOne Health.

GOH is a New Hampshire voluntary corporation that is a community-based network of three New Hampshire hospitals: Huggins, MCH and CMC. MCH and Huggins formed GOH in December, 2016; and CMC joined the system shortly thereafter. GOH is the sole corporate member of MCH and Huggins, and the co-member, along with CMCHS, of CMC. GOH was formed to establish and oversee system-wide strategy and integrate activities of the three hospital members. GOH is exempt from federal income taxation under section 501(c)(3), and is a supporting organization pursuant to section 509(a)(3) of the Code. The current Articles of Agreement, Bylaws and annual reviewed financial statements for the year ended September 30, 2022 are attached as Appendices A-12, A-13 and A-14, respectively.

B. DECISIONS TO WITHDRAW FROM GOH; DUE DILIGENCE (NH RSA 7:19-b(II), (III))

The following outlines how each of the Parties to the Affiliation determined in good faith and consistent with their trustees' fiduciary duties that it was in the best interests of each of them and of the communities they serve to withdraw from and amicably dissolve GOH. The Parties have mutually and amicably agreed to withdraw from and dissolve GOH for a number of shared circumstances, all of which informed each of their Boards' deliberations. It is in the best interest of the hospitals and consistent with each of the Board's duties of loyalty, due care and obedience to their respective charitable missions because they have determined that the solutions to these issues are likely to be different for each hospital and that GOH is unlikely to meet these needs.

1. The Challenges and Consequences of the COVID-19 Pandemic have affected the Finances and Operations of the Parties.

The country's non-profit healthcare industry is in crisis. See Fitch Industry Outlook Report at Appendix B-1. The COVID-19 pandemic has challenged, and continues to challenge the Parties. Although the federal and state governments have provided substantial relief to the Parties, there has been damage to the financial health

of all of them. The Parties' operating margins (without CARES Act funds and one-time adjustments for Huggins and MCH) are below pre-pandemic levels, driven in large part by the massive growth in expenses. Significant increases in staffing costs fueled in part by the continued healthcare work force shortage pose a serious threat to the Parties, affecting institutions in all areas and at all levels. Recruiting is challenging everywhere, particularly in rural areas all over the country. The looser structure of the system ensured that during the height of the pandemic and afterwards, each of the hospitals was able to focus its available capital on the communities that it serves to directly benefit those communities, and in so doing, each of the hospitals came to the realization that, without the availability of excess capital from each of the hospitals to pursue system-wide investments, the originally envisioned goals of the system could not reasonably be achieved. Furthermore, each of the hospitals realized that its respective communities' needs and priorities, which were quickly evolving as a result of the pandemic and the different challenges that each of the hospitals faced, would be better served by being able to react with greater flexibility and promptness and without the additional administrative hurdles of being a part of the system.

2. GOH Resources are Limited which has Limited Initiatives and Benefits of GOH.

Even prior to the formation of GOH, the Parties were facing challenging trends of rising labor costs, a shifting payor mix to the lower paying reimbursement structure of Medicare, high technology costs and expanding government and regulatory mandates eroding operating margins and requiring significant capital investments. By the third year of GOH, these trends contributed to operating losses. GOH did not have additional resources available to invest in system initiatives.

3. The State's Objection to the Proposed Combination of GOH with Dartmouth Health Derailed GOH Plans to Increase Integration and Pursue System-wide Initiatives.

Beginning in 2018, GOH entered into discussions with Dartmouth Health (formerly Dartmouth-Hitchcock Health) in an effort to find an academic health care

partner (the "DH-GOH Combination"). In September 2019, GOH and Dartmouth Health executed a non-binding letter of intent to combine GOH with and into Dartmouth Health. The effort to negotiate and document the terms, conduct due diligence, develop integration plans and prepare for and undertake the regulatory review of the combination consumed an enormous amount of expense and personnel time at all levels of the institutions. The Parties' best intentions to pursue the goals of the GOH Affiliation for the benefit of each Party and its service area were impacted by the allocation of resources devoted to the proposed DH-GOH Combination. It also made little sense to the Parties to invest time and money in initiatives that ran the risk of changing shortly after closing on the DH-GOH Combination, particularly with limited resources. Antitrust laws prevented the Parties from pursuing any future initiatives with a potential combination partner besides planning activities. Thus efforts were focused on planning, but practically speaking put the Parties in limbo for years. The State's objection to the proposed DH-GOH Combination in May 2022 caused each of the Parties to stop and reassess the benefits of remaining part of GOH.

4. Process of Unwinding Will Result in No Impact on Community Needs and Benefit.

The Parties deliberately structured the system to have limited financial, operational and clinical integration. At the time that the Parties were negotiating the Affiliation, this structure was deemed to be in the best interests of each of the Party's Board of Trustees because it allowed for continued local autonomy with the prospect of shared resources. Each Party was able to ensure that the needs of each of its communities would continue to be prioritized, while also being able to benefit from additional expertise on their Boards and access to resources that would become available for system-wide initiatives. After the Affiliation, the Parties each retained control of all of their assets, including their endowments, all other accounts and real estate. See section 2.5, 3.8 and 5 of the Affiliation Agreement at Exhibit I. Each Party's Board retained essentially all of its authority to oversee the services, planning, finances and all other generally recognized roles of a charitable hospital board. See sections 1.4,

3.8 and 3.9 of the Affiliation Agreement at Exhibit I. The debt of each Party remained separate from the system and the other Parties. See sections 3.8, 5 and 32 of the Affiliation Agreement at Exhibit I. As a result, the unwinding and dissolution of the system will be a simple process, and the Parties' community needs and benefits will not be impacted by the withdrawal from and dissolution of GOH. Each of the Parties has maintained and will continue to maintain separate community needs assessments and separate programming to address community needs. As discussed above, system-wide initiatives were never implemented that would be affected by the withdrawal from and dissolution of GOH.

The Affiliation Agreement gave each Party the right to withdraw from GOH without cause during the six (6) month period beginning two (2) years after the creation of GOH. See Affiliation Agreement, section 13 at Exhibit I. Since this six (6) month period occurred when the Parties were occupied with the negotiation and regulatory proceedings related to the DH-GOH Combination, they agreed on two occasions to extend the deadline to exercise this right. The second amendment set the deadline to give notice of withdrawal as November 13, 2022. Thus, each Party had an independent right to withdraw from GOH and spent the six (6) months between the state's objection of the DH-GOH Combination in May and the November deadline considering whether it was in its best interests to exercise its right to withdraw. The Boards of all three of the Parties voted at their separate meetings on October 26 and 27, 2022 to withdraw from GOH without cause and to approve the future dissolution of GOH by agreement subject to conducting a session for community comment on this decision and a final vote following consideration of any public comments.

In reaching their individual decisions to withdraw, each Party recognized that the process of withdrawal and dissolution of GOH will be relatively simple. GOH is the sole member of Huggins and MCH and a co-member of CMC; but its impact on each Party during the nearly seven years of its existence has been limited, because the Affiliation Agreement intentionally limited its authority over the Parties. GOH never acquired any capital assets of its own or had any control over the assets of any of the

Parties. Moreover, GOH never incurred any debt. No Party assumed any responsibility for the debt of any other Party. GOH staffing needs have been met by CMC; and its operating costs, primarily for CMC staff time, have been paid by assessments against each Party. Thus, the only financial effect of dissolution will be a final reconciliation of operating expenses and assessments to each Party. A variety of contracts for services between or among the Parties, many of which were in effect prior to the creation of GOH, will continue. Amendments to the Parties' corporate organizational documents to remove references to GOH or its powers will be relatively simple. Only one member of the Huggins and MCH boards (the interim CEO of GOH) will resign. The other members nominated by GOH have brought value to each hospital and are expected to remain.

The following subsections summarize the more specific process that each Board engaged in to evaluate its individual interests and considerations to withdraw from GOH.

Huggins Hospital.

Shortly after the state objection to the DH-GOH Combination, Huggins retained the national health care consulting firm, Stroudwater Associates *("Stroudwater")* to evaluate the hospital's strengths and weaknesses, to assist in strategic planning about remaining a part of GOH and to consider other strategic options. Stroudwater was familiar with Huggins and GOH, because beginning in 2009, it had advised Huggins in its consideration of strategic options and potential affiliations that resulted in Huggins entering into a 2015 letter of intent to pursue an affiliation with CMC and the subsequent creation of GOH.

In the current engagement, Stroudwater (i) reviewed the financial performance of Huggins, CMC and GOH; (ii) interviewed senior managers of Huggins and CMC, Huggins medical staff members, Huggins board members and the GOH board chairperson; (iii) investigated Huggins' clinical offerings and quality; and (iv) examined the status of the initial seventeen objectives and initiatives that GOH intended to accomplish. It reported its findings and analysis in a presentation to the Huggins Board

on August 25, 2022, which posed questions for the Board to consider in deciding whether to remain part of GOH or to withdraw. See Confidential Appendix B-2. Specifically, the Huggins Board discussed that any decision should address whether Huggins could expect assistance with meeting its needs for electronic medical records enhancement, for provider recruitment and for access to specialty services. In reaching a decision about whether to remain a part of GOH or withdraw, the Board understood that as a CAH, Huggins can offer any partner significant opportunities for better reimbursement by allocating expenses and moving patients to more appropriate care settings.

The Huggins Board discussed and asked questions about the Stroudwater report at its August 25 meeting and had further discussions at its September meeting. The Board voted unanimously at its October 27 meeting to withdraw without cause from GOH and to approve a cooperative effort by all Parties to dissolve GOH. See Appendix B-3 (Secretary Certificate with resolutions attached). Prior to the October meetings of the three Parties' Boards, the Parties' CEOs had shared with each other their expectations that their Boards would vote to withdraw and dissolve. Thus, when it voted, the Huggins Board understood that the other Parties would or had voted to withdraw from GOH, and the dissolution of GOH would be cooperative and amicable. The Huggins Board concluded that it is in the best interests of Huggins and the community it serves to return to its independent status and retain the benefits of the clinical and services arrangements it has had with CMC by specific contracts rather than the continuation of GOH. The Board determined that Huggins' ability to serve the community with respect to community benefits and the quality and scope of clinical services would not be adversely affected as a result of the withdrawal and dissolution of GOH. In taking this vote, the Huggins Board recognized that it was not a final decision but the first step in a process that would include public notice and an opportunity to comment, regulatory consideration, review and possible revision of contracts and arrangements, revision of corporate organizational documents and development and approval of a plan of dissolution of GOH.

Monadnock Community Hospital.

Shortly after the state's objection to the DH-GOH Combination in May 2022, the MCH executive management team in conjunction with the MCH Board Executive Committee began to develop a list of pros and cons to the question of whether to remain part of GOH. The effort recognized that a decision had to be made no later than November 13, 2022, in order to withdraw without cause pursuant to the Affiliation Agreement. The group organized its evaluation first around the "Statement of Purpose and Mutual Vision" that was Section 1 of the Affiliation Agreement. The second part of the evaluation considered the Integration Plan which GOH had developed early in its existence. The final version of what was entitled, "Stay in GOH – Pros and Cons" (the "*Pros and Cons*"), and continued to be organized around the "Statement of Purpose and Mutual Vision," which consisted of eight subsections each identifying a different item of the purpose or vision the Parties had for GOH before it was created. Pros and Cons described what had been accomplished under each subsection, what was possible or unlikely to be done in the future, what had been accomplished before GOH existed, and what was possible to be done or maintained if GOH was dissolved. See Confidential Appendix B-4. The Pros and Cons document was used to organize the Board's deliberations.

MCH also retained for advice Forvis, LLP, an outside accounting and consulting firm with expertise in healthcare. Forvis is the successor to BKD, LLP, which had assisted MCH in its strategic planning and decision making in becoming part of GOH, and thus it already had extensive background knowledge of MCH and the New Hampshire healthcare marketplace. Forvis reviewed the Pros and Cons, met with MCH leaders and staff and attended Board meetings.

By August, both the MCH executive management team and the Board Executive Committee concluded that it was in the best interest of MCH and the community it serves to withdraw from GOH. This recommendation, together with the Pros and Cons, were presented to the MCH Board at its August meeting and discussed. This recommendation and the process MCH followed were later summarized in a four-page

document by the MCH CEO that was distributed to the Board to inform its further deliberations and is attached to the Pros and Cons as part of that confidential Appendix B-4. Forvis consultants and the hospital's counsel were present to answer questions. Further discussion occurred at the Board's September meeting. At the October meeting, the Board voted unanimously that it is in the best interest of MCH and the patients in the community it serves to withdraw from and dissolve GOH. See Appendix B-5 (Secretary Certificate with resolutions attached). The Board determined that MCH's ability to serve the community with respect to community benefits and the quality and scope of clinical services would not be adversely affected as a result of the withdrawal and dissolution of GOH. There was consensus that GOH was unlikely to accomplish a number of the goals and initiatives that had been set in the Affiliation Agreement particularly in light of the current operational, financial and staffing challenges exacerbated by the COVID-19 pandemic, but that the most significant benefits of the Affiliation could be preserved in contracts or arrangements that existed among the Parties. Like the Huggins Board, the MCH Board recognized that this vote was not a final decision but the first step in a process that would include public notice and an opportunity for the public to comment, regulatory consideration, review and possible revision of contracts and arrangements, revision of corporate organizational documents and development and approval of a plan of dissolution of GOH.

Catholic Medical Center.

Like Huggins and MCH, shortly after the state's objection to the DH-GOH Combination, CMC began a process of assessing its needs, its continued participation in GOH and how it will meet strategic needs going forward. CMC retained the national healthcare consulting firm The Chartis Group to help facilitate and perform its assessments. The Chartis Group had been jointly retained by Dartmouth Health and GOH to facilitate the DH-GOH Combination and in doing so, learned a tremendous amount about CMC's challenges, opportunities, operations, financial circumstances and its expansion plans and infrastructure needs. In June 2022, The Chartis Group

facilitated a work session with CMC's senior leadership focusing on identification and articulation of challenges facing the hospital, what CMC should look like in the future, a partnership selection and evaluation process and CMC's continued participation in GOH. The Chartis Group then assisted with a summer long effort with the strategic planning committee of the Board of Trustees to assess the same with multiple meetings in July and August. On September 19, 2022, The Chartis Group led a discussion with the full Board of Trustees at the Board's annual strategic retreat. It was also reported to the Board at this time that both MCH and Huggins were likely to vote to withdraw from GOH. While benefits to remaining in GOH were identified and discussed, the Board was in agreement that the substantive clinical benefits can remain intact by continuing the contractual relationships in place with MCH and Huggins, most of which were in place before the formation of GOH. There was also a consensus that while CMC, MCH and Huggins will continue to work together, in the light of the challenges facing the healthcare industry and the Parties in particular, a loosely affiliated system like GOH will not be able to deliver the kind of solutions and improve the Parties' ability to meet the capital needs of each hospital member. See Confidential Appendix B-6 (Pertinent Slides of Strategic Discussion). In October, the Board voted unanimously that based on current and projected financial and other considerations, it is in the best interest of CMC and the patients in the community it serves to approve the intent to withdraw from GOH and to cooperate with the amicable dissolution of GOH, and the Board instructed the President and CEO to provide the requested notice. See Appendix B-7 (Secretary Certificate with resolutions attached). Since CMC is not a party to this Notice, the vote of its Board is not subject to the requirement to have a listening session or consideration of public comment prior to its vote.

C. PUBLIC NOTICE AND COMMUNITY INPUT (NH RSA 7:19-b(II)(g))

NHRSA 7:19-b(II)(g) requires "reasonable public notice" of a proposed "acquisition transaction" and an opportunity for the community to comment on the proposed transaction in order to inform the deliberations of the governing body of the

health care charitable trust regarding the proposed transaction. On May 25, 2023, MCH and Huggins gave public notice of the proposed dissolution of GOH and the date set for a virtual public listening session about the proposed dissolution of GOH. The statutorily required public notice was published (i) on May 25, 2023 and June 1, 2023, in the Granite State News, which is a local weekly newspaper distributed in the communities served by Huggins, and (ii) on May 25, 2023, May 30, 2023, June 1, 2023 and June 8, 2023, in the Monadnock Ledger Transcript, which is a local bi-weekly newspaper distributed in the communities served by MCH. The proposed dissolution documents and the draft of the proposed Joint Notice to the Director of Charitable Trusts Pursuant to RSA 7:19-b, which includes an analysis of how the withdrawal and dissolution will meet the communities' need for access to quality and affordable physical and mental health care services, were each made available on the GOH website, with links thereto provided on the MCH and Huggins websites.

In addition to the foregoing, prior to the public notice described above, on December 7, 2022, all of the Parties held meetings of their senior staff and sent emails to all employees and medical staff members informing them of the proposed dissolution. The Parties also posted an initial public notice of the proposed dissolution on their websites at the following links:

News | Catholic Medical Center

Hospital Boards Vote on Future of Granite One Health (monadnockcommunityhospital.com)

Huggins Hospital Boards Vote on Future of GraniteOne Health

In fulfillment of the requirements of the statute, the Parties held on June 12, 2023 at 4:00p.m., a joint virtual public hearing via Zoom prior to filing this Notice with the Director to allow for an opportunity for public comment for the purpose of informing the deliberations of each of the Boards of the hospitals regarding the proposed transaction prior to such Boards making their final decision to withdraw from and dissolve GOH. [*Insert any public comments which raise issues that the Boards each agree*

should be discussed in further detail before making the final decision to withdraw from and dissolve GOH.]

D. MATERIAL TERMS OF AFFILIATION DISSOLUTION (NH RSA 7:19-b(III))

The terms of the Affiliation Dissolution are simple and governed by section 13 of the Affiliation Agreement. All three Parties will be returned to their governance structures that existed on December 30, 2016. As noted above, none of the Parties' assets were transferred or encumbered by the Affiliation, no Party assumed any liability for any other Party's debt, and no Party received any financial support from GOH or any other Party. GOH acquired no assets, incurred no debt and never had any employees. The only documentation necessary to restore the Parties' governance structures is the termination of the Affiliation Agreement by mutual consent and amendment by votes of the Boards of each Party and of the GOH Board to amend each Party's articles of agreement and bylaws to remove all references (i) to GOH being a member of the Party, (ii) to GOH reserved powers and (iii) to GOH board representatives. The Parties will negotiate the final assessments to pay for staffing CMC provided to GOH and will review contractual and other arrangements to assure the continuation of relationships that two or more Parties believe are beneficial and consistent with their long history of cooperation for the benefit of their communities. Finally, the Parties will adopt a plan of dissolution of GOH including the filing of the Articles of Dissolution. See Draft Dissolution Documents at Appendix C-1.

E. REMAINING STATUTORY REQUIREMENTS FOR NOTICE UNDER RSA 7:19-B(III)

1. <u>The Affiliation Dissolution is Permitted by Law</u>. (NH RSA 7:19-b(II)(a))

Upon advice of counsel, the Parties have determined that the Affiliation Dissolution is permitted by applicable law. The Parties do not believe the proposed dissolution of a system parent organization, the creation of which six years ago did not violate antitrust laws, implicates antitrust laws in any way.

2. Conflicts of Interest. (NH RSA 7:19-b(II)(c))

No member of the Board of Trustees of any Party has engaged in any "pecuniary benefit transaction" as defined in New Hampshire RSA Chapter 7 that in any way affects or is affected by the Affiliation Dissolution or its approval, and no conflict of interest was disclosed or affected the decision of the applicable Party to engage in the Affiliation Dissolution. GOH Interim CEO, Alexander J. Walker, who also serves as President and CEO of CMC, recused himself from the MCH and Huggins Board processes to assess their future participation in GOH and also recused himself from the respective votes of the MCH and Huggins Boards regarding the same. See Appendix B-5 (Secretary Certificate with resolutions attached) and Appendix B-7 (Secretary Certificate with resolutions attached).

3. Transaction Proceeds; No Out of State Entity. (NH RSA 7:19-b(II)(f))

The proposed Affiliation Dissolution does not involve the payment of any purchase price or exchange of consideration among the Parties or any other person, and the Affiliation Dissolution will not result in any for-profit entity or person outside the State of New Hampshire controlling any Party or GOH.

4. Ownership of Assets; Devotion of Assets to Charitable Purpose.

The withdrawal from and dissolution of GOH will not impact any Party's assets, mission or charitable purposes. The Affiliation did not involve any merger or consolidation of the Parties' assets, properties, investments, revenues or liabilities. Each of Huggins and MCH maintained separate legal identities without liability for each other's or CMC's obligations and each remained responsible for its respective operations and assets. The restricted funds of each of Huggins and MCH remained under the control of Huggins and MCH and continued, and will continue, to be dedicated to each hospital's service area. Restricted assets will remain subject to donor restrictions and requirements.

5. Changes in Management Structure.

The proposed Affiliation Dissolution does not contemplate any change in the personnel of any Party, either at the Board level (except for the resignation from the Huggins and MCH boards of the GOH chief executive officer), the management level or the employee level. The Affiliation Dissolution also will not affect any Party's Medical Staff, the credentialing and privileging of which remains the sole responsibility of each Party.

6. Community Needs Assessments.

Attached as Appendices E-1, E-2 and E-3 are the most recent community needs assessments conducted by each of the Parties. Each of the Parties respective Community Benefits Reports are available on their respective websites:

https://www.hugginshospital.org/about/community-benefits

https://monadnockcommunityhospital.com/about-us/community-health-needs-and-benefits/

https://www.catholicmedicalcenter.org/about-cmc/in-the-community/community-benefits-report

7. Statements of CMCHS, CMC, MCH and Huggins.

As required by New Hampshire RSA 7:19-b(III), below are statements of CMCHS, CMC, MCH and Huggins specifying the manner in which it proposes to ensure that the Parties will continue to fulfill the charitable objects of the Parties.

CMC Healthcare System.

Pursuant to the provisions of RSA 7:19-b (III), CMCHS, as the public juridic person of CMC charged with, among other things, oversight of CMC's Catholic healthcare ministry and adherence to the Ethical and Religious Directives for Catholic Health Care Services, Canon Law and the Catholic teachings, hereby states that after the dissolution of GOH, under the direction and supervision of its Board of Governors, CMCHS shall ensure CMC's continued fulfillment of its charitable objects by operating and using its assets to further its adopted mission, values and vision which are:

Our Mission

The heart of Catholic Medical Center is to carry out Christ's healing ministry by offering health, healing and hope to every individual who seeks our care.

Our Values

The defining characteristics of CMC include: Respect, Integrity, Compassion and Commitment.

Our Vision

Guided by our Mission and Values, we are committed to becoming the finest customer experience, lowest cost and best outcome provider in the region.

Catholic Medical Center.

Pursuant to the provisions of RSA 7:19-b (III), CMC hereby states that after the dissolution of GOH, under the direction and supervision of its Board of Trustees, CMC intends to continue to fulfill its charitable objects by operating and using its assets to further its adopted mission, values and vision which are:

Our Mission

The heart of Catholic Medical Center is to carry out Christ's healing ministry by offering health, healing and hope to every individual who seeks our care.

Our Values

The defining characteristics of CMC include: Respect, Integrity, Compassion and Commitment.

Our Vision

Guided by our Mission and Values, we are committed to becoming the finest customer

experience, lowest cost and best outcome provider in the region.

Monadnock Community Hospital.

Pursuant to the provisions of RSA 7:19-b (III), MCH hereby states that after the dissolution of GOH, under the direction and supervision of its Board of Trustees, MCH intends to continue to fulfill its charitable objects by operating and using its assets to further its adopted mission, vision and values which are:

Our Mission

We are committed to improving the health and well-being of our community.

Our Vision

We will elevate the health of our community by providing accessible, high quality and value based care.

Our Values

Compassion Collaboration Honesty Respect.

Huggins Hospital.

Pursuant to the provisions of RSA 7:19-b (III), Huggins hereby states that after the dissolution of GOH, under the direction and supervision of its Board of Trustees, Huggins intends to continue to fulfill its charitable objects by operating and using its assets to further its adopted mission and vision which are:

Our Mission

To empower the fulfillment of life through better health.

Our Vision

Huggins will be the community's home for health and wellbeing.

8. Trustee Certifications.

Attached as Appendices E-4 and E-5 are the certifications of the Trustees of Huggins and MCH affirming that the standards set forth in New Hampshire RSA 7:19-b(II) have been met.

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Respectfully submitted by the duly-authorized representatives of the undersigned this day of _____, 2023.

HUGGINS HOSPITAL ("*Huggins*")

By: _____
Jeremy Roberge, its duly authorized
President & CEO

MONADNOCK COMMUNITY HOSPITAL ("*MCH*")

By: _____
Cynthia McGuire, its duly authorized
President & CEO

CATHOLIC MEDICAL CENTER ("*CMC*")

By: _____
Alexander J. Walker, its duly authorized
President & CEO

CMC HEALTHCARE SYSTEM ("*CMCHS*")

By: _____
Alexander J. Walker, its duly authorized
President & CEO

INDEX OF EXHIBITS AND APPENDICES

B-5 Secretary Certificate of resolutions adopted at a Meeting of the MCH Board of Trustees on October 26, 2022

B-6 CONFIDENTIAL The Chartis Group Slides from a Meeting of the Board on September 19, 2022

B-7 Secretary Certificate of resolutions adopted at a Meeting of the CMC Board of Trustees on October 27, 2022

C-1 Draft Articles of Dissolution and Plan of Dissolution

E-1 Huggins Community Needs Assessment Report

E-2 MCH Community Needs Assessment Report, 2021 - 2024

E-3 CMC Community Needs Assessment Report

E-4 Huggins Trustee Certification re RSA 7:19-b(II) Standards

E-5 MCH Trustee Certification re RSA 7:19-b(II) Standards

Exhibit I

Affiliation Agreement dated June 29, 2016

AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (this "Agreement") is made this 29th date of June, 2016 by and among CMC Healthcare System, a New Hampshire voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire 03102 ("CMCHS"), Catholic Medical Center, a New Hampshire voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire 03102 ("CMC"), Monadnock Community Hospital, a New Hampshire voluntary corporation with a principal place of business at 452 Old Street Road, Peterborough, New Hampshire 03458 ("MCH") and Huggins Hospital, a New Hampshire voluntary corporation with a principal place of business at 240 South Main Street, Wolfeboro, New Hampshire 03894 ("HH") (CMC, MCH and HH are also referred to herein individually as a "Hospital" and collectively referred to herein as the "Hospitals"). All capitalized terms used in this Agreement shall have the respective meanings ascribed to them in Exhibit A of this Agreement.

RECITALS

WHEREAS, CMC is a licensed acute care, three hundred thirty (330) bed hospital which provides full medical-surgical care to the Greater Manchester community, such care including more than twenty-five (25) subspecialties, comprehensive orthopedic care, inpatient and outpatient rehabilitation services, a twenty-four (24) hour emergency department, outpatient behavioral health services and diagnostic imaging;

WHEREAS, CMCHS is currently the sole member of CMC, serving as the public juridic person of diocesan right under Canon Law of the Roman Catholic Church and is responsible for assuring that CMC operates in adherence to the Ethical and Religious Directives for Catholic Health Care Services as adopted by the United States Conference of Catholic Bishops ("ERDs") and is subject to certain powers reserved to the Roman Catholic Bishop of Manchester (the "Bishop");

WHEREAS, MCH is a licensed acute care, twenty-five (25) bed, Critical Access Hospital ("CAH") which provides inpatient and outpatient medical services, emergency care, ambulatory care and primary and specialty care services to individuals of the Town of Peterborough and its surrounding communities;

WHEREAS, HH is a licensed acute care, twenty-five (25) bed, CAH which provides inpatient and outpatient medical services, emergency care, ambulatory care and primary and specialty care services to individuals of the Town of Wolfeboro and its surrounding communities;

WHEREAS, each of the Hospitals are recognized as Section 501(c)(3) tax-exempt charitable organizations pursuant to the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, the Hospitals share a common and unifying charitable mission to promote and improve the delivery of health care and the health care status of the communities that they serve by providing access to high quality, affordable health care and health care-related services;

WHEREAS, consistent with those shared values, the Hospitals have existing collaborations, which have included clinical affiliations between CMC and HH to provide cardiology, vascular and transfer center services and clinical affiliations between CMC and MCH to provide cardiology, vascular, hospitalists, laboratory, neurology and transfer center services;

WHEREAS, because of their long-standing successful relationships and collaborative experiences and in recognition of their continued shared charitable missions and the opportunity to enhance health care quality, access, efficiency and cost-effectiveness for their communities, MCH and HH intend to form a new common parent organization which will subsequently admit CMC to enable the Hospitals to participate in a more integrated healthcare delivery system (the "System");

WHEREAS, the Hospitals are committed to developing the System recognizing that having member hospital organizations provides greater opportunities for integration and for supporting, enhancing, and expanding the breadth, depth, and quality of services available to improve the health status of the communities served by the Hospitals;

WHEREAS, in furtherance of this desire, CMC and HH entered into a letter of intent dated November 19, 2015 and CMC and MCH entered into a letter of intent dated January 20, 2016 (the "Letters of Intent"), both of which are substantially similar and set forth the conditions, key components and structural framework for the System;

WHEREAS, in accordance with the Letters of Intent, the Hospitals have considered the spectrum of available collaborative options and have analyzed and negotiated the issues involved in creating the System which could further their mutual interests and respective charitable missions, and better address the health care needs of their respective communities including, but not limited to, structuring the System to maintain and preserve their respective identities and traditions;

WHEREAS, the Hospitals now desire to set forth the full and complete terms, conditions and steps necessary to form the System and govern the Hospitals' relationship within the System (the "Affiliation").

NOW, THEREFORE, in consideration of the premises and mutual agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Hospitals agree as follows:

1. Statement of Purpose and Mutual Vision. To help regulatory authorities and the general public understand the Affiliation, the Hospitals declare the following purposes and shared vision of what they expect from the Affiliation.

1.1 Furtherance of Compatible Charitable Missions. The Hospitals seek to enhance their ability to further their charitable missions to enhance the health of individuals in the communities they serve in the rapidly changing healthcare services environment. Based on the Hospitals' successful experiences with various degrees of clinical affiliations between them, the Hospitals believe that their missions to service the needs of their communities will be better achieved by creating the System.

1.2 Ensure Long-term Organizational Sustainability. The Hospitals intend to work effectively to maintain strong community ties and improve the quality of care and breadth of services delivered to their respective communities through sharing of knowledge and best practices and achieving economies of scale and scope. The Affiliation will enable the Hospitals to expand the continuum of care in each of their communities through formalized relationships with providers for pre- and post-acute care as the Hospitals move from volume to value-based reimbursement.

1.3 Integration and Collaboration of Care. The Hospitals intend to further integrate clinical services and quality improvement efforts throughout their respective communities by appropriately aligning and promoting collaboration among their respective physicians and other healthcare providers, and coordinating care and the allocation of resources. The resulting system optimization will improve the coordination, quality and value of primary and specialty care services in the Hospitals' communities.

1.4 Focus on Local Board Initiation. The Hospitals envision that the Boards of Trustees of MCH and HH and the Board of Directors of CMC, as distinct fiduciary bodies, will continue to initiate clinical and strategic planning initiatives pertaining to local care and operational decisions relating to the necessary and beneficial healthcare services for each of their communities, while respecting the overall strategic directives and Reserved Powers (as defined in Section 3.7 of this Agreement) of the System Parent.

1.5 Advancing and Supporting Information Technology. The Hospitals intend to enhance access to accurate, useable and relevant information technology support, capital, training, equipment and software as well as access to data vendors. The Affiliation will facilitate the participation in and implementation of a system-wide information technology platform to achieve a seamless transfer of data across the System.

1.6 Developing Excellence in Population Health Management. The Hospitals intend to create a strategic relationship to enhance their joint population health management capabilities, including participation in healthcare networks, site of service plans, accountable care organizations ("ACOs") and other advanced forms of delivery and population health management. CMC, directly or through the System Parent, intends, to the extent permissible by law and the terms of such arrangements, invite MCH and HH to participate fully (i.e., in the same capacity, if possible, as CMC) in the various ACO or risk-sharing arrangements or joint ventures to which CMC or its Affiliates are a party. These forms of collaboration and innovation are expected to enhance access, quality, safety and effectiveness of health care while lowering the costs of healthcare delivery.

1.7 Achieving and Maintaining Appropriate Specialty Services. The Affiliation will enable the Hospitals to build upon existing clinical relationships, provide enhancements and improvements to existing services and add new services as necessary to meet the long-term needs of each Hospital's community. This will include development of telehealth capabilities to provide local populations greater access to the highest quality of care.

1.8 Assuring Sufficient Financial Capacity. The Affiliation will facilitate the development of strategies and options to enhance the Hospitals' access to the capital required to provide necessary healthcare services in the community, including investments in expansion of primary and specialty care and new service lines, subject to good financial stewardship of the System and respecting the overall strategic directives and Reserved Powers (as defined in Section 3.7 of this Agreement) of the System.

2. Guiding Principles. The Hospitals understand that their relationship will not be static, but instead will evolve with changing patient needs, innovations in healthcare delivery and payment models, and improvements in medical care and hospital and provider administration. The Hospitals also acknowledge that not all circumstances and decisions which the System will have to address can be anticipated or addressed fully in a written agreement. The following principles will help guide the evolution of the Hospitals' relationship and the operation of the System so that together, the Hospitals will create a sustainable healthcare system that is committed to improving population health, improving quality care and patient experience, increasing value and creating or participating in new payment models to improve access to care and lower cost, for the benefit of the communities served by the Hospitals.

2.1 Commitment to Charitable Mission, Identity and Community Needs. The Hospitals acknowledge the compatibility of their charitable missions, and those of their subsidiaries and affiliates, and no Hospital will be required to take any action that would be inconsistent with or contravene its charitable mission. The System is designed to result in a patient focused culture consistent with the Hospitals' identities and values that will be operated efficiently and effectively to meet the needs of the communities that the Hospitals serve.

2.2 Commitment to Integration and Value-based Care. Through significant governance, clinical, financial and administrative integration within the System, consistent with Sections 2.1 and 3.7 of this Agreement, the Hospitals seek to provide access to the highest quality of healthcare in an efficient and cost effective manner.

2.3 Commitment to Growth of the System and Future Collaboration. The Hospitals recognize, respect and acknowledge the need for the System to maintain relationships and seek additional collaborations to achieve economies of scale and enhance access to quality healthcare in an efficient and cost-effective manner for patients in the Hospitals' Service Areas. Future collaborations shall be consistent with the stated vision and principles of the System and its strategic plan as approved by the System Parent Board of Trustees and compatible with the System's focus on local decision-making.

2.4 Principles Underlying the Provision of Healthcare Services. In providing healthcare services, the Hospitals are committed to observing the following principles:

2.4.1 Maintaining the Core Services necessary to maintain the CAH status of MCH and HH;

2.4.2 Maintaining and enhancing access to existing healthcare services while meeting or exceeding industry standards of quality and sustainability;

2.4.3 Observing the inherent dignity of all patients and respect for each Hospital's core values and identity;

2.4.4 Promoting and maintaining good health through education, wellness preventative measures, and high quality clinical outcomes;

2.4.5 Improving value and meeting local community needs, including the needs of the poor and vulnerable;

2.4.6 Advancing the knowledge and training of healthcare professionals and enhancing System physician recruitment and retention; and

2.4.7 Accounting for system-wide objectives, strategic planning and maximization of the System synergies created by the Affiliation.

2.5 Commitment to Charitable Assets. The Hospitals agree that their respective Restricted Assets (defined below) shall remain under their exclusive control for the furtherance of their charitable missions in accordance with such restrictions. The Hospitals further agree that the Pre-affiliation Assets (defined below) of each Hospital will remain dedicated to the respective patient population served by such Hospital, and the expenditure of which will be determined solely by each Hospital's Board subject to the provisions of Section 3.9.3 below.

3. General Description of the Affiliation Structure and Governance System. The Affiliation involves the formation of a New Hampshire voluntary corporation which shall serve as a member of the Hospitals and which will have certain enumerated reserved powers (the "System Parent"). MCH and HH shall form the System Parent and amend their organizational documents to identify the System Parent as the sole member of each of them as set forth in Section 4 of this Agreement. CMC shall join the System as set forth in Section 4 of this Agreement and amend its organizational documents to identify the System Parent as one (1) of its two (2) co-members with CMCHS. The System Parent shall take all actions necessary to be recognized as exempt from federal income tax pursuant to Section 501(c)(3) of the Code and to qualify for public charity status as a supporting organization pursuant to Section 509(a)(3) of the Code.

3.1 Name of the System Parent and Each of the Hospitals. The name of the System Parent shall be "GraniteOne Health" or such other name as shall be mutually agreed upon by the Hospitals. CMC, MCH and HH will each preserve the use of their respective names on all health care facilities but may include a statement identifying the Affiliation with the

System. If a new hospital becomes affiliated with the System with equal or greater representation on the System Parent Board of Trustees, or if the System Parent enters a member substitution transaction, then the System Parent will ensure that the name or good will of such new entity is made available for the benefit of the System and its affiliated members.

3.2 The System Parent Board of Trustees. The System Parent shall be governed by a Board of Trustees comprised of thirteen (13) total Trustees. Seven (7) Trustees shall be appointed by the Board of Directors of CMC, one (1) Trustee shall be appointed by the Board of Trustees of MCH, and one (1) Trustee shall be appointed by the Board of Trustees of HH. In addition to the Hospitals' appointed Trustees, the CEO of the System Parent or his or her designee, the CEO of CMC or his or her designee, the CEO of MCH or his or her designee and the CEO of HH or his or her designee shall each serve as ex-officio, full voting members of the System Parent Board of Trustees. All actions of the System Parent Board of Trustees will be made by a majority vote of its members attending the noticed meeting or participating by telephone or video conferencing at which a quorum is present or available by phone or video. A quorum shall be a simple majority of the Board.

3.3 Selection of System Board of Trustees and Additions to the System. The System Parent Board of Trustee positions shall be filled by individuals qualified by the criteria described on Schedule 3.3(a) of this Agreement, which the Hospitals agree are important factors in maintaining a strong and effective governing Board. The Hospitals hereby agree that the initial Trustees of the System Parent Board shall be those individuals identified on Schedule 3.3(b) of this Agreement. The Hospitals recognize that additional hospital members with compatible values, including a commitment to delivering high quality services, and a tradition of focusing on the needs of its community, adds clinical, administrative, and financial strength to the System and expands the population base to receive more integrated, cost-effective, high quality care. Accordingly, the Hospitals acknowledge that other hospitals and healthcare providers may be added to the System in the future. The System Parent will involve the Hospitals in the identification and development of such relationships, and the decision to admit a new hospital or healthcare provider to the System and the terms upon which such admission will be made shall be made by the System Parent Board of Trustees. In the event that another hospital joins the System by accepting the System Parent as its member through a membership substitution, the Hospitals recognize that the System Parent Board of Trustees composition as set forth in Section 3.2 and this Section 3.3(b) may require adjustment. Such adjustments will be negotiated in good faith and be reflected in the resulting affiliation agreement with such new hospital and the governing documents of the System Parent. However, any CAH admitted to the System shall have no greater board representation or management role or be subject to less comprehensive reserved powers than MCH and HH. In addition, the Hospitals recognize that representation on the System Parent Board of Trustees is expected to be proportional to the relative scope of services and revenues of each Hospital but that notwithstanding any such calculation each Hospital shall be entitled, at a minimum, to retain representation of at least one (1) voting Trustee it appoints to the System Parent Board of Trustees and the participation on the System Parent Board of Trustees of its CEO as a non-voting Trustee.

3.4 Scope of the System Parent Board of Trustees. The charitable purposes of the System Parent shall be accomplished in part through its Board of Trustees, which shall be

responsible for providing strategic planning leadership, direction and oversight for the System. In this regard, the role of the System Parent Board of Trustees shall include the following activities:

3.4.1 Oversee the charitable mission of the System Parent;

3.4.2 Oversee the performance of the System Parent CEO;

3.4.3 Develop and oversee implementation of the System strategy, including a population health strategy for the System;

3.4.4 Collaborate with the Hospitals, their Boards and other stakeholders of the System to accomplish strategic objectives;

3.4.5 Assess opportunities and risks facing the System and identify options and recommend strategies to capitalize on opportunities and minimize risks;

3.4.6 Oversee the implementation of performance metrics; and

3.4.7 Exercise the Reserved Powers set forth in Section 3.9 of this Agreement and such other rights set forth in this Agreement as the System Parent holds as the member of MCH and HH and the co-member of CMC.

3.5 Role of the System Parent Management. The System Parent shall provide management and other services to the Hospitals; however, the System Parent management shall initially be limited. The Hospitals' existing administrative officers and supporting staff will continue with their existing reporting relationships within each Hospital remaining intact. The Hospitals shall provide management and administrative services to the System Parent using existing personnel whose time shall be charged to the System Parent at the actual prorated cost of salary and benefits to the Hospital for the time its employees spend providing the services. Such cost allocation shall be no greater than standards in the industry for such services. The Hospitals shall review and approve such costs and contribute funds to the System Parent to pay for these costs based on an allocation consistent with a measure of the size and service utilization of the Hospitals relative to each other. The Hospitals agree that these services may develop over time. The System Parent shall have those executive management officers deemed appropriate by the System Parent Board of Trustees. The System Parent executives will manage, develop and assist with the execution of the Board of Trustees' strategic direction of the System. Initially, the Hospitals agree that the System Parent will have a Chief Executive Officer of the System (the "System CEO") who shall be charged with the responsibility for executive management of the System. The System CEO shall be accountable for the execution of the development of the System, keep the System Parent Board of Trustees educated and informed of healthcare issues impacting the System, recommend goals and policies for the System, and shall have the responsibility for major programs and services in the System as approved by the Board. Any System CEO may become an employee of one of the Hospitals, subject, however, to the discretion of the System Parent Board of Trustees in its authority to retain the individual as the System CEO. The Hospitals may terminate its employment arrangement with the System

CEO as his or her roles as Hospital CEO, subject to the System Parent Board of Trustees to in its discretion retain the individual as the System CEO. The initial System CEO shall be Joseph Pepe, M.D. ("Dr. Pepe"). The System Parent Board of Trustees shall oversee the System CEO, and he or she shall serve in that capacity at the pleasure of the System Parent Board of Trustees.

3.6 Role of the CEOs of CMC, MCH and HH. The CEOs of CMC, MCH and HH will continue to serve in such capacities after the Affiliation Date. Integration and development of the System will require accountability of each Hospital CEO for the application and implementation of the strategic plan and initiatives of the System Parent at their respective Hospitals. In an effort to ensure consistency in policies, best practices and execution of the strategic direction of the System as well as establishing accountability with respect to System-wide initiatives and optimization, but recognizing each Hospital CEO's primary fiduciary duty to the local Hospital, each Hospital CEO will have accountability as follows: (a) to his or her Hospital Board with respect to the management of the Hospital; and (b) to the System Parent Board of Trustees through the System CEO with respect to the management, resolution and execution of System related issues, execution of System initiatives and actions necessary to have System optimization. The accountability to the System Parent shall be through annual performance evaluations by the System CEO of the Hospital CEOs which shall be considered by each Hospital Board for purposes of determining its Hospital CEO's compensation. The System CEO's evaluation of a Hospital CEO will focus on the Hospital CEO's efforts and ability to effectively execute System-wide initiatives and the strategic plans of the System. Each Hospital Board shall account for the System CEO's evaluation of the Hospital CEO as a factor of the Hospital CEO's compensation pursuant to an executive compensation policy. The executive compensation policy will be developed through a collaborative process between the System Parent and the Hospitals prior to the Affiliation Date. If the System CEO is also the CEO of a Hospital – as will be the case with the Initial System CEO – then the same performance evaluation of that CEO's execution of System-wide initiatives and strategic plans at his or her Hospital will be performed by the Chairperson of the System Parent Board of Trustees. The System CEO's evaluation of the Hospital CEO may include a recommendation of removal of the Hospital CEO to the applicable Hospital Board. The power to terminate a Hospital CEO, however, will remain with the Hospital Board of Trustees exercising its fiduciary duty to the Hospital pursuant to Section 3.8.5. Notwithstanding the retention of this power, the Hospital Board of Trustees agrees that the Board will follow the process for removal pursuant to Section 3.9.3.4 of this Agreement.

3.7 Retention of Identity and Respect for CMC's Core Values. The Hospitals acknowledge that CMC is a Catholic organization that adheres to the ERDs. The System Parent can never require CMC to engage in any action contrary to the ERDs. Having been created by a non-Catholic organization with the Reserved Powers defined prior to becoming a co-member of CMC, and because CMC appoints the majority of its Board of Trustees, the System Parent shall not have the power to authorize or make and implement any decision with regard to, or itself engage in any, actions, policies, or practices of its member organizations that are against the teachings of the Catholic Church or in violation of the ERDs. The Hospitals acknowledge that the ERDs have no binding effect over MCH or HH, and that the System Parent cannot demand compliance with the ERDs in any exercise of its reserved powers over MCH or HH. MCH and

HH will at all times retain their identity as non-Catholic organizations, and will not be bound by the ERDs. Out of respect for CMC's core values, however, MCH and HH will continue their current practices of not performing the following procedures: direct abortion, in-vitro fertilization, embryonic stem-cell research or physician assisted suicide. The Hospitals agree to discuss, in good faith, the manner, if any, in which the Affiliation may address any future changes in technology, the standard of care for a rural hospital and clarifications regarding the applications of Roman Catholic doctrine, consistent with the agreements and principles established by this Section 3.7 specifically and by the Agreement generally. The standard of care for a rural hospital includes, without limitation, the Core Services.

3.8 Role of the CMC Board of Directors and the Respective Board of Trustees of MCH and HH. The Hospitals shall each maintain separate corporate existence; separate governing Boards, with fiduciary duties owed to their respective hospitals and communities served; separate decision-making authority, subject to the Reserved Powers of the System Parent; and separate ownership of assets and obligations of debt. The Boards of CMC, MCH and HH will each continue to have sole authority for making operational and financial decisions, subject to a system-wide strategic plan established by the System Parent and subject to the Reserved Powers (as defined and set forth in Section 3.9 of this Agreement). More specifically, each Hospital will be responsible for the initiation and execution of the following actions:

3.8.1 Adoption of the annual capital and operating budget;

3.8.2 Adoption of the mission, vision and policies;

3.8.3 Development of local strategic plans;

3.8.4 Amendment of the Articles of Agreement or Bylaws of the Hospital or any of its subsidiaries;

3.8.5 The proposed hiring or the termination by the Board of CMC, MCH or HH of its respective CEO; annual evaluation of its CEO's performance and assessment of CEO compensation (which shall include the System CEO's evaluation of performance with respect to System-wide initiatives and strategic plans);

3.8.6 Oversight of compliance with legal, licensing and accreditation requirements;

3.8.7 Implementation and oversight of standards for patient care and quality;

3.8.8 Oversight of risk management;

3.8.9 Promotion of community relationships, outreach and stakeholder engagement;

3.8.10 Evaluation and recommendation of recruitment needs;

3.8.11 Appointment of each Hospitals' trustees for participation in the System Parent Board of Trustees;

3.8.12 The incurrence of debt or the sale, disposition, mortgage, or encumbrance of any assets;

3.8.13 Election of at least seventy-five percent (75%) of the trustees for its own Board of Trustees; and

3.8.14 Approval of Medical Staff Bylaws and physician credentialing and such other authority as needed for licensing, accreditation and credentialing.

3.9 Reserved Powers. Notwithstanding the Hospitals' intent that each Board shall continue to govern the provision of healthcare services at each Hospital and, subject to the limitations of Sections 2.5, 3.7 and 3.8 of this Agreement, in order to achieve the benefits and mutual goals of the System, the exercise of the following powers by the CMC, HH and MCH Boards shall be subject to the approval of the System Parent (the "Reserved Powers"). The Hospitals recognize that neither MCH nor HH is subject to the teachings of the Catholic Church or the ERDs. Therefore, in exercising its Reserved Powers, the System Parent may not decline to authorize or approve any action by either MCH or HH that is subject to the System Parent's authority for the sole purpose of restricting other activities of MCH or HH that are outside of the System Parent's authority because they are in conflict with the teachings of the Catholic Church or the ERDs. If MCH or HH questions whether the System Parent denial or disapproval of a proposed action of MCH or HH subject to the Reserved Powers violates the foregoing prohibition, then the System Parent shall provide a written explanation of the reasons for the decision to demonstrate that it is in the best interests of the System without regard to compliance with the teachings of the Catholic Church or the ERDs in areas outside of the System Parent's authority. The Reserved Powers cannot be exercised in a manner that prevents the HH or MCH or CMC Boards from fulfilling their fiduciary duties.

3.9.1 Nature of the Reserved Powers. With the exception of the direct appointment of one-quarter (1/4) of the members of MCH and HH Boards of Trustees pursuant to Section 3.9.1.2, the Reserved Powers of the System Parent shall be in the nature of ratification rights, and may not be exercised by the System Parent to initiate or require actions by MCH or HH.

3.9.1.1 Reserved Powers Applicable to MCH and HH. The Reserved Powers of the System Parent over actions initiated by the Boards of Trustees of MCH and HH shall require the System Parent's approval of the following:

3.9.1.1.1 Adoption of the annual capital and operating budgets, provided that the expenditure of any Pre-affiliation Assets contemplated by such budgets and proposed in accordance with Section 3.9.3 below will not be subject to the approval of the System Parent;

3.9.1.1.2 Approval of any strategic plans or material nonclinical programing and marketing plans, including material modifications thereof;

3.9.1.1.3 Authorization of debt incurred, assumed, or guaranteed by the Hospital in excess of Five Hundred Thousand Dollars ($500,000.00), other than as provided for in any approved annual capital or operating budget;

3.9.1.1.4 Authorization of any material acquisition, disposition, formation, organization or investment by MCH or HH of or in any other corporation, partnership, limited liability company, other entity or joint venture, other than an acquisition funded with Pre-affiliation Assets proposed in accordance with Section 3.9.3 below will not be subject to the approval of the System Parent;

3.9.1.1.5 Authorization of the sale, disposition, mortgage, or encumbrance of any assets dedicated to the operations of MCH or HH involving assets of Five Hundred Thousand Dollars ($500,000.00) or more, with the exception of real estate identified on Schedule 3.9.3.1(b);

3.9.1.1.6 Authorization of MCH or HH to enter into any merger, consolidation or joint venture; or to sell or dispose of substantially all of the assets of MCH or HH or any of their respective subsidiaries; or to create or acquire any subsidiary organization;

3.9.1.1.7 Authorization of MCH or HH to institute any bankruptcy, insolvency or reorganization proceedings for itself or any subsidiary;

3.9.1.1.8 Authorization of a capital investment by MCH, HH or any of their subsidiaries in any individual entity or project in the form of cash or either tangible or intangible property in excess of Five Hundred Thousand Dollars ($500,000.00), except as provided in any approved annual capital or operating budget or to the extent funded by the Restricted Assets or by Pre-affiliation Assets;

3.9.1.1.9 Authorization to develop, implement or terminate clinical programs and clinical procedures by MCH, HH or their subsidiaries, subject to the limitations of Section 9 of this Agreement;

3.9.1.1.10 The amendment of the Articles of Agreement or Bylaws of MCH or HH or their respective subsidiaries to the extent that it would (a) impact the Reserved Powers; or (b) reasonably be expected to have a material strategic, competitive or financial impact on the System or any of its members; and

3.9.1.1.11 The MCH or HH Board of Trustees' appointment or reappointment of the MCH or HH CEO and the determination of the CEO's compensation.

3.9.1.2 System Parent Representation on the MCH and HH Boards of Trustees. The System Parent shall appoint, without limitation, one-quarter (1/4) of the elected trustee members of the MCH or HH Board of Trustees, with the remaining three quarters (3/4) to be nominated by the MCH or HH Board of Trustees in accordance with Section 3.9.3.5, as applicable. In addition, the System CEO, or his or her designee, shall serve on the MCH and HH Boards of Trustees, ex-officio with full voting rights and shall be included in the one-quarter (1/4) elected trustees nominated by the System Parent. The System Parent Board of Trustees will make such appointments in consideration of the Trustee criteria set forth in Schedule 3.9.1.2, which the Hospitals agree are important factors in maintaining a strong and effective governing Board. Such appointees by the System Parent may include up to two (2) members of senior management of the System Parent or CMC, inclusive of the System CEO, or his or her designee. In addition, the System Parent will endeavor to include the appointment of a System Parent Trustee to the MCH and HH Board of Trustees, when possible. The initial System Parent appointees are set forth in Schedule 3.9.1.2 (a) and Schedule 3.9.1.2(b).

3.9.1.3 Reserved Powers Applicable to CMC. The Reserved Powers of the System Parent over actions initiated by the CMC Board of Directors shall include the approval of the following:

3.9.1.3.1 Adoption of the annual capital and operating budgets, provided that the expenditure of any Pre-affiliation Assets contemplated by such budgets and proposed in accordance with Section 3.9.3 below will not be subject to the approval of the System Parent;

3.9.1.3.2 Approval of any strategic plans or material nonclinical programming and marketing plans; including material modifications thereof;

3.9.1.3.3 Authorization of debt incurred, assumed or guaranteed by CMC in excess of Three Million Dollars ($3,000,000.00), other than as provided for in any approved annual capital or operating budget;

3.9.1.3.4 Authorization of the sale, disposition, mortgage, or encumbrance of any assets in excess of Three Million Dollars ($3,000,000.00) dedicated to the operations of CMC;

3.9.1.3.5 Authorization of CMC to enter into any merger, consolidation or joint venture; or to sell or dispose of substantially all of the assets of CMC and its subsidiaries; or to create or acquire any subsidiary organization;

3.9.1.3.6 Authorization of a capital investment in excess of Three Million Dollars ($3,000,000.00) by CMC or any of its subsidiaries in any individual entity or project in the form of cash or either tangible or intangible property, except as provided in any approved annual capital or operating budget or to the extent funded by the Restricted Assets or by Pre-affiliation Assets;

3.9.1.3.7 Authorization to develop, implement or terminate clinical programs and clinical procedures by CMC and its subsidiaries; and

3.9.1.3.8 The CMC Board of Directors' appointment or reappointment of the CMC CEO and the determination of the CEO's compensation.

The Reserved Powers, as applied to CMC, are shared with CMCHS and the Roman Catholic Bishop of Manchester and shall be in the nature of ratification rights, and may not be exercised by the System Parent to initiate action by CMC or its Board of Directors.

3.9.2 Conflict Resolution of the Reserved Powers. If there is a conflict between a ratification of the Roman Catholic Bishop of Manchester or CMCHS' reserved powers with respect to CMC (the "Bishop's Reserved Powers") and the Reserved Powers of the System Parent with respect to CMC, then the decision of the Bishop shall govern the decision with respect to CMC.

3.9.3 Powers Reserved Exclusively to Each of CMC, MCH and HH. Notwithstanding the foregoing, the authority to take the following actions shall be reserved exclusively to the Board of Directors of CMC and the Board of Trustees of each of MCH and HH regarding its respective hospital:

3.9.3.1 Subject to the limitations below, the investment and expenditure of any of the Hospitals' Restricted Assets (as defined below) held by the Hospitals both before and after the Affiliation Date or the Pre-affiliation Assets (as defined below) held by the Hospitals on the Affiliation Date (collectively the "Hospital Endowment"). The charitable assets comprising each Hospital Endowment shall be used solely for the benefit of the patient population served by the Hospital that owns the Hospital Endowment, and any Restricted Assets shall be used in accordance with the applicable restrictions. Restricted Assets are those assets that are subject to donor restrictions and recorded on the Hospital's financial statements as "restricted"," including those identified in the attached Schedule 3.9.3.1(a). Pre-affiliation Assets are the cash reserves, board-designated reserves, surplus assets and other assets held by the Hospitals on the Affiliation Date and recorded on each Hospital's financial statements as unrestricted assets, as well as certain parcels of real estate not required for the operation of the Hospital as identified on Schedule 3.9.3.1(b). The current Pre-affiliation Assets of each Hospital are set forth in Schedule 3.9.3.1(b) of this Agreement, which schedule will be updated by each Hospital on the Affiliation Date.

While the use of the Hospital Endowment of each Hospital is reserved to the CMC, MCH and HH Boards respectively, the Hospitals have agreed that in order to achieve the goals of the Affiliation and ensure System optimization, Pre-affiliation Assets may not be spent for a purpose or in an amount that would be inconsistent with the strategic plan of the System, be detrimental to the System or have a Material Adverse Effect on the finances or creditworthiness/bond rating(s) of the System or the Hospitals, taking into account, among other things, both the amount of any capital expenditure and the future operating costs resulting from any capital expenditure. The Hospitals further agree that, subject to approval by its Board, the Pre-affiliation Assets may be utilized to support any future financing at the Hospital or System levels

or used towards System initiatives which benefit the Hospital or its respective service area. The Hospitals agree to develop on or before the Affiliation Date a mutually-acceptable policy to govern the expenditures of the Pre-affiliation Assets, which policy will identify the anticipated uses of such expenditures and provide for a transparent and collaborative deliberation process involving the System Parent prior to any expenditure of Pre-affiliation Assets.

3.9.3.2 The determination and approval of fundraising activities conducted by the Hospitals in the Hospitals' service area, and the approval of any fundraising efforts proposed by the System Parent in the Hospitals' service area;

3.9.3.3 Notwithstanding any provision of this Agreement, neither the System Parent nor any related entity will have the power to impose on CMC, MCH or HH a change to its charitable purpose or tax-exempt status, whether directly, by change of control of the System Parent, or otherwise;

3.9.3.4 Termination of the Hospital CEO, however, in order to incorporate the System CEO's performance evaluation of the implementation of System-wide considerations as required in Section 3.6 of this Agreement, the Hospitals agree to a termination process which, prior to termination of the CEO, requires the Hospital Board of Trustees or the System CEO (whoever recommends termination) to identify the performance failures and discuss appropriate correction plans. If the Hospital CEO fails to fulfill the correction plan, then the Hospital Board of Trustees can proceed with the termination of the Hospital CEO. If the Hospital Board of Trustees and the System CEO cannot agree on an appropriate correction plan within forty-five (45) days of the request for termination, then the local Board of Trustees can proceed with the termination of the CEO. No Hospital CEO shall be terminated without a majority vote to terminate by the Hospital Board of Trustees.

3.9.3.5 The appointment of the three-quarter (3/4) members of the MCH or HH Board of Trustees not appointed by the System Parent pursuant to Section 3.9.1.2. MCH and HH agree that their trustee appointments shall consider the criteria described in Schedule 3.9.3.5 as important factors to maintaining a strong and effective governing board and that the trustee appointments shall be of candidates who substantially satisfy the criteria on the whole. The System Parent shall have the right to object to any appointee who does not meet the qualifying criteria by providing the appointing Hospital Board of Trustees with a written objection identifying the criteria not satisfied. In the event of such objection, the Hospital Board of Trustees shall substitute an appointee that satisfies the criteria qualifications. The Hospitals and the System Parent hereby agree that the initial Trustees of MCH and HH shall be those individuals identified on Schedule 3.9.3.5 of this Agreement.

4. Process of the Formation of the System Parent and Membership Substitutions. The processes to accomplish the System will include, but not be limited to, the following:

4.1 Formation and Use of the System Parent by MCH and HH. MCH and HH agree that upon execution of this Agreement the System Parent shall be formed by the incorporators who are designated by MCH and HH as set forth in Exhibit B attached hereto. In order to effect the formation of the System Parent and to join the System, MCH and HH shall:

4.1.1 File the Articles of Agreement of the System Parent, in the form attached hereto as Exhibit C (the "Parent Articles") with the New Hampshire Secretary of State and the Clerk of the City of Manchester;

4.1.2 Cause the incorporators of the System Parent to take action by written consent, in the form attached hereto as Exhibit D ("Organizational Consent Resolutions"), appointing the members of the Board of Trustees of the System Parent and adopting the Bylaws of the System Parent in the form attached hereto as Exhibit E (the "Parent Bylaws"); and

4.1.3 Cause the System Parent to take all actions necessary to be recognized as exempt from federal income tax pursuant to Section 501(c)(3) of the Code and qualify for public charity status as a supporting organization pursuant to Section 509(a)(3) of the Code.

4.2 Membership Substitutions. In order to effectuate the member substitutions, MCH and HH agree that on the Affiliation Date, MCH and HH shall do the following:

4.2.1 Each cause their respective Board of Trustees to file an Affidavit of Amendment with the New Hampshire Secretary of State and the Clerk of the town in which the Hospital is located, substantially in the form attached hereto as Exhibits F and G identifying the System Parent as the sole member of MCH and HH; and

4.2.2 Each adopt the required amendments to its Bylaws substantially in the form set forth in Exhibits H and I attached hereto, reflecting the System Parent's sole membership of MCH and HH and application of common governance principles among the System Parent and each Hospital.

4.3 Dissolution and Liquidation of the System Parent. Unless otherwise agreed upon in writing, if this Agreement is terminated pursuant to Section 19 of this Agreement, then, if the System Parent has been created and organizational changes have been made to any of the Hospitals' governance documents, the Hospitals shall take all actions necessary to return the Hospitals to their original structure, involving, at a minimum, if necessary, the adoption of a Plan of Dissolution and Liquidation of the System Parent and amending the Hospitals' Articles of Agreement and Bylaws such that the System Parent is no longer the member of any Hospital.

4.4 Admission of CMC and Co-membership with CMCHS. Subsequent to the formation of the System Parent, and in order to effect the participation of CMC in the System, the System Parent and CMC, shall on the Affiliation Date:

4.4.1 The System Parent will file an Affidavit of Amendment with the New Hampshire Secretary of State and the City Clerk of the City of Manchester, substantially in the form attached hereto as Exhibit J identifying CMC as an Affiliated Hospital (defined therein);

4.4.2 The System Parent will adopt the required amendments to its Bylaws substantially in the form set forth in Exhibit K attached here, reflecting the admission of CMC as an Affiliated Hospital and reflecting the governance terms of this Agreement;

4.4.3 CMC, with the consent of CMCHS, will file an Affidavit of Amendment with the New Hampshire Secretary of State and the City Clerk of the City of Manchester, substantially in the form attached hereto as Exhibit L identifying the System Parent as the co-member of CMC with CMCHS; and

4.4.4 CMC, with the consent of CMCHS, will adopt the required amendments to its Bylaws substantially in the form set forth in Exhibit M attached hereto, reflecting the System Parent's co-membership of CMC with CMCHS and application of common governance principles among the System Parent and each Hospital.

5. No Cash Consideration/Merger. The transactions contemplated by this Agreement do not involve the transfer or exchange of cash or other assets, the assumption of debt or other liabilities or any other similar financial consideration; the merger or consolidation of any existing legal entities; the sale, purchase or lease of part or all of any existing hospital; or the transfer of all or substantially all of the assets of any of the Hospitals.

6. Commitment to Population Health: ACOs, Shared Savings, Payer Contracts and Other Reimbursement Arrangements. Subject to Section 3.7, CMC, directly or through the System Parent, will, to the extent permissible by law and the terms of such arrangements, invite MCH and HH to participate fully (i.e., in the same capacity, if possible, as CMC) in the various ACO or risk-based shared savings programs or joint ventures to which CMC or its Affiliates are parties. Subject to Section 3.5 of this Agreement, the System Parent also will, to the extent permitted by law, conduct negotiations with payers as a system including CMC, MCH and HH. Each of CMC, MCH and HH will be accountable for its performance pursuant to clinical standards and protocols, and a shared savings attribution model, adopted by the System Parent and approved by the CMC Board of Directors and the Boards of Trustees of MCH and HH. The System Parent will use commercially reasonable efforts to ensure that each shared savings attribution model incorporates the principles identified on the attached Schedule 6.

7. Hospital Affiliates and Joint Ventures. Each Hospital will undertake amendments to the organizational documents and agreements with respect to its current Affiliates and joint ventures as it deems appropriate to ensure implementation and achievement of the objectives of the transactions contemplated by this Agreement.

8. Integration Plan and Continued Identification and Development of the Affiliation Synergies. The Hospitals shall continue the ongoing efforts that began in April 2016 to evaluate and develop the administrative, operational and clinical integration of operations among the Hospitals to achieve the objectives of the Affiliation, including enhancement of population health and wellness and prevention services, expansion of primary care practice development, achievement of high quality clinical outcomes, reduction of risk concentration and enhancement of corporate compliance, improvement of physician recruitment and retention, achievement of efficiencies and implementation of best practices. From these efforts, the Hospitals shall develop

a framework for strategic development of the System, including the expansion of the System to additional hospitals and health care providers and develop an integration plan that is consistent with the principles set forth in Section 2 of this Agreement, to facilitate a smooth operational and administrative transition of the Hospitals to becoming a System. The integration plan will assess the requested commitments set forth in Schedule 9.5 and shall be developed and provided to the Hospitals by October 31, 2016. In addition to developing an integration plan, the Hospitals intend to develop a plan to determine whether it is prudent and advantageous to consolidate their debt obligations, and if so, how. Any actions recommended by the plan of debt consolidation requiring a commitment by CMC is unlikely to occur until the withdrawal without cause rights of Section 13.1 of this Agreement have expired.

9. Clinical Programming and Services. CMC is committed to its rural health strategy and maintaining the existing level of services provided by MCH and HH and their Affiliates within their respective communities under current standards of quality, cost, volume and reimbursement to a CAH. CMC and the System Parent will support the missions of MCH and HH, including the delivery of high quality, cost-effective Core Services within the MCH and HH service communities as appropriate for a rural community hospital or necessary to maintain their CAH status provided, however, that clinical service programming will take into account system-wide objectives identified in strategic planning and aim to maximize synergies created by the Affiliation. In furtherance of the foregoing CMC agrees to the following clinical commitments to be provided directly or through the System Parent, with the understanding that CMC's commitment does not include any obligations or intent to provide any support for any service that violates the ERDs:

9.1 Assessment of Needs and Evaluation of Clinical Services. Subject to the System Parent Reserved Powers, the Hospitals will assess the needs and demands of each of the Hospitals' communities and determine the most effective way to deliver the Core Services and specialty care while enhancing patient safety and quality of care and improving cost effectiveness and access to care. The Hospitals agree to develop on or before the Affiliation Date a mutually-acceptable collaborative and deliberate process for how clinical services shall be assessed, including agreement on the objective criteria for analyzing and implementing any consolidations or changes to clinical services. The objective criteria utilized by the System Parent Board of Trustees shall be consistent with the principles set forth in Section 2.4 of this Agreement and shall include consideration of quality, cost, reimbursement, profitability, outcome, access, and physician retention and recruitment. With respect to specialty services, the Hospitals agree that volume needs to be sufficient to support a reasonable call schedule for physician retention and recruitment purposes and that each provider must have a volume that meets applicable professional guidelines for purposes of upholding standards of safety. No Core Service will be terminated, however, solely by reason of lack of profitability of such Core Services and without the approval of the HH or MCH Board of Trustees, as applicable.

9.2 Hospitalists and General Surgery. CMC, through the System Parent, will support a full-time hospitalist program, and general surgery coverage at HH and MCH, however, the general surgery coverage must (i) ensure that general surgery patient volume is sufficient to maintain high quality and cost efficiency reasonable for a CAH, and (ii) be consistent with the System-wide considerations described in Section 9.1 and the principles described in Section 2.4

of this Agreement. This commitment, however, does not include a commitment to continue on-site general surgery coverage twenty-four (24) hours a day for seven (7) days a week.

9.3 Use of Telemedicine. CMC will assist MCH and HH with the development of telemedicine capabilities, which assistance may include financial assistance.

9.4 Physician Recruitment and Retention. In recognition that the recruitment and retention of primary care physicians, hospitalists and mid-levels to rural areas served by MCH and HH is challenging but essential to meeting the health care needs of the populations in such areas, the Hospitals shall make it a priority of the Affiliation. Within six (6) months following the Affiliation Date, the Hospitals and the System Parent will jointly prepare a primary care physician, hospitalists and mid-levels staff development, retention and recruitment plan which will identify incentives to ensure that compensation and work-life packages are competitive at both MCH and HH.

9.5 Additional Commitments. The Hospitals have agreed to additional commitments set forth in Schedules 9.5.

10. Access to Information. Each Hospital shall provide the others, subject to the terms of the Mutual NDA and Joint Defense Agreement (as defined in Section 16 of this Agreement), reasonable access at all reasonable times to the offices, properties, facilities, and books and records of the Hospital and the officers, directors, employees, accountants, counsel, consultants, advisors, agents and other representatives of the Hospital to discuss the business, financial condition or prospects of the Hospital, provided that such access does not unreasonably disrupt the normal operations of the Hospital and shall comply with all applicable Laws.

11. Representations and Warranties of the Hospitals. Each Hospital represents and warrants to the other Hospitals that each statement contained in this Section 11 is true and correct as of the date hereof and will be true and correct as of the Affiliation Date, except as described in the applicable Disclosure Schedules for each Hospital.

11.1 Organization and Good Standing. Each Hospital is duly organized, validly existing and in good standing under the laws of State of New Hampshire, and has all requisite power and authority to own, lease and operate its properties and assets, as well as all necessary licenses, accreditations, certifications and Permits to carry on its hospital as now being conducted. Each Hospital has delivered to the others a complete and accurate copy of the Hospital's organizational documents as in effect on the date hereof. No Hospital is in breach or violation of or a default under any provision of its organizational documents.

11.2 Members. None of the Hospitals has any capital stock. Each Hospital has provided to the other Hospitals a complete list of its members.

11.3 Authorization; Valid and Binding Agreement. Each Hospital has the full power and authority to execute, deliver and perform its obligations under this Agreement and to consummate the transactions contemplated by this Agreement. The execution, delivery and performance of this Agreement and the Affiliation contemplated by this Agreement have been

duly and validly authorized by all necessary action on the part of the Hospital, and with the exception of those approvals required in Section 14 of this Agreement, no other approval on the part of the Hospital is necessary for the execution, delivery and performance of this Agreement. This Agreement constitutes valid and binding agreements of the Hospital, enforceable in accordance with, and subject to, their terms.

11.4 No Conflicts; Consents. Except for the consents, approvals or notices listed on Schedule 11.4, the execution and delivery of this Agreement does not, and the performance by the Hospital of any of its obligations hereunder, and the consummation of the transactions contemplated hereby will not, directly or indirectly, (i) violate or conflict with or result in the breach of the provisions of any of the organizational documents of the Hospital or any affiliate; (ii) violate, breach, conflict with or constitute a default, an event of default, or an event creating any additional rights (including rights of amendment, impairment, modification, suspension, revocation, acceleration, termination or cancellation), impose additional obligations or result in a loss of any rights, or require a consent or the delivery of notice, under any material contract, law or permit applicable to the Hospital or any Affiliate or to which the Hospital or an affiliate is a Hospital or a beneficiary or otherwise subject; or (iii) result in the creation of any Liens upon any asset owned or used by the Hospital or any Affiliate. Except for the consents, approvals or notices listed on Schedule 11.4, no notices, reports, registrations or other filings are required to be made by the Hospital with, nor are any consents, approvals or authorizations required to be obtained by the Hospital from, any governmental authority or any other person, in connection with the execution, delivery or performance by the Hospital of this Agreement.

11.5 Tax Exempt Status and Taxes. Unless otherwise disclosed in Schedule 11.5, the Hospital and its Affiliates (i) are organizations exempt from federal income tax pursuant to Section 501(c)(3) of the Code; (ii) is a public charity pursuant to Section 509(a)(1) of the Code; has received a determination of such exemption and status from the Internal Revenue Service, which determination is in full force and effect. The Hospital and its Affiliates are in material compliance with all applicable laws related to its status as an organization exempt from tax pursuant to Section 501(c)(3) of the Code and has not taken any action or failed to take any action that could reasonably be expected to result in the loss or revocation of, or place in jeopardy, such status. The Hospital and its Affiliates have filed all tax returns required to be filed by the United States Government and the State of New Hampshire, and all taxes, assessments and other governmental charges due from the Hospital and its Affiliates, if any, have been duly paid, other than taxes or charges which are not as yet delinquent and have been properly accrued on the books of the Hospital and its Affiliates.

11.6 Compliance with Law. The Hospital and its Affiliates have conducted their operations in compliance with all applicable Laws except for such non-compliance as could not reasonably be expected to result in a Material Adverse Effect. The Hospital and its Affiliates have filed on a timely basis all reports, data and other information required to be filed with any Governmental Authority. The Hospital is duly licensed by the State of New Hampshire as a hospital. The Hospital and any Affiliate have obtained and own and hold all Permits which are necessary to conduct their business as currently conducted or by which any of its properties or assets is subject, except for Permits, the absence of which could not reasonably be expected to have a Material Adverse Effect. Each such Permit is valid and in full force and effect. Neither

the Hospital nor any Affiliate has received notice regarding (i) any violation of, conflict with, or failure to conduct its business in compliance with, any Permit or (ii) the termination, revocation, cancellation, suspension or other impairment or modification of, any Permit. The Hospital is not in default (or has not received notice of any claim of such default) with respect to any Permit, except for defaults that could not reasonably be expected to result in a Material Adverse Effect.

11.7 Absence of Certain Changes or Events. Except as disclosed on Schedule 11.7, to the Knowledge of the Hospital, no facts or circumstances exist, or are likely to occur, which might reasonably be expected to have a Material Adverse Effect on the Hospital or its operations. Except as expressly contemplated herein, the Hospital has not, at any time after the date of the most recent Financial Statements: (i) written off as uncollectible, or established any extraordinary reserve with respect to, any material account receivable or other material indebtedness of the Hospital; (ii) amended or restated, or approved the amendment or restatement of, the organizational documents of the Hospital; (iii) made or changed any material tax election, entered into any settlement or compromise of any material tax liability or surrendered any right to claim a material tax refund; (iv) settled or compromised any pending or threatened legal proceeding, suit, action, claim, arbitration, mediation, inquiry or investigation, unless in connection with such settlement or compromise there was no finding or admission of any violation of any legal requirement and the sole relief provided was monetary damages; (v) made any material capital expenditure or commitment for additions to property, plant or equipment or for any other purpose, except in the ordinary course of business or as disclosed on Schedule 11.7; (vi) sold, transferred, leased, optioned or otherwise disposed of any assets except in the ordinary course of business; (vii) granted or incurred any obligation for any increase in the compensation of any of the employees of the Hospital (including any increase pursuant to any bonus, pension, profit sharing, retirement, or other plan or commitment) except in the ordinary course of business; (viii) received any written notice from any Governmental Authority of any liability, potential liability or claimed liability based on any violation of law; or (ix) agreed or committed to take any of the actions referred to in this Section 11.7.

11.8 Opportunity for and Accuracy of Due Diligence. Each Hospital has had full opportunity to conduct due diligence regarding legal, financial, operational, regulatory, real and personal property, intellectual property, clinical and other matters pertaining to the other Hospitals specifically and the Affiliation generally. Each Hospital has responded to all requests from the other Hospitals to review due diligence materials in all of these areas, and the material produced has been complete and accurate as of the date of production in all material respects. Each Hospital shall update its responses up to and including the Affiliation Date with any additional material that is necessary to assure its production is complete and accurate in all material respects as of the date of this Agreement and the Affiliation Date. Each Hospital's completion of the actions described in Section 4 above will be conclusive evidence that the results of such diligence are satisfactory to the Hospital.

12. Accuracy of Representations, Information and Schedules. The representations and warranties of the Hospitals set forth in Section 11 shall be true and correct on the execution date of this Agreement and on the Affiliation Date. CMC shall have delivered to MCH and HH, and MCH and HH shall have delivered to CMC, all material information

requested as part of due diligence and integration planning as well as all schedules reasonably required to be delivered by it pursuant to this Agreement that have not been completed and attached to this Agreement on the Affiliation Date. The Hospitals shall deliver a certification approving the final Schedules prior to the Affiliation Date.

13. Limited Withdrawal Right, Notice and Payment. The Hospitals shall each have a limited right to withdraw from the Affiliation after closing on the Affiliation. If MCH or HH withdraws without cause (the "Withdrawing Hospital") from the Affiliation, then the Withdrawing Hospital may be assessed a withdrawal payment equivalent to the financial payments that have been made by CMC to or for the benefit of the Withdrawing Hospital less the value of identifiable and quantifiable synergies or other benefits that have been generated by the Withdrawing Party and/or enjoyed by the System as a result of the Withdrawing Party's participation in the System (the "Withdrawal Payment") prior to the date of the Withdrawal Notice (discussed in Section 13.3 of this Agreement). No financial payments shall be required for a withdrawal with cause. The specific withdrawal rights shall be limited as follows:

13.1 Withdrawal without Cause. Each Hospital shall have the right to withdraw from the System without cause for a period of six (6) months commencing with the completion of twenty-four (24) consecutive months following the Affiliation Date.

13.2 Withdrawal with Cause. Each Hospital shall have the right to withdraw from the System for cause upon the occurrence of any one (1) of the following events:

13.2.1 A change of control of the System Parent resulting in it being owned or controlled, directly or indirectly, by a for-profit entity;

13.2.2 Any action, circumstance or change in law which will jeopardize: (i) the tax-exempt status of the System Parent or the withdrawing Hospital; (ii) the CAH status of MCH or HH if either is the withdrawing Hospital; or (iii) would be inconsistent with the ERDs, if the withdrawing Hospital is CMC;

13.2.3 A decision by the System Parent to sell or close the hospital owned and operated by the Hospital;

13.2.4 The withdrawal of CMC from the System; and

13.2.5 A final decision of the System Parent to admit a new hospital to the System over the prior written objection of the Hospital seeking to withdraw.

13.3 Withdrawal Notice. In the event that a Withdrawing Hospital elects to withdraw from the System pursuant to Section 13.1, the Withdrawing Hospital shall provide to the System Parent and each of the other Hospitals a written notice of intent to withdraw from the Affiliation (a "Withdrawal Notice"). For a withdrawal without cause, the Withdrawal Notice shall be given at any time during the period beginning on the twenty-four (24) consecutive month anniversary of the Affiliation Date and ending six (6) months thereafter. The Withdrawal Notice without cause shall include the Withdrawing Hospital's calculation of the Withdrawal

Payment. A Withdrawal Notice with cause may be given at any time and shall specify the cause for the withdrawal.

13.4 Reconciliation and Approval of the Withdrawal Payment. The System Parent shall have the right to review a Withdrawal Notice and the proposed Withdrawal Payment during the sixty (60) day period after the System Parent's receipt of the Withdrawal Notice. The System Parent may accept the Withdrawal Notice as presented or object to the Withdrawal Notice's calculation of the Withdrawal Payment by providing a written notice of proposed adjustment to the Withdrawal Payment. Upon receiving notice of a proposed adjustment, the Withdrawing Hospital may object by delivering a written statement of objection explaining the basis for such objection within thirty (30) business days after receipt of the notice of proposed adjustment. Within thirty (30) days after receipt of the Withdrawing Hospital's written objection, the System Parent Board of Trustees (excluding any members nominated by the Withdrawing Hospital) shall determine whether to make any changes to the System Parent's notice of proposed adjustment. Any disagreement about the amount of the Withdrawal Payment shall be submitted first to mediation and then to binding arbitration under the arbitration rules of the American Health Lawyers Association.

13.5 Payment of the Withdrawal Payment and Effect of Withdrawal. A withdrawal shall only be effective upon payment of the Withdrawal Payment that is finally determined by the Hospitals. Upon the date of payment, the trustees nominated by the Withdrawing Hospital shall be deemed to have resigned from the System Parent Board of Trustees. In the event of a withdrawal without cause, the Hospitals will, in good faith, seek to re-establish the status quo which existed prior to the Affiliation. The System Parent and the Hospitals shall undertake the steps necessary to implement a withdrawal that meets the requirements of this Section 13, including amendments to the Withdrawing Hospital's Articles of Agreement and the System Parent Bylaws. The Trustees nominated by the Withdrawing Hospital to the System Parent Board of Trustees shall be deemed to have resigned and the Trustees appointed by the System Parent to the Withdrawing Hospital Board of Trustees shall be deemed to have resigned.

14. Closing Conditions. The Hospitals agree that the consummation of the Affiliation is expressly conditioned upon: (i) completion of satisfactory legal, financial and other due diligence by the Hospitals; (ii) the proper approval and execution of this Agreement and the Ancillary Agreements; (iii) approval by the trustees of any trust indenture related to any outstanding bonds or other debt securities of either Hospital, or in the alternative an opinion of counsel, mutually agreed upon, to the effect that no such approvals are required; (iv) approvals from any third party to any contract requiring such consent prior to implementation of the Affiliation; (v) receipt of all approvals required by the State of New Hampshire including, but not limited to, the New Hampshire Department of Justice Antitrust Division and the Charitable Trust Unit; (vi) receipt of any other necessary regulatory approvals; (vii) receipt of approval by the appropriate governing bodies of CMCHS, CMC, MCH and HH; (viii) receipt of approval of the Bishop of the Roman Catholic Diocese of Manchester; (ix) receipt of any approvals required by Canon Law or by the Bishop of the Roman Catholic Diocese of Manchester; and (x) the absence of any Material Adverse Effect in the operations of CMCHS, CMC, MCH or HH. The Hospitals will coordinate their efforts to obtain any applicable regulatory and third party

approvals, including approvals by the Bishop of the Roman Catholic Diocese of Manchester and any approvals required by Canon Law. The Hospitals shall promptly provide all required notices and cooperate on completing and submitting all filings and taking all other steps necessary to obtain required approvals for the Affiliation.

15. Affiliation Date. The Affiliation shall be effective on the Hospitals' agreed upon effective date which shall occur when all of the closing conditions set forth in Section 14 of this Agreement have been satisfied (the "Affiliation Date"). The Hospitals hereby agree that they will, in good faith, work towards an Affiliation Date to be no later than January 1, 2017.

16. Confidentiality. The Hospitals acknowledge and agree that they remain subject to a certain Mutual Confidentiality and Non-disclosure Agreement dated February 29, 2016 (the "Mutual NDA") and a Joint Defense and Common Interest Agreement dated February 29, 2016 (the "Joint Defense Agreement") and the Information and data disclosed to or obtained by one Hospital related to the other Hospitals pertaining to the Affiliation, shall continue to be treated as confidential information and the Hospitals' use of such information shall be governed by the Mutual NDA and the Joint Defense Agreement.

17. Compliance with Laws. Each Hospital will comply with all Applicable Laws.

18. Continuation of Operations in the Ordinary Course. The Hospitals shall continue to conduct their respective operations in the ordinary course and each will use its best efforts to continue the employment of all employees between the date of this Agreement and the effective date of the Affiliation.

19. Termination. Prior to the Affiliation Date, this Agreement may be terminated for any one of the following reasons:

19.1 By mutual written consent of all of the Hospitals;

19.2 By any Hospital with thirty (30) days prior written notice if the Affiliation has not become effective on or before the later of January 1, 2017 or nine (9) months after the date of this Agreement; and

19.3 By any Hospital immediately upon written notice if another Hospital has materially breached any representation and warranty or failed to comply with its obligations under the Agreement without cure for a period of at least sixty (60) days after notice of the breach.

If the Agreement is terminated, then the Agreement shall become void and have no effect, and the termination shall be without cost, expense or liability on the part of any Hospital to another, except as the hospitals may have otherwise agreed with respect to certain costs; provided, however, that no Hospital shall be relieved or released from any liabilities or damages arising out of its willful breach of any provision of the Agreement.

20. Joint Communication/Required Disclosures. Unless the Hospitals mutually agree in writing, they shall not make any public announcements regarding the Affiliation until this Agreement has been executed. The Hospitals shall jointly develop and implement a communication plan and process for purposes of publicly announcing the Affiliation, communicating the Affiliation to their employees and physicians, and responding to any inquiries regarding the Affiliation. Such communications regarding the Affiliation shall be approved by the Hospitals prior to being released. If any Hospital determines that it is required by Applicable Law to make any disclosure concerning the Affiliation, then it shall notify the other Hospitals and the Hospitals shall work cooperatively on the content of the proposed disclosure, the reasons that such disclosure is required by Applicable Law and the time and place that the disclosure will be made.

21. Expenses. Each Hospital shall be responsible for paying its own expenses relating to the Affiliation, including, without limitation, expenses of legal counsel, accountants, and other advisors, incurred at any time in connection with pursuing or consummating the Affiliation. The payment of costs and expenses associated with the joint financial due diligence engagements of Pershing Yoakley & Associates, P.C. ("PYA") and any necessary HSR and other anti-trust regulatory applications, including anti-trust filings in the State of New Hampshire, shall be split among the Hospitals on a pro rata basis as previously agreed upon by the Hospitals.

22. Liability. Each Hospital agrees that it shall be liable for any violation of the binding terms of this Agreement by its directors, trustees, officers, employees, advisors, consultants, agents, representatives, or Affiliates to the same extent as if such violation were committed by the Hospital.

23. Notices. Any notice required to be given under this Agreement shall be effective upon depositing the notice in first-class mail, overnight courier or certified mail, return receipt requested, or sent by facsimile or electronic mail with confirmation of receipt, addressed as follows:

If to CMCHS and/or CMC:

CMC Healthcare System
Catholic Medical Center
100 McGregor Street
Manchester, New Hampshire 03102
Attn: Alexander J. Walker, Esq., Executive Vice President
awalker@cmc-nh.org

With a simultaneous copy to:

Devine, Millimet & Branch, Professional Association
111 Amherst Street
Manchester, New Hampshire 03101
Attn: Jason E. Cole, Esq.
jcole@devinemillimet.com

If to MCH:

Monadnock Community Hospital
452 Old Street Road
Peterborough, New Hampshire 03458
Attn: Cynthia McGuire, President & CEO
Cynthia.McGuire@mchmail.org

With a simultaneous copy to:

Orr & Reno, P.A.
45 S. Main Street
Concord, New Hampshire 03301
Attn: John A. Malmberg, Esq.
jmalmberg@orr-reno.com

If to HH:

Huggins Hospital
240 South Main Street
Wolfeboro, New Hampshire 03894
Attn: Jeremy S. Roberge, Interim President & CEO
jroberge@HHhospital.org

With a simultaneous copy to:

Hinckley Allen & Snyder, LLP
11 South Main Street, Suite 400
Concord, New Hampshire 03301
Attn: Mark S. McCue, Esq.
mmccue@hinckleyallen.com

24. Amendments. This Agreement may not be amended in whole or in part except by a written instrument signed by each of the Hospitals.

25. Waiver. No waiver of any binding provision, condition or covenant of this Agreement shall be effective against the waiving Hospital unless such waiver is in writing and signed by the waiving Hospital.

26. Third Hospital Beneficiary. None of the provisions contained in this Agreement are intended by the Hospitals, nor shall they be deemed, to confer any benefit on any person not a Hospital to this Agreement, except as otherwise expressly provided herein.

27. Assignment. This Agreement may not be assigned by any of the Hospitals without the prior written consent of all of the Hospitals.

28. Governing Law. This Agreement shall be governed by and construed in accordance with the internal substantive laws of the State of New Hampshire without regard to conflict of law principles. The Hospitals agree to submit to the jurisdiction of New Hampshire courts to resolve any disputes which may arise from or as a result of this Agreement.

29. Counterparts and Signatures. This Agreement may be executed in counterparts, and each counterpart shall be deemed to be an original, and all such counterparts shall together constitute one and the same instrument. Electronic and facsimile signatures shall be deemed to be original signatures.

30. Severability. If any provision of this Agreement (or any portion thereof) or the application of any such provision (or any portion thereof) to any Person or circumstances is held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction and venue, then such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement (or the remaining portion thereof) or the application of such provision to any other Persons or circumstances.

31. Entire Agreement. This Agreement and the Exhibits and Disclosure Schedules constitute the full and entire understanding and agreement between the Hospitals with respect to the Affiliation and supersede and replace all prior and contemporaneous agreements between the Hospitals.

32. Effect of Affiliation. The Affiliation contemplated by this Agreement is not a merger or other joinder of the Hospitals which intend to remain separate and distinct subject to their participation in the System and subject to the Reserved Powers of the System Parent. Neither the System Parent nor any Hospital shall assume, guarantee or otherwise be liable for any of the debts or liabilities of any other Hospital except by express assumption or guarantee of a specific liability.

(*signature page follows*)

This Agreement is hereby agreed to by the Hospitals upon the date in the preamble.

CMC HEALTHCARE SYSTEM ("CMCHS")

By: _____
Joseph Pepe, M.D., its duly authorized
President & CEO

CATHOLIC MEDICAL CENTER ("CMC")

By: _____
Joseph Pepe, M.D., its duly authorized
President & CEO

MONADNOCK COMMUNITY HOSPITAL
("MCH")

By: _____
Cynthia McGuire, its duly authorized
President & CEO

HUGGINS HOSPITAL ("HH")

By: _____
Jeremy S. Roberge, its duly authorized
Interim President & CEO

This Agreement is hereby agreed to by the Hospitals upon the date in the preamble.

CMC HEALTHCARE SYSTEM ("CMCHS")

By: _____
Joseph Pepe, M.D., its duly authorized
President & CEO

CATHOLIC MEDICAL CENTER ("CMC")

By: _____
Joseph Pepe, M.D., its duly authorized
President & CEO

MONADNOCK COMMUNITY HOSPITAL
("MCH")

By: Cynthia K. McGuire
Cynthia McGuire, its duly authorized
President & CEO

HUGGINS HOSPITAL ("HH")

By: _____
Jeremy S. Roberge, its duly authorized
Interim President & CEO

This Agreement is hereby agreed to by the Hospitals upon the date in the preamble.

CMC HEALTHCARE SYSTEM ("CMCHS")

By: _____
Joseph Pepe, M.D., its duly authorized
President & CEO

CATHOLIC MEDICAL CENTER ("CMC")

By: _____
Joseph Pepe, M.D., its duly authorized
President & CEO

MONADNOCK COMMUNITY HOSPITAL ("MCH")

By: _____
Cynthia McGuire, its duly authorized
President & CEO

HUGGINS HOSPITAL ("HH")

By: _____
Jeremy S. Roberge, its duly authorized
Interim President & CEO

EXHIBIT A

DEFINITIONS

"Affiliate" means any entity which is under the Control of, or which is under common Control with, the subject entity.

"Applicable Laws" means all applicable Federal, state and local laws, statutes, ordinances, rules, regulations, codes and any judgment, decree, order, right or injunction of any court or regulatory authority and with respect to CMC and its member CMCHS, Code of Canon Law of the Catholic Church.

"CAH" means a critical access hospital as determined by the Centers for Medicare & Medicaid Services.

"Code" means the Internal Revenue Code of 1986, as amended.

"Control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity.

"Core Services" shall mean those healthcare services which are either (i) required by the Centers for Medicare & Medicaid Services to qualify as a CAH; (ii) necessary by the agreement of the Parties to meet the needs of a Hospital's community; or (iii) generally provided by comparable rural hospitals. At a minimum, Core Services shall include emergency medicine, general surgery, hospital medicine, primary care and obstetrics (with respect to MCH) and supportive services of anesthesia, and radiology/tele-radiology, however the Hospitals agree that any changes to the level, type and means of delivery of the Core Services will be a function of the criteria set forth in Section 9 of this Agreement and the Hospital's budget and the strategic planning and approval of the System Parent.

"Governmental Authority" means any federal, state, local or municipal government, any governmental or quasi-governmental authority of any nature (including any government agency, branch, board, department, official, instrumentality or entity) or any regulatory body exercising or entitled to exercise, any administrative, executive, judicial, legislation, policy, regulatory, or taxing authority or power of any nature.

"Material Adverse Effect" means any change, effect, event or occurrence that is, or would reasonably be expected to be, materially adverse to, or has, or would reasonably be expected to have, a materially adverse effect on, a hospital, condition (financial or otherwise), prospects or results of operations of a Hospital.

"Person" means any individual, corporation, partnership, limited liability company, trust, joint venture, cooperative or other association, Governmental Authority or other organization or entity.

"Tax" or "Taxes" means any and all federal, state, local or foreign net or gross income, gross receipts, net proceeds, sales, use, ad valorem, value-added, franchise, bank shares, withholding, payroll, employment, excise, property, abandoned property, escheat, deed, stamp, alternative or add-on minimum, environmental, profits, windfall profits, transaction, license, lease, service, service use, occupation, severance, energy, transfer taxes, unemployment, social security, workers' compensation, capital, premium, and other taxes, assessments, customs, duties, fees, levies, or other governmental charges of any nature whatever, whether disputed or not, together with any interest, penalties, additions to tax, or additional amounts with respect thereto.

Exhibit II

Second Amendment to Affiliation Agreement made effective May 13, 2022

SECOND AMENDMENT TO AFFILIATION AGREEMENT
To Extend Time for Withdrawal without Cause

THIS SECOND AMENDMENT (this "Amendment") to the Affiliation Agreement dated June 29, 2016 (the "Agreement") is made effective as of May 13, 2022 (the "Amendment Effective Date") by all the parties to the Agreement, which are CMC Healthcare System, a New Hampshire voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire 03102 ("CMCHS"), Catholic Medical Center, a New Hampshire voluntary corporation with a principal place of business at 100 McGregor Street, Manchester, New Hampshire 03102 ("CMC"), Monadnock Community Hospital, a New Hampshire voluntary corporation with a principal place of business at 452 Old Street Road, Peterborough, New Hampshire 03458 ("MCH") and Huggins Hospital, a New Hampshire voluntary corporation with a principal place of business at 240 South Main Street, Wolfeboro, New Hampshire 03894 ("HH") (CMC, MCH and HH are also referred to herein individually as a "Hospital" and collectively referred to herein as the "Hospitals").

WHEREAS, the Hospitals and CMCHS entered into the Agreement to create a healthcare system under a new tax-exempt corporation known as GraniteOne Health ("GOH") which became the single member of MCH and HH and a co-member with CMCHS of CMC; and

WHEREAS, the Agreement at section 13.1 provides each Hospital the right to withdraw from GOH without cause for a period of six (6) months commencing with the completion of twenty-four consecutive months following the Affiliation Date; and

WHEREAS, the six-month period for a Hospital to withdraw from GOH without cause expired on the close of business on June 30, 2019; and

WHEREAS, as of January 23, 2019, GOH entered into a Letter of Intent (the "LOI") with Dartmouth-Hitchcock Health to create a new, larger system involving all of the Hospitals and all of the hospitals and other organizations affiliated with Dartmouth-Hitchcock Health (the "Combination"); and

WHEREAS, since the execution of the LOI the Hospitals' attention and efforts have been focused on the new larger system and its organizational structure; and

WHEREAS, on September 30, 2019, the Hospitals entered into a Combination Agreement (the "Combination Agreement") to establish a bi-regional, fully integrated health care delivery system; and

WHEREAS, the Hospitals began the state and federal regulatory process on December 30, 2019 and that process continued until May 13, 2022 lasting over two (2) years; and

WHEREAS, the state regulatory process ended on May 13, 2022 when the New Hampshire Department of Justice, Charitable Trusts Unit issued its report (the "CTU Report") objecting to the Combination as unlawful based on the analysis of the Consumer Protection and

Antitrust Bureau that the Combination would adversely affect competition, effectively ending any possibility of a closing of the Combination (the "Combination Termination"); and

WHEREAS, while the parties had provided for an "extension" of the withdrawal right pursuant to a certain Amendment to Affiliation Agreement dated June 29, 2016, the parties wish to further extend that period to allow for consideration of the options for the future available to each of them; and

WHEREAS, the parties have agreed to memorialize that extension with this Amendment; and

WHEREAS the Hospitals do not want to surrender their rights to withdraw from GOH without cause by the passage of the deadline to exercise the right without having a reasonable period of time to consider their options after the Combination Termination.

NOW, THEREFORE, in consideration of the mutual promises herein and for other good and valuable consideration received, the parties amend the Agreement by this Amendment as follows:

1. Section 13.1 of the Agreement is deleted in its entirety and replaced with the following:

> Withdrawal without Cause. Each Hospital shall have the right to withdraw from the System without cause by sending written notice of withdrawal to the other Hospitals at any time during the period from the Amendment Effective Date until six (6) months after the Amendment Effective Date, which is November 13, 2022. This deadline also applies to Section 13.3.

2. Capitalized terms used, but not defined, in this Amendment will have the same meaning ascribed to them under the Agreement.

3. The parties agree that the Agreement, as amended by this Amendment, remains in full force and effect.

The remainder of this page is purposefully left blank.

The parties have caused this Amendment to be executed by their duly authorized representatives, intending it to take effect as of the Amendment Effective Date.

CMC HEALTHCARE SYSTEM ("CMHCS")

Date: 5/16, 2022

By: _____
Alexander J. Walker., its duly authorized
President & CEO

CATHOLIC MEDICAL CENTER ("CMC")

Date: 5/16, 2022

By: _____
Alexander J. Walker, its duly authorized
President & CEO

MONADNOCK COMMUNITY HOSPITAL ("MCH")

Date: 5/16, 2022

By: Cynthia K. McGuire, FACHE
Digitally signed by Cynthia K. McGuire, FACHE
DN: cn=Cynthia K. McGuire, FACHE, o=Monadnock Community Hospital, ou=President & CEO, email=cynthia.mcguire@mchmail.org, c=US
Date: 2022.05.17 08:34:42 -04'00'
Cynthia K. McGuire, its duly authorized
President & CEO

Date: _____, 2022

HUGGINS HOSPITAL ("HH")

By: _____
Jeremy S. Roberge, its duly authorized
President and CEO

The parties have caused this Amendment to be executed by their duly authorized representatives, intending it to take effect as of the Amendment Effective Date.

CMC HEALTHCARE SYSTEM ("CMHCS")

Date: 5/16, 2022

By: _____
Alexander J. Walker., its duly authorized
President & CEO

CATHOLIC MEDICAL CENTER ("CMC")

Date: 5/16, 2022

By: _____
Alexander J. Walker, its duly authorized
President & CEO

MONADNOCK COMMUNITY HOSPITAL ("MCH")

Date: _____, 2022

By: _____
Cynthia K. McGuire, its duly authorized
President & CEO

Date: 5/16, 2022

HUGGINS HOSPITAL ("HH")

By: _____
Jeremy S. Roberge, its duly authorized
President and CEO

Appendix A-1

Huggins Hospital Incorporating Statute

Appendix A-2

Huggins Hospital Bylaws, Amended and Restated

Appendix A-3

Huggins Hospital Annual Consolidated Financial Statements
for the year ended September 30, 2022

Huggins Hospital and Subsidiary

CONSOLIDATED FINANCIAL STATEMENTS
and
SUPPLEMENTARY INFORMATION

September 30, 2022 and 2021
With Independent Auditor's Report

HUGGINS HOSPITAL AND SUBSIDIARY

Index to Consolidated Financial Statements and Supplementary Information

September 30, 2022 and 2021

INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Huggins Hospital and Subsidiary

Opinion

We have audited the accompanying consolidated financial statements of Huggins Hospital and Subsidiary, which comprise the consolidated balance sheets as of September 30, 2022 and 2021, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Huggins Hospital and Subsidiary as of September 30, 2022 and 2021, and the results of their operations, changes in their net assets and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles (U.S. GAAP).

Basis for Opinion

We conducted our audits in accordance with U.S. generally accepted auditing standards (U.S. GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Huggins Hospital and Subsidiary and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with U.S. GAAP; and for 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.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Huggins Hospital and Subsidiary's ability to continue as a going concern within one year after the date that the consolidated financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with U.S. GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with U.S. GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Huggins Hospital and Subsidiary's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Huggins Hospital and Subsidiary's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Other Matter

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. Schedules 1 and 2 are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position and results of operations of the individual organizations, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. GAAS. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
January 25, 2023

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Balance Sheets

September 30, 2022 and 2021

ASSETS

	2022	2021
Current assets		
Cash and cash equivalents	**$ 20,923,820**	$ 30,699,247
Accounts receivable from patients, less allowances for uncollectible accounts and contractuals (2022 - $21,212,000; 2021 - $21,689,000)	**9,506,058**	12,413,519
Other accounts and notes receivable	**1,861,481**	2,466,337
Other current assets	**1,409,032**	953,990
Total current assets	**33,700,391**	46,533,093
Assets limited as to use	**50,011,496**	59,887,663
Property and equipment, net	**50,063,540**	50,694,972
Long-term investments	**11,157,790**	14,168,788
Beneficial interest in perpetual trust	**5,349,056**	6,170,012
Cash surrender value of life insurance	**1,248,266**	1,248,266
Total assets	**$ 151,530,539**	$178,702,794

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable and other current liabilities	**$ 4,630,134**	$ 4,787,721
Accrued salaries and related accounts	**4,575,499**	5,143,643
Current portion of long-term debt	**750,095**	730,499
Due to related parties	**1,381,044**	310,120
Medicare accelerated payments	**-**	10,484,115
Current portion of estimated third-party payor settlements	**2,755,424**	2,462,071
Total current liabilities	**14,092,196**	23,918,169
Estimated third-party payor settlements, less current portion	**25,560,335**	26,691,697
Interest rate swap	**1,107,739**	2,853,163
Long-term debt, excluding current portion	**23,036,291**	23,698,782
Total liabilities	**63,796,561**	77,161,811
Net assets		
Without donor restrictions	**71,415,085**	80,626,387
With donor restrictions	**16,318,893**	20,914,596
Total net assets	**87,733,978**	101,540,983
Total liabilities and net assets	**$ 151,530,539**	$ 178,702,794

The accompanying notes are an integral part of these consolidated financial statements.

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Statements of Operations

Years Ended September 30, 2022 and 2021

	2022	2021
Revenues, gains and other support without donor restrictions		
Patient service revenue (net of discounts and contractual allowances)	**$ 86,273,736**	$ 74,278,627
Other operating revenues	**2,533,154**	5,976,261
Provider relief and other stimulus revenues	**1,916,387**	2,628,398
Paycheck Protection Program (PPP) refundable advance revenue	**-**	6,443,200
Investment income allotted for operations	**663,000**	564,000
Net assets released from restrictions for operating purposes	**81,983**	139,741
Total revenues, gains and other support without donor restrictions	**91,468,260**	90,030,227
Expenses		
Salaries, wages, and fringe benefits	**51,005,100**	44,130,730
Supplies	**11,134,934**	9,274,182
Physician fees	**5,679,137**	4,897,364
Other	**15,551,217**	12,791,322
Medicaid enhancement tax	**3,530,734**	2,793,553
Depreciation and amortization	**5,597,523**	4,932,314
Interest	**853,262**	907,667
Total expenses	**93,351,907**	79,727,132
Operating (loss) income	**(1,883,647)**	10,303,095
Nonoperating gains (losses)		
Contributions, net	**298,713**	184,908
Development costs	**(120,469)**	(94,915)
Investment (losses) gains	**(9,886,012)**	8,073,314
Change in value of interest rate swap	**1,745,424**	1,006,974
Affiliation costs	**(365,311)**	(800,000)
Nonoperating (losses) gains, net	**(8,327,655)**	8,370,281
(Deficiency) excess of revenues, gains and other support over expenses and losses	**(10,211,302)**	18,673,376
Net assets released from restrictions for capital acquisitions	**1,000,000**	-
(Decrease) increase in net assets without donor restrictions	**$ (9,211,302)**	$ 18,673,376

The accompanying notes are an integral part of these consolidated financial statements.

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Statements of Changes in Net Assets

Years Ended September 30, 2022 and 2021

	Without Donor Restrictions	With Donor Restrictions	Total
Balances, October 1, 2020	$ 61,953,011	$ 18,523,504	$ 80,476,515
Excess of revenues, gains and other support over expenses and losses	18,673,376	-	18,673,376
Contributions	-	159,929	159,929
Investment income, net of fees	-	196,866	196,866
Net assets released from restrictions for operations	-	(139,741)	(139,741)
Spending policy allotment	-	(564,000)	(564,000)
Realized gains on sales of investments	-	1,364,617	1,364,617
Net unrealized gains on investments	-	772,483	772,483
Change in beneficial interest in perpetual trust	-	600,938	600,938
Net increase in net assets	18,673,376	2,391,092	21,064,468
Balances, September 30, 2021	80,626,387	20,914,596	101,540,983
Deficiency of revenues, gains and other support over expenses and losses	**(10,211,302)**	**-**	**(10,211,302)**
Contributions	**-**	**318,232**	**318,232**
Investment income, net of fees	**-**	**263,537**	**263,537**
Net assets released from restrictions for operations	**-**	**(81,983)**	**(81,983)**
Net assets released from restrictions for capital acquisitions	**1,000,000**	**(1,000,000)**	**-**
Spending policy allotment	**-**	**(663,000)**	**(663,000)**
Realized gains on sales of investments	**-**	**1,252,599**	**1,252,599**
Net unrealized losses on investments	**-**	**(3,864,132)**	**(3,864,132)**
Change in beneficial interest in perpetual trust	**-**	**(820,956)**	**(820,956)**
Net decrease in net assets	**(9,211,302)**	**(4,595,703)**	**(13,807,005)**
Balances, September 30, 2022	**$ 71,415,085**	**$ 16,318,893**	**$ 87,733,978**

The accompanying notes are an integral part of these consolidated financial statements.

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidated Statements of Cash Flows

Years Ended September 30, 2022 and 2021

	2022	2021
Cash flows from operating activities		
Change in net assets	**$ (13,807,005)**	$ 21,064,468
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities		
Change in beneficial interest in perpetual trust	**820,956**	(600,938)
Depreciation and amortization	**5,677,766**	5,012,557
Gain on sale of property	**-**	(2,320,099)
Net realized and unrealized losses (gains) on investments	**13,527,451**	(9,388,745)
Unrealized gain on interest rate swap	**(1,745,424)**	(1,006,974)
PPP refundable advance forgiveness	**-**	(6,443,200)
Decrease (increase) in		
Accounts receivable from patients	**2,907,461**	(6,426,502)
Other accounts and notes receivable	**604,856**	(1,460,053)
Other current assets	**(455,042)**	(51,264)
Increase (decrease) in		
Accounts payable and other current liabilities	**(157,587)**	1,622,655
Accrued salaries and related accounts	**(568,144)**	777,944
Due to related parties	**1,070,924**	(440,968)
Deferred provider relief and other stimulus funds	**-**	(2,628,398)
Medicare accelerated payments	**(10,484,115)**	(2,215,885)
Estimated third-party payor settlements	**(838,009)**	3,739,127
Net cash used by operating activities	**(3,445,912)**	(766,275)
Cash flows from investing activities		
Purchase of property and equipment	**(4,966,091)**	(7,362,506)
Proceeds from sale of property and equipment	**-**	3,250,000
Purchase of investments	**(35,127,109)**	(30,828,768)
Proceeds from sale of investments	**34,486,823**	25,342,863
Net cash used by investing activities	**(5,606,377)**	(9,598,411)
Cash flows from financing activities		
Payments on long-term debt	**(659,252)**	(639,382)
Payments on capital lease obligations	**(63,886)**	(53,238)
Net cash used by financing activities	**(723,138)**	(692,620)
Net decrease in cash and cash equivalents	**(9,775,427)**	(11,057,306)
Cash and cash equivalents, beginning of year	**30,699,247**	41,756,553
Cash and cash equivalents, end of year	**$ 20,923,820**	$ 30,699,247
Supplemental disclosure of cash flow information:		
Interest paid	**$ 877,423**	$ 827,424

During 2021, Huggins Hospital and Subsidiary entered into a capital lease obligation acquiring an asset with a value of $447,199. The lease commitment and acquisition of the asset were treated as a noncash transaction.

The accompanying notes are an integral part of these consolidated financial statements.

Organization

Huggins Hospital (the Hospital) is a not-for-profit Critical Access Hospital (CAH) in Wolfeboro, New Hampshire. The Hospital provides inpatient, outpatient, primary care and emergency care services to residents of East-Central New Hampshire. Huggins Senior Housing, Inc. (HSH) is a wholly-owned, for-profit subsidiary of the Hospital.

In January 2017, the Hospital became affiliated with Catholic Medical Center (CMC) of Manchester, New Hampshire and Monadnock Community Hospital (MCH) of Peterborough, New Hampshire, under a new organization and parent company, GraniteOne Health (GraniteOne). GraniteOne is a non-profit entity and, as a healthcare system, allows the three hospitals to enhance collaboration, strengthen clinical partnerships, and meet the health needs of the communities it serves through high-quality care and a seamless patient experience. The Hospital has two representatives on the thirteen-member Board of Trustees of GraniteOne.

On October 27, 2022, subsequent to ceased affiliation activity between GraniteOne and Dartmouth-Hitchcock Health, the Hospital's Board of Trustees (Board) voted to disaffiliate from GraniteOne. The Hospital and GraniteOne are working with the State of New Hampshire through the process, which is expected to be completed during 2023.

1. Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements represent the parent and subsidiary activities after the elimination of all material intercompany balances and activity.

Basis of Presentation

Net assets and revenues, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification Topic (ASC) 958, *Not-For-Profit Entities*. Under FASB ASC 958 and FASB ASC 954, *Health Care Entities*, all not-for-profit healthcare organizations are required to provide a balance sheet, a statement of operations, a statement of changes in net assets, and a statement of cash flows. FASB ASC 954 requires reporting amounts for an organization's total assets, liabilities, and net assets in a balance sheet; reporting the change in an organization's net assets in statements of operations and changes in net assets; and reporting the change in its cash and cash equivalents in a statement of cash flows, according to the following net asset classification:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Hospital. These net assets may be used at the discretion of the Hospital's management and the Board.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Hospital or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Donor-restricted contributions are reported as increases in net assets with donor restrictions. When a restriction expires, net assets are reclassified from net assets with donor restrictions to net assets without donor restrictions in the consolidated statements of operations and changes in net assets.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include short-term investments with original maturities of three months or less.

Investments

Investments in equity securities with readily determinable fair values, and all investments in debt securities, are recorded at fair value. Investment income from funded depreciation, Board-designated investments, and investments without donor restrictions allotted for operations per the Hospital's spending policy is included in operating revenues. The remaining investment gains and losses are reported as nonoperating gains (losses).

Realized gains or losses on the sale of investments are determined by use of the average cost method. Investment income (including realized and unrealized gains and losses on investments and other than temporary losses on debt) is included in the excess (deficiency) of revenues, gains, and other support over expenses and losses unless the income or loss is restricted by donor or law.

Investments in general are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated balance sheets. The Hospital monitors its investments and related market changes within the parameters of its investment policy.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received and the conditions are met. The gifts are reported as support with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as net assets released from restrictions.

Assets Limited as to Use

Assets limited as to use include designated assets set aside by the Board for future capital improvements. Board-designated funds are controlled by the Board and it may, at its discretion, subsequently use them for other purposes.

Interest Rate Swap

The Hospital uses an interest rate swap contract to eliminate the cash flow exposure of interest rate movements on a portion of its variable-rate debt. The Hospital has adopted FASB ASC 815, *Derivatives and Hedging*, to account for its interest rate swap contract. The interest rate swap contract has not been designated as a cash flow hedge. Unrealized gains and losses on the fair value of derivative financial instruments not designated as cash flow hedges are required to be included in the performance indicator. As a result, the changes in fair value of the interest rate swap for 2022 and 2021 have been included in the excess (deficiency) of revenues, gains and other support over expenses and losses. The Hospital expects to hold the swap until its maturity, at which point unrealized gains or losses will be zero.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. 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. Such amortization is included in depreciation and amortization in the financial statements.

Gifts of long-lived assets such as land, buildings, or equipment are reported as support without donor restrictions, and are excluded from the excess (deficiency) of revenues, gains, and other support over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Deferred Financing Costs

The costs incurred to obtain long-term financing are being amortized by the straight-line method over the repayment period of the related debt. The costs are included in long-term debt in the balance sheet.

Paycheck Protection Program (PPP) Refundable Advance

During 2020, the Hospital qualified for and received a loan pursuant to the PPP, a program implemented by the U.S. Small Business Administration (SBA) under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), in the amount of $6,443,200. The PPP provides funds to pay up to 24 weeks of payroll and other specified costs, and forgiveness of the loan is dependent upon compliance with this and other terms and conditions of the CARES Act. During 2021, the Hospital applied for forgiveness under the provisions of the CARES Act and subsequently received the approval of the lending institution and the SBA in June 2021. The Hospital had chosen to follow the conditional contribution model for the loan, under which contribution revenue is recognized when the conditions are met. The full amount forgiven is reported as operating revenue in the consolidated statement of operations for the year ended September 30, 2021. The loan forgiveness is subject to audit by the SBA for a period of six years from the date the loan was forgiven.

Provider Relief Funds

The CARES Act provided $175 billion to eligible healthcare providers to prevent, prepare for and respond to COVID-19. The CARES Act provides the U.S. Department of Health and Human Services (HHS) with discretion to operate the program and determine the reporting requirements. The funds have been appropriated to reimburse healthcare providers for COVID-19 related expenses or lost revenues that are attributable to COVID-19. During 2020, the Hospital received $5,635,785 of HHS Provider Relief Funds and attested to the receipt of the funds and agreement with the associated terms and conditions. In November and December 2021, HHS released additional Provider Relief Funds and American Rescue Plan Funds (the Funds) to providers who serve rural Medicaid and Medicare beneficiaries in the amount of $1,663,358. The Hospital has chosen to follow the conditional contribution model for the Funds. For the years ended September 30, 2022 and 2021, the Hospital recognized $1,663,358 and $2,628,398, respectively, of the Funds in operating revenue in the consolidated statements of operations, and recognized $3,007,387 during 2020. Management believes the conditions on which the Funds depend were substantially met. Management believes the position taken is a reasonable interpretation of the rules currently available. Due to the complexity of the reporting requirements and the continued issuance of clarifying guidance, it is possible the amount of income recognized related to the lost revenues and COVID-19-related costs may change by a material amount. Any difference between amounts previously estimated and amounts subsequently determined to be recoverable or payable will be included in income in the year that such amounts become known.

Medicare Accelerated Payments

In response to the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) made available an accelerated and advance payment program to Medicare providers. The Hospital received $12,700,000 in April 2020. During 2021, CMS began recouping payment from claim payments, one year after the advance was made for a period of seventeen months. The advance was repaid during 2022.

Net Patient Service Revenue and Patient Accounts Receivable

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.

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to operations and a credit to a valuation allowance based on its assessment of individual accounts and historical adjustments. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to patient accounts receivable. Net patient accounts receivable at October 1, 2020 was $5,987,017.

Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Excess (Deficiency) of Revenues, Gains and Other Support Over Expenses and Losses

The statements of operations include excess (deficiency) of revenues, gains, and other support over expenses and losses. Changes in net assets without donor restrictions which are excluded from this measure, consistent with industry practice, are net assets released from restrictions for capital acquisitions.

Employee Fringe Benefits

The Hospital has an "earned time" plan under which each employee earns paid leave for each period worked. These hours of paid leave may be used for vacations, holidays, or illnesses. Hours earned, but not used, are vested with the employee. Employees can vest up to 368 hours. The Hospital accrues a liability for such paid leave as it is earned.

Income Taxes

The Internal Revenue Service currently recognizes the Hospital as an exempt organization under Internal Revenue Code Section 501(c)(3). HSH is a for-profit corporation and, as such, is subject to federal and state taxes. Taxes were not material in 2022 or 2021.

Subsequent Events

For purposes of the preparation of these financial statements in conformity with U.S. GAAP, the Hospital has considered transactions or events occurring through January 25, 2023, which was the date the financial statements were available to be issued.

2. Net Patient Service Revenue and Patient Accounts Receivable

Revenue Recognition

Net patient service revenue and patient accounts receivable are reported at the amount that reflects the consideration to which the Hospital expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Hospital bills the patients and third-party payors several days after the services are performed or the patient is discharged. Revenue is recognized as performance obligations are satisfied.

The Hospital has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Hospital's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Hospital does in certain instances enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Performance obligations are determined based on the nature of the services provided by the Hospital. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Hospital believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in hospitals receiving inpatient acute care services or patients receiving services in outpatient centers. The Hospital measures the performance obligation from admission into the Hospital or the commencement of an outpatient service to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Hospital has elected to apply the optional exemption provided in FASB ASC 606-10-50-14 (a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Hospital determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Hospital's policy, and implicit price concessions provided to uninsured patients.

Each performance obligation is separately identifiable from other promises in the customer contract. As the performance obligations are met (i.e., room, board, ancillary services, level of care), revenue is recognized based upon the allocated transaction price. The transaction price is allocated to separate performance obligations based upon the relative standalone selling price. In instances where management determines there are multiple performance obligations across multiple months, the transaction price is allocated by applying an estimated implicit and explicit rate to gross charges based on the separate performance obligations.

In assessing collectibility, the Hospital has elected the portfolio approach. This portfolio approach is being used as the Hospital has a large volume of similar contracts with similar classes of customers. The Hospital reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all of the contracts (which are at the patient level) by the particular payor or group of payors, will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level.

Estimated Third-Party Payor Settlements

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

Medicare

With CAH designation, the Hospital is reimbursed at 101% of allowable costs for its inpatient and outpatient services provided to Medicare patients. The Hospital is reimbursed at tentative rates with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been settled by the Medicare fiscal intermediary through September 30, 2017.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates per day of hospitalization. The prospectively determined per-diem rates are not subject to retroactive adjustment. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the fiscal intermediary. The Hospital's Medicaid cost reports have been settled by the fiscal intermediary through September 30, 2017.

Prior to 2021, the Hospital received Medicaid Disproportionate Share Hospital (DSH) payments through federal and state allotments. DSH payments provide financial assistance to hospitals that serve a large proportion of low-income patients. Amounts received by the Hospital are subject to audit and are therefore subject to change. The Hospital has been audited through 2019. In 2021, the DSH payments were replaced with Medicaid directed payments which are not subject to audit.

The State of New Hampshire imposes a tax on the gross patient service revenue of every hospital in the state. The monies generated by this tax and from federal matching funds are disbursed to the hospitals in support of healthcare services to Medicaid and low-income individuals.

Revenues from the Medicare and Medicaid programs accounted for approximately 39% and 11%, respectively, of the Hospital's patient revenue for the year ended September 30, 2022, and approximately 40% and 11%, respectively, for the year ended September 30, 2021. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue increased approximately $1,475,000 and decreased approximately $1,643,000 in 2022 and 2021, respectively, due to adjustments based on settled amounts for which there was uncertainty of interpretation of the applicable regulations.

Anthem Blue Cross

Inpatient and outpatient services rendered to Anthem Blue Cross subscribers are reimbursed at submitted charges less a negotiated discount. The amounts paid to the Hospital are not subject to any retroactive adjustments.

Patient service revenue and contractual and other allowances consisted of the following for the years ended September 30:

	2022	2021
Gross patient service revenue	**$ 180,796,860**	$ 158,166,172
Less Medicare allowances	**44,163,522**	35,688,663
Less other payor allowances	**49,548,174**	47,547,691
Less free care and charity allowances	**811,428**	651,191
Net patient service revenue	**$ 86,273,736**	$ 74,278,627

Revenue related to self-pay patients was approximately $4,146,000 and $4,059,000 for the years ended September 30, 2022 and 2021, respectively.

Long-term estimated third-party payor settlements consist of estimates related to Medicare's potential disallowance of Medicaid enhancement tax as an allowance cost and state disproportionate share pending settlements. Due to unresolved issues at the federal and state levels and pending audits for both matters, the Hospital has classified the balances as long-term.

Charity Care

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy, as well as the estimated cost of those services and supplies and equivalent service statistics. The following information measures the level of charity care provided during the years ended September 30:

	2022	2021
Charges forgone, based on established rates	**$ 811,428**	$ 651,191
Estimated costs and expenses incurred to provide charity care	**$ 410,000**	$ 321,000
Equivalent percentage of charity care charges to all Hospital patient charges	**0.44 %**	0.40 %

Costs of providing charity care services have been estimated based on the relationship of charges for these services to total expenses.

3. Availability and Liquidity of Financial Assets

As of September 30, 2022 and 2021, the Hospital has working capital of $19,608,195 and $22,614,924, respectively, and average days (based on normal expenditures) cash and cash equivalents on hand of 87 and 150, respectively.

The Hospital's debt covenants require the Hospital to maintain financial assets to 100 days of operating expenses. The Hospital budgets to maintain 345 days of operating expenses. As part of the Hospital's liquidity plan, cash in excess of daily requirements is invested in short-term investments.

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, net of deferred provider relief and other stimulus funds, were as follows as of September 30:

	2022	2021
Cash and cash equivalents	**$ 20,923,820**	$ 30,699,247
Patient accounts receivable, net	**9,506,058**	12,413,519
Other accounts and notes receivable	**1,861,481**	2,466,337
Financial assets available to meet cash needs for general expenditures within one year	**$ 32,291,359**	$ 45,579,103

The Hospital has $50,011,496 and $59,887,663 at September 30, 2022 and 2021, respectively, that are designated assets set aside by the Board for future capital improvements. These assets limited as to use are not available for general expenditure within the next year; however, the internally designated amounts could be made available, if necessary. Additionally, the Hospital has available a $5,000,000 line of credit as described in Note 8.

4. Investments

Assets Limited as to Use

The composition of assets limited as to use as of September 30, 2022 and 2021 is set forth in the following table. Investments are stated at fair value.

	2022	2021
Cash and cash equivalents	**$ 2,475,673**	$ 3,666,639
Mutual funds	**29,994,465**	38,038,055
Government securities	**4,181,823**	3,262,810
Corporate notes and bonds	**13,359,535**	14,920,159
	$ 50,011,496	$ 59,887,663

Other Investments

Other investments stated at fair value as of September 30 include:

	2022	2021
Cash and cash equivalents	**$ 224,503**	$ 66,559
Mutual funds	**6,891,619**	9,545,769
Corporate notes and bonds	**3,967,068**	4,481,860
Other investments	**74,600**	74,600
Total long-term investments	**11,157,790**	14,168,788
Beneficial interest in perpetual trust	**5,349,056**	6,170,012
	$ 16,506,846	$ 20,338,800

Investment income consist of the following for the years ended September 30:

	2022	2021
Income		
Interest and dividends	**$ 2,005,692**	$ 1,656,768
Net realized gains on sales of securities	**3,989,866**	2,304,626
Net unrealized (losses) gains	**(13,653,185)**	6,311,636
	$ (7,657,627)	$ 10,273,030

	2022	2021
Investment income is reported as follows:		
Nonoperating investment (losses) gains	**$ (9,886,012)**	$ 8,073,314
Investment income allotted for operations	**663,000**	564,000
Included in other operating revenues	**49,249**	74,233
Restricted investment income	**263,537**	196,866
Restricted realized gains	**1,252,599**	1,364,617
	$ (7,657,627)	$ 10,273,030
Other changes in net assets		
Net unrealized (losses) gains with donor restrictions	**$ (3,864,132)**	$ 772,483
	$ (3,864,132)	$ 772,483

5. Endowment

The Hospital's endowment consists of donor-restricted endowment funds. As required by U.S. GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Hospital has interpreted the State of New Hampshire Uniform Prudent Management of Institutional Funds Act (UPMIFA) such that the Board is allowed to appropriate for expenditure for the uses and purposes for which the endowment fund is established, unless otherwise specified by the donor, so much of the net appreciation, realized and unrealized, in the fair value of the assets of the endowment fund over the historic dollar value of the fund as is prudent. In so doing, the Board must consider the long- and short-term needs of the Hospital in carrying out its purpose, its present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions. Appreciation over the amounts expended is retained in net assets with donor restrictions.

Changes in endowment funds for the years ended September 30, 2022 and 2021 are as follows:

Endowment funds, October 1, 2020	$ 11,962,767
Interest and dividends, net of fees	196,866
Realized gains on investments	1,364,617
Unrealized gains on investments	772,483
Total investment gain	2,333,966
Spending policy allotment	(564,000)
Endowment funds, September 30, 2021	13,732,733
Interest and dividends, net of fees	**263,537**
Realized gains on investments	**1,252,599**
Unrealized losses on investments	**(3,864,132)**
Total investment losses	**(2,347,996)**
Spending policy allotment	**(663,000)**
Endowment funds, September 30, 2022	**$ 10,721,737**

Investment Policy and Strategies Employed for Achieving Investment Objectives

The Hospital's investment strategy is for long-term growth and tolerance for a fair amount of volatility to achieve this growth. The investment time horizon is five years or more. The overall objective is to provide a strategic mix of asset classes that produce the highest expected return while controlling risk. The Hospital's target investment allocation is 55% global equities, 35% fixed income, and 10% alternatives. Investment advisors are prohibited from purchasing hedge fund and private equity investments, without prior approval of the Hospital.

Spending Policy

Each year a calculation is made to determine the maximum amount of money that can be withdrawn from the long-term portfolio to be used for each donor-restricted and Board-designated purpose. The annual amount available for spending is not to exceed 7% of the fair market value calculated on the basis of market values determined at least quarterly and averaged over a period of not less than three years immediately preceding the year in which the appropriation for the expenditure is made. The Board elected to distribute $663,000 for 2022 and $564,000 2021. Investment income, within the spending policy guidelines, is reported in revenues, gains and other support in the accompanying financial statements.

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or UPMIFA requires the Hospital to retain as a fund of perpetual duration. The Hospital's spending policy permits spending from funds with deficiencies in accordance with the prudent measures required under UPMIFA. There were no such deficiencies as of September 30, 2022 and 2021.

6. Fair Value Measurements

U.S. GAAP established a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy):

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

Assets and liabilities measured at fair value on a recurring basis are summarized below.

	Total	Fair Value Measurements at September 30, 2022 Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Assets limited as to use				
Cash and cash equivalents	**$ 2,475,673**	**$ 2,475,673**	**$ -**	**$ -**
Mutual funds	**29,994,465**	**29,994,465**	**-**	**-**
Fixed income				
U.S. Government securities	**4,181,823**	**4,181,823**	**-**	**-**
Corporate notes and bonds	**13,359,535**	**-**	**13,359,535**	**-**
Total fixed income	**17,541,358**	**4,181,823**	**13,359,535**	**-**
	$ 50,011,496	**$ 36,651,961**	**$ 13,359,535**	**$ -**
Other investments				
Cash and cash equivalents	**$ 224,503**	**$ 224,503**	**$ -**	**$ -**
Mutual funds	**6,891,619**	**6,891,619**	**-**	**-**
Fixed income				
Corporate notes and bonds	**3,967,068**	**-**	**3,967,068**	**-**
Total fixed income	**3,967,068**	**-**	**3,967,068**	**-**
Other investments	**74,600**	**-**	**-**	**74,600**
Total long-term investments	**$ 11,157,790**	**$ 7,116,122**	**$ 3,967,068**	**$ 74,600**
Beneficial interest in perpetual trust	**$ 5,349,056**	**$ -**	**$ -**	**$ 5,349,056**
Liabilities:				
Interest rate swap	**$ 1,107,739**	**$ -**	**$ 1,107,739**	**$ -**

	Total	Fair Value Measurements at September 30, 2021 Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Assets limited as to use				
Cash and cash equivalents	$ 3,666,639	$ 3,666,639	$ -	$ -
Mutual funds	38,038,055	38,038,055	-	-
Fixed income				
U.S. Government securities	3,262,810	3,262,810	-	-
Corporate notes and bonds	14,920,159	-	14,920,159	-
Total fixed income	18,182,969	3,262,810	14,920,159	-
	$ 59,887,663	$ 44,967,504	$ 14,920,159	$ -
Other investments				
Cash and cash equivalents	$ 66,559	$ 66,559	$ -	$ -
Mutual funds	9,545,769	9,545,769	-	-
Fixed income				
Government securities	-	-	-	-
Corporate notes and bonds	4,481,860	-	4,481,860	-
Total fixed income	4,481,860	-	4,481,860	-
Other investments	74,600	-	-	74,600
Total long-term investments	$ 14,168,788	$ 9,612,328	$ 4,481,860	$ 74,600
Beneficial interest in perpetual trust	$ 6,170,012	$ -	$ -	$ 6,170,012
Liabilities:				
Interest rate swap	$ 2,853,163	$ -	$ 2,853,163	$ -

The fair value of Level 2 assets and liabilities is primarily based on market prices of comparable securities, interest rates, and credit ratings. These techniques are significantly affected by the assumptions used, including the discount rate and estimates of future cash flows. Accordingly, the fair value estimates may not be realized in an immediate settlement of the instrument.

As the beneficial interest in perpetual trust is not readily available to the Hospital, the interest is classified as Level 3 and recorded based upon the fair value of the underlying assets.

Changes in fair value of assets classified as Level 3 are comprised of the following for the years ended September 30:

	Beneficial Interest
Balance, October 1, 2020	$ 5,569,074
Change in value	600,938
Balance, September 30, 2021	6,170,012
Change in value	**(820,956)**
Balance, September 30, 2022	**$ 5,349,056**

7. Property and Equipment

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

	2022	2021
Land	**$ 1,361,041**	$ 1,361,041
Land improvements	**6,531,935**	6,503,995
Buildings	**53,014,361**	52,975,743
Building services equipment	**28,640,756**	25,206,106
Major moveable equipment	**18,655,151**	15,669,605
Construction in progress	**1,996,292**	3,605,646
	110,199,536	105,322,136
Less accumulated depreciation	**60,135,996**	54,627,164
	$ 50,063,540	$ 50,694,972

In 2018, the Hospital began the installation and implementation of new enterprise resource planning (ERP) and electronic health record (EHR) systems. The Hospital went live on the ERP in 2018 and the Ambulatory portion of the EHR in 2020. The Hospital portion of the EHR was slated to go live in 2022. The Hospital made the decision mid-year to not move forward with the remaining portion of the project due to concerns surrounding long-term partnerships, as well as concerns with the products functionality co-existing with another larger institution. The Hospital wrote off $662,021 of the costs associated specifically with the Hospital portion and capitalized the remaining $2,182,233 over two years in anticipation of pursuing a new EHR independently. At September 30, 2021, the Hospital had approximately $2,682,000 of costs in construction in progress related to this project.

At September 30, 2022, the Hospital had approximately $1,775,000 of costs in construction in progress related to an infusions project. The project was completed in December 2022 with total costs of approximately $2,550,000.

8. Borrowings

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

	2022	2021
New Hampshire Health and Education Facilities Authority (NHHEFA) (Huggins Hospital Issue) Series 2017A 2.59% fixed rate direct placement bonds payable in annual installments ranging from $375,906 in 2023 to $671,000 in 2046; collateralized by gross revenues and substantially all assets of the Hospital	**$ 12,667,204**	$ 13,027,832
NHHEFA (Huggins Hospital Issue) Series 2017B variable rate (2.90% at September 30, 2022) direct placement bonds payable in annual installments ranging from $310,303 in 2023 to $776,358 in 2046; collateralized by gross revenues and substantially all assets of the Hospital	**12,775,128**	13,073,752
Capital lease payable for Hospital equipment, with interest at 0%, due in monthly installments of $5,324 through 2028.	**330,075**	393,961
Total long-term debt before unamortized debt issuance costs	**25,772,407**	26,495,545
Unamortized deferred financing costs	**(1,986,021)**	(2,066,264)
Total long-term debt	**23,786,386**	24,429,281
Less current portion	**750,095**	730,499
Long-term debt, excluding current portion	**$ 23,036,291**	$ 23,698,782

Principal maturities on long-term debt are as follows:

2023	$ 750,095
2024	765,551
2025	789,335
2026	812,263
2027	836,552
Thereafter	21,818,611
	$ 25,772,407

Under its bond agreements with NHHEFA, the Hospital must meet certain restrictive loan covenants. At September 30, 2022, the Hospital was in compliance with its financial covenants related to the bond agreements.

Interest Rate Swap

In connection with the issuance of 2007 bonds, the Hospital entered into an interest rate swap agreement. The swap agreement's notional amount was $8,460,000 and $8,635,000 at September 30, 2022 and 2021, respectively. The swap terminates on October 1, 2042. The Hospital pays a fixed rate of 3.6175% and receives a variable rate of 68% of USD-LIBOR-BBA. The Hospital records the interest rate swap at fair value, and has recorded a liability of $1,107,739 and $2,853,163 as of September 30, 2022 and 2021, respectively.

Line of Credit

The Hospital has a $5,000,000 line of credit with a bank with a variable interest rate of one-month LIBOR plus 2.1% adjusted monthly (5.02% at September 30, 2022). The line is collateralized by investments and expires March 31, 2023. As of September 30, 2022, there was no outstanding balance on the line. Under the terms of the line of credit agreement, the Hospital must meet certain restrictive covenants. At September 30, 2022, the Hospital was in compliance with its financial covenants related to the agreement.

9. Related Parties

As a member of GraniteOne, the Hospital shares in various services with the other member hospitals and the parent. For the years ended September 30, 2022 and 2021, the Hospital billed CMC $64,690 and $43,056, respectively, and was billed $276,730 and $395,327, respectively, in shared services. The Hospital also was charged a management fee of $67,589 and $102,022 which is included in amounts due to related parties at September 30, 2022 and 2021, respectively.

10. Commitments and Contingencies

The Hospital carries malpractice insurance coverage under a claims-made policy. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, will be uninsured. The Hospital intends to renew its coverable on a claims-made basis and has no reason to believe that it may be prevented from renewing such coverage. The Hospital is subject to complaints, claims and litigation due to potential claims which arise in the normal course of business. U.S. GAAP requires the Hospital to accrue the ultimate cost of malpractice and other litigative claims when the incident that gives rise to the claim occurs, without consideration of insurance recoveries. Expected recoveries are presented as a separate asset. The Hospital has evaluated its exposure to losses arising from potential claims and has properly accounted for them in the consolidated financial statements as of September 30, 2022 and 2021.

During 2020, the Hospital established a self-insured healthcare plan for substantially all of its employees. The Hospital has obtained reinsurance coverage to limit the Hospital's exposure associated with this plan of $150,000 per individual occurrence. The balance sheets include an accrual in accrued expenses for management's estimate of claims incurred, but not reported of approximately $871,217 and $681,990 as of September 30, 2022 and 2021, respectively.

The Hospital leases various equipment and facilities under operating leases expiring at various dates through November 2028. Total rental expense in 2022 and 2021 for all operating leases was approximately $263,400 and $173,500, respectively.

The following is a schedule by year of future minimum lease payments under operating leases as of September 30, 2022 that have initial or remaining lease terms in excess of one year.

Year Ending September 30	Amount
2023	$ 283,100
2024	195,400
2025	191,600
2026	123,300
2027	119,500
Thereafter	99,600
	$ 1,012,500

11. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes or periods:

	2022	2021
Funds subject to use or time restriction:		
Capital acquisitions	**$ 153,925**	$ 1,004,887
Indigent care	**94,175**	6,964
Net appreciation of funds of perpetual duration:		
Healthcare services	**6,616,551**	9,290,178
Indigent care	**595,174**	932,543
	7,459,825	11,234,572
Funds of perpetual duration:		
Endowment funds	**3,510,012**	3,510,012
Beneficial interest in perpetual trust	**5,349,056**	6,170,012
	8,859,068	9,680,024
	$ 16,318,893	$ 20,914,596

The Hospital is an income beneficiary of a perpetual trust controlled by an unrelated third-party trustee. The beneficial interest in the assets of the trust is included in the Hospital's consolidated financial statements as net assets with donor restrictions. Income is distributed in accordance with the trust documents and is included in investment return. Trust income distributed to the Hospital for the years ended September 30, 2022 and 2021 was $210,020 and $194,055, respectively, and has no donor restrictions.

12. Retirement Plans

The Hospital sponsors a contributory defined contribution plan available to substantially all employees. The Hospital's policy under the defined contribution plan is to fund its portion of amounts due under the plan on a current basis and to recognize expense as incurred. Expense related to this plan for the years ended September 30, 2022 and 2021 approximated $1,004,900 and $965,600, respectively.

13. Concentrations of Credit Risk

The Hospital has cash balances in financial institutions that exceed federal depository insurance limits. However, management believes that credit risk related to these investments is minimal. The Hospital has not experienced any losses in such accounts.

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

	2022	2021
Medicare	**19 %**	20 %
Medicaid	**9**	8
Anthem Blue Cross	**5**	7
Other third-party payors	**25**	29
Patients	**42**	36
	100 %	100 %

14. Functional Expenses

The consolidated statements of operations contain certain expense categories that are attributable to both healthcare services and support functions. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Fringe benefits are allocated based on salaries and wages, and depreciation, interest, utilities, and equipment are allocated based on square footage and location. Expenses related to providing healthcare and support services are as follows:

2022	Program Services	General and Administrative	Fundraising	Total
Salaries, wages, and fringe benefits	**$ 40,954,676**	**$ 9,940,783**	**$ 109,641**	**$ 51,005,100**
Supplies	**10,497,777**	**629,821**	**7,336**	**11,134,934**
Physician fees	**5,679,137**	**-**	**-**	**5,679,137**
Medicaid enhancement tax	**3,530,734**	**-**	**-**	**3,530,734**
Depreciation and amortization	**5,250,478**	**347,045**	**-**	**5,597,523**
Interest	**800,360**	**52,902**	**-**	**853,262**
Contracted services	**2,141,125**	**4,699,165**	**12,992**	**6,853,282**
Other professional services	**2,166,014**	**1,941,568**	**3,753**	**4,111,335**
Utilities	**1,452,690**	**96,020**	**-**	**1,548,710**
Insurance	**403,347**	**681,112**	**-**	**1,084,459**
Other	**100,947**	**1,837,725**	**14,759**	**1,953,431**
	$ 72,977,285	**$ 20,226,141**	**$ 148,481**	**$ 93,351,907**

2021	Program Services	General and Administrative	Fundraising	Total
Salaries, wages, and fringe benefits	$ 33,094,356	$ 10,955,454	$ 80,920	$ 44,130,730
Supplies	8,709,644	563,266	1,272	9,274,182
Physician fees	4,897,364	-	-	4,897,364
Medicaid enhancement tax	2,793,553	-	-	2,793,553
Depreciation and amortization	4,526,612	405,702	-	4,932,314
Interest	832,541	75,126	-	907,667
Contracted services	1,578,257	1,745,934	8,758	3,332,949
Other professional services	2,083,505	2,405,285	9,347	4,498,137
Utilities	1,463,449	132,057	-	1,595,506
Insurance	360,571	597,183	-	957,754
Other	107,602	2,289,083	10,291	2,406,976
	$ 60,447,454	$ 19,169,090	$ 110,588	$ 79,727,132

SUPPLEMENTARY INFORMATION

Schedule 1

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidating Balance Sheet

September 30, 2022

ASSETS

	Huggins	Huggins Senior Housing	Consolidated
Current assets			
Cash and cash equivalents	$ 20,435,935	$ 487,885	**$ 20,923,820**
Accounts receivable from patients, net	9,506,058	-	**9,506,058**
Other accounts and notes receivable	1,861,481	-	**1,861,481**
Other current assets	1,409,032	-	**1,409,032**
Total current assets	33,212,506	487,885	**33,700,391**
Assets limited as to use	50,011,496	-	**50,011,496**
Property and equipment, net	49,873,694	189,846	**50,063,540**
Long-term investments	11,157,790	-	**11,157,790**
Beneficial interest in perpetual trust	5,349,056	-	**5,349,056**
Cash surrender value of life insurance	1,248,266	-	**1,248,266**
Total assets	$ 150,852,808	$ 677,731	**$ 151,530,539**

LIABILITIES AND NET ASSETS

Current liabilities			
Accounts payable and other current liabilities	$ 4,630,134	$ -	**$ 4,630,134**
Accrued salaries and related accounts	4,575,499	-	**4,575,499**
Current portion of long-term debt	750,095	-	**750,095**
Due to related parties	1,381,044	-	**1,381,044**
Current portion of estimated third-party payor settlements	2,755,424	-	**2,755,424**
Total current liabilities	14,092,196	-	**14,092,196**
Estimated third-party payor settlements	25,560,335	-	**25,560,335**
Interest rate swap	1,107,739	-	**1,107,739**
Long-term debt, excluding current portion	23,036,291	-	**23,036,291**
Total liabilities	63,796,561	-	**63,796,561**
Net assets			
Without donor restrictions	70,737,354	677,731	**71,415,085**
With donor restrictions	16,318,893	-	**16,318,893**
Total net assets	87,056,247	677,731	**87,733,978**
Total liabilities and net assets	$ 150,852,808	$ 677,731	**$ 151,530,539**

HUGGINS HOSPITAL AND SUBSIDIARY

Consolidating Statement of Operations

Year Ended September 30, 2022

	Huggins Hospital	Huggins Senior Housing	Consolidated
Revenues, gains, and other support without donor restrictions			
Patient service revenue (net of discounts and contractual allowances)	$ 86,273,736	$ -	**$ 86,273,736**
Other operating revenues	2,533,154	-	**2,533,154**
Provider relief and other stimulus revenues	1,916,387	-	**1,916,387**
Investment income allotted for operations	663,000	-	**663,000**
Net assets released from restrictions for operating purposes	81,983	-	**81,983**
Total revenues, gains and other support without donor restrictions	91,468,260	-	**91,468,260**
Expenses			
Salaries, wages and fringe benefits	51,005,100	-	**51,005,100**
Supplies	11,134,934	-	**11,134,934**
Physician fees	5,679,137	-	**5,679,137**
Other	15,505,913	45,304	**15,551,217**
Medicaid enhancement tax	3,530,734	-	**3,530,734**
Depreciation and amortization	5,597,523	-	**5,597,523**
Interest	853,262	-	**853,262**
Total expenses	93,306,603	45,304	**93,351,907**
Operating loss	(1,838,343)	(45,304)	**(1,883,647)**
Nonoperating gains (losses)			
Contributions, net	298,713	-	**298,713**
Development costs	(120,469)	-	**(120,469)**
Investment losses	(9,886,012)	-	**(9,886,012)**
Change in value of interest rate swap	1,745,424	-	**1,745,424**
Affiliation costs	(365,311)	-	**(365,311)**
Nonoperating losses, net	(8,327,655)	-	**(8,327,655)**
Deficiency of revenues, gains and other support over expenses and losses	(10,165,998)	(45,304)	**(10,211,302)**
Net assets released from restrictions for capital acquisitions	1,000,000	-	**1,000,000**
Decrease in net assets without donor restrictions	$ (9,165,998)	$ (45,304)	**$ (9,211,302)**

Appendix A-4

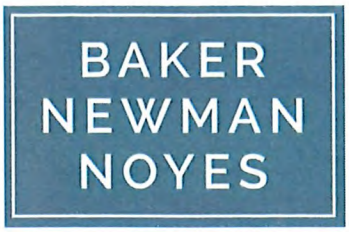
Monadnock Community Hospital Articles of Agreement

Appendix A-5

Monadnock Community Hospital Bylaws, as Amended and Restated

Appendix A-6

Monadnock Community Hospital Annual Financial Statements
for the year ended September 30, 2022



The Monadnock Community Hospital

Audited Financial Statements

Years Ended September 30, 2022 and 2021
With Independent Auditors' Report

Baker Newman & Noyes LLC
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THE MONADNOCK COMMUNITY HOSPITAL

Audited Financial Statements

Years Ended September 30, 2022 and 2021

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BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
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INDEPENDENT AUDITORS' REPORT

Board of Trustees
The Monadnock Community Hospital

Opinion

We have audited the financial statements of The Monadnock Community Hospital (the Hospital), which comprise the balance sheets as of September 30, 2022 and 2021, the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Hospital as of September 30, 2022 and 2021, and the results of its operations, changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Hospital and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Hospital's ability to continue as a going concern within one year after the date that the financial statements are issued or available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Hospital's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Hospital's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Baker Newman & Noyes LLC

Manchester, New Hampshire
January 11, 2023

THE MONADNOCK COMMUNITY HOSPITAL

BALANCE SHEETS

September 30, 2022 and 2021

ASSETS

	2022	2021
Current assets:		
Cash and cash equivalents	$ 31,146,583	$ 28,190,129
Accounts receivable	6,450,584	5,642,463
Current portion of notes receivable	81,249	13,442
Other receivables	310,365	705,668
Inventories	1,448,643	1,456,783
Prepaid expenses and other current assets	1,278,329	984,702
Total current assets	40,715,753	36,993,187
Assets limited as to use	85,695,382	102,021,202
Medical office building and related assets, net of accumulated depreciation of $2,450,354 in 2022 and $2,364,718 in 2021	1,132,753	1,218,817
Property and equipment, net	35,647,718	34,961,264
Notes receivable, less current portion	540,898	466,726
Other:		
Other assets	689,567	206,896
Total assets	$164,422,071	$175,868,092

LIABILITIES AND NET ASSETS

	2022	2021
Current liabilities:		
Accounts payable and accrued expenses	$ 7,504,455	$ 5,791,261
Accrued payroll and related accounts	3,774,854	4,199,369
Estimated third-party payor settlements	28,372,836	27,127,670
Current portion of long-term debt and capital lease obligations	808,808	775,616
Total current liabilities	40,460,953	37,893,916
Long-term debt and capital lease obligations, less current portion	21,294,858	22,036,526
Interest rate swap agreements	144,803	2,665,795
Other long-term liabilities	–	551,097
Total liabilities	61,900,614	63,147,334
Commitments and contingencies		
Net assets:		
Without donor restrictions	88,730,215	95,668,147
With donor restrictions	13,791,242	17,052,611
Total net assets	102,521,457	112,720,758
Total liabilities and net assets	$164,422,071	$175,868,092

See accompanying notes.

THE MONADNOCK COMMUNITY HOSPITAL

STATEMENTS OF OPERATIONS

Years Ended September 30, 2022 and 2021

	2022	2021
Operating revenues:		
Patient service revenue	$ 85,805,659	$ 80,177,775
Disproportionate share funding	5,700,000	4,325,004
Other revenue	4,798,653	8,324,417
Net assets released from restrictions for operations	501,720	408,503
Total operating revenues	96,806,032	93,235,699
Expenses:		
Salaries and benefits	47,990,907	41,946,502
Supplies and other	35,713,504	33,889,533
Insurance	842,033	700,949
Depreciation and amortization	4,225,134	4,266,537
Interest	914,630	958,169
New Hampshire Medicaid enhancement tax	4,221,892	3,194,153
Total expenses	93,908,100	84,955,843
Income from operations	2,897,932	8,279,856
Nonoperating (losses) gains:		
Investment (loss) income, net	(13,351,474)	13,454,018
Contributions without donor restrictions, net of fundraising expenses	1,232,120	1,230,279
Other expense	(679,779)	(1,540,089)
Nonoperating (losses) gains, net	(12,799,133)	13,144,208
(Deficiency) excess of revenue, support and nonoperating (losses) gains over expenses	(9,901,201)	21,424,064
Net unrealized losses on investments	(123,781)	(34,405)
Change in fair value of interest rate swap agreements, qualifying as hedges	2,520,992	1,290,839
Net assets released from restrictions used to purchase property and equipment	566,058	232,503
(Decrease) increase in net assets without donor restrictions	$ (6,937,932)	$ 22,913,001

See accompanying notes.

THE MONADNOCK COMMUNITY HOSPITAL

STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2022 and 2021

	2022	2021
Net assets without donor restrictions:		
(Deficiency) excess of revenue, support and nonoperating (losses) gains over expenses	$ (9,901,201)	$ 21,424,064
Net unrealized losses on investments	(123,781)	(34,405)
Change in fair value of interest rate swap agreements, qualifying as hedges	2,520,992	1,290,839
Net assets released from restrictions used to purchase property and equipment	566,058	232,503
(Decrease) increase in net assets without donor restrictions	(6,937,932)	22,913,001
Net assets with donor restrictions:		
Donor-restricted contributions	595,517	320,441
Investment (loss) income, net	(1,509,781)	1,723,590
Change in perpetual trusts	(1,279,327)	991,407
Net assets released from restrictions for operations	(501,720)	(408,503)
Net assets released from restrictions used to purchase property and equipment	(566,058)	(232,503)
(Decrease) increase in net assets with donor restrictions	(3,261,369)	2,394,432
(Decrease) increase in net assets	(10,199,301)	25,307,433
Net assets, beginning of year	112,720,758	87,413,325
Net assets, end of year	$102,521,457	$112,720,758

See accompanying notes.

THE MONADNOCK COMMUNITY HOSPITAL

STATEMENTS OF CASH FLOWS

Years Ended September 30, 2022 and 2021

	2022	2021
Cash flows from operating activities:		
(Decrease) increase in net assets	$(10,199,301)	$ 25,307,433
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	4,225,134	4,266,537
Bond issuance costs amortization	6,279	11,031
Realized and unrealized losses (gains) on investments and perpetual trusts, net	17,759,978	(14,899,435)
Change in fair value of interest rate swap agreements	(2,520,992)	(1,290,839)
Restricted contributions and investment loss/income	914,264	(2,044,031)
Loss on disposal of property and equipment	17,469	–
Changes in operating assets and liabilities:		
Accounts receivable	(808,121)	14,504
Inventories	8,140	(110,434)
Prepaid expenses and other current assets	(293,627)	(61,378)
Notes and other receivables	253,324	2,955,897
Other assets	(482,671)	–
Accounts payable and accrued expenses	1,713,194	(2,511,909)
Accrued payroll and related accounts	(424,515)	1,642,480
Estimated third-party payor settlements	1,245,166	(2,511,109)
Other long-term liabilities	(551,097)	(9,587,138)
Net cash provided by operating activities	10,862,624	1,181,609
Cash flows from investing activities:		
Purchases of property and equipment	(4,766,920)	(2,998,153)
Proceeds on sale of investments	430,685	538,278
Purchases of investments	(1,864,843)	(4,748,000)
Net cash used by investing activities	(6,201,078)	(7,207,875)
Cash flows from financing activities:		
Principal payments on long-term debt and capital lease obligations	(790,828)	(768,182)
Restricted contributions and investment loss/income	(914,264)	2,135,654
Net cash (used) provided by financing activities	(1,705,092)	1,367,472
Net increase (decrease) in cash and cash equivalents	2,956,454	(4,658,794)
Cash and cash equivalents at beginning of year	28,190,129	32,848,923
Cash and cash equivalents at end of year	$ 31,146,583	$ 28,190,129
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 908,351	$ 947,138
During 2022, the Hospital entered into capital lease obligations to finance certain equipment totaling $76,073.		

See accompanying notes.

1. Description of Organization and Summary of Significant Accounting Policies

Organization

The Monadnock Community Hospital (the Hospital) is a not-for-profit, acute care hospital located in Peterborough, New Hampshire.

On December 30, 2016, the Hospital became affiliated with Catholic Medical Center (CMC), a 330-bed acute care hospital in Manchester, New Hampshire, and Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of the Hospital and HH and co-member of CMC, along with CMC Healthcare System, Inc. GraniteOne is governed by a thirteen-member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional healthcare planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying financial statements do not include the accounts and activity of GraniteOne, HH and CMC.

Subsequent to year end, the Board of Trustees authorized and approved the Hospital's withdrawal without cause from GraniteOne as permitted by the affiliation agreement.

On September 30, 2019, GraniteOne, CMC, CMC Healthcare System (CMCHS), certain subsidiaries of CMCHS, HH and the Hospital entered into a combination agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system.

On December 30, 2019, GraniteOne, CMC, HH and the Hospital submitted a Joint Notice of Change of Control to the New Hampshire Attorney General (AG), Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b beginning the regulatory review and approval process of the combination. During fiscal year 2022, the AG objected to the proposed affiliation transaction and the combination agreement was canceled. The Hospital incurred approximately $326,000 and $1.3 million in affiliation costs for the years ended September 30, 2022 and 2021, respectively, which amounts are reflected within nonoperating (losses) gains in the accompanying statements of operations.

Basis of Accounting

The accompanying financial statements have been prepared on an accrual basis of accounting.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less at the date of purchase, excluding donor-restricted amounts and assets whose use is limited by Board designation or other arrangements under trust agreements. The Hospital maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Hospital has not experienced any losses on such accounts.

Accounts Receivable

Patient accounts receivable for which the unconditional right to payment exists are receivables if the right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. Accounts receivable at September 30, 2022 and 2021 reflect the fact that any estimated uncollectible amounts are generally considered implicit price concessions that are a direct reduction to accounts receivable rather than allowance for doubtful accounts. At September 30, 2022 and 2021, estimated implicit price concessions of $6,359,541 and $6,568,803, respectively, have been recorded as reductions to accounts receivable balances to enable the Hospital to record revenues and accounts receivable at the estimated amounts expected to be collected.

Accounts receivable as of September 30, 2022, 2021 and 2020 are $6,450,584, $5,642,463 and $5,656,967, respectively.

Inventories

Inventories of supplies and pharmaceuticals are carried at the lower of cost or net realizable value. Costs are determined on the first-in, first-out (FIFO) basis.

Assets Limited as to Use

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

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Investments and Investment (Loss) Income

Investments are carried at fair value in the accompanying balance sheets. See note 15 for further discussion regarding fair value measurements. Investment (loss) income (including realized gains and losses on investments, interest and dividends) and the net change in unrealized gains and losses on equity securities, are included in the (deficiency) excess of revenue, support and nonoperating (losses) gains over expenses in the accompanying statements of operations, unless the income or loss is restricted by donor or law. The change in net unrealized gains and losses on debt securities is reported as a separate component of the change in net assets without donor restrictions, except declines that are determined by management to be other than temporary, which are reported as an impairment charge (included in the (deficiency) excess of revenue, support and nonoperating (losses) gains over expenses). No such losses were recorded in 2022 or 2021.

Property and Equipment

Property and equipment, including the medical office building, is stated at cost or, if donated, at fair value at the date of donation, less accumulated depreciation. The Hospital's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the life of the related assets. When assets are retired or disposed of, the assets and related accumulated depreciation are eliminated from the accounts and any resulting gain or loss is reflected in the accompanying statements of operations.

Depreciation is computed using the straight-line method in a manner intended to amortize the cost of the assets over their estimated useful lives. Costs of construction and acquisition of assets not yet placed in service are included in capital improvements and no depreciation expense is recorded.

Bond Issuance Costs

Bond issuance costs are being amortized to interest expense using the straight-line method, which approximates the effective interest method, over the life of the respective bonds. Bond issuance costs are presented as a reduction of long-term debt.

Earned Time

The Hospital provides and accrues for paid time off for vacation, holiday and sick leave under an earned time system for nonexempt employees. Hours earned, but not used, are capped and vested with the employee.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Net Assets With Donor Restrictions

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

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

Endowment, Investment and Spending Policies

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

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

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events. The Finance Committee of the Board of Trustees of the Hospital determines the method to be used to appropriate endowment funds for expenditure. As a guideline, approximately 4% of the total value of the three year quarterly average of available funds is intended to be distributed annually. The Finance Committee has the ability to distribute up to 5.99% of the total market value of the three-year quarterly average of available funds. Distributions of 6% or over must be approved by a vote of the Board of Trustees. The corresponding calculated spending allocations are distributed in equal quarterly installments from the current net total or accumulated net total investment returns for individual endowment funds. In establishing this policy, the Board of Trustees considered the expected long term rate of return on its endowment.

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

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees. Assets limited as to use at September 30, 2022 and 2021 includes board designated funds of $71,905,806 and $84,967,028, respectively, that are subject to board authorization before being spent.

Management of these assets is to increase, with minimum risk, the inflation adjusted principal and income of the endowment funds over the long term. The Hospital targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

(Deficiency) Excess of Revenue, Support and Nonoperating (Losses) Gains Over Expenses

The accompanying statements of operations include (deficiency) excess of revenue, support and nonoperating (losses) gains over expenses. Changes in net assets without donor restrictions which are excluded from (deficiency) excess of revenue, support and nonoperating (losses) gains over expenses, consistent with industry practice, include net assets released from restrictions used for the purposes of acquiring long-lived assets, net unrealized gains/losses on debt investments and the changes in the fair value of interest rate swap agreements deemed to be effective hedges.

Patient Service Revenue

Revenues generally relate to contracts with patients in which the Hospital's performance obligations are to provide health care services to patients. Revenues are recorded during the period obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over a period of days. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by Medicare and Medicaid or negotiated with managed care health plans and commercial insurance companies, the third-party payors. The payment arrangements with third-party payors for the services provided to related patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services under a cost reimbursement methodology. Services provided to patients having Medicaid coverage are generally paid on a prospectively determined fixed price depending on the diagnosis for inpatient services and under a cost reimbursement methodology for outpatient services. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the revenue recognition process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payors and patients is the Hospital's primary source of cash and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of hospital revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of accounts receivable. Management performs the hindsight analysis regularly, utilizing rolling twelve-months accounts receivable collection and write-off data. Management believes its regular updates to the estimated implicit price concession amounts provides reasonable estimates of revenues and valuations of accounts receivable. These routine, regular changes in estimates have not resulted in material adjustments to the valuations of accounts receivable or period-to-period comparisons of operations.

The Hospital receives payment for Medicare and Medicaid inpatient and outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost reports. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known. For the years ended September 30, 2022 and 2021, patient service revenue in the accompanying statements of operations increased by approximately $3.2 million and $3.6 million, respectively, due to actual settlements and changes in assumptions underlying estimated future third-party settlements.

Revenues from the Medicare and Medicaid programs accounted for approximately 60% and 8% and 61% and 6% of the Hospital's patient service revenue for the years ended September 30, 2022 and 2021, respectively.

Financial Assistance Program

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a financial assistance patient by reference to certain established policies of the Hospital. Essentially, these policies define the financial assistance program as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes federally established poverty guidelines. The financial assistance program is measured based on the Hospital's established rates. These charges are not included in patient service revenue. The costs and expenses incurred in providing these services are included in operating expenses. The cost is estimated by utilizing a ratio of cost to gross charges applied to the gross uncompensated charges associated with providing charity care. See note 14.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Self-Insurance Programs

The Hospital self-insures its employee health and dental benefits and has estimated and accrued amounts to meet its expected obligations under the program. The plan is administered by an insurance company which assists in determining the current funding requirements of participants under the terms of the plan and the liability for claims and assessments that would be payable at any given point in time. The Hospital recognizes revenue for services provided to employees of the Hospital during the year. Stop loss insurance coverage is in effect which mitigates the Hospital's exposure to loss on an individual and aggregate basis. Estimated unpaid claims, and those claims incurred but not reported at September 30, 2022 and 2021, have been recorded as a liability of approximately $550,000 within accrued payroll and related accounts in the accompanying balance sheets.

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in note 13. Accordingly, costs have been allocated among program services and supporting services benefitted.

Income Taxes

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

Advertising Costs

The Hospital expenses advertising costs as incurred, and such costs totaled approximately $59,000 and $74,000 for the years ended September 30, 2022 and 2021, respectively.

Derivatives and Hedging Activities

The interest rate swap agreements held by the Hospital meet the definition of derivative instruments and, consequently, the Hospital is required to record as an asset or liability the fair value of the interest rate swap agreements described in note 7. The Hospital is exposed to repayment loss equal to any net amounts receivable under the swap agreements (not the notional amounts) in the event of nonperformance of the other parties to the swap agreements. However, the Hospital does not anticipate nonperformance and does not obtain collateral from the other parties.

1. Description of Organization and Summary of Significant Accounting Policies (Continued)

Related Party Activity

The Hospital has engaged in various transactions with GraniteOne and CMC. The Hospital recognized revenue from these related parties of approximately $296,000 and $273,000 for the years ended September 30, 2022 and 2021, respectively, which amounts are reflected in other revenue in the accompanying statements of operations. The Hospital also incurred expenses to these related parties of approximately $3.1 million and $4.2 million for the years ended September 30, 2022 and 2021, respectively, of which $2.8 million and $2.9 million, respectively, is reflected within operating expenses. Additionally, approximately $270,000 and $1.3 million in related party expenses is reflected within nonoperating (losses) gains in the accompanying statements of operations for the years ended September 30, 2022 and 2021, respectively. These transactions resulted in a net amount due to related parties of approximately $612,000 and $294,000 at September 30, 2022 and 2021, respectively, which amounts are reflected within accounts payable and accrued expenses in the accompanying balance sheets.

Reclassifications

Certain 2021 amounts have been reclassified to permit comparison with the 2022 financial statements presentation format.

Recent Accounting Pronouncements

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-02, *Leases (Topic 842)*. Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the Hospital on October 1, 2022. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. Management expects the adoption of this ASU to result in the recognition of a liability and offsetting right-of-use asset totaling approximately $500,000.

In September 2020, the FASB issued ASU No. 2020-07, *Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets.* ASU 2020-07 enhances the presentation of disclosure requirements for contributed nonfinancial assets. ASU 2020-07 requires entities to present contributed nonfinancial assets as a separate line item in the statement of operations and disclose the amount of contributed nonfinancial assets recognized within the statement of operations by category that depicts the type of contributed nonfinancial assets, as well as a description of any donor-imposed restrictions associated with the contributed nonfinancial assets and the valuation techniques used to arrive at a fair value measure at initial recognition. ASU 2020-07 was effective for the Hospital beginning October 1, 2021. The adoption of this ASU did not have a significant impact on the Hospital's financial statements.

Subsequent Events

Management has evaluated subsequent events occurring between the end of its fiscal year and January 11, 2023, the date the financial statements were available to be issued.

2. Risks and Uncertainties

On March 11, 2020, the World Health Organization declared the outbreak of coronavirus (COVID-19) a pandemic. The COVID-19 pandemic has significantly affected employees, patients, systems, communities and business operations, as well as the U.S. economy and financial markets. While some restrictions have been eased across the U.S. and the State of New Hampshire has lifted limitations on non-emergent procedures, some restrictions remain in place. Consolidated patient volumes and revenues experienced gradual improvement beginning in the latter part of April 2020, and continuing, but at times impacted through fiscal year 2022, however uncertainty still exists as the future is unpredictable. The Hospital's pandemic response plan has multiple facets and continues to evolve as the pandemic unfolds. The Hospital has taken precautionary steps to enhance its operational and financial flexibility, and react to the risks the COVID-19 pandemic presents in its operations.

Since the declaration of the pandemic, the Hospital received approximately $10.7 million of accelerated Medicare payments (Note 3) as provided for under the *Coronavirus Aid, Relief and Economic Security Act* (CARES Act).

During 2022, the Hospital received approximately $1.9 million of *American Rescue Plan Act* (ARPA) rural payments, approximately $225,000 of Provider Relief Funds (PRF) under the CARES Act, and approximately $75,000 from the Governor's Office of Emergency Relief and Recovery (GOFERR) under the CARES Act. Distributions from ARPA, PRF and GOFERR are not subject to repayment provided the Hospital is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants, and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the cumulative funding through September 30, 2022, the Hospital recognized approximately $1.3 million of the funding in 2022, and these payments are recorded within other revenue in the accompanying statement of operations for the year ended September 30, 2022. Approximately $2 million is included in estimated third-party settlements in the accompanying 2022 balance sheet, and represents amounts to be recognized prospectively. The Hospital also received PRF and GOFERR funding in previous years. Based on an analysis of the compliance and reporting requirements of the cumulative funding through September 30, 2021, the Hospital recognized approximately $4.2 million related to these funds, and these payments were recorded within other revenue in the statement of operations for the year ended September 30, 2021. Approximately $1 million was included in estimated third-party settlements in the accompanying 2021 balance sheet, and represented amounts to be recognized prospectively, all of which was recognized in fiscal year 2022.

The CARES Act also provides for a deferral of payments of the employer portion of payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 2021, and the remaining half until December 2022. At September 30, 2022 and 2021, the Hospital had deferred approximately $600,000 and $1.2 million, respectively, of payroll taxes, of which approximately $600,000 is recorded within accrued payroll and related accounts in the accompanying 2022 and 2021 balance sheets. Further, approximately $600,000 of deferred payroll taxes was recorded within other long-term liabilities in the accompanying 2021 balance sheet.

3. Estimated Third-Party Settlements

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

Medicare

The Hospital was granted critical access hospital (CAH) designation on December 27, 2004. As a result of this designation, the Hospital is entitled to cost-based reimbursement from Medicare for services provided to Medicare beneficiaries. Inpatient acute care services rendered to Medicare program beneficiaries are paid under a cost reimbursement methodology. Outpatient services are paid based on a combination of rate schedules and reimbursed cost. The Hospital is reimbursed for cost reimbursable items at an interim rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. As of the date of these financial statements, the Hospital's Medicare cost reports have been final settled through September 30, 2015. The Hospital has received Final Notices of Reimbursement for the cost reports ending September 30, 2016 through 2018; however, the three year statutory period to reopen those cost reports by CMS has not expired.

Medicaid

Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology subject to certain limitations. The Hospital is reimbursed at an interim rate with final settlement determined after submission of annual costs reported by the Hospital and audits thereof by the State of New Hampshire Division of Audit. As of the date of these financial statements, the Hospital's Medicaid cost reports have been final settled through September 30, 2018.

Anthem

Inpatient and outpatient services rendered to Anthem subscribers are reimbursed at submitted charges less a discount withholding or through a per diem or fee schedule. The amounts paid to the Hospital are not subject to any retroactive adjustments.

Other

The Hospital has also entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, per diems and discounts from established charges.

The Hospital has made a provision in the financial statements for estimated final settlements to be paid as a result of the retroactive provision for third-party reimbursement programs. Actual results could differ from those estimates.

3. Estimated Third-Party Settlements (Continued)

Medicaid Enhancement Tax and Medicaid Disproportionate Share Funding

Under the State of New Hampshire's tax code, the State imposes a MET equal to 5.4% of net patient service revenue in State fiscal years 2022 and 2021, with certain exclusions. The amount of tax incurred by the Hospital for fiscal 2022 and 2021 was $4,221,892 and $3,194,153, respectively. The Hospital has accrued $1,055,451 and $1,022,790 in MET at September 30, 2022 and 2021, respectively, within accounts payable and accrued expenses in the accompanying balance sheets.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. In 2022 and 2021, the Hospital recognized disproportionate share revenues (net of related reserves) totaling $5,700,000 and $4,325,004, respectively, in the accompanying statements of operations. Currently, the State of New Hampshire makes disproportionate share hospital payments to support up to 75% of the actual uncompensated care costs for New Hampshire's hospitals with critical access designation.

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

Accelerated Medicare Payments

As discussed in note 2, during fiscal year 2020, the Hospital requested accelerated Medicare payments as provided for in the CARES Act, which allows for eligible health care facilities to request up to six months of advance Medicare payments for acute care hospitals, or up to three months of advance Medicare payments for other health care providers. One year from the date of receipt of the advance payments (beginning April 2021), 25% of the advances were to be recouped in the first eleven months. An additional 25% of the advances were to be recouped in the next six months, with the entire amount repayable in 29 months. Any outstanding balance after 29 months is repayable at a 4% interest rate. During the third and fourth quarters of fiscal 2020, the Hospital received approximately $10.7 million from these accelerated Medicare payment requests. The Hospital paid the accelerated Medicare payments in full during fiscal year 2021 and there was no remaining liability as of September 30, 2022 or 2021.

4. Concentration of Credit Risk

Financial instruments which subject the Hospital to credit risk consist of cash and cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Hospital's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. Investments that exceeded 10% of investments include the Vanguard Total Stock Market Index Fund as of September 30, 2022 and the Vanguard Total Stock Market Index Fund and the Vanguard Total International Stock Index Fund as of September 30, 2021.

4. Concentration of Credit Risk (Continued)

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The Hospital's accounts receivable are primarily due from third-party payors. The mix of gross patient accounts receivable at September 30, 2022 and 2021 was as follows:

	2022	2021
Medicare	35%	33%
Medicaid	7	6
Anthem	9	8
Other third-party payors	21	25
Patients	28	28
	100%	100%

5. Assets Limited as to Use and Restricted Funds

The composition of assets limited as to use at September 30, 2022 and 2021 is set forth in the following table. Investments are stated at fair value.

	2022	2021
Board designated, donor restricted and long-term investments:		
Cash and cash equivalents	$ 1,644,108	$ 4,368,195
Marketable equity securities	41,049,000	48,860,567
Mutual funds	34,059,312	41,453,313
U.S. Treasury obligations	4,001,356	1,118,194
Interests in perpetual trusts	4,941,606	6,220,933
	$85,695,382	$102,021,202

Assets limited as to use are comprised of the following at September 30:

	2022	2021
Board designated for capital, working capital and community services	$71,905,806	$ 84,967,028
Donor-restricted	13,789,576	17,054,174
	$85,695,382	$102,021,202

As a result of bequests, the Hospital is the beneficiary of two trust funds, one of which is administered by an outside trustee and the other administered by the Hospital. The terms of the perpetual trusts require that income or a percentage of income be paid to the Hospital in perpetuity; however, distribution of principal is not permitted under the terms of the trusts. The amounts recorded in the accompanying balance sheets represent the fair values of the assets upon notification of the trusts' existence, which are adjusted annually to reflect the appreciation or depreciation in the fair value of the assets. Offsetting amounts are included in net assets with donor restrictions. Income distributed to the Hospital from these trusts is included in the accompanying statements of operations as investment income.

6. Property and Equipment

Property and equipment consists of the following at September 30:

	2022	2021
Land and land improvements	$ 4,686,848	$ 4,686,848
Building and building improvements	29,949,565	29,157,921
Equipment, including capital leases	60,837,482	59,186,833
Capital improvements in progress	2,972,772	2,306,413
	98,446,667	95,338,015
Less accumulated depreciation and amortization	(62,798,949)	(60,376,751)
	$ 35,647,718	$ 34,961,264

The cost of assets recorded under capital leases totaled $614,046 and $537,973 at September 30, 2022 and 2021, respectively. The cost of these assets has been included with property and equipment, and accumulated amortization is included with accumulated depreciation. Accumulated amortization associated with assets recorded under capital leases was $478,170 and $350,530 at September 30, 2022 and 2021, respectively.

7. Long-Term Debt and Capital Lease Obligations

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

	2022	2021
New Hampshire Business Finance Authority (NHBFA) in conjunction with Revenue Bonds Series 2013 with variable rate interest, amended and restated as of June 27, 2018, as described below	$21,949,717	$22,603,449
Capital lease obligations with interest rates ranging from 3.50% to 5.25%, due in monthly installments ranging from $3,277 to $7,495, maturity dates ranging from October 2023 to April 2024, collateralized by equipment (note 6)	155,175	216,198
	22,104,892	22,819,647
Less unamortized bond issuance costs	(1,226)	(7,505)
Less current portion	(808,808)	(775,616)
	$21,294,858	$22,036,526

On January 1, 2013, the Hospital refinanced its existing 2007 Series Bonds outstanding in the amount of $17,810,000 and its 2009 Series Bonds outstanding in the amount of $9,424,908 through the issuance of $27,240,000 in 2013 Series Bonds with NHBFA. The initial interest rate on the bonds through January 1, 2023 was a variable rate equal to 75% of the one-month LIBOR (London Interbank Offered Rate) plus 1.3125%. The final maturity of the bonds is January 1, 2043 and on January 1, 2028, the bonds are required to be remarketed upon a stipulated mandatory redemption. The Hospital expects to convert the underlying interest rate on the bonds from LIBOR to SOFR (Secured Overnight Financing Rate) by March 1, 2023. As part of this transaction, the Hospital will be extending the tender date of the bonds to 2033.

7. **Long-Term Debt and Capital Lease Obligations (Continued)**

On June 27, 2018, the 2013 Series Revenue Bonds with NHBFA were amended and restated. The original bonds were exchanged for amended bonds and the original bond issuance was cancelled. The amended 2013 Series Bonds with NHBFA were issued in the amount of $24,584,872, which was the amount of the outstanding balance of the original 2013 Series Bonds at the time of closing. The initial interest rate on the amended bonds through July 1, 2028 is a variable rate equal to the sum of 81.5% of the one-month LIBOR plus 1.45%. The interest rate at September 30, 2022 was 3.27%. The final maturity of the amended bonds remained January 1, 2043. On January 1, 2028, the amended bonds must be remarketed upon a stipulated mandatory redemption. The Hospital is also required to comply with certain financial and other covenants and has granted as security all gross receipts, together with all real and personal property, as defined. The amended Series 2013 Bonds require the same debt service payments as the original 2013 Series Bonds with payments ranging from $408,605 to $1,589,792 per year.

Concurrent with the 2007 NHBFA bond issuance, the Hospital executed an interest rate swap agreement to hedge its exposure to the volatility of interest payments on a portion of its variable rate Series 2007 Revenue Bonds. During 2013, the Series 2007 Revenue Bonds were refinanced through the issuance of Series 2013 Revenue Bonds, as previously discussed. All existing terms of the swap remained in effect. At September 30, 2022, an interest rate swap agreement was outstanding at a notional amount totaling approximately $7.2 million. The swap agreement hedged the Hospital's interest exposure by effectively converting interest payments from variable rates to a fixed rate of 3.57%. The swap agreement, which expires in October 2033, is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. The swap agreement had a fair value of $(398,574) and $(1,318,987) as of September 30, 2022 and 2021, respectively.

Concurrent with the amended and restated 2013 Series Revenue Bonds, the Hospital executed an interest rate swap agreement effective July 1, 2018 to hedge its exposure to the volatility of interest payments on a portion of its variable rate on the amended and restated 2013 Series Revenue Bonds. At September 30, 2022, an interest rate swap agreement was outstanding at a notional amount totaling approximately $12.7 million. The swap agreement hedges the Hospital's interest exposure by effectively converting interest payments from variable rates to a fixed rate of 2.64%. The swap agreement, which expires July 1, 2028, is designated as a cash flow hedge of the underlying variable interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. The swap agreement had a fair value of $253,771 and $(1,346,808) as of September 30, 2022 and 2021, respectively.

During the year, the Hospital pays or receives the difference between the fixed and variable rates applied to the notional amounts of the above interest rate swap agreements. During 2022 and 2021, such charges were $468,385 and $603,697, respectively.

In connection with the amended and restated 2013 Series Revenue Bonds, the Hospital is required to comply with certain restrictive financial covenants including, but not limited to, debt service coverage and debt to equity ratios. At September 30, 2022, the Hospital was in compliance with these restrictive covenants.

7. Long-Term Debt and Capital Lease Obligations (Continued)

The scheduled maturities on long-term debt for the next five years ending September 30 and thereafter are as follows:

	Long-Term Debt	Capital Lease Obligations	Total
2023	$ 683,835	$124,973	$ 808,808
2024	714,684	30,202	744,886
2025	747,144	–	747,144
2026	781,078	–	781,078
2027	816,554	–	816,554
Thereafter	18,206,422	–	18,206,422
	$21,949,717	$155,175	$22,104,892

The Hospital also has an available $3,000,000 revolving demand line of credit with a financial institution. The line of credit bears no interest unless drawn at the Hospital's option in which case the rate is equal to the prime rate or 1, 2 or 3 month LIBOR plus 2.5% (6.25% at September 30, 2022). There was no balance outstanding under this agreement at September 30, 2022 or 2021. The line of credit was subject to renewal on September 30, 2022 and, as of the date of these financial statements, is in the process of being renewed with the bank.

In May 2020, the Hospital entered into an additional $7,000,000 revolving demand line of credit with a financial institution. The line of credit bears no interest unless drawn at the Hospital's option in which case the rate is equal to one month LIBOR plus 1.75% (index floor of 1.00%). There was no balance outstanding under this agreement at September 30, 2021. The line of credit expired December 31, 2021 and was not renewed.

8. Net Assets With Donor Restrictions

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

	2022	2021
Subject to expenditure for specific purposes:		
Purchase of equipment	$ 148,061	$ 217,550
Health education and other	658,442	602,021
	806,503	819,571
Restricted endowments:		
General endowment to ensure the Hospital's long-term sustainability, its services and its many community outreach programs	8,043,133	10,012,107
Perpetual trusts (described below)	4,941,606	6,220,933
	$13,791,242	$17,052,611

8. Net Assets With Donor Restrictions (Continued)

Net assets with donor restrictions of $4,941,606 and $6,220,933 at September 30, 2022 and 2021, respectively, are to be held in perpetuity and include two perpetual trusts (note 5). The income and dividends on net assets held in perpetuity are generally expendable to support health care services and capital purchases at the discretion of the Hospital.

The Hospital's endowment funds are donor-restricted, and therefore exclude board-designated funds. The endowment net assets as of September 30, 2022 and 2021 are as follows:

	With Donor Restrictions	
	2022	2021
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	$4,220,482	$ 4,220,482
Accumulated investment gains	3,822,651	5,791,625
	$8,043,133	$10,012,107

Activity in fiscal 2022 and 2021 related to endowment funds was as follows:

	2022	2021
Balances, beginning of year	$10,012,107	$ 8,699,934
Investment (loss) return, net	(1,498,627)	1,736,787
Amounts released under spending policy	(331,992)	(301,665)
Appropriation for expenditure	(138,355)	(122,949)
Balances, end of year	$8,043,133	$10,012,107

From time to time, certain donor-restricted endowment funds may have fair values less than the amount required to be maintained by donors or by law (underwater endowments). The Hospital has interpreted UPMIFA to permit spending from underwater endowments in accordance with prudent measures required under law. At September 30, 2022 and 2021, the Hospital had no underwater endowments.

9. Patient Service Revenue

An estimated breakdown of patient service revenues (including disproportionate share funding) by major payor sources is as follows for the years ended September 30:

	2022	2021
Private payors (includes coinsurance and deductibles)	$25,863,456	$25,163,289
Medicaid	7,562,189	5,089,462
Medicare	54,931,009	51,599,447
Self-pay	3,149,005	2,650,581
Patient service revenue	$91,505,659	$84,502,779

9. Patient Service Revenue (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

10. Employee Benefit Plans

The Hospital has a tax-sheltered annuity plan covering substantially all of its employees. Participating employees become eligible for employer contributions following the completion of two years of service, as defined, and attainment of age 21. Employer contributions are determined based on a percentage of employees' salaries and are discretionary. Benefit expense related to this plan for the years ended September 30, 2022 and 2021 amounted to approximately $572,000 and $229,000, respectively.

The Hospital also offers to a select group of management or highly compensated employees the option to participate in an Internal Revenue Code Section 457 deferred compensation plan to which the Hospital may make a discretionary contribution. The Hospital made contributions to the plan for the years ended September 30, 2022 and 2021 totaling $50,700 and $17,500, respectively.

11. Commitments and Contingencies

Operating Leases

The Hospital has various operating leases relative to certain equipment and various office facilities. The future annual minimum lease payments under these noncancellable leases as of September 30, 2022 is $194,940 for the year ending September 30, 2023.

Rent expense was approximately $342,000 and $338,000 for the years ended September 30, 2022 and 2021, respectively.

Malpractice Loss Contingencies

The Hospital maintains malpractice insurance coverage on a claims-made basis. The claims-made policies, which are subject to retrospective adjustment and renewal on an annual basis, cover only claims made during the term of the policies, but not those occurrences for which claims may be made after expiration of the policies. The Hospital intends to renew its coverage and has no reason to believe that it will be prevented from renewing such coverage.

In accordance with ASU No. 2010-24, *"Health Care Entities" (Topic 954): Presentation of Insurance Claims and Related Recoveries*, the Hospital is required to record a liability related to estimated professional liability losses and also a receivable related to estimated recoveries under insurance coverage for recoveries of potential losses. At September 30, 2022 and 2021, management of the Hospital estimated that the Hospital did not have any significant exposure arising from estimated professional liability losses or significant estimated recoveries under insurance coverage for recoveries of potential losses.

12. Volunteer Services (Unaudited)

In 2022 and 2021, total volunteer service hours received by the Hospital were approximately 4,300 and 1,700, respectively. The volunteers provide nonspecialized services to the Hospital, none of which have been recognized as revenue or expense in the statements of operations.

13. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses, excluding the New Hampshire Medicaid enhancement tax of $4,221,892 and $3,194,153 for 2022 and 2021, respectively, related to providing these services are as follows for the years ended September 30:

	Health Services	General and Administrative	Total
2022			
Salaries and benefits	$42,328,809	$ 5,662,098	$47,990,907
Supplies and other	32,396,534	3,316,970	35,713,504
Insurance	504,117	337,916	842,033
Depreciation and amortization	4,007,293	217,841	4,225,134
Interest	–	914,630	914,630
	$79,236,753	$10,449,455	$89,686,208
2021			
Salaries and benefits	$36,760,226	$ 5,186,276	$41,946,502
Supplies and other	31,107,494	2,782,039	33,889,533
Insurance	448,698	252,251	700,949
Depreciation and amortization	4,046,736	219,801	4,266,537
Interest	–	958,169	958,169
	$72,363,154	$ 9,398,536	$81,761,690

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

14. Financial Assistance Program and Community Benefits (Unaudited)

The Hospital maintains records to identify and monitor the level of financial assistance it provides. These records include the amount of charges foregone for services and supplies furnished under its financial assistance program, the estimated cost of those services and supplies, and equivalent service statistics. The following information measures the level of financial assistance provided during the years ended September 30, 2022 and 2021:

	2022	2021
Charges foregone, based on established rates (note 1)	$665,000	$1,021,000
Estimated costs incurred to provide financial assistance	$485,000	$ 646,000
Equivalent percentage of financial assistance services to all services	0.39%	0.65%

In addition to the financial assistance identified above, the Hospital does not receive full payment from the Medicare and Medicaid programs for the cost of services to certain poor and elderly patients served. In 2022 and 2021, the Hospital incurred costs in excess of payments in these programs amounting to approximately $7,499,000 and $5,247,000, respectively.

The Hospital also provides other services to the community at no cost or reduced cost, such as screenings, clinics, etc. The cost of providing these services was approximately $3,408,000 and $4,001,000 for the years ended September 30, 2022 and 2021, respectively.

The Hospital also has direct subsidies of approximately $5,425,000 and $4,866,000 for primary care and various specialty practices for the years ended September 30, 2022 and 2021, respectively.

15. Fair Value of Financial Instruments

Fair value of a financial instrument is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Hospital uses various methods including market, income and cost approaches. Based on these approaches, the Hospital often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Hospital utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the Hospital is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

15. Fair Value of Financial Instruments (Continued)

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

In determining the appropriate levels, the Hospital performs a detailed analysis of the assets and liabilities that are subject to fair value measurements. At each reporting period, all assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as Level 3.

For the fiscal year ended September 30, 2022, the application of valuation techniques applied to similar assets and liabilities has been consistent with prior years.

The following presents the balances of assets and liabilities measured at fair value on a recurring basis at September 30:

	Total	Level 1	Level 2	Level 3
2022				
Assets:				
Assets limited as to use:				
Cash and cash equivalents	$ 1,644,108	$ 822,660	$ 821,448	$ –
U.S. Treasury obligations	4,001,356	4,001,356	–	–
U.S. common stock:				
Technology	12,234,160	12,234,160	–	–
Healthcare	4,407,208	4,407,208	–	–
Consumer goods	9,785,644	9,785,644	–	–
Industrial goods	4,246,664	4,246,664	–	–
Services	7,518,924	7,518,924	–	–
Financial	1,288,200	1,288,200	–	–
Utilities	1,568,200	1,568,200	–	–
Mutual funds:				
Domestic	11,210,480	11,210,480	–	–
International	6,695,510	6,695,510	–	–
Fixed income	16,153,322	16,153,322	–	–
Investments in perpetual trusts	4,941,606	–	4,941,606	–
	$ 85,695,382	$79,932,328	$5,763,054	$ –
Interest rate swap agreements	$ 144,803	$ –	$ –	$ 144,803

15. Fair Value of Financial Instruments (Continued)

	Total	Level 1	Level 2	Level 3
2021				
Assets:				
Assets limited as to use:				
Cash and cash equivalents	$ 4,368,195	$ 835,957	$3,532,238	$ –
U.S. Treasury obligations	1,118,194	1,118,194	–	–
U.S. common stock:				
Technology	14,705,084	14,705,084	–	–
Healthcare	4,945,880	4,945,880	–	–
Consumer goods	13,142,236	13,142,236	–	–
Industrial goods	3,900,420	3,900,420	–	–
Services	9,334,195	9,334,195	–	–
Financial	1,380,132	1,380,132	–	–
Utilities	1,452,620	1,452,620	–	–
Mutual funds:				
Domestic	13,674,142	13,674,142	–	–
International	8,937,864	8,937,864	–	–
Fixed income	18,841,307	18,841,307	–	–
Investments in perpetual trusts	6,220,933	–	6,220,933	–
	$102,021,202	$92,268,031	$9,753,171	$ –
Liabilities:				
Interest rate swap agreements	$ 2,665,795	$ –	$ –	$2,665,795

The valuation of the interest rate swap agreements is estimated by a third party based on the anticipated cash flows under the swap agreements over their duration at market interest rates at September 30, 2022 and 2021.

There were no significant purchases, issues or transfers into or out of Level 3 for the years ended September 30, 2022 or 2021.

Investments, in general, are exposed to various risks, such as interest rate, credit and overall market volatility. As such, it is reasonably possible that changes in the fair value of investments will occur in the near term and that such changes could materially affect the amounts reported in the accompanying balance sheets and statements of operations.

The following methods and assumptions were used by the Hospital in estimating the "fair value" of other financial instruments in the accompanying financial statements and notes thereto:

Cash and cash equivalents: The carrying amounts reported in the accompanying statements of financial position for these financial instruments approximate their fair values.

15. Fair Value of Financial Instruments (Continued)

Accounts and other receivables, pledges receivable, notes receivable, accounts payable and estimated third-party payor settlements: The carrying amounts reported in the accompanying statements of financial position approximate their respective values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value.

Long-term debt: The carrying value of substantially all long-term debt approximates its fair value due to the variable rate interest terms.

16. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, consisted of the following at September 30, 2022:

Cash and cash equivalents	$31,146,583
Accounts receivable	6,450,584
Other receivables	310,365
	$37,907,532

To manage liquidity, the Hospital maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the Hospital. In addition, the Hospital has board-designated assets without donor restrictions that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2022, the balance in board-designated assets was approximately $71.9 million.

Appendix A-7

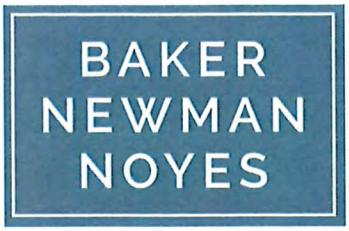
Catholic Medical Center Articles of Agreement

Appendix A-8

Catholic Medical Center Bylaws, as Amended and Restated

Appendix A-9

Catholic Medical Center Consolidated Financial Statements
for the year ended September 30, 2022



Catholic Medical Center

Audited Financial Statements

Years Ended September 30, 2022 and 2021
With Independent Auditors' Report

Baker Newman & Noyes LLC
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CATHOLIC MEDICAL CENTER

AUDITED FINANCIAL STATEMENTS

Years Ended September 30, 2022 and 2021

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INDEPENDENT AUDITORS' REPORT

Board of Trustees
Catholic Medical Center

Opinion

We have audited the financial statements of Catholic Medical Center (the Medical Center), which comprise the balance sheets as of September 30, 2022 and 2021, the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Medical Center as of September 30, 2022 and 2021, and the results of its operations, changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Medical Center and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Medical Center's ability to continue as a going concern within one year after the date that the financial statements are issued or available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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 Medical Center's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Medical Center's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Baker Newman & Noyes LLC

Manchester, New Hampshire
February 23, 2023

CATHOLIC MEDICAL CENTER

BALANCE SHEETS

September 30, 2022 and 2021

ASSETS

	2022	2021
Current assets:		
Cash and cash equivalents	$ 41,793,666	$104,311,091
Short-term investments	3,603,910	3,582,157
Accounts receivable	70,378,411	70,239,991
Inventories	3,816,582	3,912,718
Other current assets	13,370,992	17,204,497
Total current assets	132,963,561	199,250,454
Property, plant and equipment, net	125,421,215	122,341,467
Other assets:		
Intangible assets and other	11,082,819	11,803,240
Assets whose use is limited:		
Pension and insurance obligations	20,598,446	24,811,739
Board designated and donor restricted investments and restricted grants	139,270,604	159,294,609
Held by trustee under revenue bond agreements	1,119,341	1,250,410
	160,988,391	185,356,758
Total assets	$430,455,986	$518,751,919

LIABILITIES AND NET ASSETS

	2022	2021
Current liabilities:		
Accounts payable and accrued expenses	$ 31,425,157	$ 33,828,878
Accrued salaries, wages and related accounts	19,909,349	20,240,317
Amounts payable to third-party payors	11,525,383	52,285,526
Amounts due to affiliates	1,234,110	715,592
Current portion of long-term debt	4,178,597	3,188,609
Total current liabilities	68,272,596	110,258,922
Accrued pension and other liabilities, less current portion	94,321,024	136,156,024
Long-term debt, less current portion	157,102,822	153,854,001
Total liabilities	319,696,442	400,268,947
Net assets:		
Without donor restrictions	81,934,391	87,915,051
With donor restrictions	28,825,153	30,567,921
Total net assets	110,759,544	118,482,972
Total liabilities and net assets	$430,455,986	$518,751,919

See accompanying notes.

CATHOLIC MEDICAL CENTER

STATEMENTS OF OPERATIONS

Years Ended September 30, 2022 and 2021

	2022	2021
Operating revenues:		
Patient service revenues	$470,371,106	$439,948,002
Other revenue	31,521,767	32,181,226
Disproportionate share funding	21,383,859	21,483,694
Total operating revenues	523,276,732	493,612,922
Operating expenses:		
Salaries, wages and fringe benefits	264,139,413	218,908,177
Supplies and other	186,550,034	183,801,624
New Hampshire Medicaid enhancement tax	22,288,821	19,248,461
Depreciation and amortization	12,335,408	12,067,385
Interest	4,783,146	4,659,054
Total operating expenses	490,096,822	438,684,701
Income from operations	33,179,910	54,928,221
Nonoperating (losses) gains:		
Investment (loss) income, net	(21,778,151)	24,527,566
Net periodic pension cost, other than service cost	(1,302,959)	(871,021)
Contributions without donor restrictions	295,134	551,406
Development costs	(697,147)	(577,663)
Other nonoperating expenses and losses	(3,153,518)	(10,451,058)
Total nonoperating (losses) gains, net	(26,636,641)	13,179,230
Excess of revenues and (losses) gains over expenses	6,543,269	68,107,451
Unrealized depreciation on investments	(24,002)	(4,872)
Change in fair value of interest rate swap agreement	540,490	204,639
Assets released from restriction used for capital	495,416	70,304
Pension-related changes other than net periodic pension cost	31,252,260	45,394,659
Net assets transferred to affiliates	(44,788,093)	(47,240,399)
Change in net assets without donor restrictions	(5,980,660)	66,531,782
Net assets without donor restrictions at beginning of year	87,915,051	21,383,269
Net assets without donor restrictions at end of year	$ 81,934,391	$ 87,915,051

See accompanying notes.

CATHOLIC MEDICAL CENTER

STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2022 and 2021

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total Net Assets
Balances at September 30, 2020	$ 21,383,269	$26,995,958	$ 48,379,227
Excess of revenues and gains over expenses	68,107,451	–	68,107,451
Restricted investment income	–	542,188	542,188
Changes in interest in perpetual trust	–	1,546,976	1,546,976
Donor-restricted contributions	–	2,854,022	2,854,022
Unrealized depreciation on investments	(4,872)	(254,325)	(259,197)
Change in fair value of interest rate swap agreement	204,639	–	204,639
Assets released from restriction used for operations	–	(1,046,594)	(1,046,594)
Assets released from restriction used for capital	70,304	(70,304)	–
Pension-related changes other than net periodic pension cost	45,394,659	–	45,394,659
Net assets transferred to affiliates	(47,240,399)	–	(47,240,399)
	66,531,782	3,571,963	70,103,745
Balances at September 30, 2021	87,915,051	30,567,921	118,482,972
Excess of revenues and (losses) gains over expenses	6,543,269	–	6,543,269
Restricted investment income	–	55,047	55,047
Changes in interest in perpetual trust	–	(1,965,979)	(1,965,979)
Donor-restricted contributions	–	1,713,209	1,713,209
Unrealized depreciation on investments	(24,002)	(328,700)	(352,702)
Change in fair value of interest rate swap agreement	540,490	–	540,490
Assets released from restriction used for operations	–	(720,929)	(720,929)
Assets released from restriction used for capital	495,416	(495,416)	–
Pension-related changes other than net periodic pension cost	31,252,260	–	31,252,260
Net assets transferred to affiliates	(44,788,093)	–	(44,788,093)
	(5,980,660)	(1,742,768)	(7,723,428)
Balances at September 30, 2022	$ 81,934,391	$28,825,153	$110,759,544

See accompanying notes.

CATHOLIC MEDICAL CENTER

STATEMENTS OF CASH FLOWS

Years Ended September 30, 2022 and 2021

	2022	2021
Operating activities:		
Change in net assets	$ (7,723,428)	$ 70,103,745
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities:		
Depreciation and amortization	12,335,408	12,067,385
Pension-related changes other than net periodic pension cost	(31,252,260)	(45,394,659)
Net assets transferred to affiliates	44,788,093	47,240,399
Restricted gifts and investment income	(1,768,256)	(3,396,210)
Net realized and unrealized losses (gains) on investments	25,498,544	(21,584,462)
Change in interest in perpetual trust	1,965,979	(1,546,976)
Change in fair value of interest rate swap agreement	(540,490)	(204,639)
Bond discount/premium and issuance cost amortization	(240,199)	(250,128)
Changes in operating assets and liabilities:		
Accounts receivable	(138,420)	(8,700,325)
Inventories	96,136	924,157
Other current assets	4,819,550	3,350,720
Amounts due to affiliates	518,518	81,977
Other assets	720,421	(682,146)
Accounts payable and accrued expenses	(2,403,721)	(21,337,182)
Accrued salaries, wages and related accounts	(330,968)	(35,629)
Amounts payable to third-party payors	(40,760,143)	31,126,220
Accrued pension and other liabilities	(10,055,176)	(46,747,628)
Net cash (used) provided by operating activities	(4,470,412)	15,014,619
Investing activities:		
Purchases of property, plant and equipment	(13,992,433)	(8,415,395)
Net change in assets held by trustee under revenue bond agreements	131,069	94,602
Proceeds from sales of investments	12,080,753	112,589,566
Purchases of investments	(15,808,176)	(114,257,793)
Net cash used by investing activities	(17,588,787)	(9,989,020)
Financing activities:		
Payments on long-term debt	(2,765,405)	(2,438,722)
Proceeds from issuance of long-term debt	6,258,900	1,727,244
Payments on capital leases	(424,284)	(223,098)
Restricted gifts and investment income	1,260,656	2,226,560
Net assets transferred to affiliates	(44,788,093)	(47,240,399)
Net cash used by financing activities	(40,458,226)	(45,948,415)
Decrease in cash and cash equivalents	(62,517,425)	(40,922,816)
Cash and cash equivalents at beginning of year	104,311,091	145,233,907
Cash and cash equivalents at end of year	$ 41,793,666	$ 104,311,091

Supplemental disclosure:
During 2022 and 2021, the Medical Center entered into capital lease obligations to finance certain equipment totaling $1,409,797 and $1,739,803, respectively.

See accompanying notes.

1. Organization

Catholic Medical Center (the Medical Center) is a voluntary not-for-profit acute care hospital based in Manchester, New Hampshire. The Medical Center, which primarily serves residents of New Hampshire and northern Massachusetts, was controlled by CMC Healthcare System, Inc. (the System), a not-for-profit corporation which functioned as the parent company and sole member of the Medical Center until December 30, 2016. On December 30, 2016, the System became affiliated with Huggins Hospital (HH), a 25-bed critical access hospital in Wolfeboro, New Hampshire, and Monadnock Community Hospital (MCH), a 25-bed critical access hospital in Peterborough, New Hampshire, through the formation of a common parent, GraniteOne Health (GraniteOne). GraniteOne is a New Hampshire voluntary corporation that is recognized as being a Section 501(c)(3) tax-exempt and "supporting organization" within the meaning of Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the Code). GraniteOne serves as the sole member of HH and MCH and co-member of the Medical Center, along with the System. GraniteOne is governed by a thirteen-member Board of Trustees appointed by each of the respective hospitals within the GraniteOne system. The GraniteOne Board of Trustees governs the GraniteOne system through the existence and execution of reserved powers to approve certain actions by the Boards of Trustees of each of the hospitals. Through GraniteOne, this more integrated healthcare system enhances the affiliated hospitals' ability to coordinate the delivery of patient care, implement best practices, eliminate inefficiencies and collaborate on regional healthcare planning. These efforts strengthen the hospitals' ability to meet the healthcare needs of their respective communities and provide for a more seamless patient experience across the continuum of care. The accompanying financial statements for the years ended September 30, 2022 and 2021 do not include the accounts and activity of GraniteOne, HH and MCH.

On September 30, 2019, GraniteOne, the Medical Center, the System, certain subsidiaries of the System, HH and MCH entered into a Combination Agreement (the Agreement) with Dartmouth-Hitchcock Health (D-HH) to combine GraniteOne and D-HH and its members into a more fully integrated healthcare delivery system. The combining parties began the state and federal regulatory review process with the filing of a Joint Notice of Change of Control to the New Hampshire Attorney General (AG), Director of Charitable Trusts pursuant to New Hampshire RSA 7:19-b on December 30, 2019. On May 13, 2022, the New Hampshire Attorney General's office issued its report objecting to the proposed combination. On May 31, 2022, GraniteOne, the Medical Center, the System, certain subsidiaries of the System, HH, MCH and D-HH entered into an Agreement to Mutually Terminate the Combination Agreement ending the efforts to combine the two healthcare systems. The Medical Center incurred approximately $1.6 million and $5.9 million in combination costs for the years ended September 30, 2022 and 2021, respectively, which amounts are reflected within nonoperating (losses) gains in the accompanying statements of operations.

Pursuant to the Affiliation Agreement that formed GraniteOne, the Medical Center, HH and MCH each had a right, after two years of GraniteOne, to evaluate whether they would continue participation in the system. The time period on this limited right to withdraw had been extended a number of times while the proposed combination with D-HH was under review. Upon the termination of the combination efforts with D-HH, the Medical Center, MCH and HH each assessed their continued participation in GraniteOne and after a six-month review process, each concluded it was best to withdraw from GraniteOne and subsequently provided the required notice on October 28, 2022. The parties mutually agreed to work together over several months to seek the necessary regulatory approvals and wind down GraniteOne. The parties intend to continue their clinical collaborations after the withdrawal and wind down of GraniteOne. The parties anticipate completing these processes within the 2023 fiscal year.

2. Significant Accounting Policies

Basis of Presentation

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

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

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

Performance Indicator

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

Charity Care and Community Benefits

The Medical Center has a formal charity care policy under which patient care is provided to patients who meet certain criteria without charge or at amounts less than its established rates. The Medical Center does not pursue collection of amounts determined to qualify as charity care; therefore, they are not reported as revenues. The Medical Center rendered charity care in accordance with this policy, which, at established charges, amounted to $14,784,022 and $16,294,258 for the years ended September 30, 2022 and 2021, respectively.

Of the Medical Center's $490,096,822 total expenses reported for the year ended September 30, 2022, an estimated $4,400,000 arose from providing services to charity patients. Of the Medical Center's $438,684,701 total expenses reported for the year ended September 30, 2021, an estimated $4,700,000 arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the Medical Center's total expenses divided by gross patient service revenue.

2. Significant Accounting Policies (Continued)

The Medical Center provides community service programs, without charge, such as the Medication Assistance Program, Community Education and Wellness, Patient Transport, and the Parish Nurse Program. The costs of providing these programs amounted to $876,500 and $837,489 for the years ended September 30, 2022 and 2021, respectively.

Concentration of Credit Risk

Financial instruments which subject the Medical Center to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Medical Center's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The Medical Center's accounts receivable are primarily due from third-party payors and amounts are presented net of expected explicit and implicit price concessions, including estimated implicit price concessions from uninsured patients. The Medical Center's investment portfolio consists of diversified investments, which are subject to market risk. Investments that exceeded 10% of investments include the Fidelity 500 Index Fund as of September 30, 2022 and 2021.

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit with maturities of three months or less when purchased and investments in overnight deposits at various banks. Cash and cash equivalents exclude amounts whose use is limited by board designation and amounts held by trustees under revenue bond and other agreements. The Medical Center maintains approximately $38,000,000 and $100,000,000 at September 30, 2022 and 2021, respectively, of its cash and cash equivalent accounts with a single institution. The Medical Center has not experienced any losses associated with deposits at this institution.

Accounts Receivable

Patient accounts receivable for which the unconditional right to payment exists are receivables if the right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. Accounts receivable at September 30, 2022 and 2021 reflect the fact that any estimated uncollectible amounts are generally considered implicit price concessions that are a direct reduction to accounts receivable rather than allowance for doubtful accounts. At September 30, 2022 and 2021, estimated implicit price concessions of $22,678,344 and $22,614,208, respectively, have been recorded as reductions to accounts receivable balances to enable the Medical Center to record revenues and accounts receivable at the estimated amounts expected to be collected.

Accounts receivable as of September 30, 2022, 2021 and 2020 are $70,378,411, $70,239,991 and $61,539,666 respectively.

2. Significant Accounting Policies (Continued)

Inventories

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

Property, Plant and Equipment

Property, plant and equipment is stated at cost at time of purchase or fair value at the time of donation, less accumulated depreciation. The Medical Center's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. The provisions for depreciation and amortization have been determined using the straight-line method at rates intended to amortize the cost of assets over their estimated useful lives. See also Note 5. Assets which have been purchased but not yet placed in service are included in construction in progress and no depreciation expense is recorded.

Conditional Asset Retirement Obligations

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

As of September 30, 2022 and 2021, $943,004 and $932,489, respectively, of conditional asset retirement obligations are included within accrued pension and other liabilities in the accompanying balance sheets.

Goodwill

The Medical Center reviews its goodwill and other long-lived assets annually to determine whether the carrying amount of such assets is impaired. Upon determination that an impairment has occurred, these assets are reduced to fair value. There were no impairments recorded for the years ended September 30, 2022 or 2021.

2. Significant Accounting Policies (Continued)

Patient Service Revenues

Revenues generally relate to contracts with patients in which the Medical Center's performance obligations are to provide health care services to patients. Revenues are recorded during the period obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over a period of days. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by Medicare and Medicaid or negotiated with managed care health plans and commercial insurance companies, the third-party payors. The payment arrangements with third-party payors for the services provided to related patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the revenue recognition process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payors and patients is the Medical Center's primary source of cash and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of hospital revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of accounts receivable. Management performs the hindsight analysis regularly, utilizing rolling twelve-month accounts receivable collection and write-off data. Management believes its regular updates to the estimated implicit price concession amounts provide reasonable estimates of revenues and valuations of accounts receivable. These routine, regular changes in estimates have not resulted in material adjustments to the valuations of accounts receivable or period-to-period comparisons of operations.

2. Significant Accounting Policies (Continued)

Retirement Benefits

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

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

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

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

The Medical Center also maintains tax-sheltered annuity benefit programs in which it matches one half of employee contributions up to 3% of their annual salary, depending on date of hire, plus an additional 0% - 2% based on tenure. The Medical Center made matching contributions under the program of $2,868,775 and $3,206,365 for the years ended September 30, 2022 and 2021, respectively.

During 2007, the Medical Center created a nonqualified deferred compensation plan covering certain employees under Section 457(b) of the Code. Under the plan, a participant may elect to defer a portion of their compensation to be held until payment in the future to the participant or his or her beneficiary. Consistent with the requirements of the Code, all amounts of deferred compensation, including but not limited to any investments held and all income attributable to such amounts, property, and rights will remain subject to the claims of the Medical Center's creditors, without being restricted to the payment of deferred compensation, until payment is made to the participant or their beneficiary. No contributions were made by the Medical Center for the years ended September 30, 2022 or 2021.

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

2. Significant Accounting Policies (Continued)

During 2007, the Medical Center created a supplemental executive retirement plan covering certain executives of the Medical Center under Section 457(f) of the Code. The Medical Center recorded compensation expense of $577,252 and $1,002,235 for the years ended September 30, 2022 and 2021, respectively related to this plan.

Employee Fringe Benefits

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

Debt Issuance Costs/Original Issue Discount or Premium

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

Assets Whose Use is Limited or Restricted

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

Net Assets With Donor Restrictions

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

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

2. Significant Accounting Policies (Continued)

Pledges Receivable

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

Investments and Investment (Loss) Income

Investments are carried at fair value in the accompanying balance sheets. See Note 8 for further discussion regarding fair value measurements. Investment (loss) income (including realized gains and losses on investments, interest and dividends) and the net change in unrealized gains and losses on equity securities, are included in the excess of revenues and (losses) gains over expenses in the accompanying statements of operations, unless the income or loss is restricted by donor or law. The change in net unrealized gains and losses on debt securities is reported as a separate component of the change in net assets without donor restrictions, except declines that are determined by management to be other than temporary, which are reported as an impairment charge (included in the excess of revenues and (losses) gains over expenses). No such losses were recorded in 2022 or 2021.

Derivative Instruments

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

Beneficial Interest in Perpetual Trust

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

Endowment, Investment and Spending Policies

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

2. Significant Accounting Policies (Continued)

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

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

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

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

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

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

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

Federal Grant Revenue and Expenditures

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

Malpractice Loss Contingencies

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

2. Significant Accounting Policies (Continued)

In accordance with Accounting Standards Update (ASU) No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2022 and 2021, the Medical Center recorded a liability of $14,397,448 and $15,491,857, respectively, related to estimated professional liability losses covered under this policy. At September 30, 2022 and 2021, the Medical Center also recorded a receivable of $10,429,948 and $11,402,607, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other liabilities, and intangible assets and other, respectively, on the balance sheets.

Workers' Compensation

The Medical Center maintains workers' compensation insurance under a self-insured plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the Medical Center against excessive losses. The Medical Center has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $2,370,808 and $2,493,406 at September 30, 2022 and 2021, respectively, have been discounted at 1.25% and, in management's opinion, provide an adequate reserve for loss contingencies. At September 30, 2022, $1,050,109 and $1,320,699 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying balance sheet. The Medical Center has also recorded $148,287 and $255,402 within other current assets and intangible assets and other, respectively, in the accompanying balance sheet to limit the accrued losses to the retention amount at September 30, 2022. At September 30, 2021, $1,088,072 and $1,405,334 is recorded within accounts payable and accrued expenses and accrued pension and other liabilities, respectively, in the accompanying balance sheet. The Medical Center has also recorded $147,120 and $266,633 within other current assets and intangible assets and other, respectively, in the accompanying balance sheet to limit the accrued losses to the retention amount at September 30, 2021.

Health Insurance

The Medical Center has a self-funded health insurance plan. The plan is administered by an insurance company and the Medical Center has employed independent actuaries to estimate unpaid claims, and those claims incurred but not reported at fiscal year end. The Medical Center was insured above a stop-loss amount of approximately $1.1 million and $903,000 at September 30, 2022 and 2021, respectively, on individual claims. Estimated unpaid claims, and those claims incurred but not reported, at September 30, 2022 and 2021 of $3,079,700 and $2,511,000, respectively, are reflected in the accompanying balance sheets within accounts payable and accrued expenses.

Functional Expense Allocation

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

2. Significant Accounting Policies (Continued)

Advertising Costs

The Medical Center expenses advertising costs as incurred, and such costs totaled approximately $1,203,000 and $947,000 for the years ended September 30, 2022 and 2021, respectively.

Recent Accounting Pronouncements

In February 2016, the Financial Accounting Standards Board (FASB) issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the Medical Center on October 1, 2022. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. Management expects the adoption of this ASU to result in the recognition of a liability and offsetting right-of-use asset totaling approximately $40 million.

In August 2018, FASB issued ASU No. 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General (Topic 715)* (ASU 2018-14). Under ASU 2018-14, the disclosure requirements for employers that sponsor defined benefit pension and other postretirement plans are modified. ASU 2018-14 was effective for the Medical Center for the year ended September 30, 2022. The adoption of this ASU did not have a significant impact on the Medical Center's financial statements.

In September 2020, the FASB issued ASU No. 2020-07, *Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets.* ASU 2020-07 enhances the presentation of disclosure requirements for contributed nonfinancial assets. ASU 2020-07 requires entities to present contributed nonfinancial assets as a separate line item in the statement of operations and disclose the amount of contributed nonfinancial assets recognized within the statement of operations by category that depicts the type of contributed nonfinancial assets, as well as a description of any donor-imposed restrictions associated with the contributed nonfinancial assets and the valuation techniques used to arrive at a fair value measure at initial recognition. ASU 2020-07 was effective for the Medical Center beginning October 1, 2021. The adoption of this ASU did not have a significant impact on the Medical Center's financial statements.

Risks and Uncertainties

On March 11, 2020, the World Health Organization declared the outbreak of coronavirus (COVID-19) a pandemic. The COVID-19 pandemic has significantly affected employees, patients, systems, communities and business operations, as well as the U.S. economy and financial markets. While some restrictions have been eased across the U.S. and the State of New Hampshire has lifted limitations on non-emergent procedures, some restrictions remain in place. Consolidated patient volumes and revenues experienced gradual improvement beginning in the latter part of April 2020, and continuing, but at times impacted through fiscal year 2022, however uncertainty still exists as the future is unpredictable. The Medical Center's pandemic response plan has multiple facets and continues to evolve as the pandemic unfolds. The Medical Center has taken precautionary steps to enhance its operational and financial flexibility, and react to the risks the COVID-19 pandemic presents in its operations.

2. Significant Accounting Policies (Continued)

Since the declaration of the pandemic, the Medical Center received approximately $49.0 million of accelerated Medicare payments (Note 4) as provided for under the *Coronavirus Aid, Relief and Economic Security Act* (CARES Act).

During 2022, the Medical Center received approximately $2.2 million of *American Rescue Plan Act* (ARPA) rural payments, approximately $11.9 million of Provider Relief Funds (PRF) (under the CARES Act) and approximately $1.0 million from the Governor's Office of Emergency Relief and Recovery (GOFERR) (under the CARES Act). Distributions from ARPA, PRF and GOFERR are not subject to repayment provided the Medical Center is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants, and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the funding, the Medical Center recognized approximately $15.1 million of the funding in 2022, and these payments are recorded within other revenue in the accompanying statement of operations for the year ended September 30, 2022. The Medical Center also received PRF and GOFERR funding in 2021 and recognized approximately $17.6 million related to these funds, which was recorded within other revenue in the accompanying statement of operations for the year ended September 30, 2021.

The CARES Act also provides for a deferral of payments of the employer portion of payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 2021, and the remaining half until December 2022. At September 30, 2022 and 2021, the Medical Center had deferred approximately $3.3 million and $6.5 million, respectively, of payroll taxes, of which approximately $3.3 million are recorded within accrued salaries, wages and related accounts in the accompanying 2022 and 2021 balance sheets. Further, approximately $3.2 million of deferred payroll taxes were recorded within accrued pension and other liabilities in the accompanying 2021 balance sheet.

Subsequent Events

Management of the Medical Center evaluated events occurring between the end of the Medical Center's fiscal year and February 23, 2023, the date the financial statements were available to be issued. See also Note 6.

3. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs consisted of the following at September 30, 2022:

Cash and cash equivalents	$ 41,793,666
Short-term investments	3,603,910
Accounts receivable	70,378,411
	$115,775,987

3. Financial Assets and Liquidity Resources (Continued)

To manage liquidity, the Medical Center maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the Medical Center. In addition, the Medical Center has board-designated assets that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2022, the balance in board-designated assets was approximately $111 million.

4. Patient Service Revenues

The Medical Center maintains contracts with the Social Security Administration ("Medicare") and the State of New Hampshire Department of Health and Human Services ("Medicaid"). The Medical Center is paid a prospectively determined fixed price for each Medicare and Medicaid inpatient acute care service depending on the type of illness or the patient's diagnosis related group classification. Capital costs and certain Medicare and Medicaid outpatient services are also reimbursed on a prospectively determined fixed price. The Medical Center receives payment for other Medicaid outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports. The percentage of patient service revenues earned from the Medicare and Medicaid programs was 37% and 4%, respectively, for the year ended September 30, 2022 and 31% and 4%, respectively, for the year ended September 30, 2021.

Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenues in the year that such amounts become known. Such differences decreased patient service revenues by approximately $36,000 for the year ended September 30, 2022. Such differences increased patient service revenues by approximately $3.5 million for the year ended September 30, 2021. Settlements for the Medical Center have been finalized through 2018 and 2017 for Medicare and Medicaid, respectively.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Medical Center believes that it is in compliance with all applicable laws and regulations; compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs (Note 14).

As discussed in Note 2, during fiscal year 2020, the Medical Center requested accelerated Medicare payments as provided for in the CARES Act, which allowed for eligible health care facilities to request up to six months of advance Medicare payments for acute care hospitals or up to three months of advance Medicare payments for other health care providers. One year from the date of receipt of the advance payments (beginning April 2021) 25% of the advances were recouped in the first eleven months. An additional 25% of the advances were recouped in the next six months, with the entire amount repayable in 29 months. Any outstanding balance after 29 months is repayable at a 4% interest rate. During the third quarter of fiscal 2020, the Medical Center received approximately $49.0 million from these accelerated Medicare payment requests. At September 30, 2021, the current portion due within a year, totaling approximately $35.7 million, was recorded under the caption "amounts payable to third-party payors" in the accompanying 2021 balance sheet. The remaining amount was repaid in full during fiscal year 2022, and there is no remaining liability as of September 30, 2022.

4. Patient Service Revenues (Continued)

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

An estimated breakdown of patient service revenues by major payor sources is as follows for the years ended September 30:

	2022	2021
Private payors (includes coinsurance and deductibles)	$268,893,956	$ 278,441,313
Medicaid	18,543,239	15,941,141
Medicare	175,511,508	136,062,134
Self-pay	7,422,403	9,503,414
	$470,371,106	$ 439,948,002

Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of the Medical Center's patient service revenues, with certain exclusions. The amount of tax incurred by the Medical Center for the years ended September 30, 2022 and 2021 was $22,288,821 and $19,248,461, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded in operating revenues and amounted to $21,383,859 and $21,483,694 for the years ended September 30, 2022 and 2021, respectively, net of reserves referenced below.

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

5. Property, Plant and Equipment

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

	2022	2021
Land and land improvements	$ 1,472,137	$ 1,472,137
Buildings and improvements	112,077,416	110,046,683
Fixed equipment	43,818,831	43,305,136
Movable equipment	133,712,594	133,370,597
Construction in progress	24,957,824	17,728,986
	316,038,802	305,923,539
Less accumulated depreciation and amortization	(190,617,587)	(183,582,072)
Net property, plant and equipment	$ 125,421,215	$ 122,341,467

In 2021, the Medical Center engaged an independent third party to assist in reassigning the useful lives of certain property, plant and equipment as of October 1, 2020. The impact of changes to estimated useful lives of certain property, plant and equipment of the Medical Center was reported as a change in accounting estimate on a prospective basis to more accurately reflect estimated asset lives based on use. Depreciation expense before this change in estimate for the year ended September 30, 2021 was $13,783,735. As a result of this change in estimate, depreciation expense for 2021 was reduced by $1,728,743 to $12,054,992.

The cost of equipment under capital leases was $9,110,999 and $9,551,202 at September 30, 2022 and 2021, respectively. Accumulated amortization of the leased equipment at September 30, 2022 and 2021 was $6,313,502 and $7,837,413, respectively. Amortization of assets under capital leases is included in depreciation and amortization expense.

As of September 30, 2022, construction in progress primarily consists of the cost related to expand the Medical Center adjacent to the current hospital building, intended for a future expansion of the Medical Center. As of the date of these financial statements, the Medical Center had no significant purchase commitments related to this project.

6. Long-Term Debt and Notes Payable

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

	2022	2021
New Hampshire Health and Education Facilities Authority (the Authority) Revenue Bonds:		
Series 2012 Bonds with interest ranging from 4.00% to 5.00% per year and principal payable in annual installments ranging from $1,125,000 to $1,665,000 through July 2032	$ 13,900,000	$ 15,500,000
Series 2015A Bonds with interest at a fixed rate of 2.27% per year and principal payable in annual installments ranging from $185,000 to $1,655,000 through July 2040	19,750,000	20,400,000
Series 2015B Bonds with variable interest subject to interest rate swap described below and principal payable in annual installments ranging from $435,000 to $665,000 through July 2036	7,420,000	7,640,000
Series 2017 Bonds with interest ranging from 3.38% to 5.00% per year and principal payable in annual installments ranging from $2,900,000 to $7,545,000 beginning in July 2033 through July 2044	61,115,000	61,115,000
	102,185,000	104,655,000
Construction loans – see below	18,531,163	12,566,668
Term loan – see below	35,000,000	35,000,000
Capitalized lease obligations	2,672,981	1,688,468
Unamortized original issue premiums/discounts	4,005,529	4,339,925
Unamortized debt issuance costs	(1,113,254)	(1,207,451)
	161,281,419	157,042,610
Less current portion	(4,178,597)	(3,188,609)
	$157,102,822	$153,854,001

The Authority Revenue Bonds

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

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

On September 3, 2015, the Authority issued $32,720,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2015, consisting of the $24,070,000 aggregate principal amount Series 2015A Bonds and the $8,650,000 aggregate principal amount Series 2015B Bonds sold via direct placement to a financial institution. Although the Series 2015B Bonds were issued, they were not drawn on until July 1, 2016, as discussed below. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Series 2015A Bonds were issued to provide funds for the purpose of (i) advance refunding a portion of the outstanding 2006 Bonds in an amount of $20,655,000 to the first call date of July 1, 2016, (ii) funding certain construction projects and equipment purchases in an amount of approximately $3,824,000, and (iii) paying the costs of issuance related to the Series 2015 Bonds. The Series 2015B Bonds were structured as drawdown bonds. On July 1, 2016, the full amount available under the Series 2015B Bonds totaling $8,650,000 was drawn upon and the proceeds in combination with cash contributed by the Medical Center totaling $555,000 were used to currently refund the remaining balance of the Series 2006 Bonds totaling $9,205,000. Subsequent to year end, the Medical Center entered into a commitment letter with TD Bank, N.A. (TD Bank) to extend the tenor of the Series 2015A and Series 2015B Bonds. The Series 2015A Bonds will continue to be amortized in line with the existing schedule, with a final maturity of July 1, 2040, subject to a mandatory tender seven years from the date of closing on the new commitment. The interest rate will be a 7-year fixed rate equal to TD Bank's 7/17 Open Cost of Funds (COF) rate plus 0.65%, multiplied by 81.5%. The Series 2015B Bonds will continue to be amortized in line with the existing schedule, with a final maturity of July 1, 2036, subject to a mandatory tender seven years from the date of closing on the new commitment. The interest rate will be a variable rate equal to the Term SOFR rate plus 1.35%, multiplied by 81.5%, adjusted monthly.

On September 1, 2017, the Authority issued $61,115,000 of Revenue Bonds, Catholic Medical Center Issue, Series 2017. The Series 2017 Bonds were issued to fund various construction projects and equipment purchases, as well as pay certain costs of issuance related to the Series 2017 Bonds. Under the terms of the loan agreements, the Medical Center has granted the Authority a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment.

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

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

Construction Loans

On July 1, 2019, the Medical Center established a nonrevolving line of credit up to $10,000,000 with a bank in order to fund the expansion of the Medical Center. The line of credit bore interest at the LIBOR lending rate plus 0.75%. Advances from the line of credit were available through July 1, 2021, at which time the then outstanding line of credit balance automatically converted to a term loan. Upon conversion, the Medical Center began making monthly payments of principal and interest, assuming a 30-year level monthly principal and interest payment schedule, with a final maturity of July 1, 2029. The bank computed the schedule of principal payments based on the interest rate applicable on the conversion date (0.85%). Payments of interest only were due on a monthly basis until the conversion date. The Medical Center has pledged gross receipts as collateral. As of September 30, 2022 and 2021, the balance outstanding under the converted term loan is $9,656,857 and $9,951,192, respectively.

On March 20, 2020, the Medical Center established a second nonrevolving line of credit up to $10,000,000 with a bank in order to further fund certain costs related to the expansion of the Medical Center. The line of credit bears interest at the LIBOR lending rate plus 0.75% (3.31% at September 30, 2022). Advances from the line of credit were available through March 20, 2022, at which time the then outstanding line of credit balance will automatically convert to a term loan. During 2022, the conversion date was extended through December 31, 2022. Upon conversion, the Medical Center began making monthly payments of principal and interest, assuming a 30-year level monthly principal and interest payment schedule, with a final maturity of March 20, 2030. The bank shall compute the schedule of principal payments based on the interest rate applicable on the conversion date. Payments of interest only are due on a monthly basis until the conversion date. The Medical Center has pledged gross receipts as collateral. As of September 30, 2022 and 2021, the Medical Center has drawn $8,874,306 and $2,615,476, respectively, on this line of credit. In December 2022, the outstanding balance of the line of credit at the date of conversion totaling $9,207,005 was converted to a term loan with an interest rate of 5.12%.

Term Loan

On August 21, 2020, the Medical Center entered into a term loan with TD Bank totaling $35,000,000 with the proceeds to be used for general working capital and liquidity purposes, as well as to pay the costs of issuance related to the term loan. Interest is fixed at 2.11%, and payments of interest only are due on a monthly basis through August 21, 2023, at which time the full principal amount outstanding is due, along with any accrued and unpaid interest. The Medical Center has pledged gross receipts as collateral, and the term loan is further secured by a mortgage until such time the aforementioned Authority bonds are no longer outstanding.

Subsequent to year end, the Medical Center entered into a commitment letter with TD Bank to extend the tenor of the term loan. The new term is a 7-year term with amortization based on a 20-year schedule, with a final maturity in 2030. The interest rate is a fixed rate equal to the bank's 7-year COF rate, plus 0.95%.

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

The aggregate principal payments due on the revenue bonds, capital lease obligations and other debt obligations for each of the five years ending September 30 and thereafter are as follows (including the term extensions provided by the TD Bank commitment letter received subsequent to year end, as previously discussed):

2023	$ 4,178,597
2024	5,465,826
2025	5,764,360
2026	5,969,709
2027	6,183,725
Thereafter	130,826,927
	$158,389,144

Interest paid by the Medical Center totaled $4,925,200 for the year ended September 30, 2022 and $4,977,828 (including capitalized interest of $53,202) for the year ended September 30, 2021.

The fair value of the Medical Center's long-term debt is estimated using discounted cash flow analysis, based on the Medical Center's current incremental borrowing rate for similar types of borrowing arrangements. The fair value of the Medical Center's long-term debt, excluding capitalized lease obligations, was approximately $154,500,000 and $168,100,000 at September 30, 2022 and 2021, respectively.

On March 27, 2018, the MOB LLC (a subsidiary of Alliance Enterprises, Inc., which is a subsidiary of the System) refinanced an existing note payable to a term loan totaling $8,130,000. Principal payments of $19,500 are due in monthly installments beginning May 1, 2018, continuing until March 27, 2028, at which time the remaining unpaid principal and interest shall be due in full. During 2021, the fixed interest rate on this note payable was modified to a fixed rate of 4.52%. All other payment terms remained the same. Under the terms of the loan agreement, the Medical Center and MOB LLC (the Obligated Group) has granted the bank a first collateralized interest in all gross receipts and a mortgage lien on existing and future property, plant and equipment. The Medical Center and the System also guarantee the note payable.

Debt Covenants

In conjunction with the revenue bonds, construction loans and term loan outlined above, the Medical Center is required to maintain a minimum debt service coverage ratio of 1.20 and a cash to debt requirement of 0.60. The Medical Center, as well as the Obligated Group for the MOB LLC note payable, was in compliance with all required debt covenants as of September 30, 2022 and 2021. Subsequent to year end, in conjunction with the TD Bank commitment letter previously discussed for the Series 2015A and Series 2015B Bonds and the term loan, certain debt covenants were modified.

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

Derivatives

The Medical Center uses derivative financial instruments principally to manage interest rate risk. In January 2016, the Medical Center entered into an interest rate swap agreement with an initial notional amount of $8,650,000 in connection with its Series 2015B Bond issuance. The swap agreement hedges the Medical Center's interest exposure by effectively converting interest payments from variable rates to a fixed rate. The swap agreement is designated as a cash flow hedge of the underlying variable rate interest payments, and changes in the fair value of the swap agreement are reported as a change in net assets without donor restrictions. Under this agreement, the Medical Center pays a fixed rate equal to 1.482%, and receives a variable rate of 69.75% of the one-month LIBOR rate (1.79% at September 30, 2022). Payments under the swap agreement began August 1, 2016 and the agreement will terminate August 1, 2025.

The fair value of the Medical Center's interest rate swap agreement amounted to an asset (liability) of $263,468 and $(277,022) as of September 30, 2022 and 2021, respectively, which amount has been recorded within intangible assets and other and accrued pension and other liabilities in the accompanying balance sheets, respectively. The change in the fair value of this derivative of $540,490 and $204,639, respectively, has been included within the statements of changes in net assets as a change in net assets without donor restrictions for the years ended September 30, 2022 and 2021. Subsequent to year end, and in connection with the new TD Bank commitment letter on the Series 2015B Bonds discussed above, the interest rate on the above swap agreement was converted from LIBOR to SOFR. Further, the Medical Center was provided with the option to extend the swap agreement maturity to match the new tenor of the Series 2015B Bonds. At the date of these financial statements, management of the Medical Center had not exercised this option.

7. Operating Leases

The Medical Center has various noncancelable agreements to lease various pieces of medical equipment. The Medical Center also has noncancelable leases for office space and its physician practices. Certain real estate leases are with related parties. Total rent expense paid to related parties for the years ended September 30, 2022 and 2021 was $2,829,428 and $2,781,321, respectively. Rental expense under all leases for the years ended September 30, 2022 and 2021 was $6,149,210 and $5,945,116, respectively.

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

2023	$ 5,794,745
2024	2,791,662
2025	2,491,084
2026	1,596,170
2027	718,943
Thereafter	561,132
	$13,953,736

8. Investments and Assets Whose Use is Limited

Short-term investments and assets whose use is limited (including pledges receivable) are comprised of the following at September 30:

	2022		2021	
	Fair Value	Cost	Fair Value	Cost
Cash and cash equivalents	$ 26,595,538	$ 26,595,538	$ 21,976,516	$ 21,976,516
U.S. federal treasury obligations	2,476,435	2,595,002	2,907,898	2,888,132
Marketable equity securities	91,014,461	100,355,056	112,087,037	99,183,893
Fixed income securities	36,483,285	40,848,321	41,022,868	40,695,230
Private investment funds	7,179,211	4,527,110	9,828,460	4,549,812
Pledges receivable	1,829,416	1,829,416	6,791,741	6,791,741
	$165,578,346	$176,750,443	$194,614,520	$176,085,324

Pledges receivable are due as follows at September 30:

	2022	2021
In one year or less (included in other current assets)	$ 986,045	$5,675,605
Between one and five years	860,179	1,161,246
	1,846,224	6,836,851
Less unamortized discount	(16,808)	(45,110)
	$1,829,416	$6,791,741

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

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

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

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

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

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

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

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

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

In determining the appropriate levels, the Medical Center performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2022 and 2021.

The following are descriptions of the valuation methodologies used:

U.S. Federal Treasury Obligations and Fixed Income Securities

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

Marketable Equity Securities

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

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

Private Investment Funds

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

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

Fair Value on a Recurring Basis

The following table presents information about the Medical Center's assets and liabilities measured at fair value on a recurring basis based upon the lowest level of significant input to the valuations at September 30, 2022:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 26,595,538	$ –	$ –	$ 26,595,538
U.S. federal treasury obligations	2,476,435	–	–	2,476,435
Marketable equity securities	91,014,461	–	–	91,014,461
Fixed income securities	36,483,285	–	–	36,483,285
	$156,569,719	$ –	$ –	156,569,719
Investments measured at net asset value:				
Private investment funds				7,179,211
Total investments at fair value				163,748,930
Interest rate swap agreement	$ –	$ –	$263,468	263,468
Total assets at fair value				$164,012,398

Total investments, excluding pledges receivable, net, included the following as of September 30, 2022:

Short term investments	$ 3,603,910
Assets whose use is limited	160,145,020
	$163,748,930

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

The following table presents information about the Medical Center's assets and liabilities measured at fair value on a recurring basis based upon the lowest level of significant input to the valuations at September 30, 2021:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 21,976,516	$ –	$ –	$ 21,976,516
U.S. federal treasury obligations	2,907,898	–	–	2,907,898
Marketable equity securities	112,087,037	–	–	112,087,037
Fixed income securities	41,022,868	–	–	41,022,868
	$177,994,319	$ –	$ –	177,994,319
Investments measured at net asset value:				
Private investment funds				9,828,460
Total investments at fair value				$187,822,779
Liabilities				
Interest rate swap agreement	$ –	$ –	$277,022	$ 277,022

Total investments, excluding pledges receivable, net, included the following as of September 30, 2021:

Short-term investments	$ 3,582,157
Assets whose use is limited	184,240,622
	$187,822,779

There were no significant purchases, issues or transfers into or out of Level 3 for the years ended September 30, 2022 or 2021.

Net Asset Value Per Share

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

Category	Fair Value	Unfunded Commitments	Redemption Frequency	Notice Period
2022				
Private investment funds	$ 7,179,211	$ –	Monthly	5 day notice
2021				
Private investment funds	$ 9,828,460	$ –	Monthly	5 day notice

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

Investment Strategies

U.S. Federal Treasury Obligations and Fixed Income Securities

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

Marketable Equity Securities

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

Private Investment Funds

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

Fair Value of Other Financial Instruments

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

9. Retirement Benefits

As previously discussed in Note 2, the Plan provides retirement benefits for certain employees of an affiliated organization. The disclosure below provides information for the Plan as a whole. A reconciliation of the changes in the Catholic Medical Center Pension Plan and the Medical Center's Supplemental Executive Retirement Plan projected benefit obligations and the fair value of assets for the years ended September 30, 2022 and 2021, and a statement of funded status of the plans for both years are as follows:

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2022	2021	2022	2021
Changes in benefit obligations:				
Projected benefit obligations at beginning of year	$ (333,300,327)	$ (351,365,307)	$(3,404,278)	$ (4,046,357)
Service cost	(1,600,000)	(1,500,000)	–	–
Interest cost	(9,442,623)	(8,807,235)	(69,258)	(67,304)
Benefits paid	10,516,182	10,561,754	248,345	406,705
Actuarial gain	81,777,574	16,230,510	928,082	302,678
Expenses paid	1,708,691	1,579,951	–	–
Projected benefit obligations at end of year	(250,340,503)	(333,300,327)	(2,297,109)	(3,404,278)
Changes in plan assets:				
Fair value of plan assets at beginning of year	230,969,065	193,634,925	–	–
Actual (loss) return on plan assets	(40,221,086)	40,943,728	–	–
Employer contributions	5,782,460	8,532,117	248,345	406,705
Benefits paid	(10,516,182)	(10,561,754)	(248,345)	(406,705)
Expenses paid	(1,708,691)	(1,579,951)	–	–
Fair value of plan assets at end of year	184,305,566	230,969,065	–	–
Funded status of plan at September 30	$ (66,034,937)	$ (102,331,262)	$(2,297,109	$ (3,404,278)
Amounts recognized in the balance sheets consist of:				
Current liability	$ –	$ –	$ (278,033)	(331,563)
Noncurrent liability	(66,034,937)	(102,331,262)	(2,019,076)	(3,072,715)
	$ (66,034,937)	$ (102,331,262)	$ (2,297,109)	$ (3,404,278)

The current portion of accrued pension costs included in the above amounts for the Medical Center amounted to $278,033 and $331,563 at September 30, 2022 and 2021, respectively, and has been included in accounts payable and accrued expenses in the accompanying balance sheets.

9. Retirement Benefits (Continued)

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

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2022	2021	2022	2021
Amounts recognized in the balance sheets – total plan:				
Net assets without donor restrictions:				
Net loss	$(101,879,882)	$(135,195,854)	$(758,834)	$(1,814,229)
Net amount recognized	$(101,879,882)	$(135,195,854)	$(758,834)	$(1,814,229)

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

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2022	2021	2022	2021
Service cost	$ 1,600,000	$ 1,500,000	$ –	$ –
Interest cost	9,442,623	8,807,235	69,258	67,304
Expected return on plan assets	(13,219,077)	(13,523,452)	–	–
Amortization of actuarial loss	4,980,228	5,408,409	127,763	166,900
Net periodic pension cost	$ 2,803,774	$ 2,192,192	$197,021	$ 234,204

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

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2022	2021	2022	2021
Net (gain) loss	$(28,342,395)	$(43,650,786)	$ (928,082)	$(302,678)
Amortization of actuarial loss	(4,980,228)	(5,408,409)	(127,763)	(166,900)
Net amount recognized	$(33,322,623)	$(49,059,195)	$(1,055,845)	$(469,578)

9. Retirement Benefits (Continued)

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

	Target Allocation		Catholic Medical Center Pension Plan	
	2022	2021	2022	2021
Cash and cash equivalents	0.0%	0.0%	2.3%	1.3%
Equity securities	70.0	70.0	61.8	66.4
Fixed income securities	20.0	20.0	30.5	26.4
Other	10.0	10.0	5.4	5.9
	100.0%	100.0%	100.0%	100.0%

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

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

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2022	2021	2022	2021
Discount rate	5.39%	2.81%	5.18%	2.13%
Rate of compensation increase	N/A	N/A	N/A	N/A

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

	Catholic Medical Center Pension Plan		Pre-1987 Supplemental Executive Retirement Plan	
	2022	2021	2022	2021
Discount rate	2.81%	2.57%	2.13%	1.77%
Rate of compensation increase	N/A	N/A	N/A	N/A
Expected long-term return on plan assets	6.30%	6.90%	N/A	N/A

The Medical Center does not expect to make any significant employer contributions to the Catholic Medical Center Pension Plan or Pre-1987 Supplemental Executive Retirement Plan for the fiscal year ending September 30, 2023.

9. Retirement Benefits (Continued)

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

	Catholic Medical Center Pension Plan	Pre-1987 Supplemental Executive Retirement Plan
2023	$11,832,493	$ 285,143
2024	12,624,595	274,285
2025	13,553,384	262,535
2026	14,235,877	249,926
2027	15,049,976	236,506
2028 - 2032	83,857,865	959,866

The Medical Center contributed $5,782,460 and $248,345 to the Catholic Medical Center Pension Plan and the Pre-1987 Supplemental Executive Retirement Plan, respectively, for the year ended September 30, 2022. The Medical Center contributed $8,532,117 and $406,705 to the Catholic Medical Center Pension Plan and the Pre-1987 Supplemental Executive Retirement Plan, respectively, for the year ended September 30, 2021. The Medical Center plans to make any necessary contributions during the upcoming fiscal 2023 year to ensure the plans continue to be adequately funded given the current market conditions.

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

	Level 1	Level 2	Level 3	Total
2022				
Cash and cash equivalents	$ 4,311,338	$ –	$ –	$ 4,311,338
Marketable equity securities	113,967,344	–	–	113,967,344
Fixed income securities	56,116,026	–	–	56,116,026
	$174,394,708	$ –	$ –	174,394,708
Investments measured at net asset value:				
Private investment funds				9,910,858
Total investments at fair value				$184,305,566

9. Retirement Benefits (Continued)

	Level 1	Level 2	Level 3	Total
2021				
Cash and cash equivalents	$ 3,212,324	$ –	$ –	$ 3,212,324
Marketable equity securities	153,263,129	–	–	153,263,129
Fixed income securities	60,911,412	–	–	60,911,412
	$217,386,865	$ –	$ –	217,386,865
Investments measured at net asset value:				
Private investment funds				13,582,200
Total investments at fair value				$230,969,065

10. Related Party Transactions

During 2022 and 2021, the Medical Center made and received transfers of net assets (to) from affiliated organizations as follows:

	2022	2021
Alliance Health Services	$ (5,770,000)	$ (5,960,000)
Physician Practice Associates	(44,318,093)	(44,732,000)
Alliance Ambulatory Service	2,100,000	4,064,000
Alliance Resources	1,000,000	–
Alliance Enterprises	2,200,000	–
NH Medical Laboratory	–	(612,399)
	$ (44,788,093)	$ (47,240,399)

The Medical Center entered into various other transactions with the aforementioned related organizations. The net effect of these transactions was an amount due to affiliates of $1,234,110 and $715,592 at September 30, 2022 and 2021, respectively. See Note 7 for related party leasing activity.

The Medical Center has engaged in various transactions with GraniteOne, HH and MCH. The Medical Center recognized approximately $3.0 million and $3.1 million in revenue from these related parties for the years ended September 30, 2022 and 2021, respectively, which is reflected within other revenues in the accompanying statements of operations. The Medical Center also incurred expenses to these related parties of approximately $1.9 million and $6.5 million for the years ended September 30, 2022 and 2021, respectively, of which $300,000 and $600,000, respectively, is reflected within operating expenses. Additionally, approximately $1.6 million and $5.9 million for the years ended September 30, 2022 and 2021, respectively, is reflected within nonoperating (losses) gains in the accompanying statements of operations. As of September 30, 2022, the Medical Center had a net amount due from these related parties of approximately $2.0 million, which is reflected within other current assets in the accompanying 2022 balance sheet. As of September 30, 2021, the Medical Center had a net amount due from these related parties of approximately $1.3 million, of which $1.8 million is reflected within other current assets and $500,000 is reflected within accounts payable and accrued expenses in the accompanying 2021 balance sheet. See also Note 1.

11. Functional Expenses

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

	Healthcare Services	General and Administrative	Total
2022			
Salaries, wages and fringe benefits	$225,148,988	$38,990,425	$264,139,413
Supplies and other	153,048,709	33,501,325	186,550,034
New Hampshire Medicaid enhancement tax	22,288,821	–	22,288,821
Depreciation and amortization	7,122,924	5,212,484	12,335,408
Interest	4,028,867	754,279	4,783,146
	$411,638,309	$78,458,513	$490,096,822
2021			
Salaries, wages and fringe benefits	$183,398,285	$35,509,892	$218,908,177
Supplies and other	151,124,424	32,677,200	183,801,624
New Hampshire Medicaid enhancement tax	19,248,461	–	19,248,461
Depreciation and amortization	7,038,102	5,029,283	12,067,385
Interest	3,873,112	785,942	4,659,054
	$364,682,384	$74,002,317	$438,684,701

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

12. Concentration of Credit Risk

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

	2022	2021
Medicare	40%	39%
Medicaid	13	14
Commercial insurance and other	20	22
Patients (self pay)	8	7
Anthem Blue Cross	19	18
	100%	100%

13. Endowments and Net Assets With Donor Restrictions

Endowments

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

Endowment net assets consist of the following at September 30:

	Without Donor Restrictions	With Donor Restrictions	Total
2022			
Board-designated endowment funds	$111,045,914	$ –	$111,045,914
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	9,476,635	9,476,635
Accumulated investment gains	–	602,774	602,774
Total endowment net assets	$111,045,914	$10,079,409	$121,125,323

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

	Without Donor Restrictions	With Donor Restrictions	Total
2021			
Board-designated endowment funds	$132,618,999	$ –	$132,618,999
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	–	8,680,900	8,680,900
Accumulated investment gains	–	4,058,751	4,058,751
Total endowment net assets	$132,618,999	$12,739,651	$145,358,650

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

	Without Donor Restrictions	With Donor Restrictions	Total
Balance at September 30, 2020	$110,329,140	$10,683,541	$121,012,681
Investment return, net	22,219,555	1,834,839	24,054,394
Contributions	–	1,338,169	1,338,169
Appropriation for operations	–	(1,046,594)	(1,046,594)
Appropriation for capital	70,304	(70,304)	–
Balance at September 30, 2021	132,618,999	12,739,651	145,358,650
Investment loss, net	(22,068,501)	(2,239,632)	(24,308,133)
Contributions	–	795,735	795,735
Appropriation for operations	–	(720,929)	(720,929)
Appropriation for capital	495,416	(495,416)	–
Balance at September 30, 2022	$111,045,914	$10,079,409	$121,125,323

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Medical Center to retain as a fund of perpetual duration. There were no such deficiencies as of September 30, 2022 or 2021.

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

Net Assets With Donor Restrictions

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

	2022	2021
Funds subject to use or time restrictions:		
Capital acquisitions	$17,068,009	$11,143,157
Healthcare services	1,143,769	1,270,257
Indigent care	676,640	801,323
Pledges receivable	1,829,416	6,791,741
	20,717,834	20,006,478
Funds of perpetual duration	8,107,319	10,561,443
	$28,825,153	$30,567,921

14. Commitments and Contingencies

Litigation

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

Regulatory

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

Appendix A-10

CMC Healthcare System Articles of Agreement

Appendix A-11

CMC Healthcare System Bylaws, as Amended and Restated

Appendix B-1

Fitch Outlook Report dated August 2022 entitled "U.S. Not-for-Profit Hospitals Health Systems Outlook 2023"

Appendix B-2

CONFIDENTIAL Stroudwater Report

Appendix B-3

Secretary Certificate of resolutions adopted at a Meeting of the Huggins Hospital Board of Trustee on October 27, 2022

Appendix B-4

CONFIDENTIAL the “Pros and Cons” Discussion

Appendix B-5

Secretary Certificate of resolutions adopted at a Meeting of the Monadnock Community Hospital Board of Trustees on October 26, 2022

Appendix B-6

CONFIDENTIAL The Chartis Group Slides

Appendix B-7

Secretary Certificate of resolutions adopted at a Meeting of the CMC Board of Trustees on October 27, 2022

Appendix C-1

Draft Articles of Dissolution and Plan of Dissolution

DISSOLUTION OF
GRANITEONE HEALTH (the "GOH")

PROPOSED DISSOLUTION: _____ ___, 2023

DOCUMENT AGENDA

1. Proposed Resolutions for the Board of Trustees of GOH (if Board votes done by meeting, 2/3rds vote required pursuant to RSA 292:10-a, I).

2. Plan of Dissolution and Satisfaction of Debt.

3. Statement of Dissolution for filing with the New Hampshire Secretary of State (New Hampshire Secretary of State Form NP-5).

4. Letter notification to New Hampshire Charitable Trust Unit Re Dissolution (Reg.3601).

5. Final Tax Return, including Schedule N, Liquidation, Termination, Dissolution, or Significant Disposition of Assets (To be completed by CMC or its accountants post-dissolution and liquidation-Due to IRS by _____ ___, 2023 assuming a _____ ___, 2023 Dissolution).

6. Application for Registration of Trade Name of "GraniteOne Health" and Consent of Use of Name (if necessary).

PROPOSED RESOLUTIONS FOR A MEETING
OF THE BOARD OF TRUSTEES
OF
GRANITEONE HEALTH

RESOLVED: That it is in the best interests of GraniteOne Health ("GraniteOne") to dissolve as of _____ ___, 2023 in accordance with the GraniteOne's Articles of Agreement, as amended, GraniteOne's By-laws, as amended and restated from time to time, and Section 292:10-a, I of the New Hampshire Revised Statute Annotated (the "Act").

RESOLVED: To adopt and approve the Plan of Dissolution and Satisfaction of Debt attached hereto as Exhibit A (the "Plan of Dissolution") and to authorize the dissolution of GraniteOne pursuant to the Plan of Dissolution, the GraniteOne's Articles of Agreement, as amended, GraniteOne's Bylaws, as amended and restated from time to time, and Section 292:10-a of the Act.

RESOLVED: That GraniteOne is hereby authorized to pay all of its creditors prior to its dissolution in accordance with the Plan of Dissolution and to transfer all of its remaining assets, if any, to Catholic Medical Center, Huggins Hospital, and Monadnock Community Hospital (the "Affiliated Hospitals"), pursuant to the Plan of Dissolution.

RESOLVED: That to the extent that they deem such action necessary or desirable, the GraniteOne Trustees and Corporate Officers are hereby jointly and severally authorized and empower to grant any consent or waive any conditions precedent to any obligations of GraniteOne.

RESOLVED: To authorize and direct the Officers and Trustees of GraniteOne to pay all of its known debts, costs, expenses, taxes and obligations of GraniteOne, and to set aside a reserve fund in an amount estimated by the Officers of GraniteOne, if deemed necessary, to be reasonably necessary for the payment of all unascertained or contingent liabilities, costs and expenses of GraniteOne, in accordance with the Plan of Dissolution.

RESOLVED: To authorize and direct the Officers and Trustees of GraniteOne to take all appropriate and necessary action and to execute, deliver ·and where appropriate file all necessary documents to dissolve GraniteOne in accordance with the Plan of Dissolution, GraniteOne 's Articles of Agreement, as amended, GraniteOne's By-laws, as amended and restated from time to time, and the laws of the State of New Hampshire including, but not limited to, filing a Statement of Dissolution with the Secretary of State of New Hampshire.

Exhibit A

GraniteOne Health Plan of Dissolution and Satisfaction of Debt

EXHIBIT A

PLAN OF DISSOLUTION AND SATISFACTION OF DEBT OF GRANITEONE HEALTH

1. Purpose of Plan. This Plan of Dissolution and Satisfaction of Debt (this "Plan of Dissolution") is intended to be a plan of complete liquidation and dissolution of GraniteOne Health, a New Hampshire voluntary corporation (the "GraniteOne").

2. Discharge of Liabilities. Prior to any liquidating distribution, the Corporate Officers and Trustees of GraniteOne shall pay all known, ascertainable and enforceable liabilities, debts and obligations of GraniteOne, and all other known costs, expenses, and taxes (including the costs and expenses of liquidation, dissolution and distribution of the assets of GraniteOne), and shall set aside a reserve fund in an amount estimated by the Officers of GraniteOne to be reasonably necessary for the payment of all unascertained or contingent liabilities, costs and expenses of GraniteOne.

3. Complete Liquidation and Distribution. On or before _____ ___, 2023, after giving effect to Section 2 hereof, the Officers of GraniteOne shall effect and complete the liquidation of all of the assets and properties of GraniteOne. Such assets and properties shall be assigned and transferred to Catholic Medical Center, Huggins Hospital, and Monadnock Community Hospital (the "Affiliated Hospitals"), as directed and authorized by the Articles of Agreement of GraniteOne, as amended, its By-laws, as amended and restated from time to time, and the Board of Trustees of GraniteOne pursuant to this Plan of Dissolution and shall be used to operate a hospital in the Greater Manchester area, and provide health care without pecuniary gain and without distinction as to race, color, creed, sex or ability to pay. In all events, the complete liquidation and distribution of GraniteOne and all of its assets and properties shall be completed by _____ ____, 2023.

4. Dissolution. The Officers of the Corporation are authorized to execute and file with the New Hampshire Secretary of State such documents as may be deemed necessaly or appropriate to dissolve GraniteOne pursuant to the laws of the State of New Hampshire. In addition, if such Officers deem it necessary or if required by applicable law, they shall cause notice of the dissolution of GraniteOne to be mailed to each known creditor of GraniteOne, and are authorized to take such further action as they deem appropriate in order to effect such dissolution.

5. Further Action. The Officers of GraniteOne are authorized and directed to carry out the provisions of this Plan of Dissolution, and to take such further action and see to the preparation, execution and filing of such further documents and instruments, as may be necessary or appropriate to effect the purposes and transactions contemplated by this Plan of Dissolution.

PLAN OF DISSOLUTION AND SATISFACTION OF DEBT
OF
GRANITEONE HEALTH

1. Purpose of Plan. This Plan of Dissolution and Satisfaction of Debt (this "Plan of Dissolution") is intended to be a plan of complete liquidation and dissolution of GraniteOne Health, a New Hampshire voluntary corporation (the "GraniteOne").

2. Discharge of Liabilities. Prior to any liquidating distribution, the Corporate Officers and Trustees of GraniteOne shall pay all known, ascertainable and enforceable liabilities, debts and obligations of GraniteOne, and all other known costs, expenses, and taxes (including the costs and expenses of liquidation, dissolution and distribution of the assets of GraniteOne), and shall set aside a reserve fund in an amount estimated by the Officers of GraniteOne to be reasonably necessary for the payment of all unascertained or contingent liabilities, costs and expenses of GraniteOne.

3. Complete Liquidation and Distribution. On or before _____ ___, 2023, after giving effect to Section 2 hereof, the Officers of GraniteOne shall effect and complete the liquidation of all of the assets and properties of GraniteOne. Such assets and properties shall be assigned and transferred to Catholic Medical Center, Huggins Hospital, and Monadnock Community Hospital (the "Affiliated Hospitals"), as directed and authorized by the Articles of Agreement of GraniteOne, as amended, its By-laws, as amended and restated from time to time, and the Board of Trustees of GraniteOne pursuant to this Plan of Dissolution and shall be used to operate a hospital in the Greater Manchester area, and provide health care without pecuniary gain and without distinction as to race, color, creed, sex or ability to pay. In all events, the complete liquidation and distribution of GraniteOne and all of its assets and properties shall be completed by _____ ____, 2023.

4. Dissolution. The Officers of the Corporation are authorized to execute and file with the New Hampshire Secretary of State such documents as may be deemed necessaly or appropriate to dissolve GraniteOne pursuant to the laws of the State of New Hampshire. In addition, if such Officers deem it necessary or if required by applicable law, they shall cause notice of the dissolution of GraniteOne to be mailed to each known creditor of GraniteOne, and are authorized to take such further action as they deem appropriate in order to effect such dissolution.

5. Further Action. The Officers of GraniteOne are authorized and directed to carry out the provisions of this Plan of Dissolution, and to take such further action and see to the preparation, execution and filing of such further documents and instruments, as may be necessary or appropriate to effect the purposes and transactions contemplated by this Plan of Dissolution.

Print Reset

State of New Hampshire

No filing fee.
Use black print or type.

Form NP-5
RSA 292:10-a

STATEMENT OF DISSOLUTION
OF

GraniteOne Health ("GOH")
A NEW HAMPSHIRE NONPROFIT CORPORATION

We, the undersigned, being the Treasurer and a majority of the Directors (or Trustees) of the above New Hampshire nonprofit corporation, do hereby certify that:

1. At a meeting of the members or stockholders of said corporation, a UNANIMOUS vote (Note 1) of all the members or stockholders was adopted, of which the following is a true copy:
See Attached.

2. The plan for distribution of the corporation's assets and satisfaction of its obligations is as follows:
See attached Plan of Dissolution and Satisfaction of Debt.

Signed under the penalties of perjury.

	Signatures	Print or Type Names
Treasurer		Marie McKay
Director or Trustee		Rick Botnick
Director or Trustee		Joseph Graham
Director or Trustee		Matthew Albuquerque
Director or Trustee		Andy Crews
Director or Trustee		Les MacLeod
Director or Trustee		Cynthia McGuire
Director or Trustee		Maria Mongan
Director or Trustee		Marcia Ober
Director or Trustee		Jeremy Roberge
Director or Trustee		Keith Stahl, MD
Director or Trustee		Alexander J. Walker, Esq.

Note 1. A CHURCH must have a UNANIMOUS vote and must state that all members eligible to vote voted for dissolution. ALL OTHER NONPROFIT CORPORATIONS must have a TWO-THIRDS vote. (See RSA 292:10-a I and II)

DISCLAIMER: All documents filed with the Corporation Division become public records and will be available for public inspection in either tangible or electronic form.

Mailing Address - Corporation Division, NH Dept. of State, 107 N Main St, Rm 204, Concord, NH 03301-4989
Physical Location - State House Annex, 3rd Floor, Rm 317, 25 Capitol St, Concord, NH

CMC
CATHOLIC MEDICAL CENTER

_____ ___, 2023

SENT VIA EMAIL AND FIRST CLASS MAIL

Michael Haley, Assistant Attorney General
Charitable Trusts Unit
Office of the Attorney General
33 Capitol Street
Concord, New Hampshire 03301

Re: Notification of Dissolution of GraniteOne Health, Registration No. 30567

Dear Attorney Haley,

GraniteOne Health ("GOH") is a New Hampshire voluntary corporation and recognized tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. On behalf of GOH, this letter is providing you with notification that effective _____ ___, 2023, GOH will be dissolved and completely liquidated. All debts and obligations will be paid prior to its dissolution. The remaining assets, if any, will be distributed to the affiliated hospitals, Catholic Medical Center, Huggins Hospital, and Monadnock Community Hospital (the "Affiliated Hospitals"), pursuant to GOH's Articles of Agreement, as amended, in furtherance of its tax-exempt purposes. GOH has no restricted assets. A copy of the Statement of Dissolution and Plan of Dissolution and Satisfaction of Debt is enclosed for your records.

We will provide you with copies of the filed documents, as well as the final tax return when they are available.

If you have any questions or concerns, then please feel free to call me at (603) 314-7582. Thank you.

Very truly yours,

Jason E. Cole, Esq.
General Counsel & Vice President

Enclosures

Cc: Alexander J. Walker, Esq., President & CEO

State of New Hampshire

Filing fee: $50.00
Use black print or type.

Form TN-1
RSA 349

APPLICATION FOR REGISTRATION OF TRADE NAME

(PLEASE TYPE OR PRINT CLEARLY)

1. Business name: GraniteOne Health
(Name **cannot include "INC."** or other corporate designation)

2. Business address: 100 McGregor Street (No. & Street) Manchester (City / town) NH (State) 03102 (Zip)

Mailing address (if different): _____ (No. & Street) _____ (City / town) _____ (State) _____ (Zip)

3. Brief description of kind of business to be carried on (and if known, list the NAICS Code and Sub-Code): OTHER / charitable, educational, religious or scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended

4. Date business organized: _____

5-A. **BUSINESS APPLICANT:** If the applicant is a corporation or other entity, list corporation's or entity's exact name and include title of person signing. If more space is needed for additional entity applicants, please attach additional sheet(s).

Catholic Medical Center
Entity name (type or print)

100 McGregor Street
No. Street

Manchester NH 03102
Town/City State Zip

AUTHORIZED SIGNATURE

Matthew Kfoury, Secretary
Signer's name and title (type or print)

5-B. **INDIVIDUAL APPLICANTS:** Please type or print applicants' name(s), address(es) and include signature. If more space is needed for additional individual applicants, please attach additional sheet(s).

1. _____
Type or print name

_____
No. Street

SIGNATURE

_____
Town/City State Zip

2. _____
Type or print name

_____
No. Street

SIGNATURE

_____
Town/City State Zip

Business E-Mail: _____

Business Phone: (603) 663-8760

____ Please check if you would prefer to receive the Reminder Notice by email.

DISCLAIMER: All documents filed with the Corporation Division become public records and will be available for public inspection in either tangible or electronic form.

Mailing Address - Corporation Division, NH Dept. of State, 107 N Main St, Rm 204, Concord, NH 03301-4989
Physical Location - State House Annex, 3rd Floor, Rm 317, 25 Capitol St, Concord, NH

Consent to Use of Name

I, Alexander J. Walker, Jr.,Esq., being the Manager of GraniteOne Health, a voluntary corporation (the "GraniteOne"), in the name of and on behalf of GraniteOne, does hereby consent to the use of the name "GraniteOne" for the purposes of promoting _____ _____.

Dated this _____ day of _____ 2023.

GraniteOne Health

By: _____
Alexander J. Walker, Jr. , its duly authorized President & CEO

Appendix E-1

Huggins Hospital 2022 Community Needs Assessment Report

Huggins Hospital

2022

Huggins Hospital

Community Health Needs Assessment

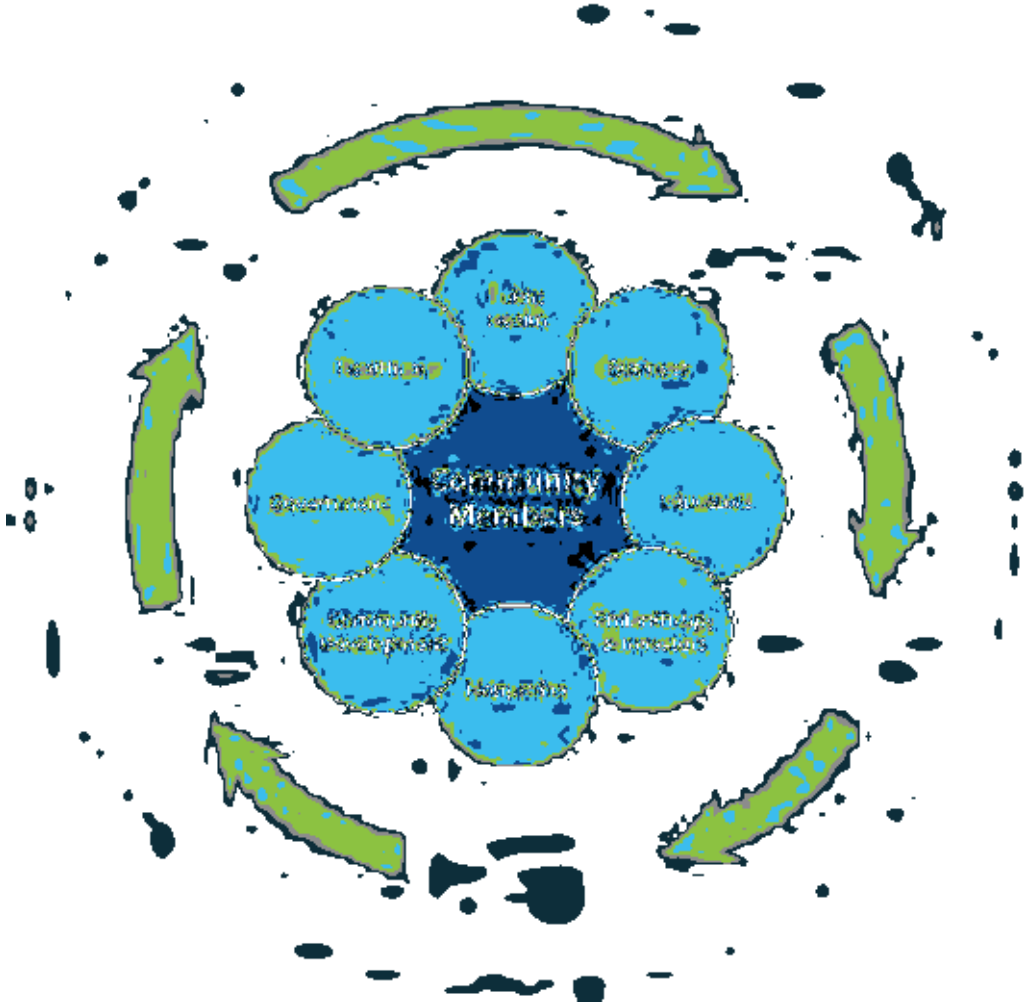
New Hampshire

Hard copies of this document may be obtained at Huggins Hospital, 240 South Main Street, Wolfeboro, NH 03894 or by phone at 603.515.2073 or via the hospital website http://www.hugginshospital.org.

Included in this Community Report

Perspective/Overview

Creating a culture of health in the community



Action Cycle Source Source: the Robert Wood Johnson Foundation's County Health Rankings website: http://www.countyhealthrankings.org/roadmaps/action-center

The Action Cycle shows how to create healthy communities. The rankings later in the document assist in understanding what makes a healthy community.

The Community Health Needs Assessment (CHNA) uses systematic, comprehensive data collection and analysis to define priorities for health improvement, creates a collaborative community environment to engage stakeholders, and an open and transparent process to listen and truly understand the health needs of the communities served by Huggins Hospital.

Huggins Hospital, as the sponsors of the assessment, engaged national leaders in community health needs assessments to assist in the project. Stratasan, a healthcare analytics and facilitation company based out of Nashville, Tennessee, provided the analysis of community health data, facilitated the focus groups, conducted the interviews and facilitated a community health survey to receive community input into the priorities and brainstorm goals and actions the community could take to improve health. This document is a hospital facility-specific Community Health Needs Assessment (CHNA) for Huggins Hospital.

- Huggins Hospital's Board of Trustees will approve and adopt this CHNA and an implementation strategy in 2022.

- Starting on September 23, 2022, this report was made widely available to the community via Huggins Hospital's website, www.hugginshospital.org, and paper copies are available free of charge at Huggins Hospital.

Participants

Twenty-nine ndividuals from nineteen organizations participated in focus groups for their input into the community's health issues. An additional 391 community members submitted input through an online survey along with over forty Huggins Hospital employees particpating in the online survey and in-person focus groups. The six-month process centered on gathering and analyzing data as well as receiving input from persons who represented the broad interests of the community to provide direction for creating a plan to improve the health of the communities.

Project Goals

1. To continue a formal and comprehensive community health assessment process which allows for the identification and prioritization of significant health needs of the community to assist with resource allocation, informed decision-making and collective action that will improve health.

2. To continue a collaborative partnership between all stakeholders in the community by seeking input from persons who represent the broad interests of the community.

3. To support the existing infrastructure and utilize resources available in the communities to instigate health improvement.

Community

Input and Collaboration

Durgin Bridge, Sandwich, NH

Data Collection and Timeline

In March 2022, Huggins Hospital began a Community Health Needs Assessment for Carroll County and other communities served by Huggins Hospital, seeking input from persons who represent the broad interests of the community using several methods:

- Information gathering, using secondary public health sources, occurring in April and May 2022.
- Twenty-nine community members participated in focus groups for their perspectives on community health needs on April 12, 2022.
- Community members also participated in a survey to share their perspectives on community health needs from June 20 - August 15, 2022.

Information Gaps

While this assessment was quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all the community's health needs.

Participation by those representing the broad interests of the community

Participation in the focus groups and creating the Community Health Needs Assessment and Implementation Plan:

Organization	Population Represented (kids, low income, minorities, those w/o access)
Alton Family Medicine	All
Carroll County Coalition for Public Health	All
Eastern Lakes Region Housing Coalition	Low income
Wentworth Economic Development Corporation	Business, nonprofits, etc.
Food Pantry	Community
Governor Wentworth School District	Lower elementary pre-6 and families
Granite Visiting Nurse Association	Children, older adults
Huggins Hospital	All
Kingswood High School	All
Kingswood Middle School	All
Northern Human Services	All (mental health)
SeniorLink	Aging adults, individuals with disabilities
Starting Point	All
TriCounty Community Action Program	Social services
White Horse Recovery	Substance use disorder, mental health
Wolfeboro Family Medicine	All
Wolfeboro Fire-Rescue	First responders
Wolfeboro Pediatrics	Children
Wolfeboro Women's Health	Women

In many cases, several representatives from each organization participated.

Input of Public Health Officials

Carroll County Coalition for Public Health (C3PH) participated in the focus groups for this Community Health Needs Assessment process and our ongoing partners with Huggins Hospital in community health improvement. C3PH is a member of the Huggins Community Health Network Board and will be working with Huggins Hospital and the Network members to develop collaborative efforts toward the Community Health Needs Assessment's Implementation Plan.

Input of Medically Underserved, Low-Income, and Minority Populations

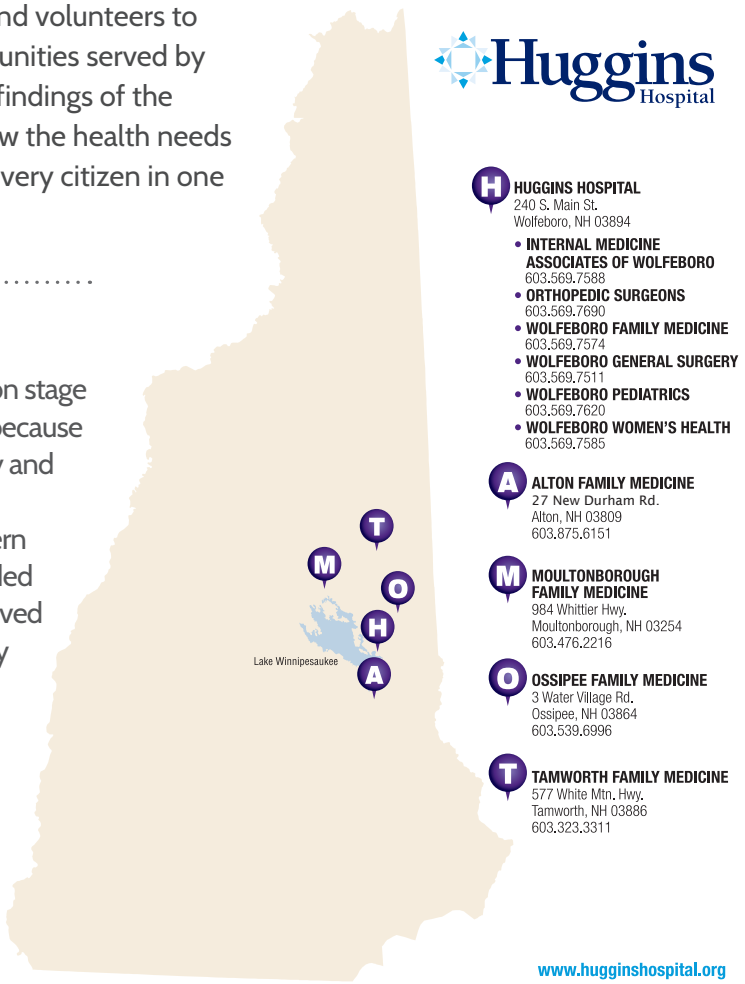
Input of medically underserved, low-income and minority populations was received during the focus groups and surveys. Agencies representing these population groups were intentionally invited to the focus groups.

Community Engagement and Transparency

Many members of the community participated in the focus groups. We are pleased to share the results of the Community Health Needs Assessment with the rest of the community in hopes of attracting more advocates and volunteers to improve the health of Carroll County and the communities served by Huggins Hospital. The following pages highlight key findings of the assessment. We hope you will take the time to review the health needs of our community as the findings impact each and every citizen in one way or another.

Huggins Hospital Study Area

Carroll County was the focus of the health data collection stage of the Community Health Needs Assessment process because many health rankings reports are determined by county and the majority of patients served by Huggins Hospital live within Carroll County. Northeastern Belknap and northern Strafford county community members were also included in collection of data through surveys as they are also served by Huggins Hospital. The community includes medically underserved, low-income and minority populations. All patients were used to determine the service area without regard to insurance coverage or eligibility for financial assistance under Huggins Hospital's Financial Assistance Policy.



Key Findings

Community Health Assessment

Most Significant Community Health Needs

The following needs were defined during the 2022 Community Health Needs Assessment process, including the community survey, focus groups and secondary data. We have also included the needs defined in the 2019 process. The following pages display the data collected and the processes and methods used to complete the Community Health Needs Assessment.

Needs identified by Focus Groups:

- Mental Health care
- Access to care
- Social Determinants of Health (housing, financial insecurities)
- Pandemic effects (isolation, exacerbated health issues)
- Addiction treatment & prevention
- More healthcare workers

Needs identified by Community Survey:

- Access to care
- Mental Health care
- Access to health insurance
- Addiction treatment services
- Exercise opportunities
- Chronic disease care

Areas for improvement identified by Secondary Data:

- Cancer incidence and deaths
- Accidental (injury) deaths
- Suicide
- Mental health (care and access)
- Access (insurance and care)

The most significant health needs identified in the 2019 Community Health Needs Assessment process were:

1. Access to Care - Specialty Care
2. Access to Care - Primary Care
3. Access to Care - Mental Health Services
4. Social Determinants of Health Improvement

The top three needs identified in the 2019 process included access to care (including affordability), addiction treatment and prevention services, mental health services.

Process and Methods

Both primary and secondary data sources were used in the CHNA.

Primary methods included:

- Community Focus Groups
- Community Survey

Secondary methods included:

- Public Health Data – death statistics, County Health Rankings, cancer incidence
- Demographics and Socioeconomics – population, poverty, uninsured, unemployment
- Psychographics - behavior measured by spending and media preferences

Demographics of the Community

The table below shows the demographic summary of Carroll County compared to New Hampshire and the U.S.

	Carroll County	New Hampshire	USA
Population	50,466	1,399,122	333,934,112
Median Age	52.5	43.4	38.8
Median Household Income	$67,320	$77,879	$64,730
Annual Pop. Growth (2021-2026)	0.38%	0.54%	0.71%
Household Population	22,560	557,262	126,470,675
Dominant Tapestry	Rural Resort Dwellers (6E)	The Great Outdoors (6C)	Green Acres (6A)
Businesses	3,088	67,388	12,013,469
Employees	28,645	771,036	150,287,786
Health Care Index*	103	112	100
Average Health Expenditures	$6,438	$6,960	$6,237
Total Health Expenditures	$145.2 M	$3.9 B	$788.8 B
Racial and Ethnic Make-up			
White	97%	91%	69%
Black	1%	2%	13%
American Indian	0%	0%	1%
Asian/Pacific Islander	1%	3%	6%
Other	0%	1%	7%
Mixed Race	1%	2%	4%
Hispanic Origin	2%	4%	19%

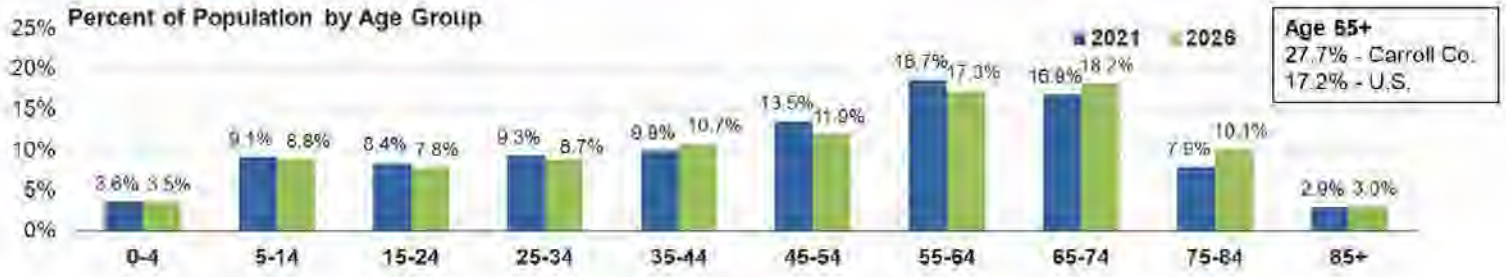
Source: ESRI

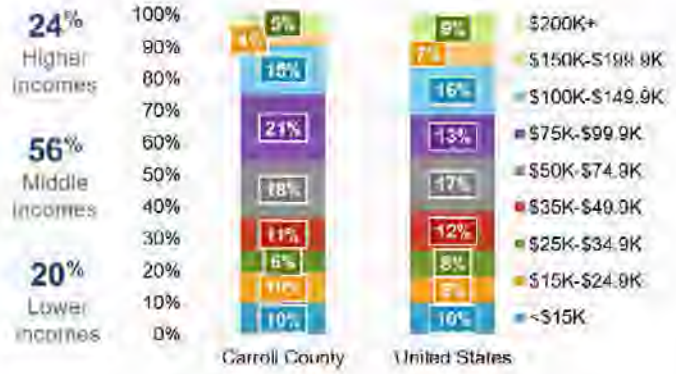
**The Health Care Index is household-based, and represents the amount spent out of pocket for medical services and insurance relative to a national index of 100.*

The median is the value at the midpoint of a frequency. There is an equal probability of falling above or below the line.

Demographics, cont.

Carroll County





Source: ESRI

- The population of Carroll County is projected to increase from 2021 to 2026 (0.38% per year). New Hampshire is projected to increase 0.54% per year. The U.S. is projected to increase 0.71% per year.
- Carroll County had a higher median age (52.5 median age) than NH (43.4) and the U.S. (38.8). In Carroll County the percentage of the population 65 and over was 27.7%, higher than the U.S. population 65 and over at 17.2%.
- Carroll County median household income at $67,320 was lower than NH ($77,879), but higher than the U.S. ($64,730). The rate of poverty in Carroll County was 7.5% which was higher than NH (7.0%) but lower than the U.S. (11.9%).
- The household income distribution of Carroll County was 24% higher income (over $100,000), 56% middle income, and 20% lower income (under $25,000).
- The health care index measures how much the populations spent out-of-pocket on health care services including insurance premiums. The U.S. index was 100. Carroll County was 103, indicating 3% more spent out of pocket than the average U.S. household on medical care (doctor's office visits, prescriptions, hospital visits) and insurance premiums.
- The racial and ethnic make-up of Carroll County was 97% White, 1% Black, 2% Hispanic Origin, 1% mixed race, and 1% Asian/Pacific Islander. *(These percentages total to over 100% because Hispanic is an ethnicity, not a race.)*

2021 Population by Census Tract and Change (2021-2026)

Census tracts generally have a population size between 1,200 and 8,000 people, with an optimum size of 4,000 people.

The census tracts in Fryeburg and the Town of Wolfeboro have the majority of the population in the county.

Carroll County's population was projected to increase from 2021 to 2026, 0.28% per year. The majority of the census tracts in the southern part of Carroll County are projected to grow about twice as quickly as those in northern Carroll County. One decreasing census tract to note is that of the Town of Bartlett at -0.17%.

Source: Esri

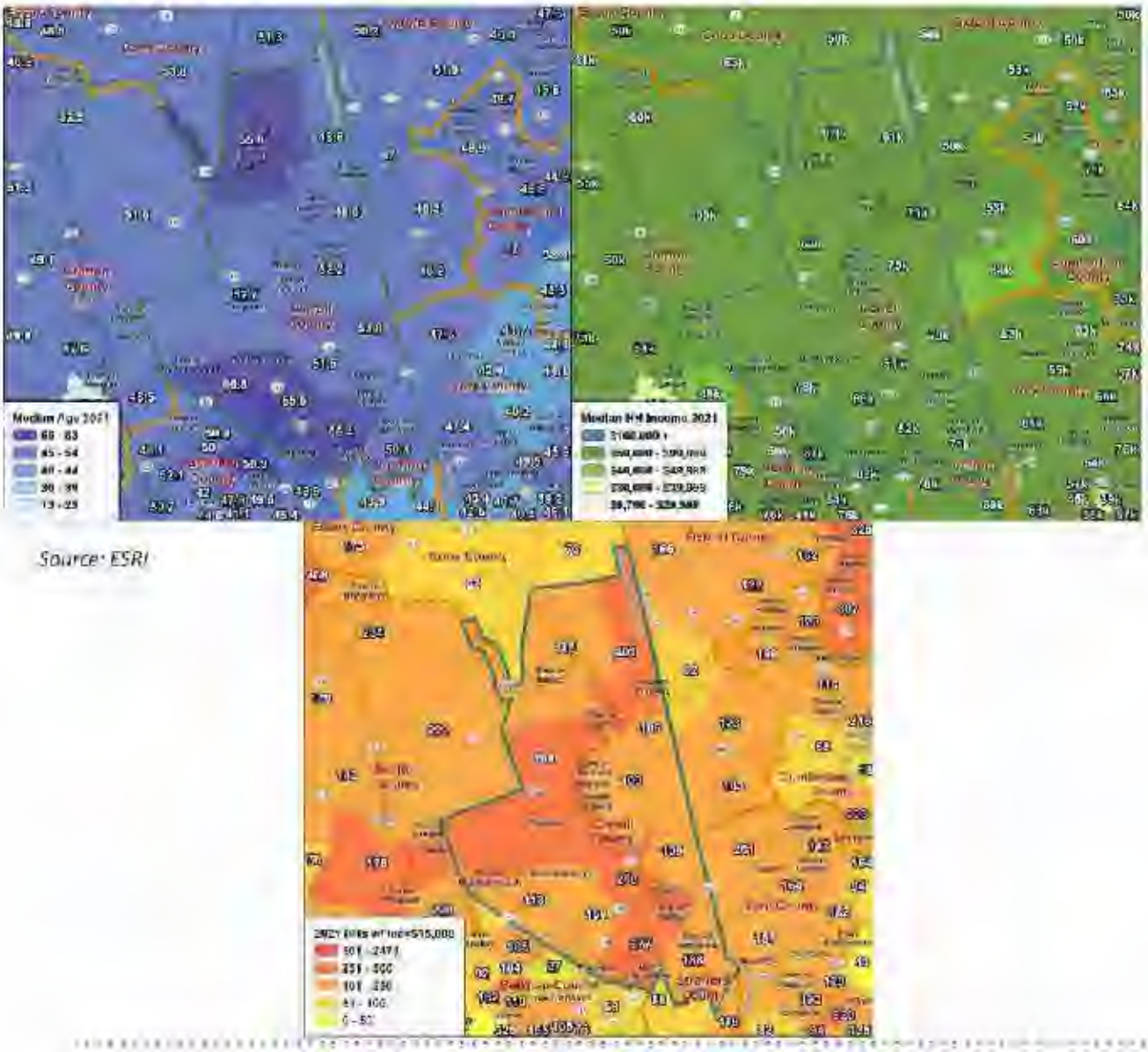
Business Profile

Carroll County, New Hampshire

65.4% percent of employees in Carroll County were employed in:

- Accommodation & food services (25.4%)
- Retail trade (15.9%)
- Health care and social assistance (9.8%)
- Educational services (7.7%)
- Public Administration (6.6%)

2021 Median Age & Income



The top two maps depict median age and median income by census tract. Looking at age and income by census track is helpful to demonstrate all areas of a county are not the same. The health needs may be different in the census tracts with a lower median age than those with a higher median age.

Looking at median household income by census tract also gives insight into health status. The lower income areas may require more assistance than the higher income tracts. The lowest income census tract was in Ossipee, with $51K median in household incomes.

The lower map is the number of households making less than $15,000 per year.

Demographics, cont.

Carroll County's 2020 poverty percentage was 7.5% compared to New Hampshire at 7% and the U.S. at 11.9%. The cost of living in Carroll County is lower than NH and the U.S.

Cost of Living

	Carroll County	New Hampshire	USA
Overall	101.6	105.4	100
Grocery	109.6	107	100
Housing	110.2	118.6	100
Median Home Cost	$366,000	$357,000	$291,700
Utilities	122.3	120.5	100
Transportation	79.4	87.6	100
Miscellaneous	103.3	104.3	100

100 index = National Average

https://www.bestplaces.net/cost_of_living/county/New Hampshire/Carroll

The total of all the cost-of-living categories weighted subjectively as follows: housing (30%), food and groceries (15%), transportation (10%), utilities (6%), health care (7%), and miscellaneous expenses such as clothing, services, and entertainment (32%). State and local taxes are not included in any category. The overall index for transportation costs, including gasoline, commuting, and auto insurance

Health Status

The Health of the Community - Secondary Data

Health Status Data

When analyzing the health status data, local results were compared to New Hampshire, the U.S. (where available), and the top 10% of counties in the U.S. (the 90th percentile). Where Carroll County's results were worse than NH and U.S., groups and individuals have an opportunity to act and improve these community measures. To become the healthiest community in New Hampshire and eventually the nation, Carroll County must close several lifestyle gaps. For additional perspective, New Hampshire was ranked the 1sthealthiest state out of the 50 states. (Source: 2019 America's Health Rankings; lower is better) New Hampshire strengths were low prevalence of non-medical drug use, low percentage of households with food insecurity, and low teen birth rate. New Hampshire challenges were high prevalence of excessive drinking, high prevalence of frequent physical distress, and low percentage of fluoridated water.

Comparisons Health Status Data

Information from County Health Rankings and America's Health Rankings was analyzed in the CHNA in addition to the previously reviewed sociodemographic information and other public health data. Other data analyzed is referenced in the bullets below, such as: causes of death, demographics, socioeconomics, consumer health spending, and interviews. If a measure was better than New Hampshire, it was identified as a strength, and where an indicator was worse than New Hampshire, it was indicated an opportunity for improvement. To prevent strengths from becoming opportunities for improvement, it's important to continually focus on them. Opportunities were denoted with red octagons, and strengths were denoted with green stars for easy interpretation. The years displayed on the County Health Rankings graphs show the year the data was released. The actual years of the data are contained in the source notes below the graphs.

Comparisons of Health Status

In most of the following graphs, Carroll County will be blue, New Hampshire (NH) will be red, U.S. grey and the 90th percentile of counties in the U.S. gold.

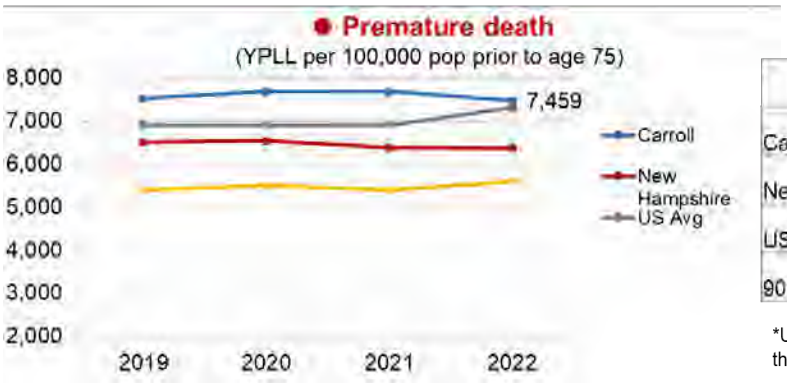
Health Outcomes (Length of Life and Quality of Life)

Health Outcomes are a combination of length of life and quality of life measures. Carroll County ranked 6th in health outcomes out of 10 New Hampshire counties.

Length of Life

Length of life was measured by years of potential life lost per 100,000 population prior to age 75, lower is better. For example, a 25-year-old is killed in an accident, equates to 50 years of potential life lost prior to age 75. Carroll County ranked 8th in length of life in NH. Carroll County lost 7,459 years of potential life per 100,000 population which was higher than both NH and the U.S.

Carroll County residents can expect to live 1.2 years longer than the average U.S. resident.



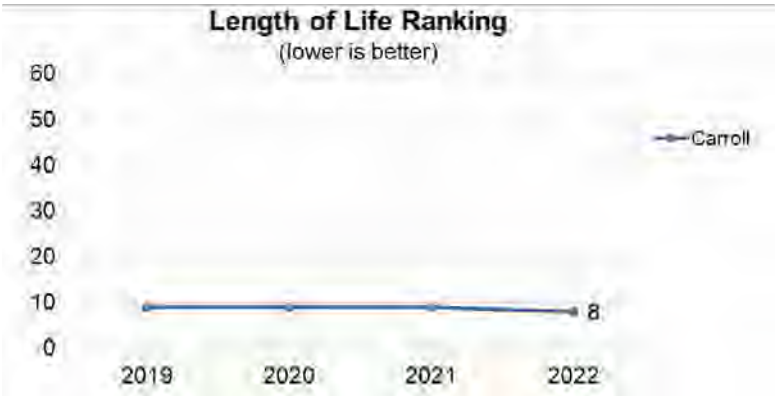
★ Life Expectancy

(Average number of years a person can expect to live)

	2022
Carroll County	79.7
New Hampshire	79.6
US Avg*	78.5
90th Percentile	80.6

Carroll County	2022
American Indian & Alaska Native	NR
Asian	NR
Black	NR
Hispanic	NR
White	NR

*US is 2019 data; due to Covid and impacts of Covid, life expectancy in the US decreased 1.87 years in 2020.



Source: Premature death and life expectancy - County Health Rankings; National Center for Health Statistics – Mortality File 2018-2020

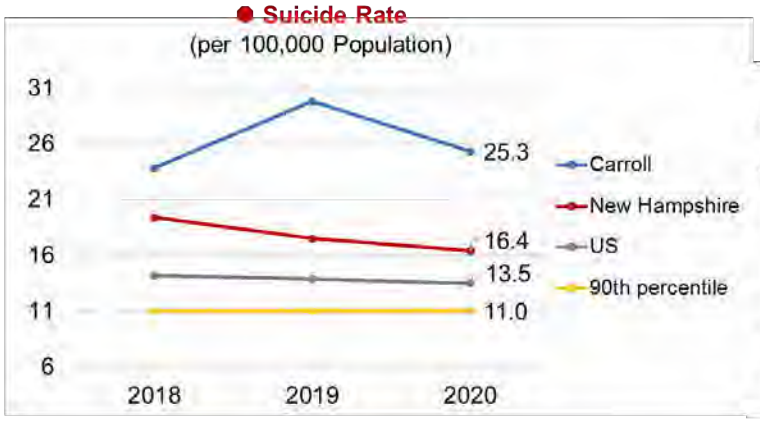
Leading Causes of Death: Age-Adjusted Death Rates per 100,000 Population

Cause of Death	Carroll County	New Hampshire	US
Heart Disease	136.6	146.5	168.2
Cancer	143.3	145.0	144.1
COVID-19*	116.3	40.9	85.0
Accidents (Unintentional Injuries)	65.2	58.1	57.6
Respiratory Diseases	46.8	33.4	36.4
Strokes	32.3	29.8	38.8
Suicide	25.3	16.4	13.5
Alzheimer's	21.2	26.1	32.4
Diabetes	15.9	19.2	24.8
Hypertension and Hypertensive Renal Disease	11.8	7.2	10.1
Influenza and Pneumonia	11.6	9.6	13.0
Parkinson Disease	10.9	10.7	9.9
Liver Disease	9.8	11.9	13.3
Nephritis, nephrosis	9.1	9.4	12.7

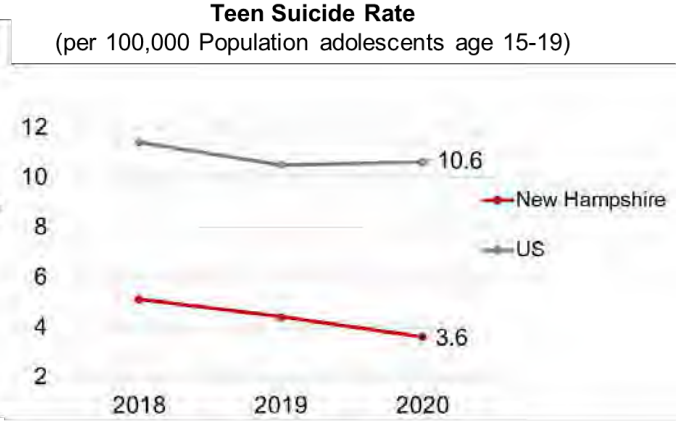
.* Covid 19 Data from 2020

Source: Wonder.cdc.gov. Age-adjusted rates per 100,000 population. Carroll County data from 2018-2020. US and NH data from 2020. Rates that appear in red for a county denote a higher value compared to state data. Age Adjustment Uses 2000 Standard Population.

Rates in red had death rates higher than NH. The leading causes of death in Carroll County were cancer, heart disease, and Covid-19, followed by accidents, respiratory disease, strokes, suicide, Alzheimer's disease, diabetes, hypertension and hypertensive renal disease, the flu and pneumonia, Parkinson disease, liver disease, and nephritis and nephrosis.



Age-adjusted rates per 100,000 population.
Carroll County data from combined years
2018: (2016-2018)
2019: (2017-2019)
2020: (2018-2020)
New Hampshire, and US data are from individual years.
Age Adjustment Uses 2000 Standard Population.



Crude rates per 100,000 population.
New Hampshire data is from combined years
2018: (2017-2018)
2019: (2018-2019)
2020: (2019-2020)
US data are from individual years.
Age Adjustment Uses 2000 Standard Population.

Although the suicide trend decreased in 2020, Carroll County's rate was still higher than NH and the U.S.

Source(s): Wonder CDC.gov (2019) Age-adjusted rates per 100,000 population. Age Adjustment Uses 2000 Standard Population.

Photo Credit: HH

Length of Life STRENGTHS

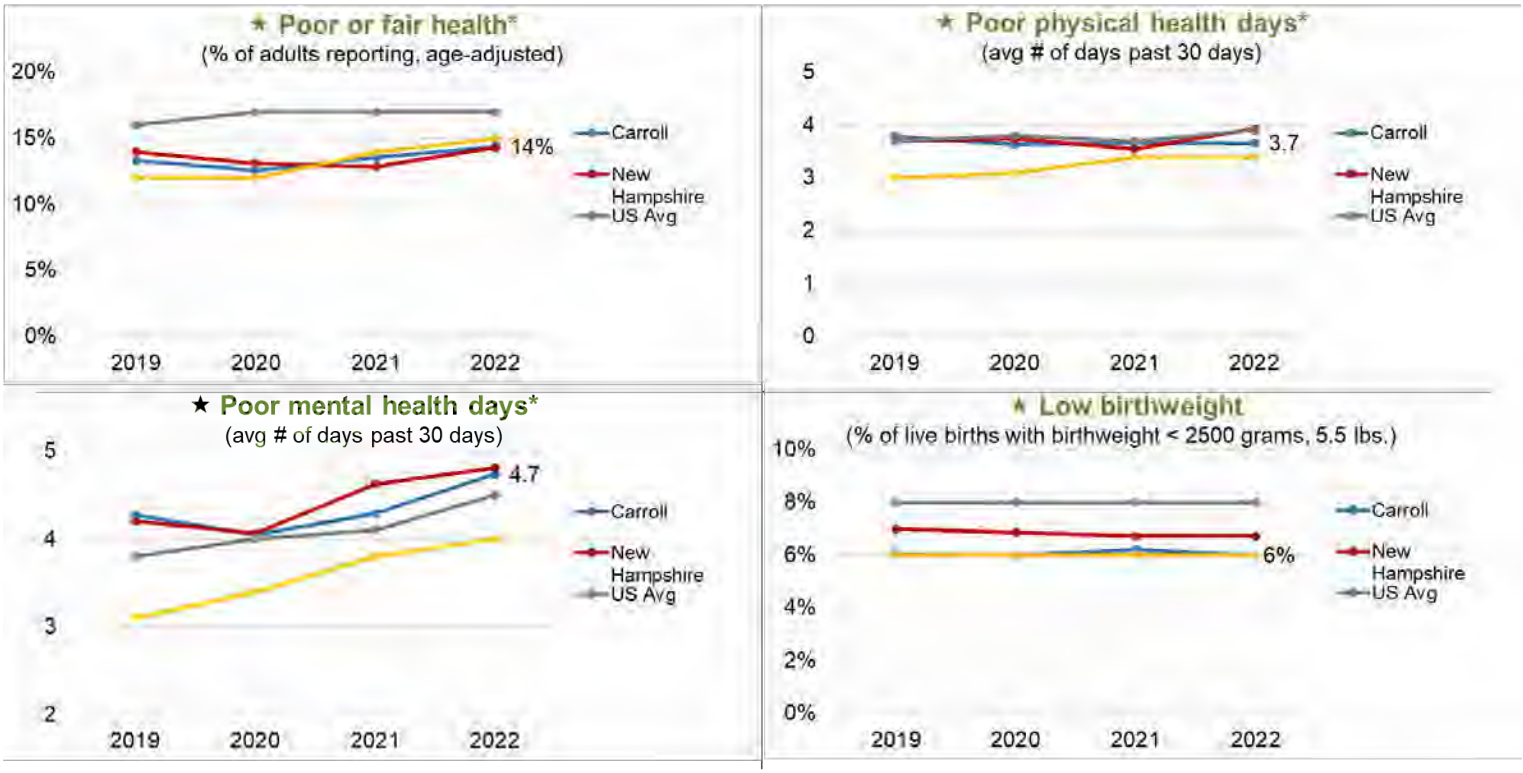
- Carroll County had a longer life expectancy than both NH and the U.S.
- Carroll County had lower death rates attributable to heart disease, cancer, Alzheimer's disease, diabetes, liver disease and nephritis than both NH and the U.S.

Length of Life OPPORTUNITIES

- Carroll County had higher death rates for accidents, respiratory diseases, suicide, hypertension and Parkinson disease than both NH and the U.S.
- COVID-19 death rates indicate higher than NH and the U.S.
- Carroll County had higher number of years of potential life lost prior to age 75 than NH and the U.S.
- Although the suicide rate in Carroll County decreased from 2019 to 2020, it is still substantially higher than both NH and the U.S.

Quality of Life

Quality of life was measured by: % reporting fair or poor health, the average number of poor physical health days and poor mental health days in the past 30 days, and % of live births with birthweight less than 2500 grams, or 5.5 lbs. Carroll County ranked 3rd in quality of life out of 10 New Hampshire counties.



Source: County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS) 2019

Source: County Health Rankings: National Center for Health Statistics – Natality files (2014-2020)

Quality of Life STRENGTHS

- Carroll County had a lower percentage of adults reporting poor or fair health at 14% than the U.S., and the same as NH.
- Carroll County had a lower percentage of low birthweight babies at 6% than both NH and the U.S.
- Carroll County had a lower number of adults reporting poor mental health days at 4.7 than NH (4.8).
- Carroll County had a lower number of adults reporting poor physical health days at 3.7 than both NH and the U.S.

Quality of Life OPPORTUNITIES

- Although Carroll County performed the same or better than New Hampshire in quality-of-life measures, Carroll County had more poor mental health days than the U.S. average.

Health Factors or Determinants

Health factors or determinants rankings are comprised of measures related to health behaviors (30%), clinical care (20%), social & economic factors (40%), and physical environment (10%). Carroll County ranked 9th in health factors out of 10 New Hampshire counties.

Health Behaviors

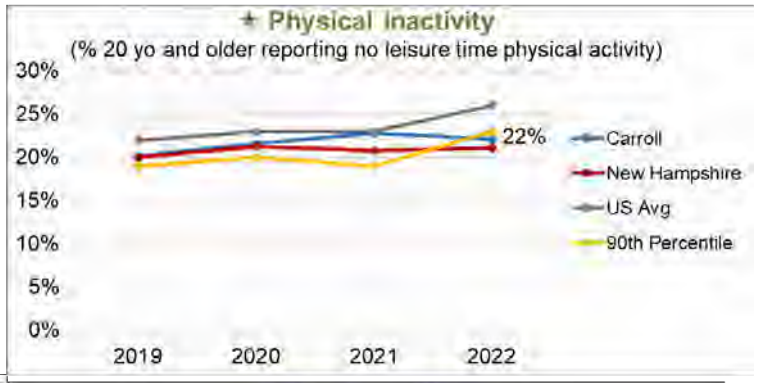
Health behaviors are made up of nine measures and account for 30% of the county rankings. Carroll County ranked 4th in health behaviors out of 10 counties in New Hampshire.

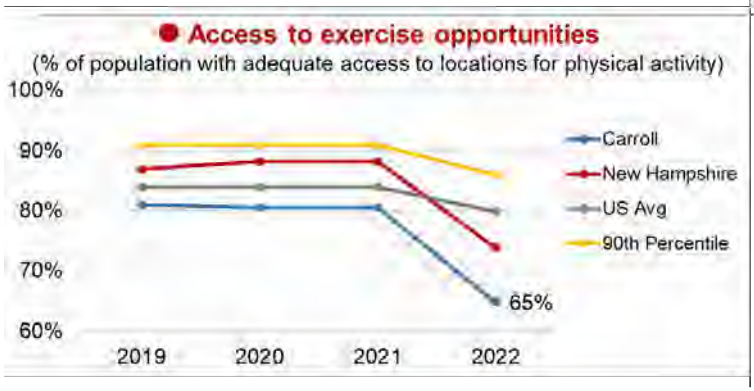
★ Adult obesity

(% of adults that report a BMI of 30 or more)

	2022
Carroll County	29%
New Hampshire	32%
US Avg	32%
90th Percentile	30%

*Beginning with 2021 CHR, the CDC has updated their modeling procedure for producing small-area estimates. 2021 released data should not be compared to prior years.





★ Adult smoking

(% that report every day or "most days")

	2022
Carroll County	17%
New Hampshire	17%
US Avg	16%
90th Percentile	15%

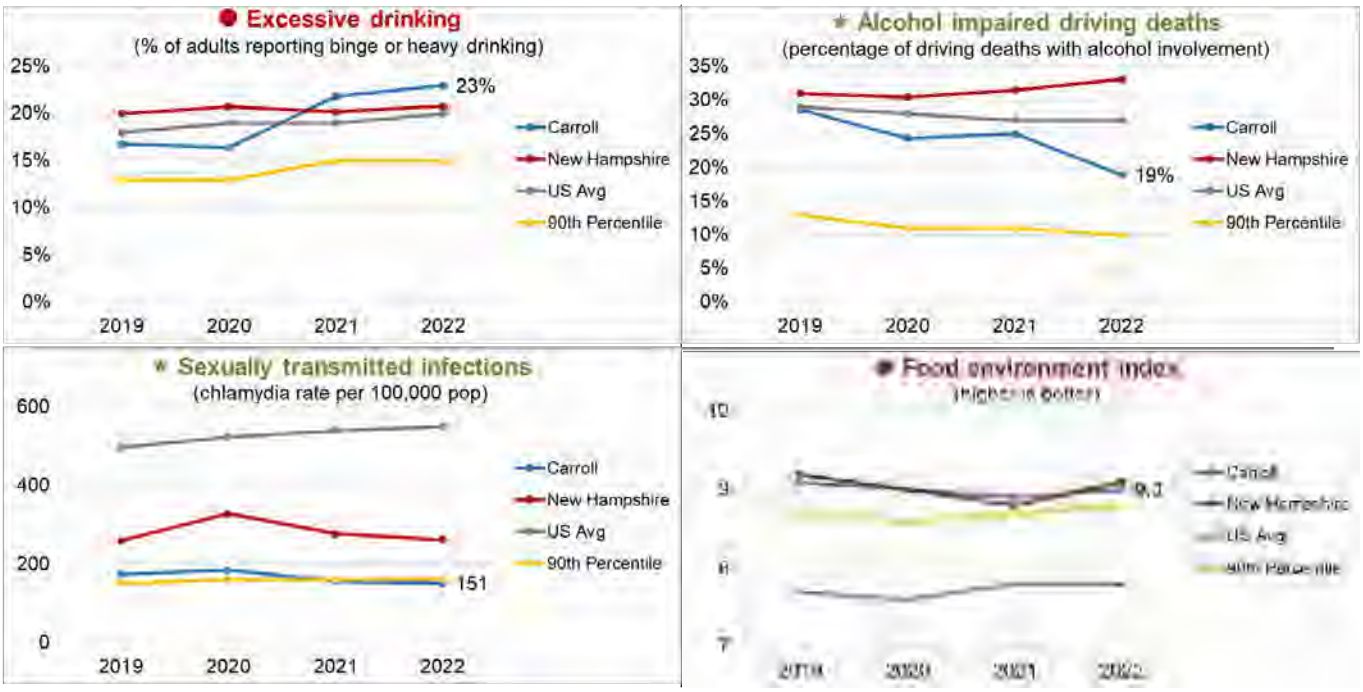
*Beginning with 2022 CHR, the CDC has updated their modeling procedure for producing small-area estimates. 2022 released data should not be compared to prior years.

Source: Obesity & Physical Inactivity – CHR, United States Diabetes Surveillance System, 2019

Source: Access to exercise opportunities – CHR, Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files, 2010 and 2021. Measures the percentage of individuals in a County who live reasonably close to a location for physical activity, defined as parks or recreational facilities (local, state national parks, gyms, community centers, YMCAs, dance studios and pools based on SIC codes)

Source: Smoking - CHR; Behavioral Risk Factor Surveillance System (BRFSS), 2019

Health Behaviors, Cont.



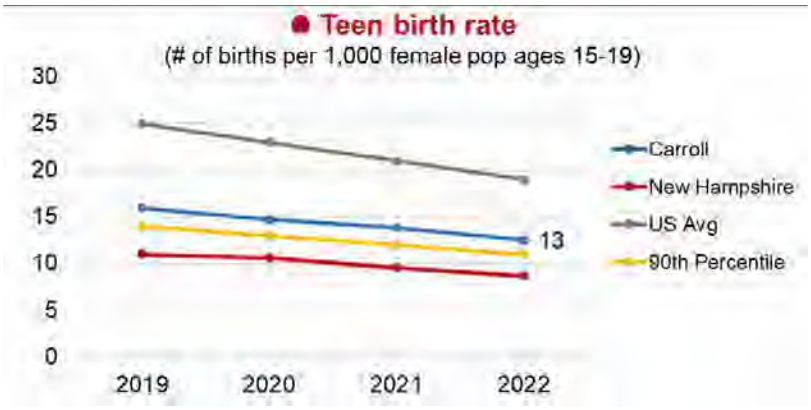
Source: Excessive drinking - CHR; Behavioral Risk Factor Surveillance System (BRFSS), 2019

Source: Alcohol-impaired driving deaths - CHR; Fatality Analysis Reporting System, 2016-2020

Source: STIs - CHR; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2019

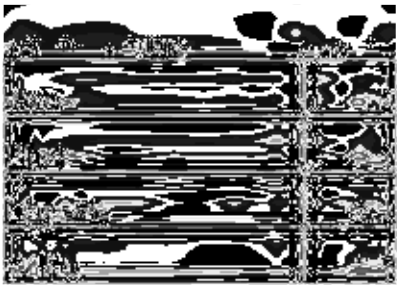
Source: Food environment: CHR; USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019

The food environment index is comprised of % of the population with limited access to healthy foods and % of the population with food insecurity. Limited access to foods estimates the % of the population who are low income and do not live close to a grocery store. Food insecurity is the % of the population who did not have access to a reliable source of food during the past year.



Teen birth rate

(# of births per 1,000 female pop ages 15-19)



Source: Teen birth rate – CHR; National Center for Health Statistics – Natality files, 2014-2020

Health Behaviors, Cont.

Adverse Childhood Experiences (ACEs)

Abuse, neglect and household disfunction have the effect of poor health behaviors as well as poor physical and mental health. The more ACES a child has the higher risk they are for poor health outcomes.

	0 ACEs	1 ACEs	2+ ACEs
United States	54%	25%	22%
New Hampshire	58%	23%	20%

https://www.childhealthdata.org/browse/survey/results?q=4783&r=1&r2=31

Among children from birth through age 17, percentage reported to have had zero, one, and two or more ACEs, nationally and by state. Data Source: National Survey of Children's Health 2016, Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.hrsa.gov/data/national-surveys. Citation: Child and Adolescent Health Measurement Initiative. 2016 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [09/15/21] from [www.childhealthdata.org].

ACEs data is not available for Carroll County. However, New Hampshire had a higher percentage of youth with no aces and lower percentages of youth with 1, 2 or more ACEs.

Photo Credit: HH

Health Behaviors STRENGTHS

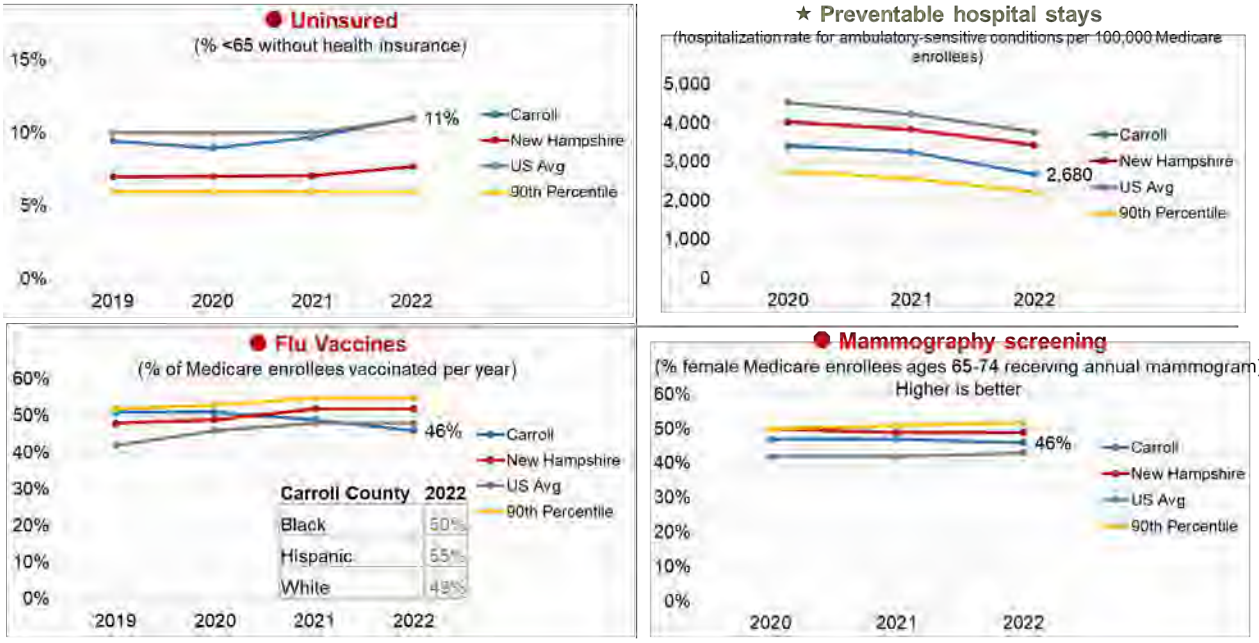
- Adult obesity in Carroll County was 29%, lower than both NH and the U.S. at 32%. The obesity trend had been decreasing in Carroll County. Obesity in New Hampshire and the U.S. continue to rise, putting people at increased risk of chronic diseases including diabetes, kidney disease, joint problems, hypertension and heart disease. Obesity can cause complications in surgery and with anesthesia. It has been implicated in Alzheimer's and often leads to metabolic syndrome and type 2 diabetes.
- Physical inactivity was lower in Carroll County at 22% than in the U.S. at 26%, but higher than NH at 21%.
- Alcohol impaired driving deaths were lower in Carroll County (19%) than in NH (33%) and the U.S. at 27%.
- Sexually transmitted infections measured by chlamydia rate per 100,000 population were lower in Carroll County (151) than NH (263) and the U.S. (551).
- The food environment index was higher (better) in Carroll County (9.0) than the U.S. (7.8), but lower than the NH (9.1).
- New Hampshire had a higher percentage of youth with no aces and lower percentages of youth with 1, 2 or more ACEs.

Health Behaviors OPPORTUNITIES

- 17% of Carroll County smokes, higher than the U.S. at 16%, and the same as NH.
- 23% of Carroll County reported binge or heavy drinking, higher than both NH and the U.S.
- 65% of Carroll County had access to exercise opportunities compared to 80% of the US and 74% of NH.
- Although lower than the U.S. (19), the teen birth rate in Caroll County (13) was higher than NH (9).

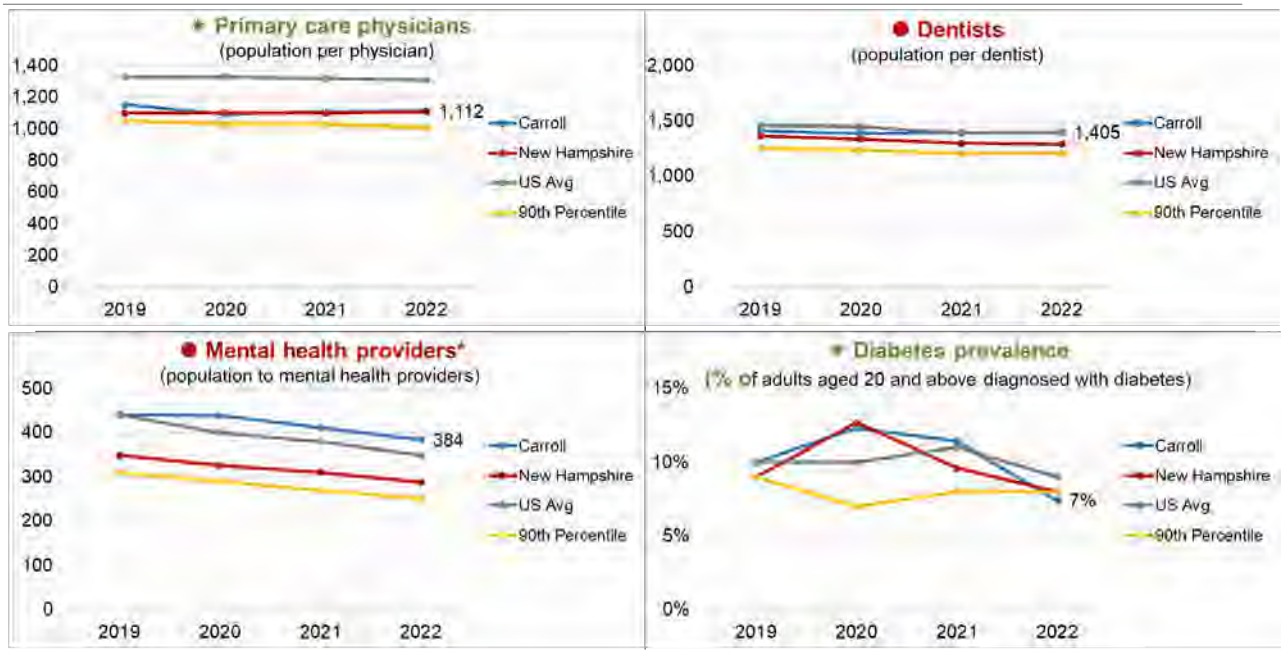
Clinical Care

Clinical care ranking is made up of seven indicators, and account for 20% of the county rankings. Carroll County ranked 9th in clinical care out of 10 New Hampshire counties.



Source: Uninsured - CHR; Small Area Health Insurance Estimates, 2019

Source: Preventable hospital stays, mammography screening, flu vaccinations – CHR, CMS Mapping Medicare Disparities Tool, 2019



Source: Pop to PCP - CHR; Area Health Resource File/American Medical Association, 2019

Source: Pop to Dentists - CHR; Area Health Resource File/National Provider Identification file, 2020

Source: Pop to mental health provider (psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health) CHR; CMS, National Provider Identification, 2021

Source: Diabetes prevalence – Behavioral Risk Factor Surveillance System, 2019

Clinical Care, cont.

NH had a higher vaccination percentage among children 19-35 months old than the U.S.

Vaccination Coverage Among Children

Combined 7-vaccine Series Vaccination % coverage among children 19-35 months by state National Immunization Survey-Child (NIS-Child), 2017

72% of the total residents of Carroll County are fully vaccinated for COVID 19.
NH = 68%
US = 65%
3/31/2022

Combined 7 vaccine series (4:3:1:3*:3:1): 4 or more doses of DTaP, 3 or more doses of Polio, 1 or more doses of MMR, Hib full series (3 or 4 doses, depending on product type received), 3 or more doses of HepB, 1 or more doses of Varicella, and 4 or more doses of PCV (In 2013 data, referred to as 4:3:1:4:3:1:4-FS)

Source: CDC, National Center for Immunization and Respiratory Diseases (2017 data posted 2020)

Cancer Incidence Rates – NH Counties

Cancer incidence rates (cases per 100,000 population) were higher in Carroll County (465) than in NH, and the U.S. (479).

Clinical Care STRENGTHS

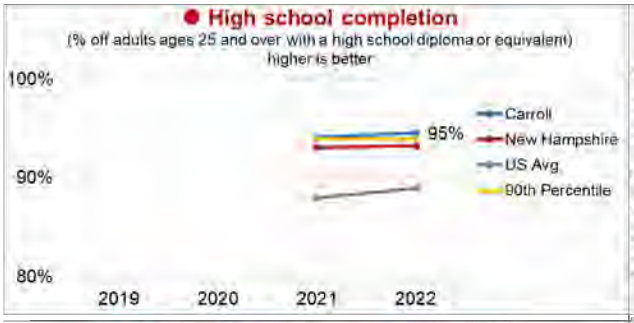
- Preventable hospital stays in Carroll County were 2,680 per 100,000 Medicare enrollees which was lower than NH (3,436) and the U.S. (3,767). Hospitalization ambulatory-care sensitive conditions, which are diagnoses treatable in outpatient settings, suggests that the quality of care provided in the outpatient setting was less than ideal. This measure may also represent a tendency to overuse hospitals as a main source of care. Preventable Hospital Stays could be classified as both a quality and access measure, as some literature describes hospitalization rates for ambulatory care-sensitive conditions primarily as a proxy for access to primary health care. *Source: CHR; Brumley R, Enguidanos S, Jamison P, et al. Increased satisfaction with care and lower costs: Results of a randomized trial of in-home palliative care. J Am Geriatric Soc. 2007;55:993-1000.*
- The percentage of adults with diabetes in Carroll County was 7%, lower than NH (8%) and the U.S. (9%).
- Mammography screening was higher in Carroll County at 46% than the US at 43%, but lower than NH at 49%.
- The population per primary care physician was at 1,112 in Carroll County, lower than the U.S. (1,310) though slightly higher than NH (1,111).
- The cancer incidence rate in Carroll County was 465 cases per 100,000 population which was lower than NH (479), and the US (449).
- The percentage of vaccination coverage among children 19-35 months was higher in NH at 78.9% than the U.S. at 70.4%. COVID-19 vaccinations were also higher in Carroll County than NH and the U.S.

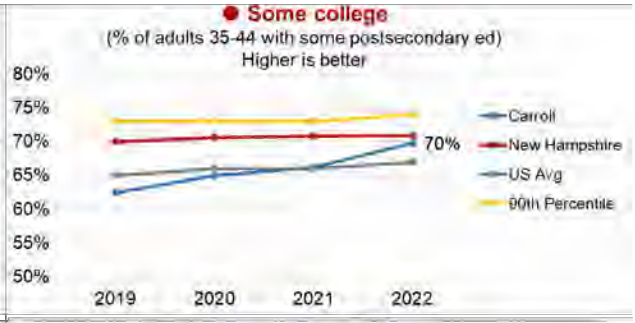
Clinical Care OPPORTUNITIES

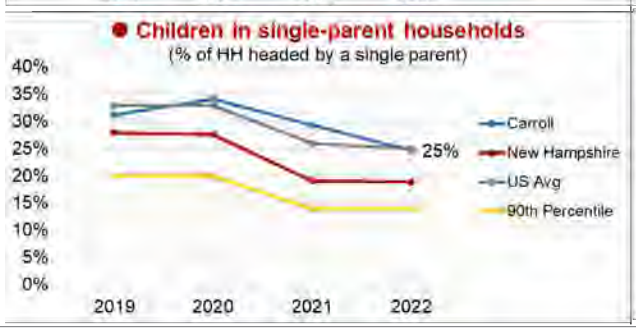
- The percent of Medicare enrollees with flu vaccines per year was lower in Carroll County at 46% than NH (52%) and the U.S. (48%).
- The population per dentists was 1,405 in Carroll County, higher than NH (1,295) and the U.S. (1,400).
- The population per mental health provider was 384 in Carroll County higher than NH (288) and the U.S. (350).
- The percent of population under sixty-five without health insurance was 11% in Carroll County, higher than NH (8%) and the same as the U.S.

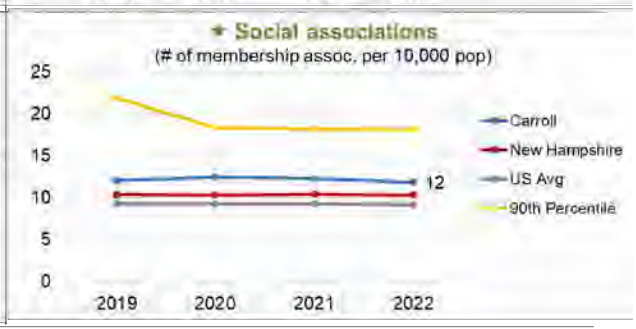
Social & Economic Factors

Social and economic factors account for 40% of the county rankings. There are eight measures in the social and economic factors category. Carroll County ranked 9th in social and economic factors out of 10 New Hampshire counties.







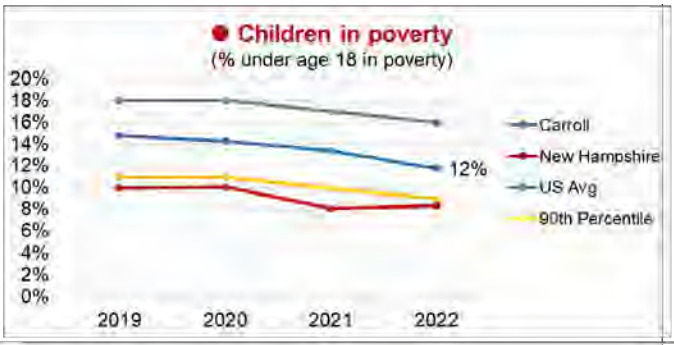


Source: High school completion– CHR, American Community Survey, 5-yr estimates, 2016-2020

Source: Some college CHR; American Community Survey, 5-year estimates, 2016-2020.

Source: Children in poverty - CHR; U.S. Census, Small area Income and Poverty Estimates, 2020

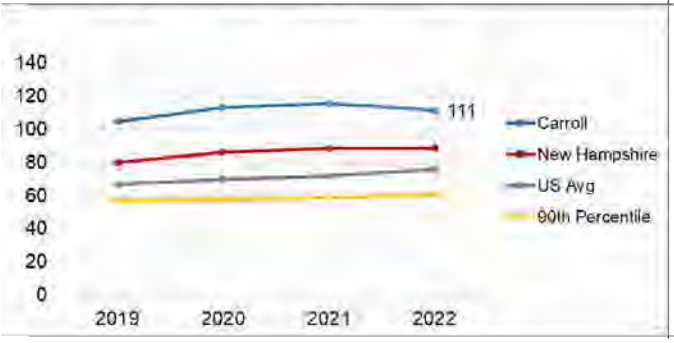
Source: Social associations - CHR; County Business Patterns, 2019



Children in poverty
(% under age 18 in poverty)

Carroll County	2022
American Indian & Alaska Native	NR
Asian	7%
Black	46%
Hispanic	27%
White	13%

27% of children are eligible for free or reduced-price lunches 2021-2022, compared to 21% for NH



Injury deaths
(Injury mortality per 100,000)

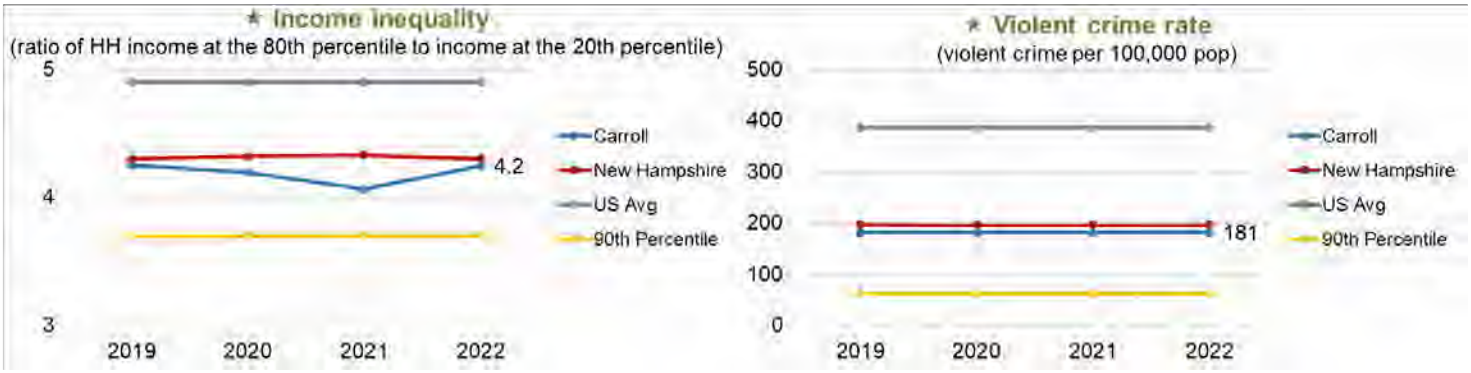
Carroll County	2022
American Indian & Alaska Native	NR
Asian	NR
Black	NR
Hispanic	NR
White	NR

Source: Income inequality and children in single-parent households - CHR; American Community Survey, 5-year estimates 2016-2020

Source: Injury deaths – CHR; National Center for Health Statistics – Mortality Files, 2016-2020

Source: Violent crime - CHR; Uniform Crime Reporting – FBI, 2014 & 2016

Social & Economic Factors Cont.



Social & Economic Factors STRENGTHS

- The high school graduation rate was higher in Carroll County at 95% than NH (93%)% and the U.S. (89%).
- 70% of Carroll County adults had some postsecondary education which was higher than the U.S. at 67%, but lower than NH (71%).
- The children in poverty rate was lower for Carroll County at 12% than the U.S. at 16%, but higher than NH (8%).
- Income inequality represents the ratio of household income at the 80th percentile compared to income at the 20th percentile. Income inequality was lower in Carroll County at 4.2 than NH at 4.3 and the U.S. at 4.9.
- The violent crime rate in Carroll County was 181 violent crimes per 100,000 population, which was lower than in NH at 197 and the U.S. at 386.
- The poverty estimates for 2020 showed Carroll County at 7.5%, lower than the U.S. (11.9%) but higher than NH (7%).
- Social associations were higher in Carroll County at 12 memberships per 10,000 population than NH at 10 and the U.S. at 9 memberships. Associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations

Social & Economic Factors OPPORTUNITIES

- A higher percentage of Black children (46%) were in poverty in general.
- Injury deaths were higher in Carroll County at 111 per 100,000 population than NH (89) and the U.S. (76).
- The median household income in Carroll County was $67,320, lower than NH at $77,879 but higher than the U.S. at $64,730.
- The percentage of children in single-parent households was 25% in Carroll County, higher than NH (19%) and the same as the U.S.

Physical Environment

Physical environment contains four measures in the category and accounts for 10% of the county rankings. Carroll County ranked 7th in physical environment out of 10 New Hampshire counties.

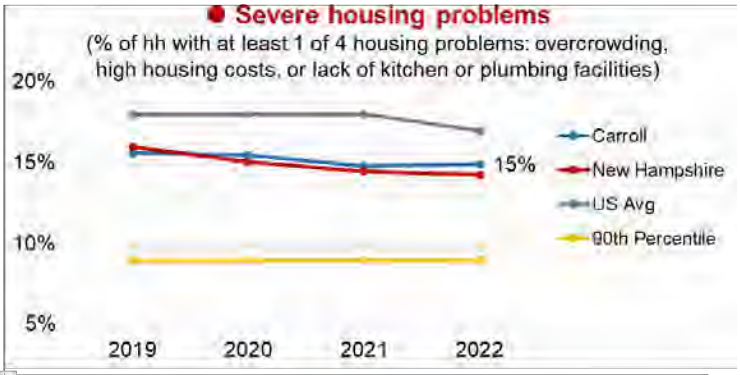
● **Drinking water violations**

	2020	2021	2022
Carroll County	Yes	Yes	Yes

Source: EPA Safe Drinking Water Information System.

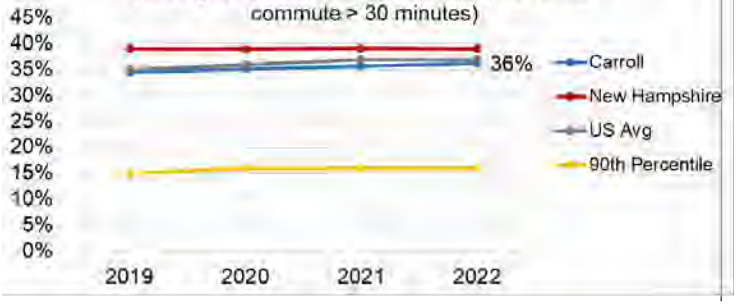
● **Severe housing problems**

(% of hh with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)



★ **Long commute- driving alone**

(among workers who commute alone, the % that commute > 30 minutes)



★ **Broadband access**

(% of households with broadband internet connection)

Carroll County	2022
Carroll County	89%
New Hampshire	89%
US Avg	85%
90th Percentile	88%

Source: Drinking water violations – County Health Rankings; EPA, Safe Drinking Water Information System, 2020
Source: Severe housing problems – County Health Rankings; HUD Comprehensive Housing Affordability Strategy data, 2014-2018. Source: Driving alone to work and long commute – County Health Rankings: American Community Survey, 5-year estimates, 2016-2020. Source: Air pollution – County Health Rankings: CDC National Environmental Health Tracking Network, 2018
Source: Broadband access – CHR; American Community Survey, 5-yr estimates, 2016-2020

Physical Environment STRENGTHS

- Carroll County had a lower percentage of severe housing problems at 15% than the U.S. (17%) though slightly higher than NH at 14%.
- Broadband access was higher in Carroll County at 89% than the US at 85%, and the same as NH.
- 36% of workers in Carroll County who commute alone commute over 30 minutes, which is lower than both NH (39%) and the U.S. (37%).

Physical Environment OPPORTUNITIES

- Carroll County reported drinking water violations every year for the last three years.

Photo Credit: HH

Themes that emerged in this Process:

- There is a direct relationship between health outcomes and affluence (income and education). Those with the lowest income and education generally have the poorest health outcomes.
- While any given measure may show an overall good picture of community health, subgroups such as the lower income census tracts may experience lower health status measures.
- It will take a partnership with a wide range of organizations and citizens pooling resources to meaningfully impact the health of the community. The service area has many assets to improve health.

Results of the CHNA

Community Health Prioritized Health Needs

Prioritization of Health Needs

Prioritization Criteria

The HH leadership team reviewed the community health information and used the criteria below to prioritize the health needs in the community.

Magnitude / scale of the problem	How big is the problem? How many people does the problem affect, either actually or potentially? In terms of human impact, how does it compare to other health issues?
Seriousness of Consequences	What degree of disability or premature death occurs because of this problem? What would happen if the issue were not made a priority? What is the level of burden on the community (economic, social or other)?
Feasibility	Is the problem preventable? How much change can be made? What is the community's capacity to address it? Are there available resources to address it sustainably? What's already being done, and is it working? What are the community's intrinsic barriers and how big are they to overcome?

Most Significant Community Health Needs

The following needs were prioritized by the HH leadership team using all of the input from the community and the secondary data.

1. Access to Care – specialty care
2. Access to Care – primary care
3. Access to Care – mental health services
4. Social Determinants of Health improvement

Photo Credit: HH

Community Health Needs Assessment for Huggins Hospital's Service Area

Completed by Huggins Hospital in partnership with:

Stratasan

Photo Credit: Carroll County Resources

Appendix

1. **Community Focus Group Summary**
2. **Community Survey Summary**
3. **Community Asset Inventory**
4. **2019 Implementation Plan Impact Evaluation**

Focus Groups Summary

Focus Groups

On April 12, 2022, twenty-nine people from nineteen organizations participated in focus groups for their input into the community's health issues. Below is a summary of their input. The full summary is included in the appendix.

The participants defined health as multidimensional, mental, physical, wellness, living conditions, wellbeing, resilience as well as an environment in which to thrive and have basic human rights.

They agreed that the health of the county depended on where people lived and there is health disparity. The health variances are based on economics, age, activity level, and resilience.

The biggest health issues in the communities were:

- Mental health – worsened during the pandemic, issues for tweens and teens, lack of mental health professionals
- Substance use disorder – drugs and alcohol, contributing to domestic violence and suicide.
- Delayed care – due to the pandemic, people delayed and avoided care. Diabetes worsened, complicated acute conditions occurred due to avoiding care. Cultural independence and message of "don't go to health facilities" impacted care utilization.
- Access to care – Shortage of healthcare workers, access to primary care with long waits, cost of medications and insurance.
- Social determinants of health – poverty, food insecurity, inability to find housing, lack of transportation, unhoused population growing.
- Effects of the pandemic – isolation, loneliness, kids with maladaptive issues and no social skills, tired and burned out workforce.
- Disabilities – Falls at home, aging adults applying for disability, chronic diseases – heart disease, diabetes, high blood pressure, cancer, family issues.

Biggest health issues facing medically underserved and low-income were:

- Basic needs – housing, food, finances
- Education – health literacy, understanding health and vaccines
- Access – not everyone has access to technology, internet, computers, limited childcare, mental health access, limited access to medicine, accessing the ED instead of primary care.

Focus Groups Summary

Focus Groups

On April 12, 2022, twenty-nine people from nineteen organizations participated in focus groups for their input into the community's health issues. Below is a summary of their input. The full summary is included in the appendix.

1. **How do you define health?**
    - Condition with many dimensions - mental, living conditions, wellness
    - Overall wellbeing, absence of illness, presence of resilience
    - Cycle where you are in the lifespan can change over time
    - Environment that people to thrive. Basic needs are met. Basic human rights
    - Not just absence of disease but also access to transportation, no food insecurity, affordable housing options. Community resilience, infrastructure, economics. Can't thrive without all aspects of health
    - Thriving children, engaged, happy organism indoor community

2. **For the purposes of this Community Health Needs Analysis, the community is Carroll County, generally, how would you describe the community's health?**
    - Variable, pockets of disparity, depends on where you live. Social, economic status varies widely - some are super active and well off and then older adults dealing with chronic conditions. It's bipolar with those who live on the lake and those who live in a trailer without heat.
    - Large population lacking resources who are scattered, and wealthy, well-educated people. Those with access to care and those in poverty. There's a big gap between the two. Really different health statuses.
    - Unequal - cater to wealth through tourism and hide the unappealing aspects. However, want to see a network of support. The middle class are the doers.
    - The pandemic colored everything. We're incredibly resilient, very resourceful Yankees

3. **What are the biggest health concerns or issues for the communities today?**
    - Mental Health
        - Mental health worsened during the pandemic
        - 12–14-year-old girls on the line when responding to crisis calls. Will be interested in suicidal ideation in the YRBS survey data for 2020. Females in crisis increased compared males. Hearing how kids are using language and how they understand words. They throw around words in a much more casual way. Social media may be desensitizing them to the words. Social norms play a role. Kids are freer to say things. Kids dealing with anxiety and stress
        - Lack of therapists. People are willing to seek mental health treatment because it has been destigmatized, but now don't have staff. We're least prepared to take care of mental health

Focus Groups Summary, cont.

Focus Groups

- Substance Use Disorder
  - Drugs and alcohol - concerned about what we're seeing in the schools.
  - Domestic violence, substance abuse generational cycles. People didn't have access to services to get out of circumstances
  - Substance misuse, leads to suicide in older adults
- Delayed care
  - Diabetes worsened because people didn’t seek care. Issues were there but have worsened
  - There is a trend of complicated acute conditions due to avoiding healthcare during pandemic. Six-month barrier to primary care
  - The health system hasn't been as proactive as we wanted. The message of “don't go to healthcare facilities” was heard and some are still not going
  - New England mentality-I don't need any help. Cultural independence
- Shortage of healthcare workers
  - Workforce issues, shortage of physicians & staff in general, left healthcare. If staff is not available to address the needs, then can't meet the needs of others. Focus needs to be on the workforce. Difficulty paying people to work in healthcare
  - Community mental health center staffing
- Social Determinants of Health – Poverty, Housing, Food Insecurity, Transportation
  - Poverty
  - Food insecurity
  - People's ability to find affordable housing, statewide
  - SDOH are concerns to older folks isolated - lack of transportation
  - Afraid homelessness will increase based on new tax assessments and returning to pre pandemic level of Medicaid and snap benefits. Can't afford their rent
  - Ability to afford medications
  - Climate change-farmers, loggers, tourist skiing season shortened, harvest season changing. lengthening summer season

Focus Groups Summary, cont.

Focus Groups

- Access to care
  - Lack of healthcare services, access to primary care. Fuses are short, people tired of complications and waiting for healthcare, wait times awful
  - Access to specialty care is limited. It is impossible to get appointments. Offices not taking new patients for specialty care. Endocrinology, psychiatric issues, huge issue
  - Lack of access to dental insurance
  - Cost of effective drugs for diabetes. Drug companies pulled back on their prose
  - Diet, access to heathy foods. Cheap foods
  - Formula shortage
  - DME footwear in particular shortages
  - Sleep apnea machines shortages
  - Have community care coordination here at Huggins, and it has been tremendous at decreasing barriers. Siloed and isolated population, organizations came together worked well together. Silos went away
- Pandemic Effects
  - Isolation-trapped at home. Kids have become maladaptive with no social skills. Exacerbated issues already there
  - Aging and loneliness
  - Parents w/school age kids, masks are off and kids are getting sick and not allowed to return to school puts more pressure on parents
  - Uncertainty around telehealth- is it a sure thing? what appointments can we use telehealth?
  - Workforce-tired, mental health issues themselves due to COVID fatigue
- Health and Disability
  - Falls at home
  - Isolation
  - Aging adults, increase in people applying for disabilities. Disability becomes a safety net and doesn't incorporate healing and recovery
  - Chronic diseases – high blood pressure, heart disease, diabetes, canc
  - Family issues, neglect, avoidance, denial

Focus Groups Summary, cont.

Focus Groups

4. **What are the most important health issues facing various populations including medically-underserved, low-income populations?**
    - Basic Needs
        - Affordable housing, unhoused population -putting people up in hotels now, but how to comp
        - Food, good quality, food insecurity leads to obesity
        - Finances
        - Insecure transportation, fragmented services. Difficult to get to Conway
        - When in survival state, hard to think about other things
    - Education
        - Health literacy, need access to health information
        - Generational families-when kids sick, go to doctor. what they do. Don't have to think about it. Things get passed down
        - Flow of info for the group, lack of understanding of vaccinations. Politics plays a role in heath – promote flu shots and vaccines
        - Immigrant population, getting information to them
    - Access
        - Not everyone has access to technology, internet, computers
        - Can't get home care in seniors' homes
        - Limited childcare
        - Limited mental health and medicine access
        - Lack of community – do we suffer from societal trend of not knowing our neighbors, families, social fabric has deteriorated? Affects health
        - Healthcare system trying to deliver care, so there's a mismatch. How to match up needs and services. Ex: access ED instead of primary care, limited specialty care
    - Life at Home
        - Serving record number of relates taking care of kids, doubled in the last year
        - Children not seeing doctors, telehealth is great, but not for severe issues
        - Generations of a habit hard to break
    - Effects of COVID
        - Many neglected during pandemic
        - Prices increased, so many made decisions not to see doctors
        - Natural evolution of sending providers out to the home, reaching out and eliminating barriers. Preventative program keeps them out of the hospital, very popular and appreciated. Anyone who tested positive received info pulse oximeter
        - The clinics vaccine testing now come here for care

Focus Groups Summary, cont.

Focus Groups

5. What are the most important health issues facing various populations including minority populations?

- More minority here increases concerns about their health. Seasonal International workers. Brewster Academy and Summers see international seasonal workers.
- Mental health component from kids - adoption, cultural stress depression, culture, pull up by bootstraps, compared to other students, access to familiar foods, services they're familiar with. Emotional trauma of being different
- Language and cultural barriers – Indian families feel isolated by differences. Migrant populations have language barriers. Puerto Rican and Mexican populations have differences in culture. Asian population – fear of human trafficking.
- Massive gentrification during COVID, came here from cities
- Substance abuse, STD increases hopelessness
- When someone comes up with a plan – Not in My Backyard " NIMBY"
- Have small pockets of ethnic minorities but don't have a handle on them. Seeing more refugee kids in schools
- Can't access Medicaid or SNAP
- Unknowingly intolerant, ignorant of other cultures. Issues with racism and discrimination, racism due to lack of exposures to minorities, racism in school systems. Regional high schools bringing different people together from all over, may get treated like a minority. Active white supremacist groups.
- What everyone else is dealt with

6. The community performed a CHNA in 2019 and identified priorities for health improvement,

1. Access to care (including affordability)
2. Addiction treatment and prevention services
3. Mental health services
4. Social Determinants of health improvement (transportation/housing)
5. Individual & family health behaviors and literacy
6. Healthy aging

What has changed most related to health status in the last three years?

- Physical Health
  - Having Wolfeboro Pediatrics being so consistent has been so positive. Still work to be done, but some have improved
  - Been some movement on healthy aging
  - Elderly were most compliant around vaccines

Focus Groups Summary, cont.

Focus Groups

- Mental Health / Addiction
  - Mental health worse, COVID added to it. Seeing it in kids,
  - So much silo-ing
  - Mental health now has mobile crisis unit, a crisis line rapid response
  - Improved public communication about health, addiction treatment, hear people talking about addiction more
  - Substance misuse community getting more money, moving in the right direction.
  - NH 1 of 4 states that didn't increase overdose deaths during covid. See lots of opportunity going forward.
- Housing
  - Expensive, less accessible
  - Hope House-transitional care housing 7 units, no lack of resources but a lack of connect the dots
  - People living in campgrounds
  - Transportation Mobility managers from the State. Could be an influx of money funds for housing but need to find areas who welcome affordable housing.
- Access to Care
  - Dental care access, dental health a concern for special education kids
  - Staff shortages
  - Glasses. Vision care during COVID went away
  - Social services becoming more available but need more inroads into undeserved populations. Big improvements
  - Early childhood development? Saw grassroots community groups come together during Covid pediatric practice here is great, engaged
  - After COVID, need more services, but now less people to provide the services
  - White Horse people works there with life experience est. recovery coaches in the ED peer support
  - Access to specialty care worse, endocrinology is a nightmare, rheumatology hard
  - White House open and expanded
  - SDOH underpinnings to all issues all related these items, overall awareness of SDOH has improved

Focus Groups

7. What behaviors have the most negative impact on health?

- Substance Use
  - Normalizing poor drinking behaviors, contributes to alcoholism in the community. Alcohol use is escapism, legal form of self-medication but a depressant. Rampant and glorified. A lot of alcohol bottles at the dump. Cultural acceptance of drinking during COVID
  - Fentanyl and meth increased opiate overdoses. Poly substance use
  - High school – THC, vaping, expansion of marijuana use. Kids think it's no big deal. Parents don't want kids to be stigmatized. Don't want to label the kids. Stress and anxiety escalated use of alcohol and drugs. Access to treatment for stress and anxiety has been limited so they self-medicate. Lost young people to overdoses
  - Denial that these things don't happen here. Because of tourism dollars. The whole tourism culture - "everything is wonderful"

8. What environmental factors have the biggest impact on community health?

- Water
  - Water good
- Community / Culture
  - Continued isolation, need to figure out how to bring people back to the community. Kids who haven't had socialization, don't know how to navigate social situations
  - Community has no idea what goes on here
  - Tempers now, fuses are short. Behavior now undercurrent of acceptance of bad behavior. Sense of entitlement and lack of accountability since COVID. Behaviors at school have dramatically worsened
  - Strong culture of outdoor activity, mountains, paths. Appeal of outdoor activities, lakes. Also makes it difficult to get around, though very physically active population across all ages
  - Social Media
  - Difficult to find reliable sources of information, trust of information
  - Libraries providing services-game nights, support, activities, information
  - Real pockets of segregation
  - Now seeing parents who don't know how to cook. Food from Dollar
  - General Exercise has really declined since Covid, gyms and tracks closed
  - Arsenic in wells, most people on well water
  - Lack of access to water. Can't get access. Close public beaches to public
  - Sporadic water issues and state not responsive

Focus Groups

- Lead Exposure
  - Lead concern in older houses
  - People likely to live with lead
  - Raising awareness
- Housing
  - Lack of housing and if available, they have issues. Rentals so difficult to find. Moving out further due to the cost. Also impacts their ability to access care and services. Waiting list for affordable housing
  - Don't have low-income housing and get into bad housing that leaves kids unprotected. Elderly also trying to get into housing
  - Families living in campgrounds.
    - Weather issues- cold, gray expensive, resource intense heating costs, snow control, vehicle maintenance. Natural environment super healthy have access to outdoors
  - Rural pockets of poverty, older communities lack accessibility for those with disabilities
- Outdoors
  - No sidewalks, nowhere to ride a road bike or running luring people here for outdoors but not that easy. lots of 1 hiking
  - Positive from pandemic found places to be outside
  - More dangerous to bike on the roads; don't respect riders anymore. In some ways, harder to exercise here than in the city. Must get access to Rail trails
  - Lyme disease, tick borne illness
  - Kids don't live in neighborhoods, live far apart
- Tourist Culture
  - Tourist culture beach protection. Seem to have resources, but execution fails
  - So many came during the pandemic it got crowded but now went back in North County. Not the south county lakes region. Lack infrastructure for people to more here. More people came to Lakes Region & didn't go back. WFH tele world. No breathing time anymore

9. What do you think the barriers will be to improve health in the communities?

- Health literacy
- World view baked in, confidence and trust. Resource for truth, big sources or truth alternative truths, science. Pandemic became so politicized and became barrier to doing what was best for health. People are so entrenched and afraid of getting kicked out of your group
- Dispersed throughout county. Sparsely populated. Disconnected areas barriers are endless

Focus Groups

- Lack of childcare - cost, workforce issues
- Geography, transportation. Rural never enough funding, don't have people to manage the grants
- Brought more focus to mental health and domestic violence. Balance the positive with the need to assess what didn't work in the last two years
- Huggins Community Health Network
- Stuffing, workforce Money
- Financial Education Access
- Access to medications, cost of medicine
- Regulations

10. What, if any, health issues or inequities did the Covid-19 pandemic expose in the community?

- Technology
  - Inconsistent internet coverage. There are ways to reach people if they have internet
  - Exposed technological gaps. School closures exposed lack of internet; how many people couldn't access Zoom. Connectivity issues for home schools. ADHD did terrible at home school
  - Access to technology – pick up groceries, online groceries
  - Impact of COVID telecommuting found a location here. Pushed telehealth to people and forced people to receive a support it. Telehealth really helped customers + receive reimbursement. Video helped in so many ways. There are resources here but need to find them, advertise more. communication. Hospital-thanked God it was there testing and vaccine personal connections helped each other. Learning experience
  - Need alternative paths for young adults to prepare for the future, alternative ways of learning online
  - Vaccine microchips
- Food
  - Schools had food pick up, lunches
  - 68 hours of hunger magnified the disparities that were there all along. Would love to keep free breakfast and lunch at schools - makes it more acceptable stigma with free meals
  - Spotlight on resources communities had + how important they were
- Jobs
  - Low paying jobs who had to go to work and couldn't work from home, people who had to continue to go to work. Exposed low wages

Focus Groups

  - Discovered important jobs. Essential workers so valued, pay increase
  - Burnout of staff
  - Volunteer organizations
- Isolation
  - Calls needing emergency services needed testing, needed vaccines, needed help at home
  - Older adult isolation, lack of access to internet and technology. Dump and run, nursing homes dropping patients at the hospital because they don't want to take care of them. Opened up the rules and telehealth silver lining, enabled people to receive care they wouldn't have received prior to COVID
  - Elevated anxiety, people who were pretty good at dealing with life were challenged, depression
  - Lack of access to healthcare and social support. Failure to have resources to help
  - More mental health issues who could have benefitted from VNA, but wasn't available due to staffing
  - Loss of social connectedness
  - Being so divisive, at odds with patients. No meeting in the middle, used to be able to talk, data supports your belief
  - Brought awareness of ways we can work together, good will. Seen some amazing things
- Information
  - Misinformation-CDC, state, news so politicized, not a lot of trust. Evidence-based guidelines. Gained and regained communities' trust
  - Ignorance frustrating, maddening. Understanding what was true and good information, blurred

11. If you had a magic wand, what improvement activity should be a priority for the counties to improve health?

- Youth
  - More childcare, and pay more to childcare workers
  - Enhanced recreation opportunities for kids. Kingswood Youth Center, expand afterschool and before school programs. Summer programs for whole day
  - Active support groups for parents with kids with issues. Peer groups for anything – brothers and sisters of kids with drug issues, grandparents raising kids. Significant work and funding for systems
  - 3 – 5-year-olds need support, lots of programs for 0-3 and 6-10. Huggins provides school

Focus Groups Summary, cont.

Focus Groups

- Access to services
  - Housing-lower cost, more rentals, affordable housing units second group
  - Hire mental health workers, mental health providers
  - Continue to grow care coordination & bring together resources
  - Take services to people-mobile care, food pantry. Public transportation for dental work, mobile services, beautiful teeth for kids
  - Transportation – more robust rideshare
  - Decrease cost of medicine
  - Open access to care all the time, no waiting lists. Immediate access, remove barriers
  - Get rid of EMR, paper record
  - More specialty providers. Pay medical specialties more to get more specialists like Endocrinologists. More support staff, more psychotherapists, more counseling for mental health. Change the way mental health is delivered – local, outpatient focused
  - More care coordination. One stop shop-see all providers you need. Blend funding streams, balance primary care and mobile care. Medicare negotiate drug prices
  - Provide training with desire
  - Community care coordination team natural extension to home visits, 10-15% of hard-core cases target those to receive home care and reimbursement. Generational issues – break some of those
  - Medicare negotiate drug prices
- Connection
  - People who live here access their own resources. Need to go back to the community. Small town America, huge campaign about getting to know your neighbor
  - Would love to see people break down silos and bridge those gaps
  - Universal home visits for anyone – kids, seniors
  - Don’t have the capability to keep up with technology. Public private partnership with decision-makers and social service providers shared responsibility across groups. Individual orgs can't solve these issues
  - Remove the tribes getting more narrow in views, rid of divisiveness

Focus Groups Summary, cont.

Focus Groups

12. What population changes have you seen in the community in the last two and a half years?

- 2000 gain from census in the county
- People staying at their second home. Concerned that in 2 years, they'll go back to their urban life. Some made life changes, telecommuting or retired. Mid to older population coming here to live. Expectations that are hard to keep up with. Would be nice to see the data
- Police calls increased
- Need to get more specialties here, Oncology Infusion Centers
- Med staff already maxed out. What if care spikes this summer? how to staff?

Survey Results

Survey

Huggins Hospital and Stratasan conducted an online surveys in Carroll County. 391 surveys were completed via online surveys from June 20, 2022, through Aug 15, 2022. Surveys were sent via email distribution lists and promoted through social media placement. Complete survey results are in the appendix.

Seventeen percent of respondents indicated their health was excellent, 63% good, 17% fair and 3% poor.

Q37. What are the top three most significant health issues in the counties?

1. Access to care (31.5%)
2. Mental health assistance (31.5%)
3. Access to health insurance (29.8%)
4. Substance use disorder assistance (21.4%)
5. More exercise opportunities (18.5%)
6. Chronic diseases (diabetes, cancer) (16.4%)

Q30. What are the top three social determinants of health issues that are impacting people's health? (Select up to three)Responsible, involved parents (36.1%)

1. Affordable health care (24.5%)
2. Chronic health issues (24.5%)
3. Affordable health insurance (24.5%)
4. Affordable dental care (19.3%)

Q33. Have you ever been told by a doctor you have any of these conditions, diseases or challenges?

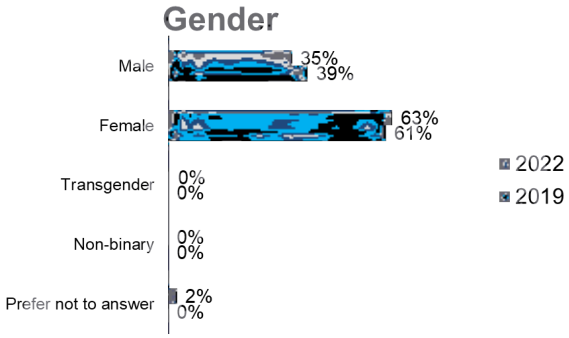
1. High blood pressure/hypertension (49.2%)
2. High cholesterol (41.6%)
3. Arthritis (40.0%)
4. Overweight or obese (24.0%)
5. Cancer (23.2%)
6. Heart disease (18.0%)
7. Diabetes (16.4%)
8. None (15.2%)
9. Other responses were less than 15%

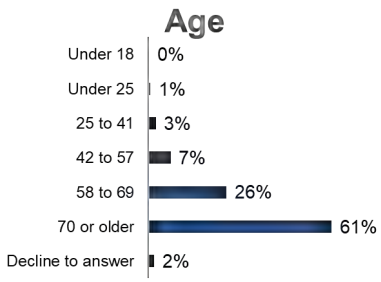
Surveys

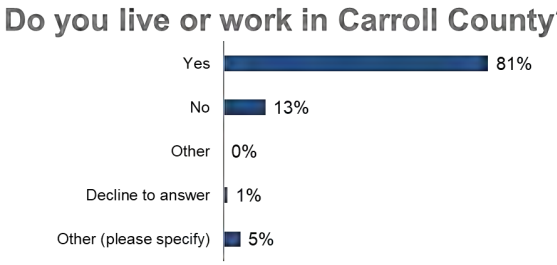
Community Survey

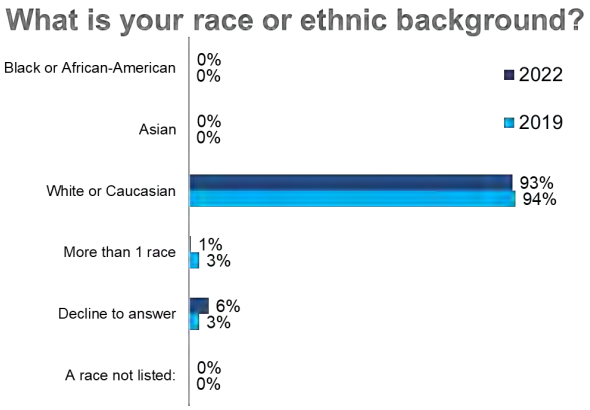
Huggins Hospital and Stratasan conducted an online surveys in Carroll County. 391 surveys were completed via online surveys from June 20, 2022, through Aug 15, 2022. Surveys were sent via email distribution lists and promoted through social media placement.

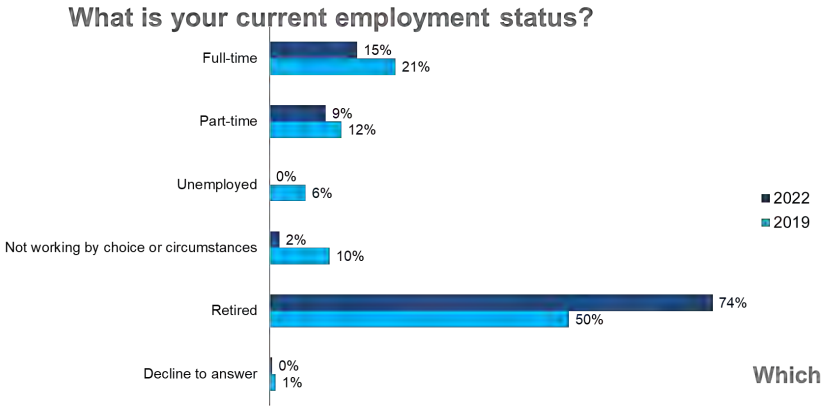
Demographics

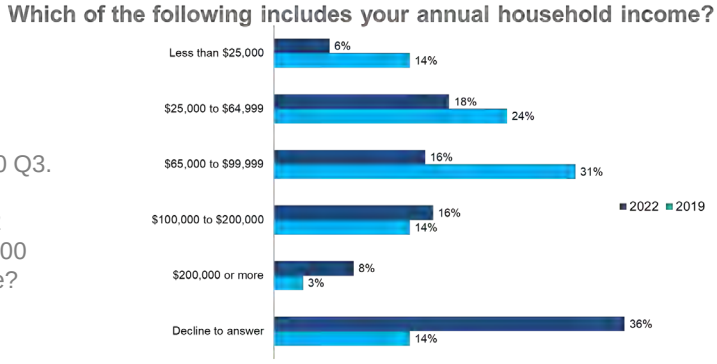










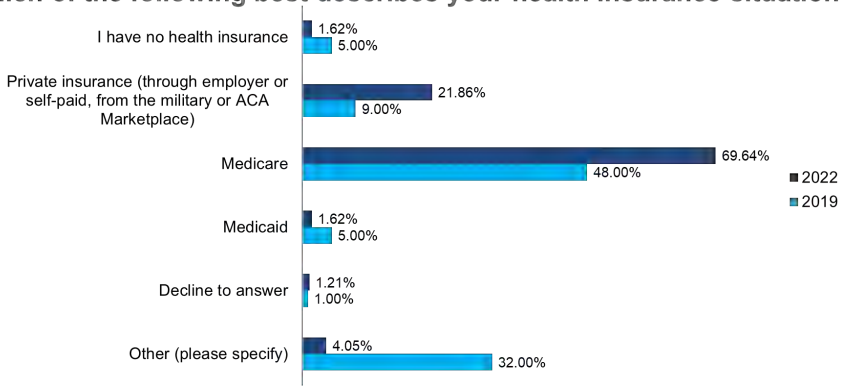


N=387 N=300 Q1: What is your gender?
N=389 Q2: Which of the following ranges includes your age? N=390 Q3. Do you live or work in Carroll County?
N=388 N=300 Q4: What is your race or ethnic background? N=182 N=300 Q45. What is your current employment status? N=244 N=300 Q46. Which of the following includes your annual household income?

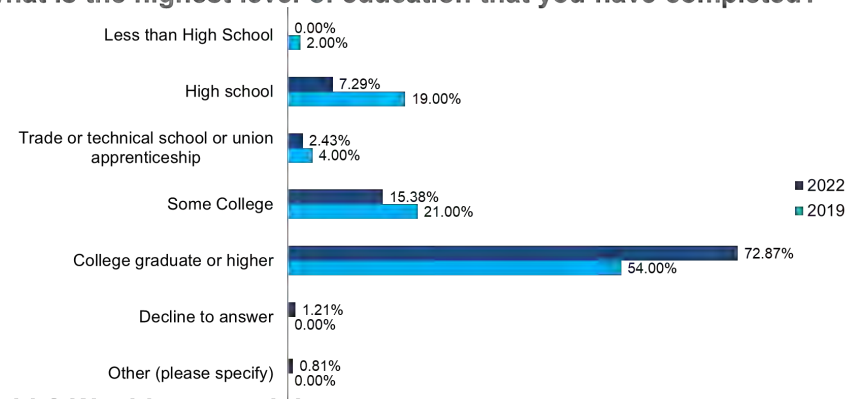
Surveys

Community Survey

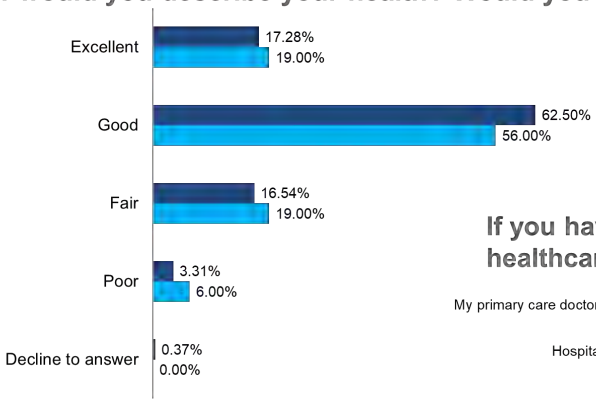
Which of the following best describes your health insurance situation?



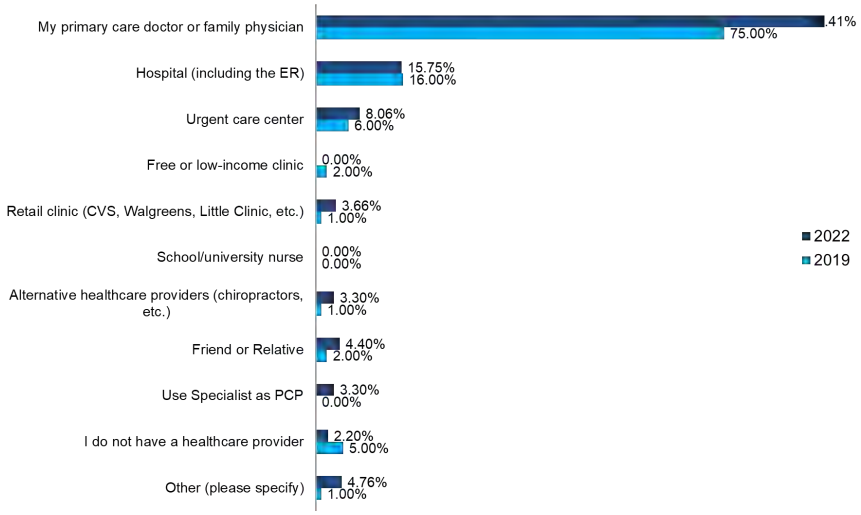
What is the highest level of education that you have completed?



Generally, how would you describe your health? Would you say it is…



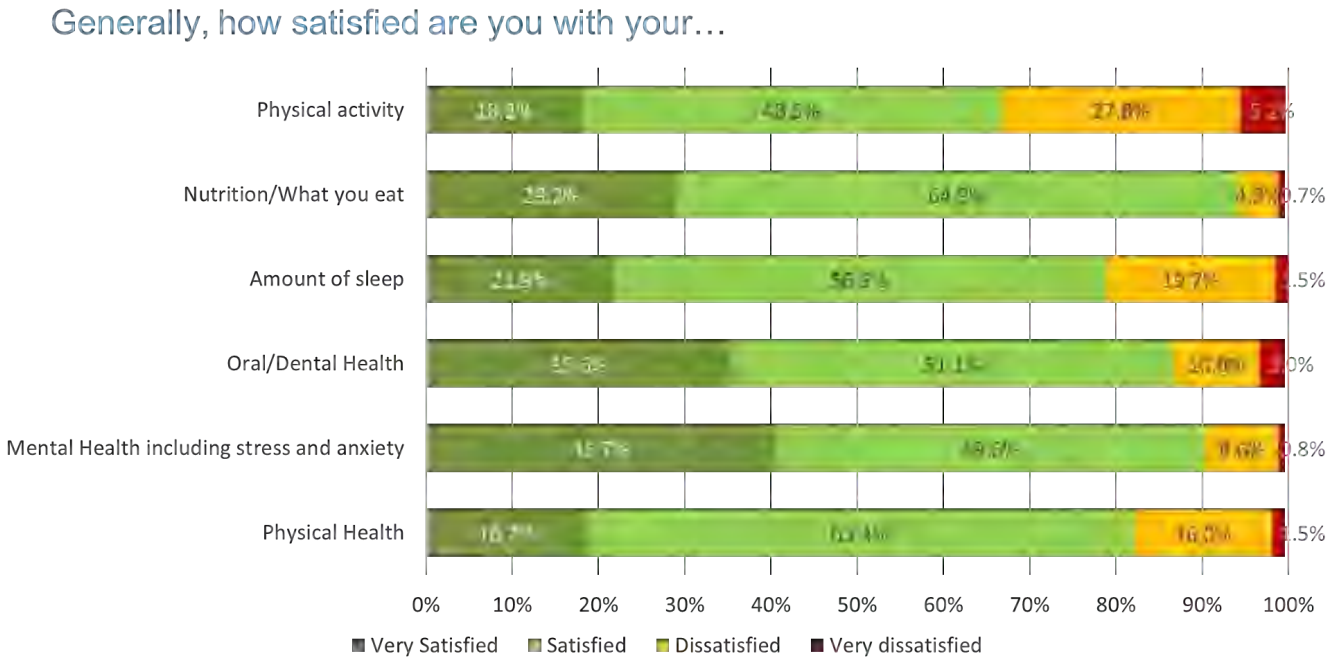
If you have one person or group you turn to for basic healthcare needs, where do you go most often?



N=247 N=300 Q43. Which of the following best describes your health insurance situation? N=247 N=300 Q44. What is the highest level of education that you have completed?
N=272 N=300 Q5. Generally, how would you describe your health? Would you say it is…
N=273 N=300 Q7. If you have one person or group you turn to for basic healthcare needs, where do you go most often? (Select all that apply)

Surveys

Community Surveys

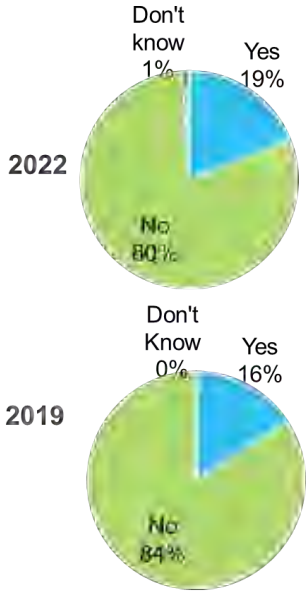


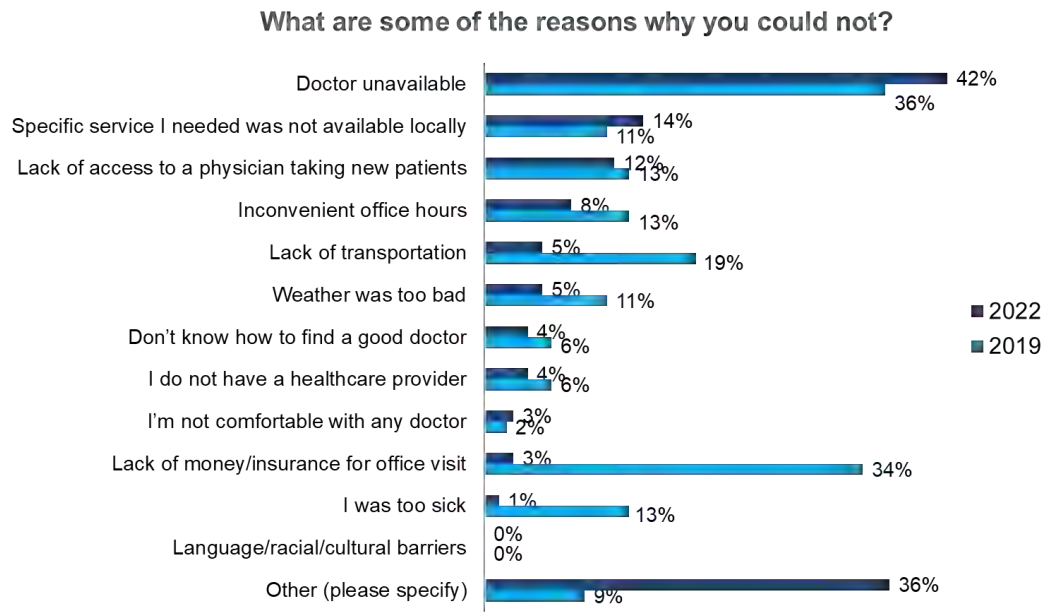
N=272 Q6. Generally, how satisfied are you with your…

Surveys

Community Survey

Was there a time in the past 12 months when you needed to see a **doctor** but could not?

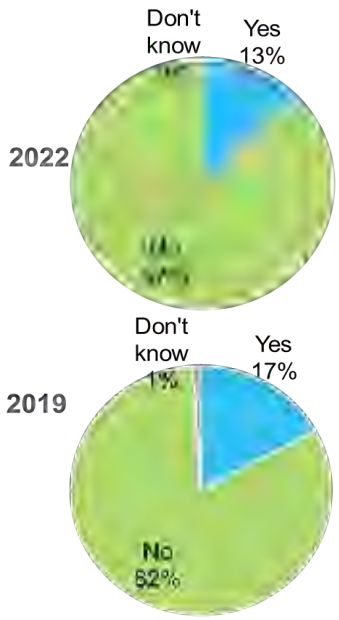


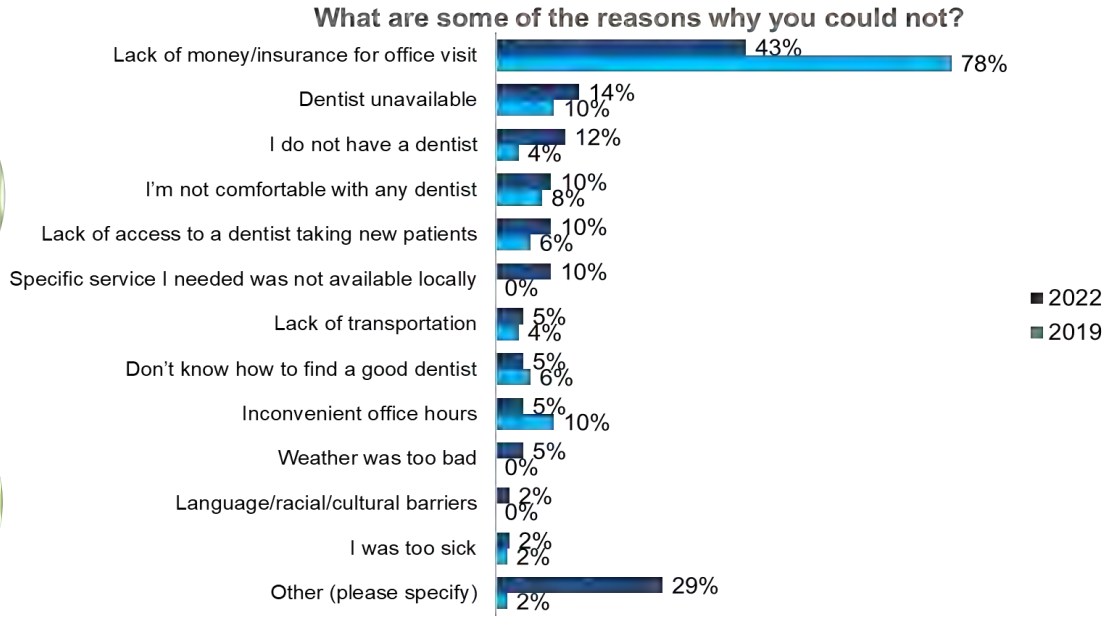


N=274 N=300 Q8. Was there a time in the past 12 months when you needed to see a doctor but could not?

N=77 N=47 Q9. What are some of the reasons why you could not see a doctor? (Select all that apply)

Was there a time in the past 12 months when you needed to see a **dentist** but could not?





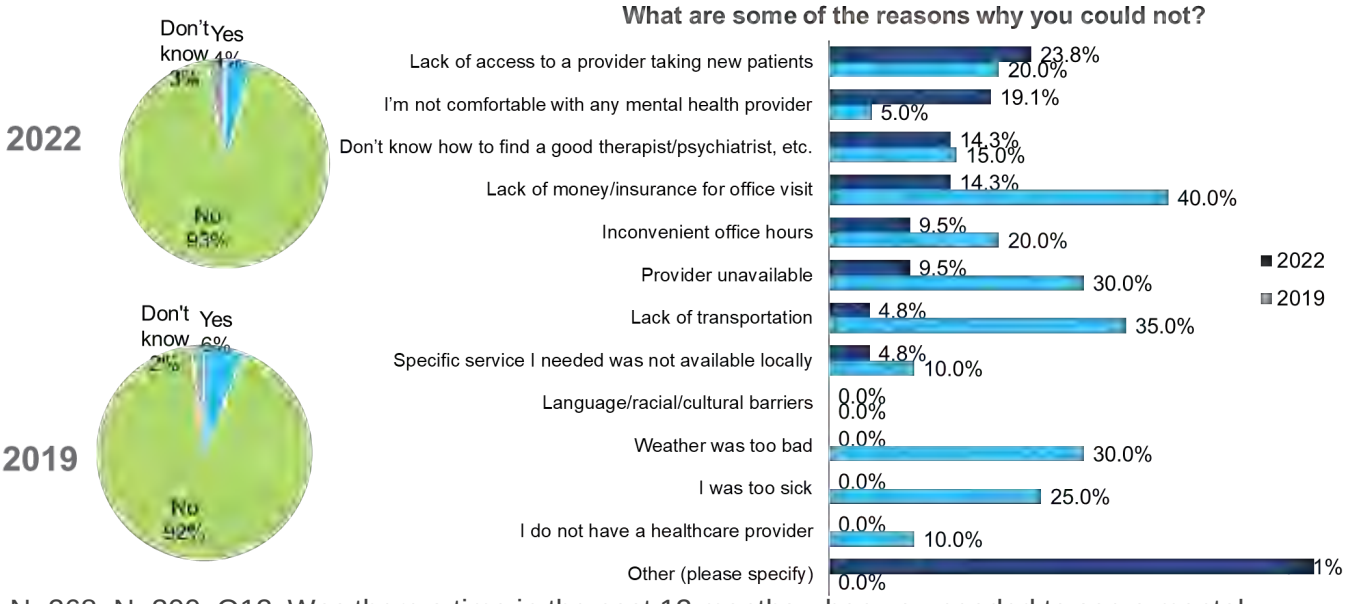
N=273 N=300 Q10. Was there a time in the past 12 months when you needed to see a dentist but could not?

N=42 N=51 Q11. If "Yes", what are some of the reasons why you could not see a dentist? (Select all that apply)

Surveys

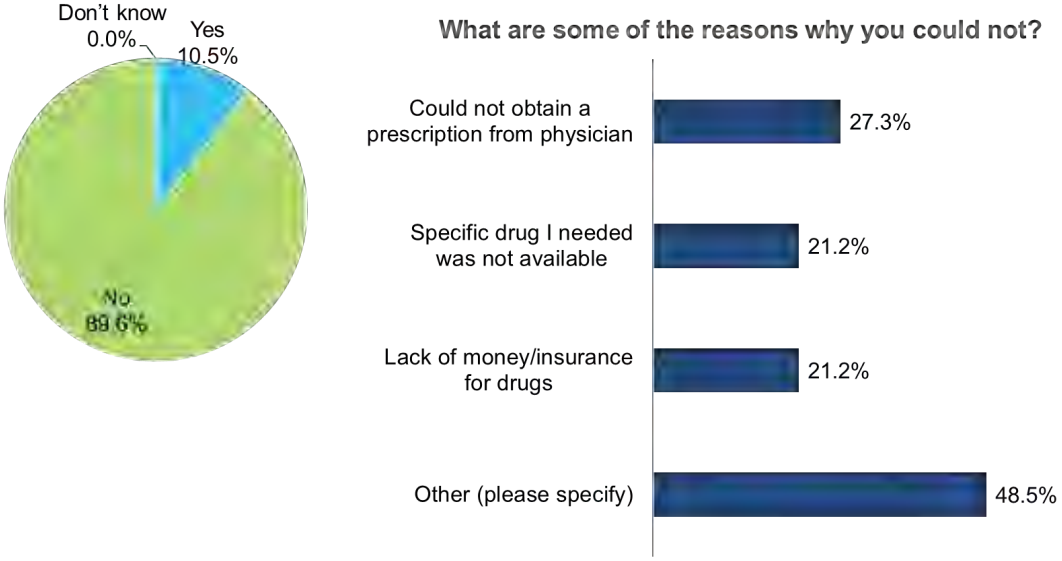
Community Surveys

Was there a time in the past 12 months when you needed to see a **mental health professional** but could not?



N=268 N=300 Q12. Was there a time in the past 12 months when you needed to see a mental health professional but could not?
N=21 N=20 Q13. If "Yes", what are some of the reasons why you could not see a mental health professional? (Select all that apply)

Was there a time in the past 12 months when you needed medications but could not obtain them?

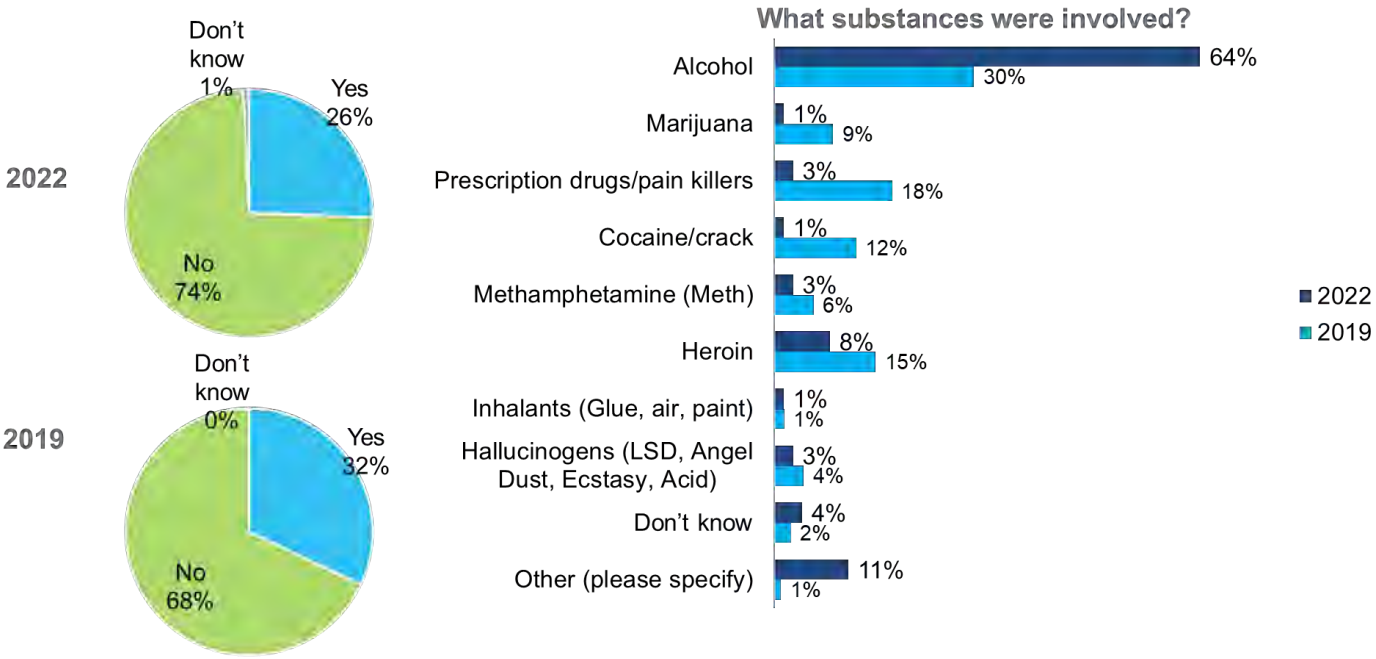


N=268 Q18. Was there a time in the past 12 months when you needed medications but could not obtain them?
N=33 Q20. If "Yes", what are some of the reasons why you could not obtain needed medications? (Select all that apply)

Surveys

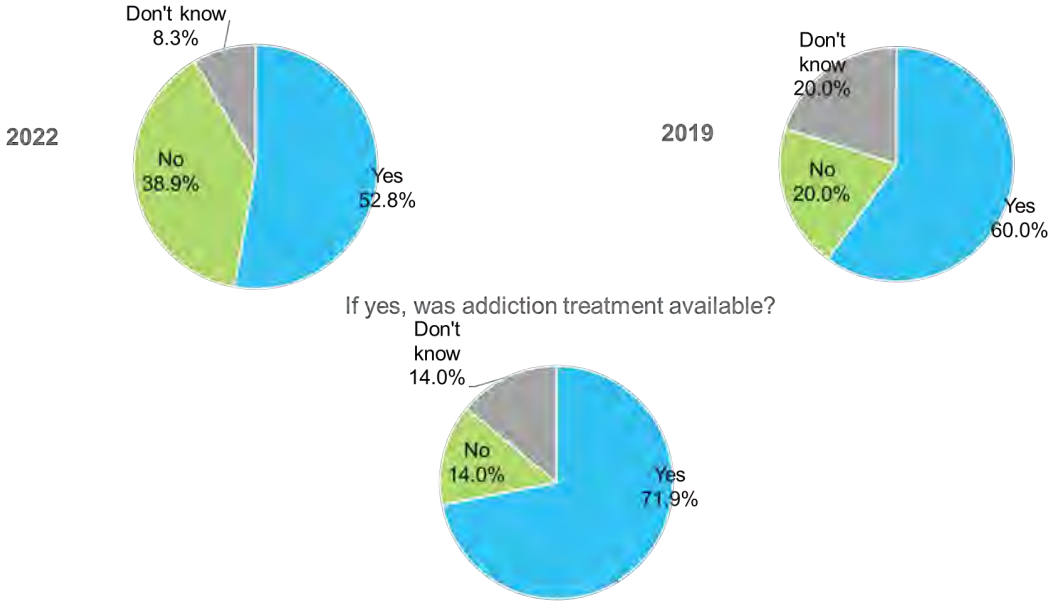
Community Surveys

Have you, a relative, or a close friend experienced substance abuse or addiction?



N=270 N=300 Q14. Have you, a relative or close friend experienced substance use or addiction?
N=72 N=96 Q15. If "Yes", what substance use or addiction was involved?(Select all that apply)

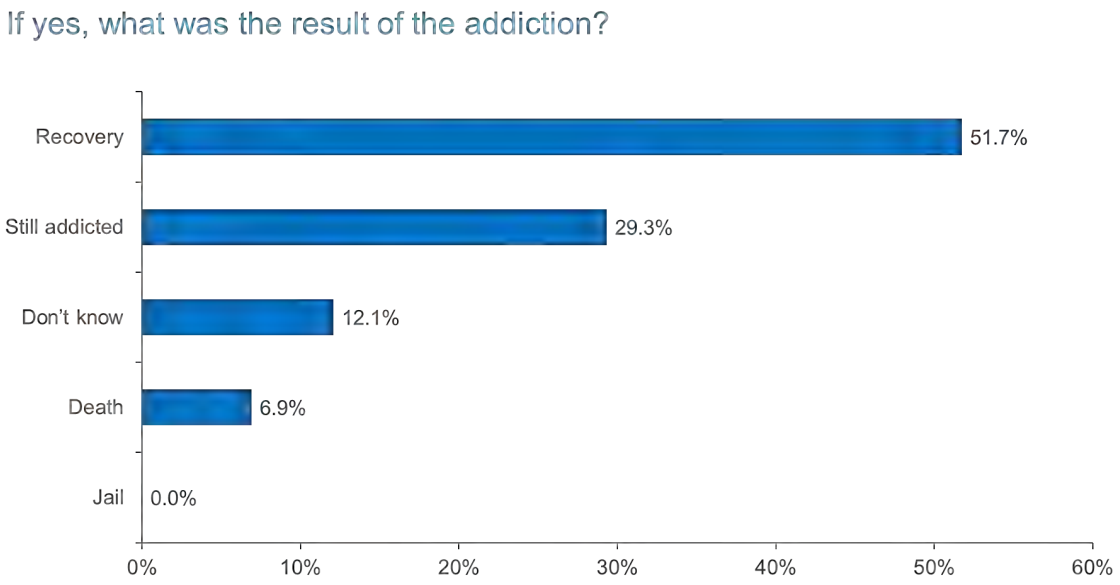
If yes, did the person search for or want treatment?



N=72, Q16. If yes, did the person search for or want treatment?
N=57 N=96 Q17. If yes, was treatment available?

Surveys

Community Surveys

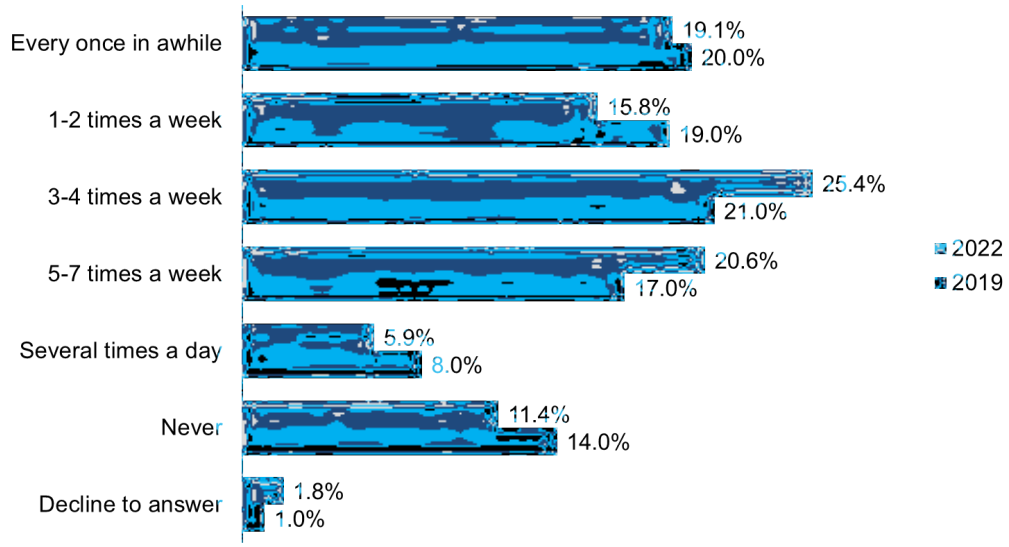


N=72, Q18. If yes, what was the result of the addiction?

Surveys

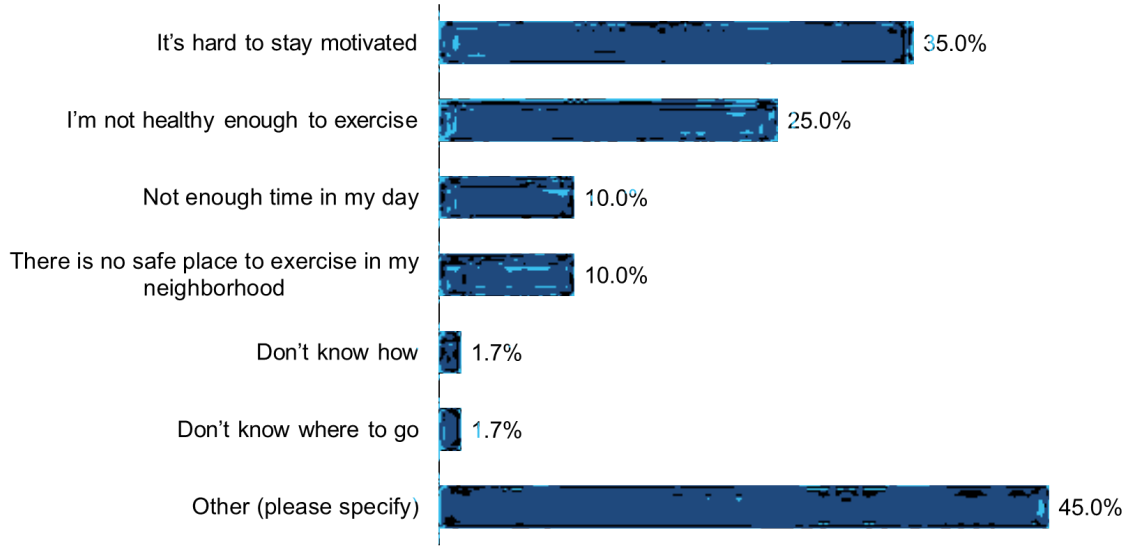
Community Surveys

How often did you participate in any physical activities or exercise such as fitness walking, running, weight-lifting, team sports, etc.?



N=272 N=300 Q20. During the past month, other than on your regular job, about how often did you participate in any physical activities or exercise such as fitness walking, running, weight-lifting, team sports, etc.?

If "never", What are the reasons you have not participated in any exercise during the past month? (Select all that apply)

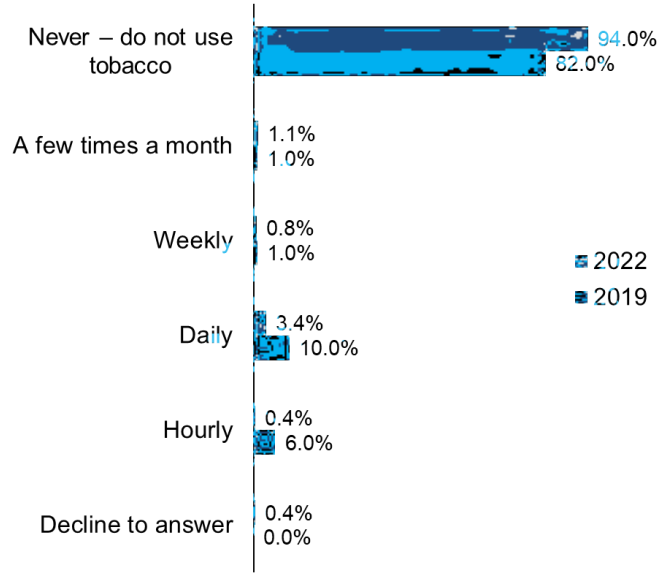


N=60 Q22. If "Never" was selected, what are the reasons you have not participated in any exercise during the past month?(Select all that apply)

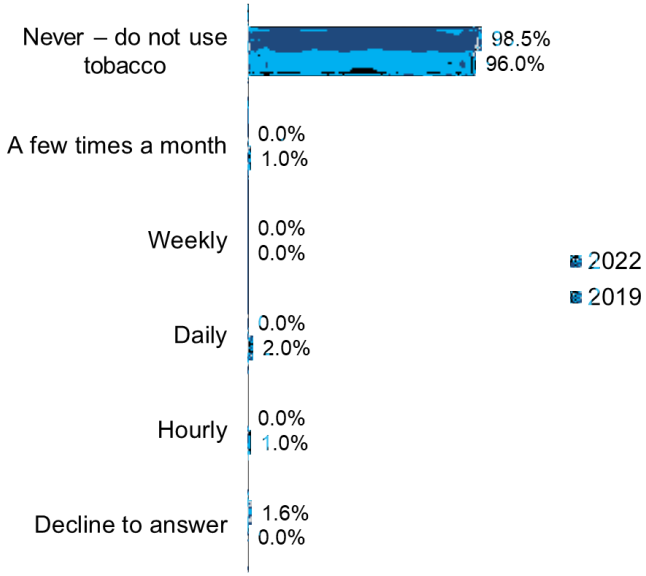
Surveys

Community Surveys

How often do you smoke or use smokeless tobacco, if you do?

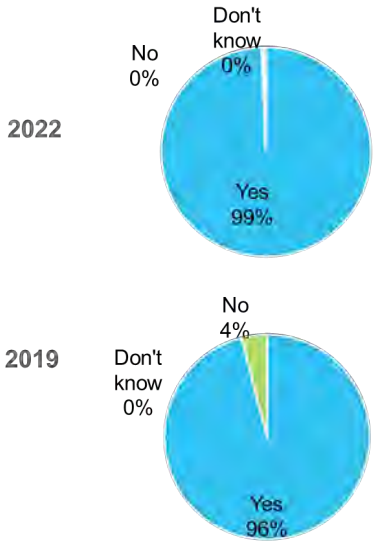


How often do you use e-cigarettes or vape, if you do?

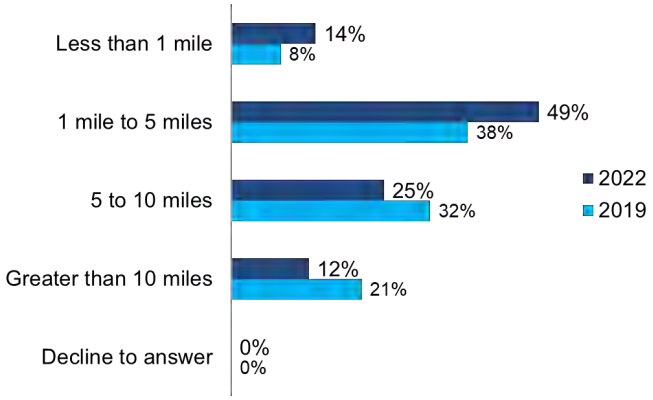


N=268 N=300 Q23. How often do you smoke or use smokeless tobacco, if you do?
N=258 N= 300 Q24. How often do you use e-cigarettes or vape, if you do?

Do you have access to healthy food?



How close in distance is the nearest store or market that offers fresh fruits and vegetables?

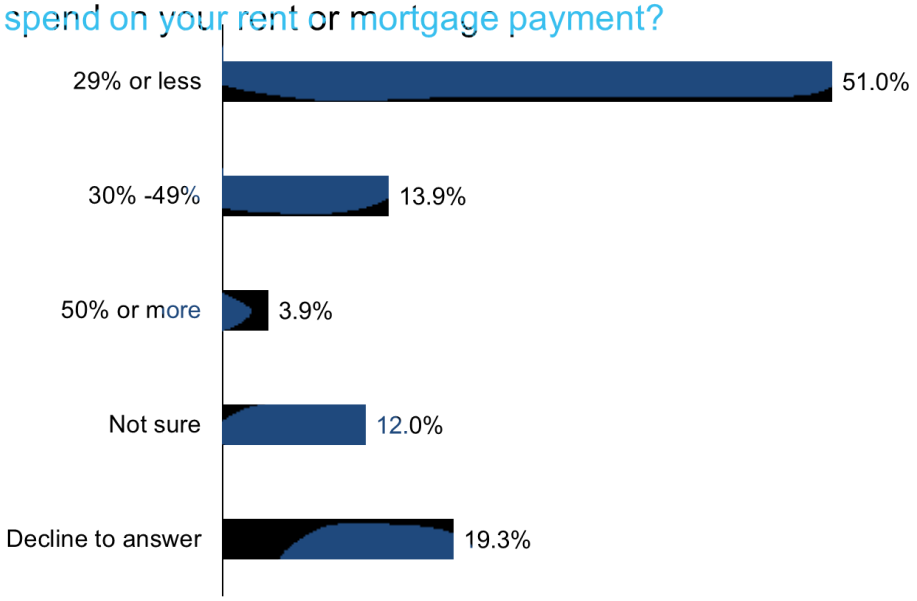


N=268 N=560 Q25. Do you have access to healthy food?
N=273 N=557 Q28. How close in distance is the nearest store or market that offers fresh fruits and vegetables?

Surveys

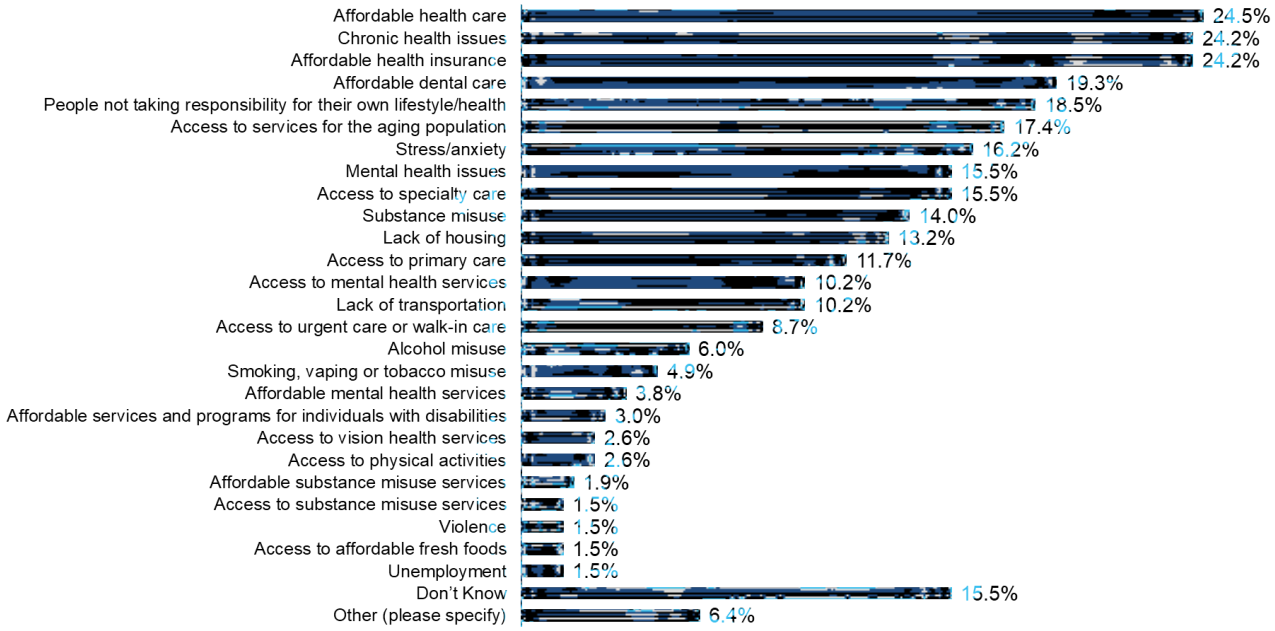
Community Surveys

Approximately what percentage of your total household monthly income would you say you spend on your rent or mortgage payment?



N=259 Q29. Approximately what percentage of your total household monthly income would you say you spend on your rent or mortgage payment?

What are the top three social determinants of health issues that are impacting people's health? (Select up to three)

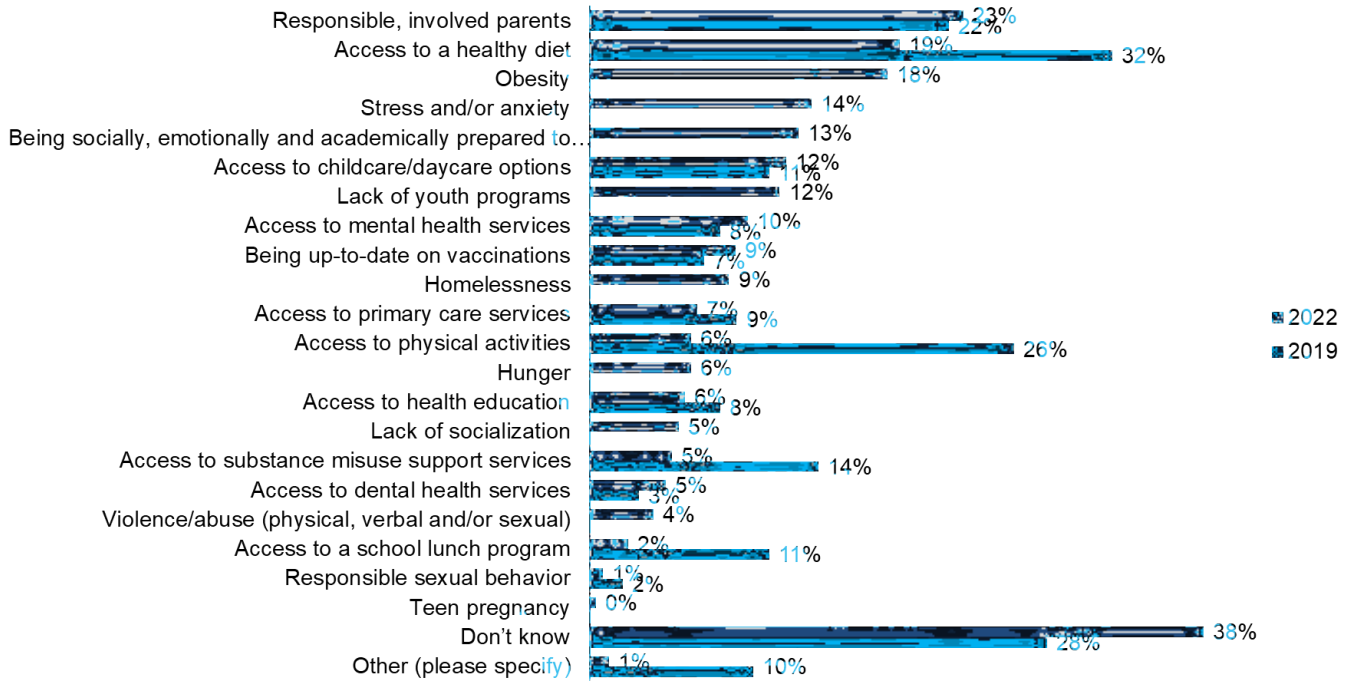


N=265 Q30. What are the top three social determinants of health issues that are impacting people's health? (Select up to three)

Surveys

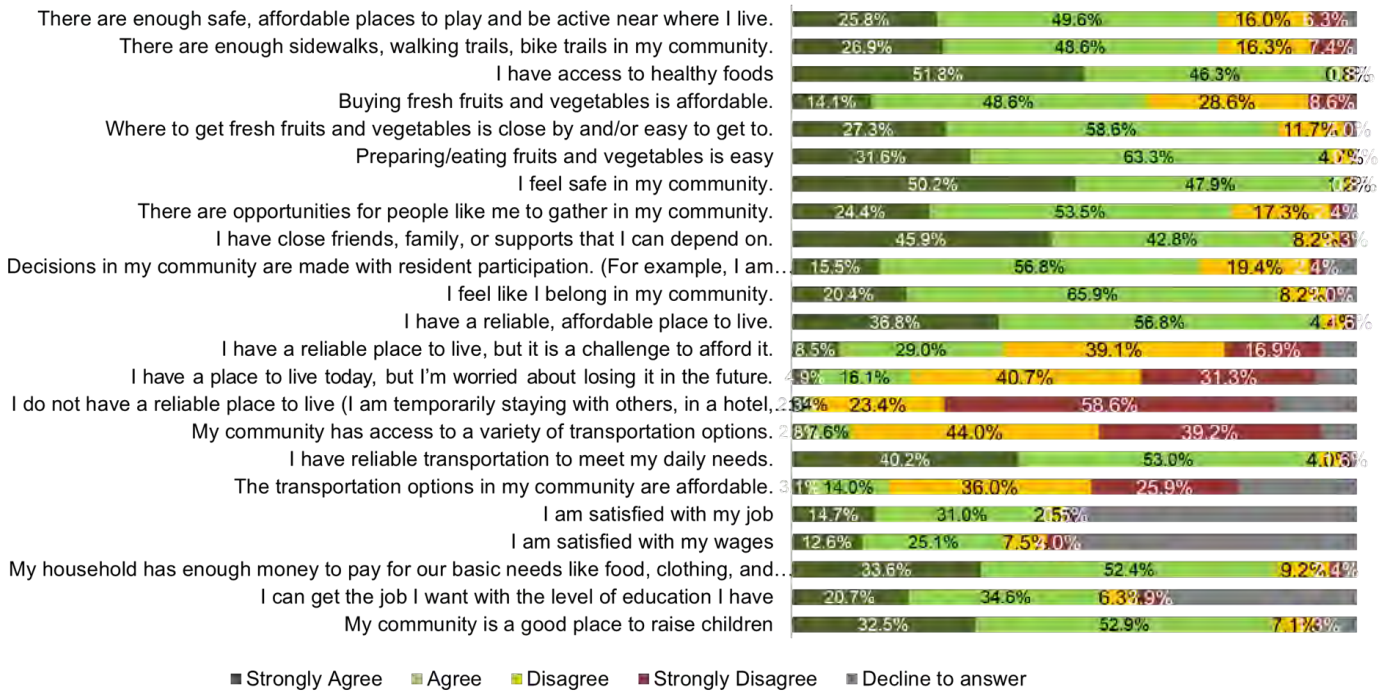
Community Surveys

In your opinion, what are the top 3 health concerns for children and youth in your community? (Select up to three)



N=258 N=300 Q31. In your opinion, what are the top 3 health concerns for children and youth in your community? (Select up to three)

Please tell us how much you agree or disagree with the following statements.

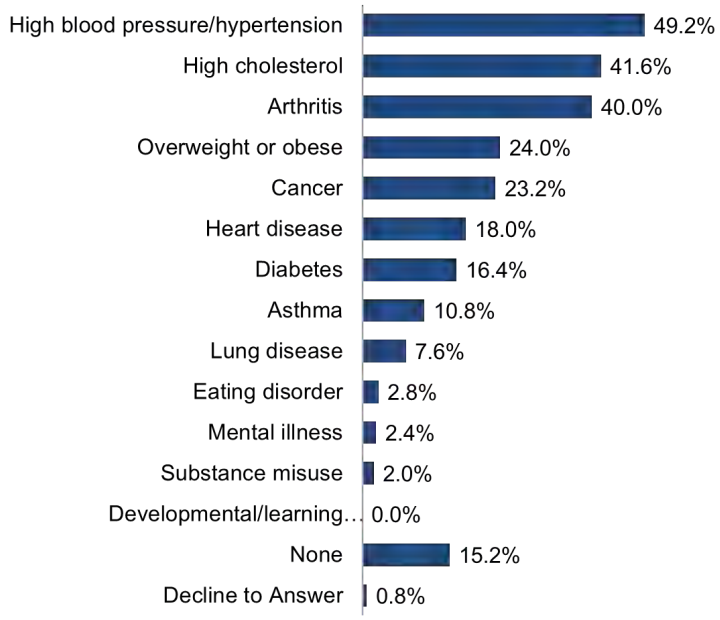


N=259 Q32. Please tell us how much you agree or disagree with the following statements.

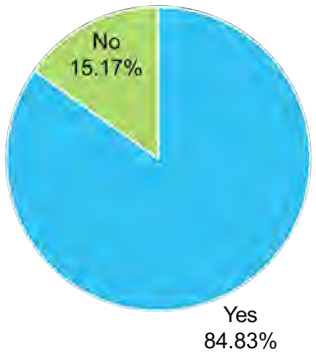
Surveys

Community Surveys

Have you ever been told by a doctor you have any of these conditions, diseases or challenges?

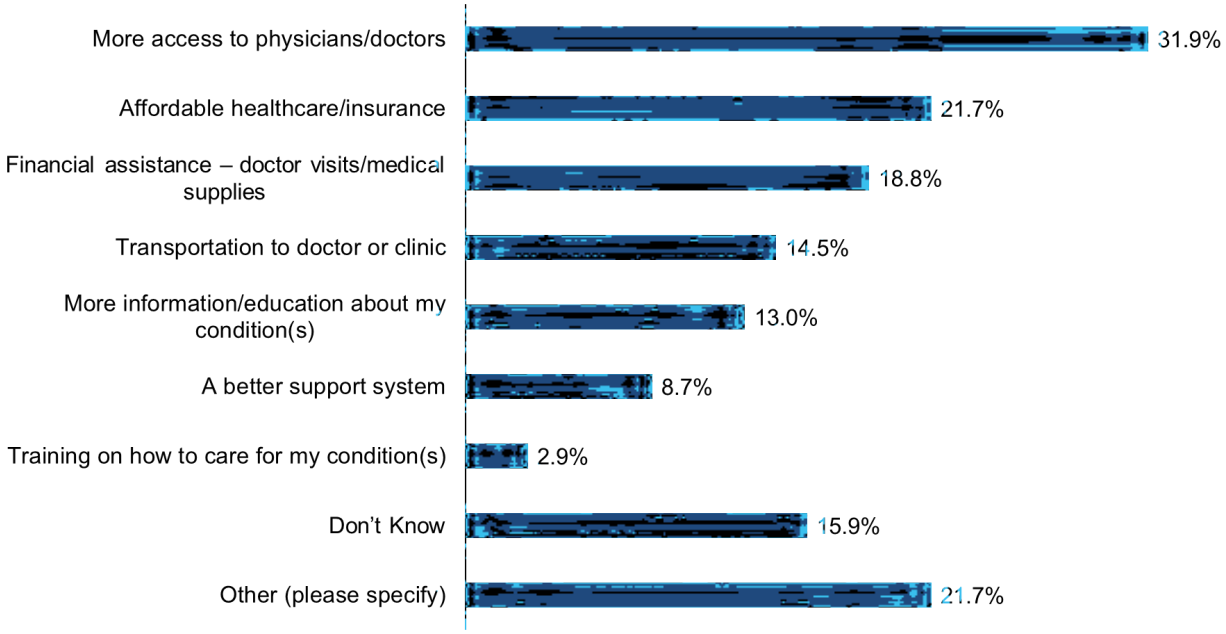


If yes, do you feel you have all that you need to manage your health condition(s)?



N=250 Q33. Have you ever been told by a doctor you have any of these conditions, diseases or challenges? (Select all that apply)
N=211 Q34. If yes, do you feel you have all that you need to manage your health condition(s)?

If no, what do you need in order to manage your health condition(s)?

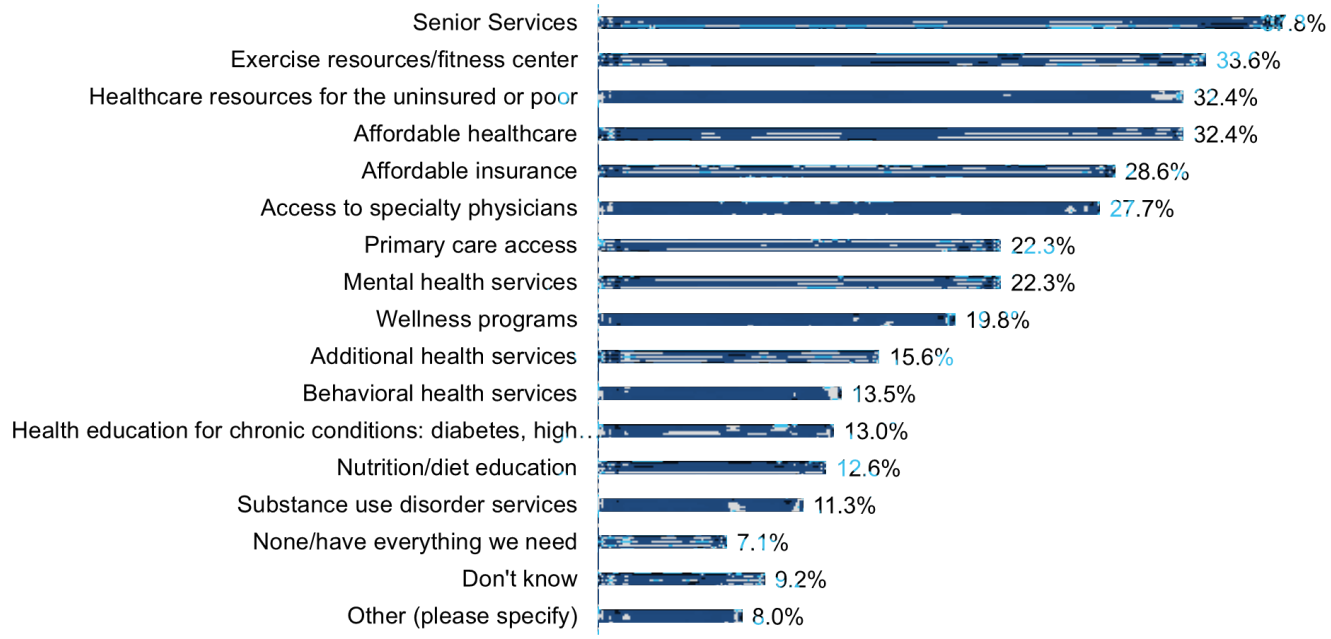


N=69 Q35. If no, what do you need in order to manage your health condition(s)? (Select all that apply)

Surveys

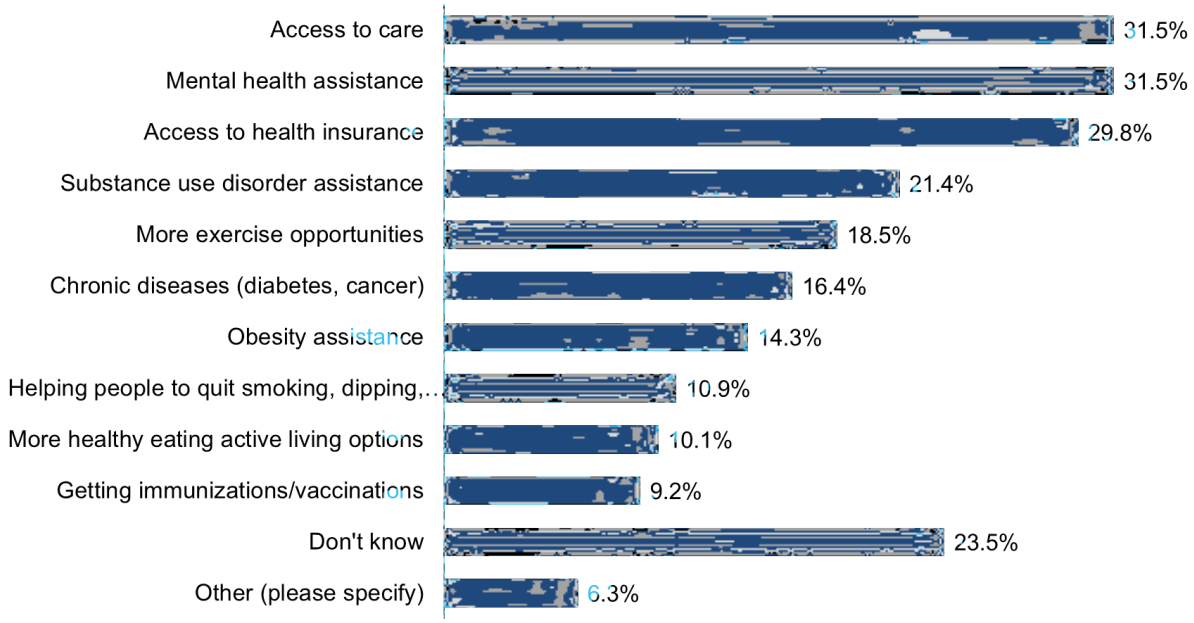
Community Surveys

What healthcare, health education or public health services or programs would you like to see offered in your community?



N=238 Q36. What healthcare, health education or public health services or programs would you like to see offered in your community? (Select all that apply)

In your opinion, what are the top 3 health needs in your community? (Select up to 3)



N=238 Q37. In your opinion, what are the top 3 health needs in your community? (Select up to 3)

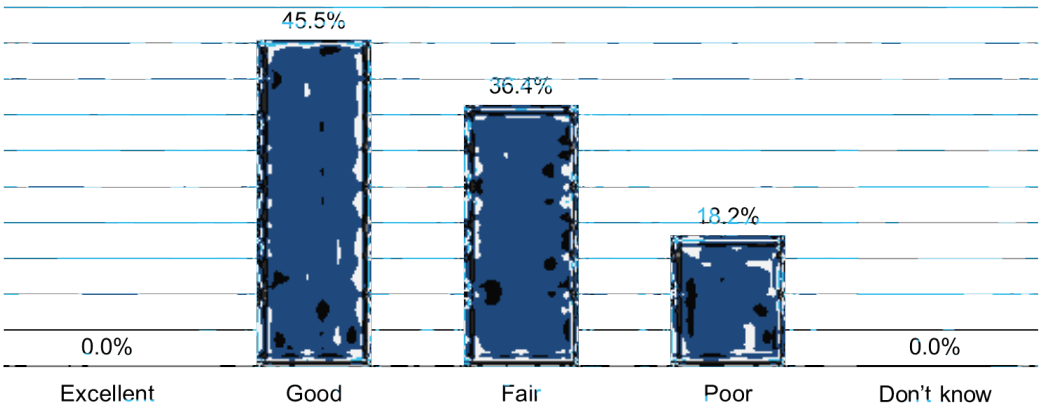
Surveys

Employee Surveys

Huggins Hospital and Stratasan conducted an online surveys of employees of Huggins Hospital. 26 surveys were completed via online surveys from June 20, 2022, through July 25, 2022.

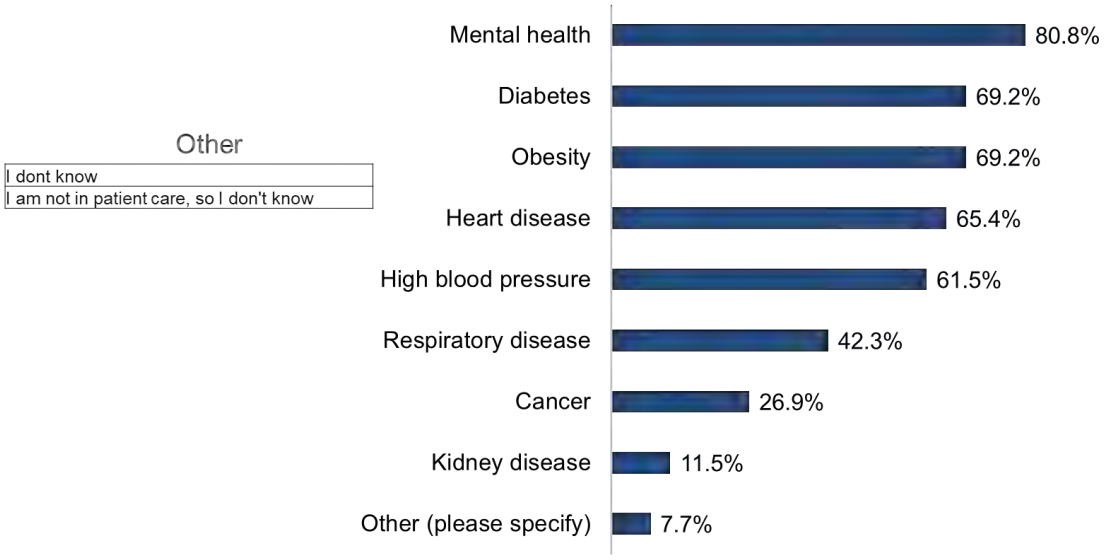
Demographics

Q1. How would you describe the overall health status of the citizens of Huggins Hospital's service area? Would you say it is…



N= 10 Q1. How would you describe the overall health status of the citizens of Huggins Hospital's service area? Would you say it is…

Q2. What are the most prevalent chronic diseases in your community? (Mark all that apply)



N=271 (2022), 499 (2019) Q2. What are the most prevalent chronic diseases in your community? (Mark all that apply)

Surveys

Employee Surveys

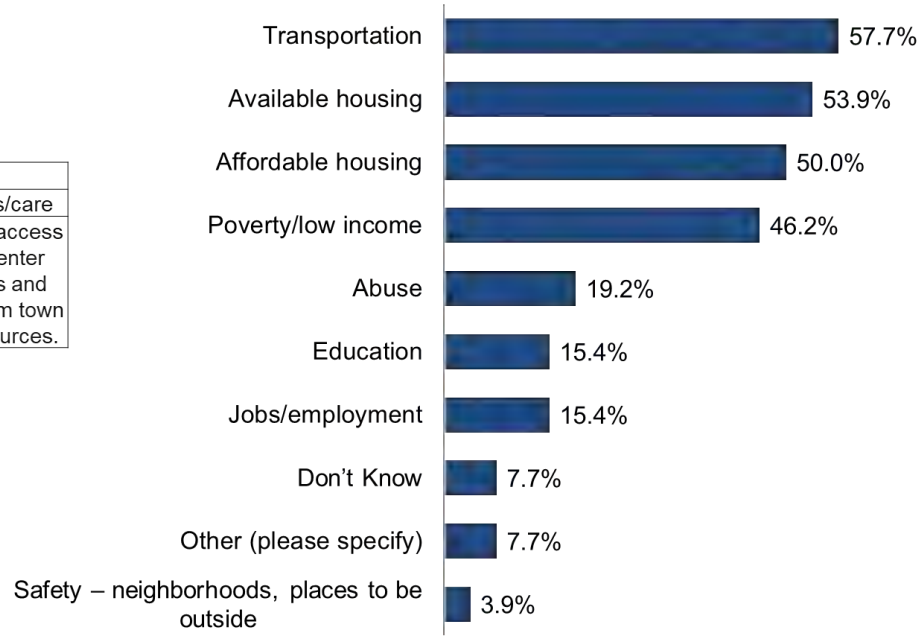
Q3. What are the top 3 issues in Huggins Hospital's service area that impact people's health? These issues could be related to Healthcare Access, Community Issues, General Lifestyle, Quality of Life issues or any other issues you can think of.

Top Issues	2022 %'s
Access to mental health services	60.0%
Mental health issues	50.0%
Affordable health care	40.0%
Chronic health issues	30.0%
Access to specialty care	30.0%
Affordable health insurance	30.0%
Affordable dental care	30.0%
Access to urgent care or walk-in care	20.0%
People not taking responsibility for their own lifestyle/health	20.0%
Lack of transportation	20.0%
Substance misuse	10.0%
Access to primary care	10.0%
Affordable mental health services	10.0%
Smoking, vaping or tobacco misuse	10.0%
Other (please specify)	10.0%

N=10 Q3. What are the top 3 issues in Huggins Hospital's service area that impact people's health? These issues could be related to Healthcare Access, Community Issues, General Lifestyle, Quality of Life issues or any other issues you can think of.

Q4. What are the top three social determinants of health issues that are impacting people's health? (Select up to 3)

Q4. Other
Lack of available in-home services/care
Available affordable housing with access to transportation. Wealthy in the center of Wolfeboro with all the resources and low income pushed further out from town away from hospital and other resources.

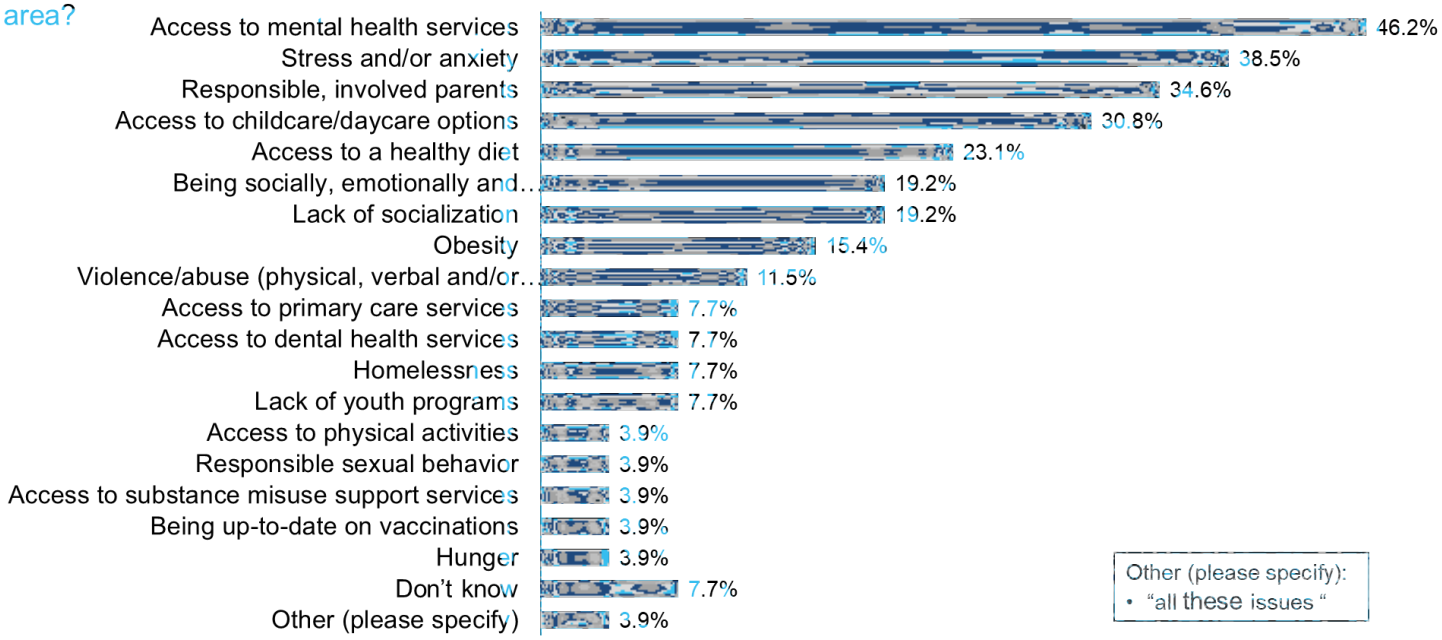


N=26 Q4. What are the top three social determinants of health issues that are impacting people's health?(Select up to 3)

Surveys

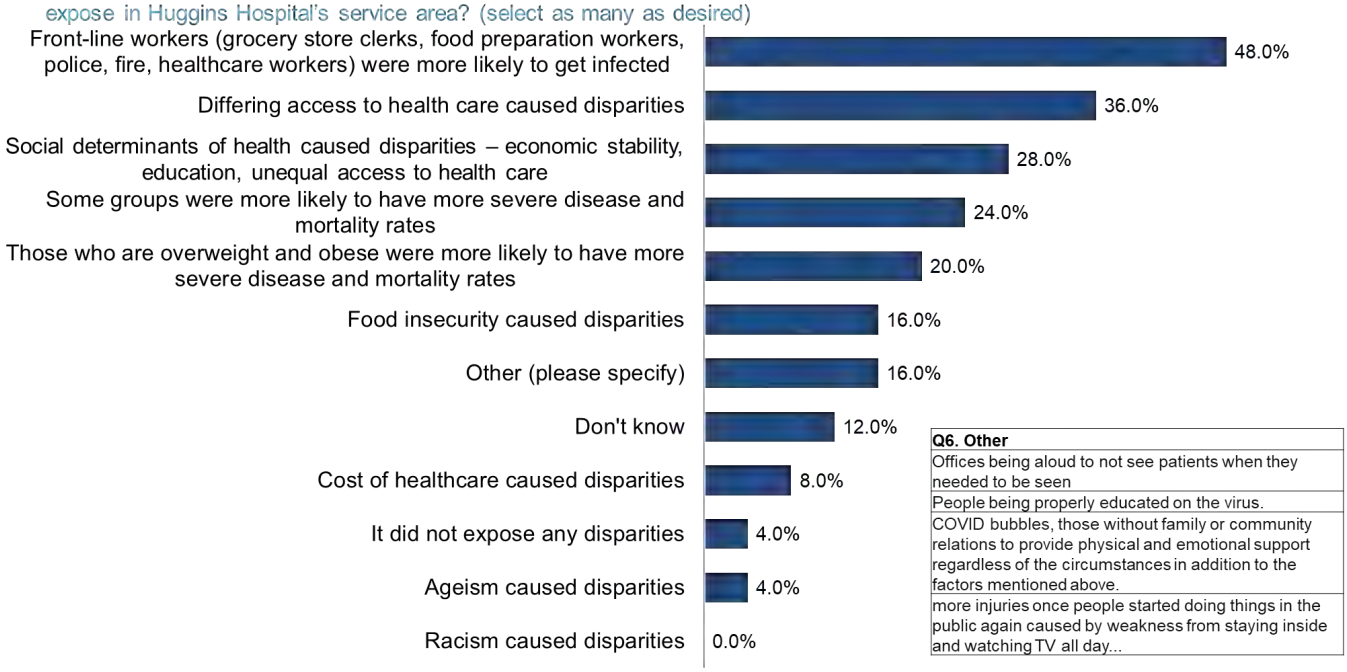
Employee Surveys

Q5. In your opinion, what are the top 3 health concerns for youth and children in Huggins Hospital's service area?



N=26 Q5. In your opinion, what are the top 3 health concerns for youth and children in Huggins Hospital's service area?

What, if any, health disparities or inequities (avoidable, unfair, or remediable differences in health) did the COVID-19 pandemic expose in Huggins Hospital's service area? (select as many as desired)



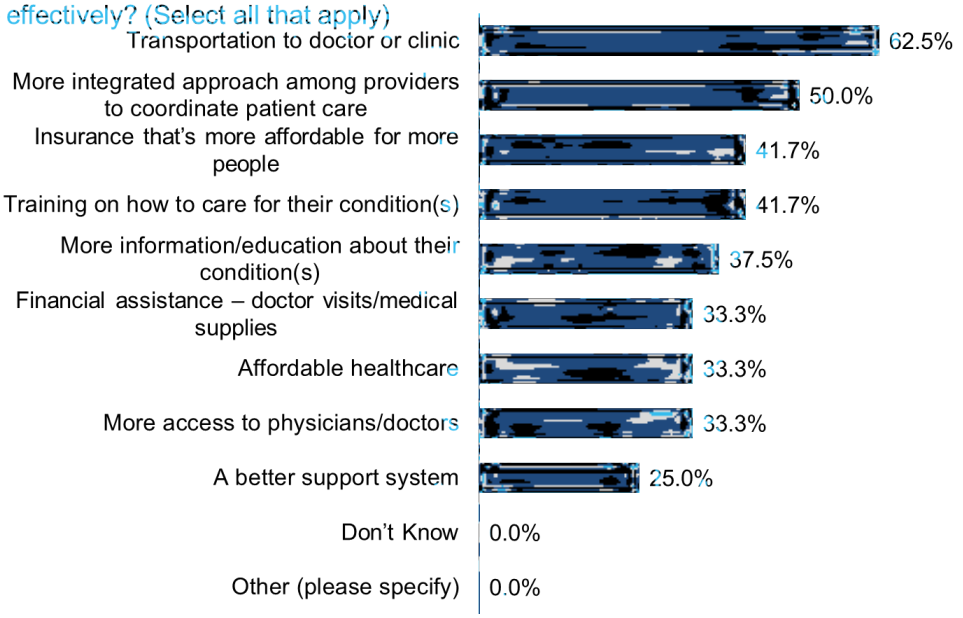
Q6. Other
Offices being aloud to not see patients when they needed to be seen
People being properly educated on the virus.
COVID bubbles, those without family or community relations to provide physical and emotional support regardless of the circumstances in addition to the factors mentioned above.
more injuries once people started doing things in the public again caused by weakness from staying inside and watching TV all day...

N=25 Q6. What, if any, health disparities or inequities (avoidable, unfair, or remediable differences in health) did the COVID-19 pandemic expose in Huggins Hospital's service area? (select as many as desired)

Surveys

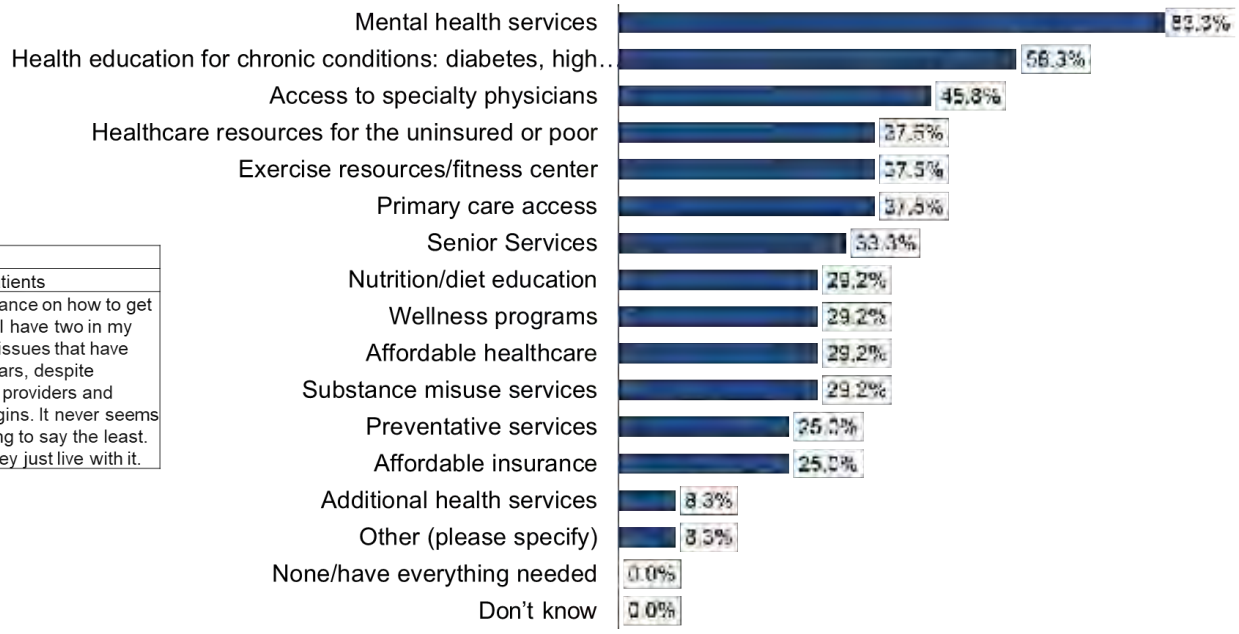
Employee Surveys

Q7. What, if anything, do you think the people in the Huggins Hospital service area need in order to manage their health more effectively? (Select all that apply)



N=24 Q7. What, if anything, do you think the people in the Huggins Hospital service area need in order to manage their health more effectively? (Select all that apply)

What healthcare, health education or public health services or programs would be most beneficial to Huggins Hospital's service area for Huggins Hospital to provide/offer? (Select all that apply)



Q8. Other
adequate staff to treat patients
Patient advocacy or guidance on how to get help getting a diagnosis. I have two in my family who have chronic issues that have been undiagnosed for years, despite multiple visits to different providers and specialists in and of Huggins. It never seems to go anywhere, frustrating to say the least. We have given up and they just live with it.

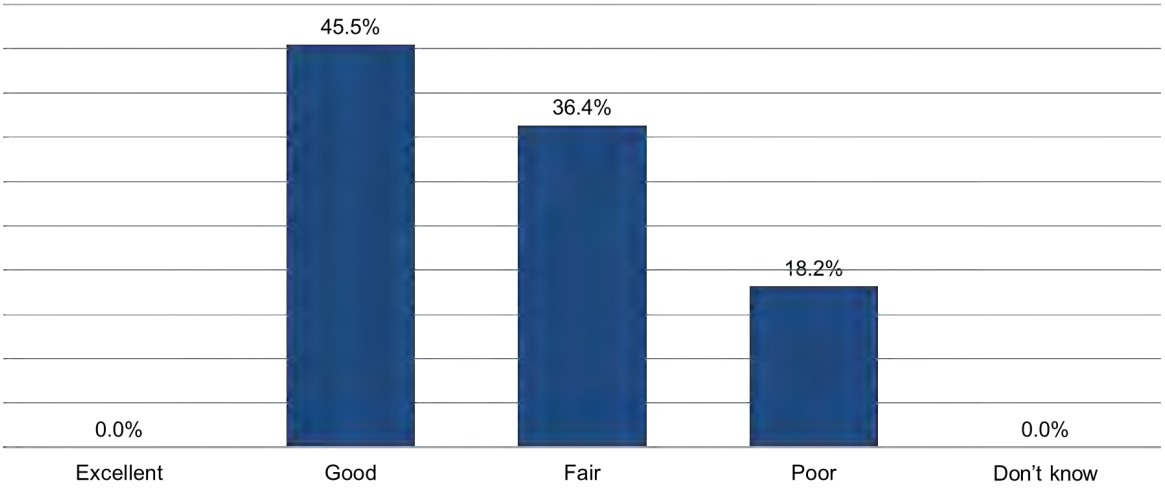
N=24 Q8. What healthcare, health education or public health services or programs would be most beneficial to Huggins Hospital's service area for Huggins Hospital to provide/offer? (Select all that apply)

Surveys

Provider Surveys

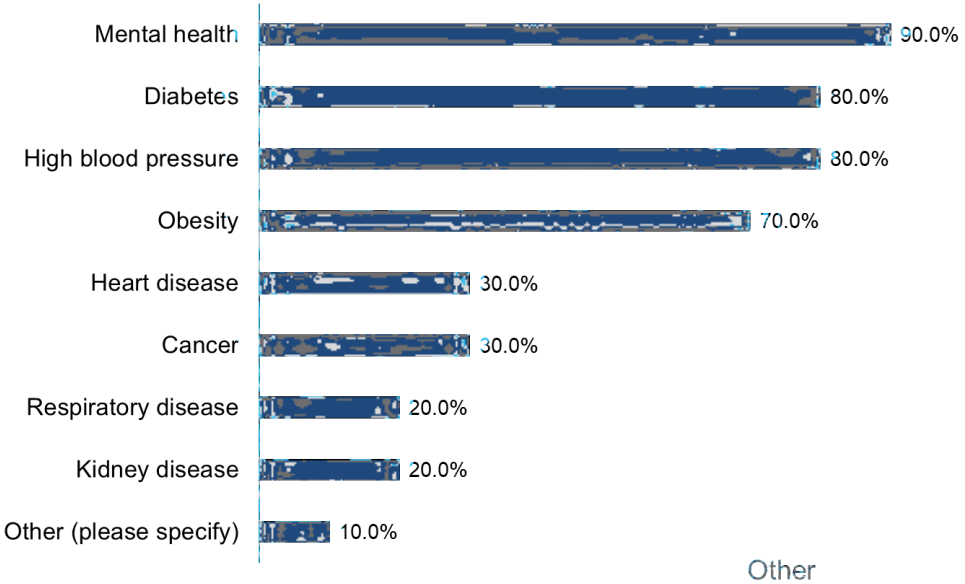
Huggins Hospital and Stratasan conducted an online surveys of medical providers in Carroll County. 10 surveys were completed via online surveys from June 20, 2022, through September 5, 2022. Surveys were sent via email distribution lists.

How would you describe the overall health status of the citizens of Huggins Hospital's service area? Would you say it is…



N=11 Q1. How would you describe the overall health status of the citizens of Huggins Hospital's service area? Would you say it is…

What are the most prevalent chronic diseases in your community?



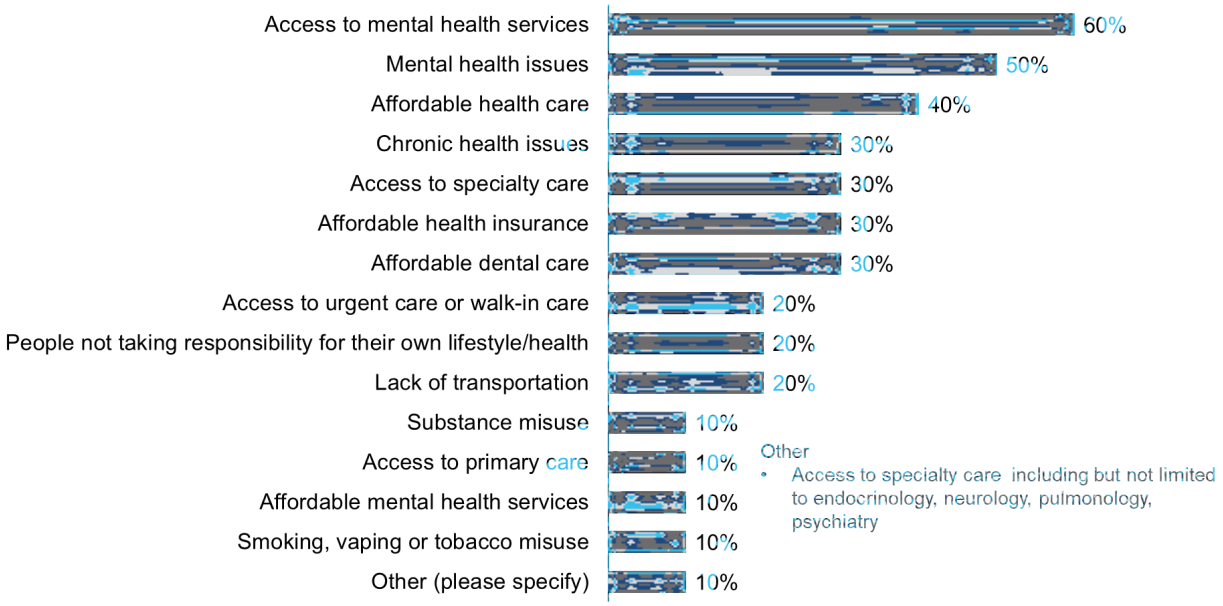
Other
- Drug use

N=10 Q2. What are the most prevalent chronic diseases in your community?

Surveys

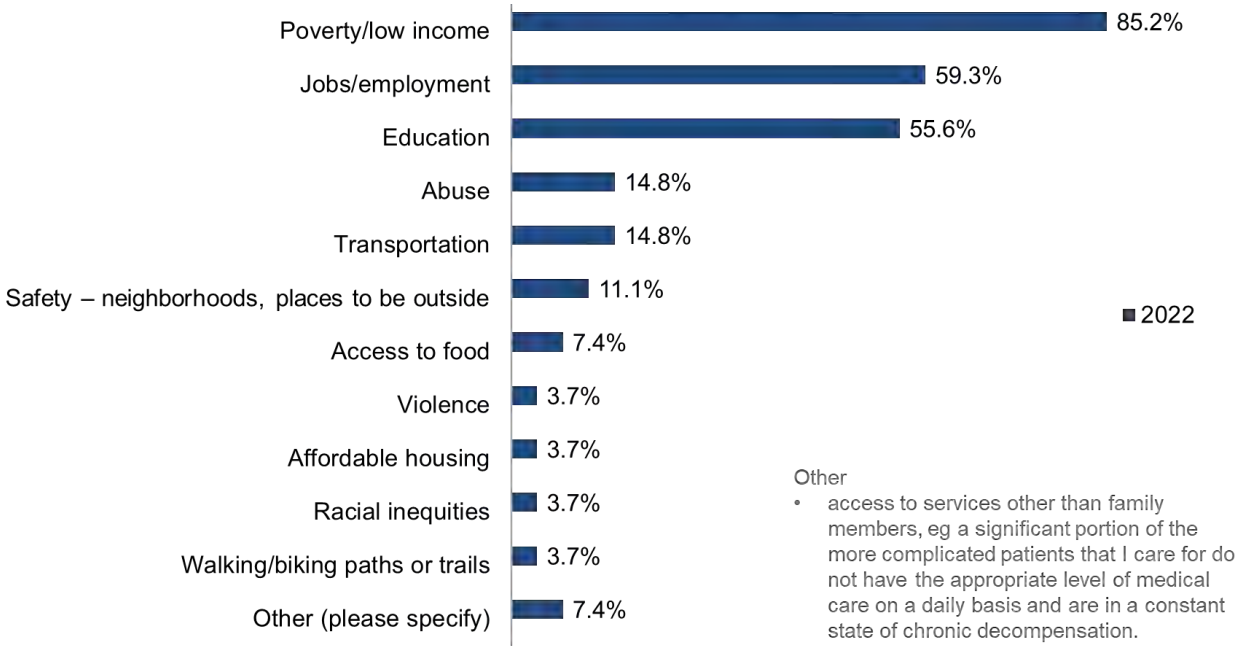
Provider Surveys

What are the top 3 issues in your community that impact people's health?



N=10 Q3. What are the top 3 issues in your community that impact people's health? These issues could be related to Healthcare Access, Community Issues, General Lifestyle, Quality of Life issues or any other issues you

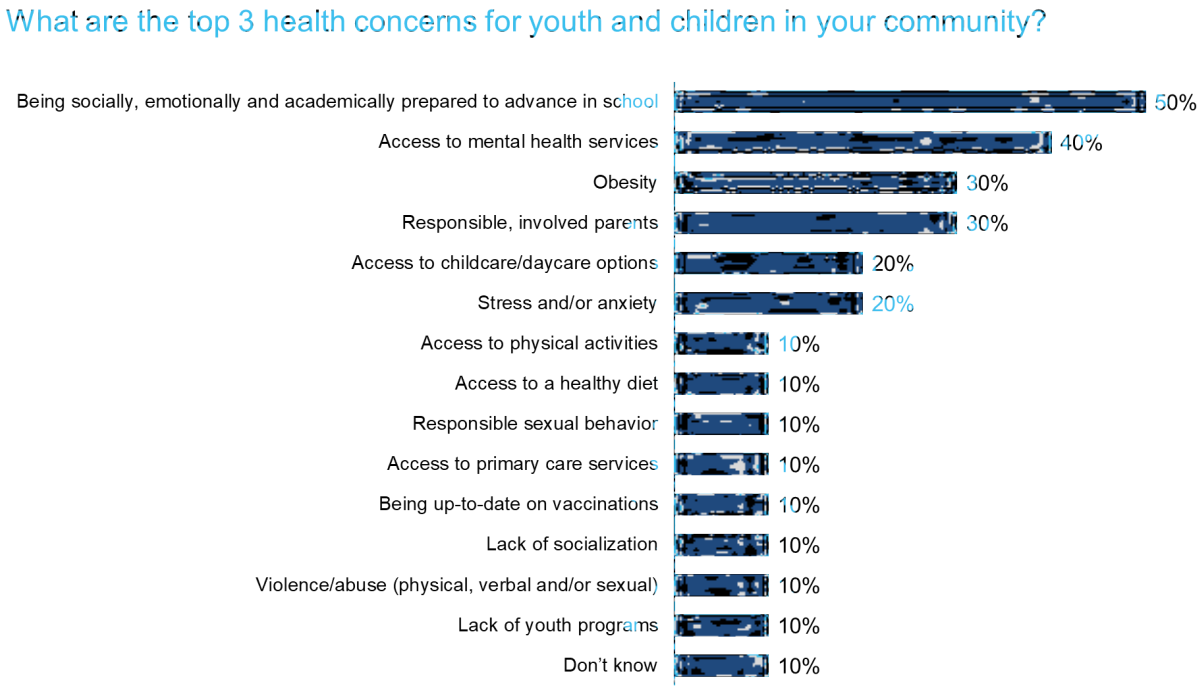
What are the top three social determinants of health issues that are impacting people's health?



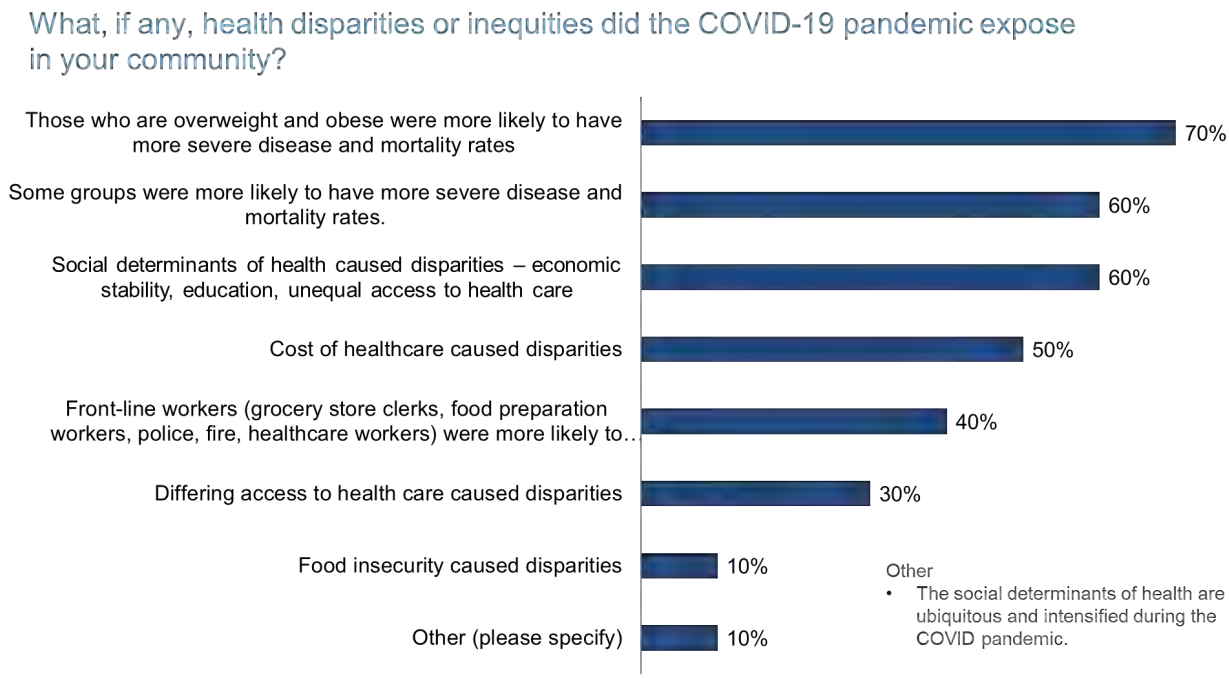
N=10 Q4. What are the top three social determinants of health issues that are impacting people's health? (Select up to 3)

Surveys

Provider Surveys



N=10 Q5. In your opinion, what are the top 3 health concerns for youth and children in Huggins Hospital's service area?

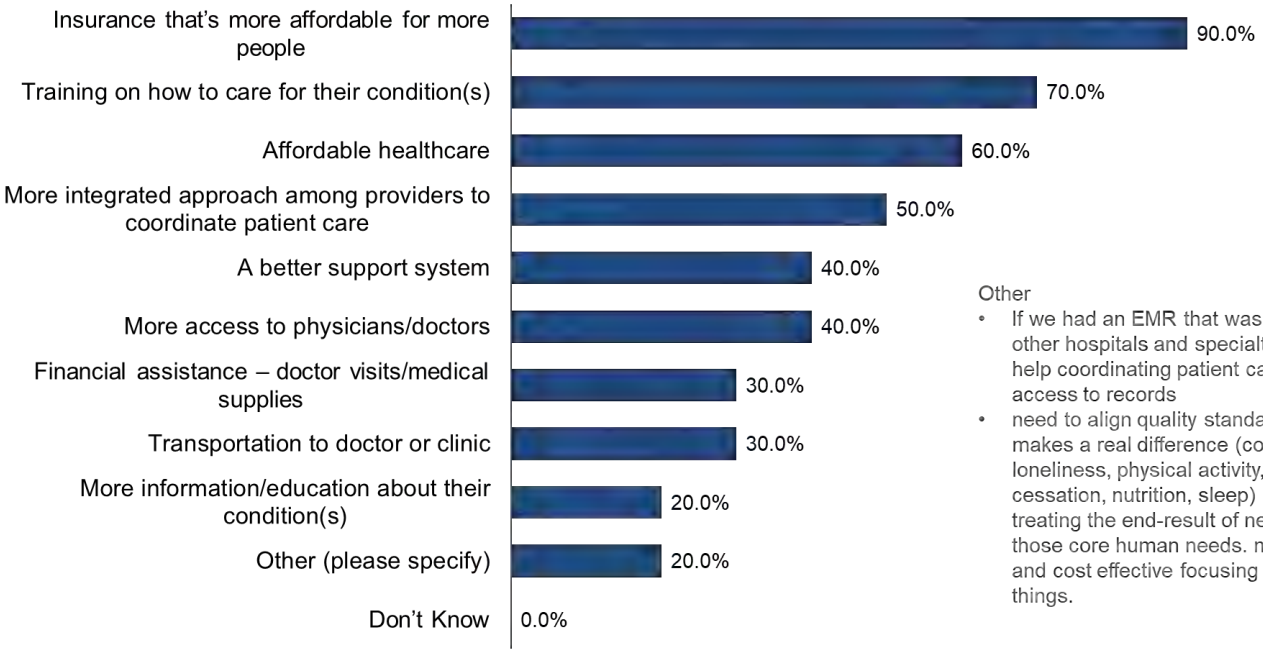


N=27 Q6. What, if any, health disparities or inequities (avoidable, unfair, or remediable differences in health) did the COVID-19 pandemic expose in your community(Select as many as desired)

Surveys

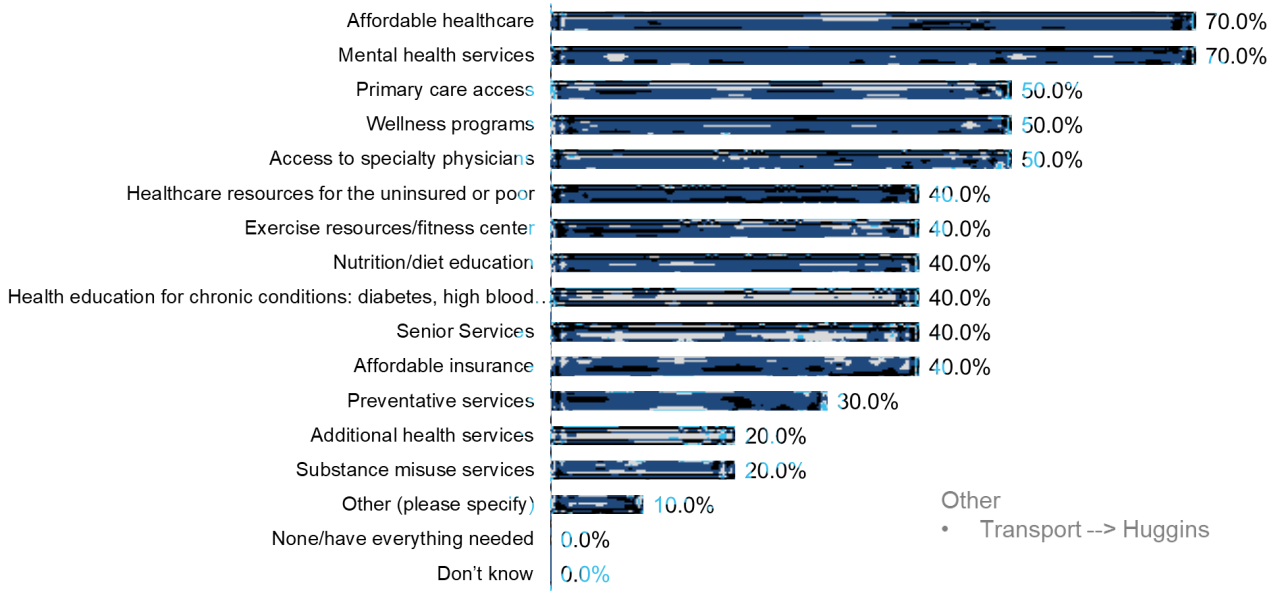
Provider Surveys

What If anything, do you think the people in the Huggins Hospital service area need in order to manage their health more effectively?



N=10 Q7. What If anything, do you think the people in the Huggins Hospital service area need in order to manage their health more effectively? (Select all that apply)

What healthcare, health education or public health services or programs would be most beneficial to your community for hospitals to provide/offer?



N=10 Q8. What healthcare, health education or public health services or programs would be most beneficial to your community for Huggins hospital to provide/offer?

Community Assets and Resources

Community Asset Inventory

During the Community Focus Groups, members of the community and public health, mental health and physical health organizations listed a few resources that are available, currently, as community assets. For a more complete listing of resources in our communities, please access 2-1-1.

211 NH is the connection for New Hampshire residents to the most up to date resources they need from specially trained Information and Referral Specialists. 211 NH is available 24 hours, 365 days a year. Simply call 2-1-1 or find them online at www.211NH.org. Multilingual assistance and TDD access is also available. For those outside of New Hampshire, call 1.866.444.4211.

211 NH

Changing the way New Hampshire finds help

Next Steps

2022 Implementation Plan

In the upcoming months, Huggins Hospital will be working in collaboration with Huggins Community Health Network Board members to define an Implementation Plan based on the 2022 Community Health Needs Assessment. The Implementation Plan will be approved by the Huggins Hospital Board of Trustees and added to this report to be posted online at www.hugginshospital.org and available in print through the hospital's Community Relations Department.

Huggins Hospital

2019 Huggins Hospital Implementation Plan/Impact Evaluation

Huggins Hospital adopted an implementation plan in 2019. The results of this plan were reviewed during the Community Focus Groups in 2022.

The top health issues in 2019 were:

- *Access to Care (including affordability)*
- *Mental Health, Addiction Treatment and Prevention Services*
- *Social Determinants of Health Improvement*

The Implementation Plan from 2019 included strategies such as the following:

- *Increase specialty and primary care services and access*
- *Increase Care Coordination services at Huggins Hospital*
- *Increase access to services that help navigate to social service resources*
- *Provide education regarding financial stability and its impact to overall wellbeing*
- *Develop MAT Program at Huggins Hospital*
- *Participate in multiple groups of the Medicaid 1115 Waiver, a program to transform NH behavioral health delivery*
- *Advocate for patients through multiple forums to improve the continuum of care*
- *Partner with Huggins Community Health Network members to provide services to those in need*
- *Support other organizations that focus on substance misuse, mental health and behavioral health*
- *Develop navigation services inside Huggins Hospital for those with medical needs as well as those with social service needs*
- *Develop strong referral resources to social needs in the local community*
- *Address gaps in services with members of the Huggins Community Health Network*
- *Collaborate with social service providers to develop a community-integrated healthcare system*

With this Implementation Plan, Huggins Hospital:

- *Developed and supported MAT programming and normalized the service into Huggins Hospital Emergency and Primary Care*
- *Expanded the Care Coordination team at Huggins Hospital*
- *Worked with Huggins Community Health Network to share information during the COVID-19 Pandemic*
- *Expanded specialty and primary care services in the area*
- *Expanded resource allocations to navigate patients through social service needs*
- *Supported organizations in the community that are dedicated to health and overall wellbeing*
- *Participated in the Medicaid 1115 Waiver wrap-up projects*

A summary of comments regarding the 2019 Community Health Needs Assessment and implementation Plan:

- *Huggins Hospital continues to make progress in coordinating care and social service resources for community members.*
- *Huggins Hospital continues to support patients with mental health needs as the industry has seen an increase in need throughout the COVID-19 Pandemic.*
- *The COVID-19 Pandemic made progress on the 2019 CHNA difficult. Huggins Hospital still maintained a strong focus on community, providing one of the first drive-up testing and hospital-based COVID-19 vaccine clinics in the state.*

Community Health Needs Assessment

completed by Huggins Hospital in partnership with Stratasan

Huggins Hospital's Selected Initiatives and Implementation Plan 2022

Implementation Plan 2022

In order to be successful in improving the health of our community, Huggins Hospital involved care providers, community members, government, social service providers and businesses with a comprehensive Community Health Needs Assessment (CHNA). With their feedback in mind, Huggins Hospital has selected key elements of the CHNA and will develop strategies and initiatives to address those elements.

Based on the results of this CHNA, Huggins Hospital selected three (3) of the identified significant health needs to address and focus on primarily.

1. **Access to Care (including primary and specialty care)**
2. **Access to Care (Mental Health Care)**
3. **Social Determinants of Health Improvement**

Access to Care (primary and specialty care)	**Access to Care** (Mental Health Care)	**Social Determinants of Health Improvement**

Strategy to address needs:
• Improve access to primary care services during a time of increased demand and higher acuity
  • Improve internal processes to remove barriers to access
  • Evaulate resource needs
• Increase telehealth options for specialty care for both outpatient and inpatient care
 	
Anticipated impact:
• Reduction in ED visits for non-emergency needs
• Reduction in "new patient" waitlist
• Increase in same-day access for primary care appointments
• Addition of new specialty services based on community need
 	
Resources proposed or needed:
• Telehealth providers
• Process improvement
 	
Collaborations anticipated:
• Medical Staff
• Community members
• Telehealth providers
	Strategy to address needs:
	• Develop a Huggins-specific plan to address the shortage in mental health resources in our local areas
	• Advocate for patients through multiple forums to assist statewide efforts to improve access to mental health care
	• Partner with Huggins Community Health Network members to provide shared services whenever possible
	• Support other organizations that focus in mental health resources
	
	Anticipated impact:
	• Reduction in ED visits and "holds" for mental health needs
	• Improved access to treatment, locally, for mental health needs
	
	Resources proposed or needed:
	• Staff focused on mental health
	• Funding for collaboration and support
	• Integrated resources amongst Huggins Community Health Network members
	
	Collaborations anticipated:
	• Huggins Community Health Network
	• Public Health
	• Local mental health organizations
	• State of New Hampshire
		Strategy to address needs:
		• Continue navigation services offered by Huggins Hospital for those with medical needs as well as those with social service needs
		• Develop strong referral resources to social needs in the local community
		• Address gaps in services with members of the Huggins Community Health Network
		• Collaborate with social service providers to develop a community-integrated healthcare system
		
		Anticipated impact:
		• Seamless access from Huggins Hospital to social determinants of health resources and vice versa
		• Increase care coordination and social service navigation resources
		
		Resources proposed or needed:
		• Huggins Community Health Network
		• Outpatient Social Service Navigation
		• Funding to fill gaps in services
		
		Collaborations anticipated:
		• Huggins Community Health Network
		• Public Health
		• Town Agencies
		• Community members

Appendix E-2

Monadnock Community Hospital Community Needs Assessment Report
2021 - 2024

Monadnock
COMMUNITY HOSPITAL
a member of GraniteOne Health

2021-2024 Community Health Needs Assessment

September 7, 2021

crescendo

Contents

Introduction

Organizational History

In 1918, Robert M. Parmelee donated his summer home in Peterborough for use as a community hospital, and in 1923 "The Peterborough Hospital" opened its doors. Parmelee hoped that his contribution would create a local hospital that the residents of the area would consider their own and would continue to support in the coming years. Mr. Parmelee's dream of a community-supported hospital has become a reality. Monadnock Community Hospital (MCH) is an integral part of the healthcare community in the Monadnock Region.

MCH Today

The major strength of MCH is found in the ability of our physicians and staff to offer extensive services utilizing state-of-the-art technology, while maintaining the personalized care of a community hospital. MCH is a 25-bed Critical Access Hospital offering Medical, Surgical and Intensive Care; Obstetrics; Pediatrics; and Mental Health services. In addition, a wide variety of outpatient services are available, including Pulmonary, Cardiac and Physical Rehabilitation; 24-hour Emergency Care; a fully equipped laboratory; and an extensive Radiology department. MCH is fortunate to have strong leadership and a dedicated community that allows us to meet the ever-changing requirements of today's healthcare environment. As that environment changes, MCH is also committed to changing and providing the communities we serve with appropriate and innovative programs.

MCH Emergency Department

The MCH Emergency Department offers health services 24 hours a day, 7 days a week to patients of all ages with all presenting complaints. The Emergency Department is responsible for the immediate treatment of any medical or surgical emergency; for initiating lifesaving procedures in all types of emergency situations; and for providing emergency and initial evaluations and treatment for other conditions including minor illnesses and injuries, and subacute medical problems. After initial assessment and stabilization, patients can be transported to other medical institutions if necessary.

Board Certified Physicians

The MCH Medical Staff includes over 135 primary and specialty care physicians, 3 dentists and 64 health professional affiliates. Medical staff offices are located in the Medical Arts Building on MCH's campus as well as in the communities of Peterborough, Jaffrey, and Antrim. One hundred percent of the Medical Staff are Board Certified in their medical specialty area.

Primary Care Services

Monadnock Community Hospital has a primary care network of physicians, nurse practitioners, psychiatrists, psychologists, and social workers. This network provides a wide range of primary and behavioral health care services for individuals and families with offices in Peterborough, Rindge, Jaffrey, and Antrim.

Mission, Vision, and Values

The Board of Trustees and staff at at Monadnock Community Hospital are committed to the following Mission, Vision and Values statement:

Our Mission

MCH is committed to improving the health and well-being of our community.

Our Vision

We will elevate the health of our community by providing accessible, high quality and value-based care.

Our Values

Compassion, Collaboration, Honesty and Respect.

Methodology, Purpose, and Data Limitations

Community Health Needs Assessment Participants and Purpose

MCH reached out to a group of individuals to participate in its Community Health Needs Assessment (CHNA) to contribute insights from patients, community service organizations, and staff. Each person provided project feedback regarding perceptions of area health needs, data evaluation, and other guidance during the CHNA process. The individuals had a breadth of community health vision, knowledge, and leadership to impact the well-being of the service area.

Section 9007(a) of the Affordable Care Act (March 2010) requires that all non-profit hospitals and health systems to complete a Community Health Needs Assessment every three years. The purpose of the Monadnock Community Hospital CHNA is to identify and prioritize community needs. In doing so, it will also provide a solid technical platform to analyze service area population health, finely tune outreach activities, highlight opportunities for collaboration, strengthen the existing community health activities, and meet IRS regulations.

The practical purpose is this: the CHNA provides a data- and research-based foundation from which to develop and drive hospital activities that impact the most people, address the most urgent needs, and otherwise respond to the highest priority needs within the hospital's purview.

Methodology Components

The CHNA methodology includes a combination of quantitative and qualitative research methods designed to evaluate perspectives and opinions of area stakeholders and healthcare consumers – especially those from underserved populations. The methodology used helped prioritize the needs and establish a basis for continued community engagement – in addition to simply developing a broad, community-based list of needs.

The major sections of the methodology include the following:

- **Strategic Secondary Research.** This type of research includes a thorough analysis of previously published materials that provide insight regarding the community profile and health-related measures.

- **Qualitative Interviews and Discussion Groups.** This form of primary research includes discussion groups and interviews with a MCH CHNA Leadership Group, other community service providers, and healthcare consumers who represent a span of healthcare consumers in the service area.
- **Community Survey.** Crescendo conducted an online survey with more than 440 community members. Survey results and analysis can be found in this report. The survey instrument is contained in the appendices.
- **A Needs Prioritization Process.** Following the secondary research, qualitative interviews, focus group discussions, and community survey, a list of 28 community health issues was generated. MCH CHNA Leadership Group members participated in a needs prioritization meeting where top needs were discussed, along with MCH locus of control for each item. The discussions allowed a formation of a prioritized needs analysis.

Leadership Group

To ensure broad and deep community engagement in the CHNA, MCH compiled a group of community leaders, which represented public health and diverse community interests. The MCH CHNA Leadership Group is listed below:

Leadership Group Member	Community Agency
Owen Houghton	JR Rotary
Mary Drew	Reality Check
Pam Murphy	Peterborough Elementary School
Ellen Avery	Community Volunteer Transportation Company
Dennis Calcutt	Regional System of Care
Margaret Nelson	The River Center
Erika Alusic-Bingham	Southern New Hampshire Services
Susan Howard	Monadnock Area Transitional Shelter
Sandra Faber	Monadnock At Home
Karen Peterson	Monadnock Developmental Service
Chief Ed Walker	Peterborough Fire and Rescue
Phil Wyzik	Monadnock Family Services
Glo Morison	Peterborough Food Pantry
Leaf Seligman	Monadnock Restorative
Kimberly Johnston	Monadnock Center for Violence Prevention
Elizabeth Kenny	Community Volunteer at Monadnock Community Hospital

Data Limitations

In general, the secondary data utilizes the most current data sets available. The dramatic changes in 2020 and 2021 due to the COVID-19 pandemic may have impacted some of the traditional projection tools, source data, and data collection methods. For example, the American Community Survey (ACS) which provides detailed population and housing information revised its messaging, altered their mailout strategy, and made sampling adjustments to accommodate the National Processing Center's staffing limitations.[1] Where relevant, the impacts or new data due to the COVID-19 pandemic are noted.

In addition, in-person interviews and focus group discussions were conducted only by telephone or in a virtual setting. The decision to may have impacted some of traditional in-person dynamics.

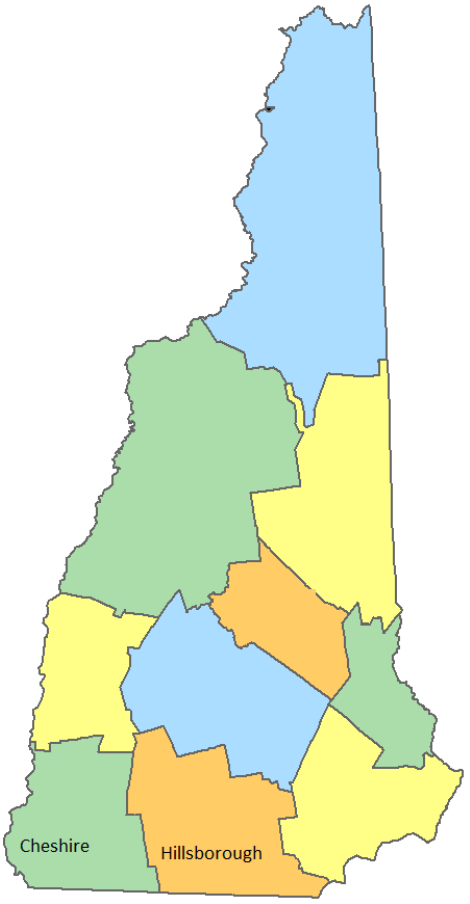
[1] See U.S. Census Bureau: https://www2.census.gov/ces/wp/2021/CES-WP-21-02.pdf

Overview of Communities Served

Area Description and Map

Monadnock Community Hospital is a 25-bed acute care facility serving a geographically distinctive market in the Greater Monadnock region of New Hampshire, whose population of 38,816[2] includes 13 towns in Cheshire and Hillsborough counties. Outlined in red, below, the towns include:

Exhibit 1: Service Area Map



Antrim	Jaffrey
Bennington	New Ipswich
Dublin	Peterborough
Francestown	Rindge
Greenfield	Sharon
Greenville	Temple
Hancock	

[2] American Community Survey, 5-Year Estimates. https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true

The Social Vulnerability Index

The Social Vulnerability Index (SVI) helps identify areas of community health need. Developed by the Centers for Disease Control and Prevention as a metric for analyzing population data to identify vulnerable populations, the SVI's measures are housed within the domains of Socioeconomic Status, Household Composition and Disability, Minority Status and Language, Housing, and Transportation. The tool may be used to rank overall population wellbeing and mobility relative to County and State averages. It can also be used to determine the most vulnerable populations during disaster preparedness and global pandemics.

Exhibit 2: Social Vulnerability Index by Town

	Antrim	Bennington	Dublin	Francestown	Greenfield	Greenville	Hancock	Jaffrey	New Ipswich	Peterborough	Rindge	Sharon	Temple
Population	2,753	1,568	1,708	1,626	1,837	2,086	1,665	5,363	5,399	6,566	6,444	369	1,432
Below Poverty	7.3%	4.3%	4.8%	3.7%	7.3%	6.5%	1.6%	8.7%	4.2%	7.5%	7.8%	3.8%	6.9%
Median Income ($)	56,250	71,667	83,438	103,588	77,059	75,721	56,458	57,405	80,882	60,324	81,737	78,750	82,917
Age 65+	19.2%	15.2%	24.9%	22.0%	17.7%	19.4%	28.1%	19.7%	14.1%	26.0%	14.6%	20.3%	20.2%
Age 17 or Younger	18.0%	21.1%	17.9%	16.3%	17.9%	20.8%	15.6%	20.5%	25.8%	18.0%	19.4%	16.8%	16.7%
Household with Disability	7.9%	7.9%	4.8%	6.3%	10.2%	17.3%	8.4%	10.6%	7.0%	9.1%	7.1%	7.0%	7.3%
Single-Parent Household	22.9%	33.3%	ND	ND	ND	18.7%	32.0%	38.4%	ND	40.3%	ND	ND	ND
Ethnic Minority	3.6%	3.7%	4.3%	4.5%	3.2%	4.3%	3.8%	5.4%	3.0%	5.8%	6.3%	2.7%	3.0%
Do not Speak English	0.0%	0.0%	ND	ND	ND	0.0%	0.0%	0.0%	ND	0.0%	ND	ND	ND
Multi-Unit Housing Structures	17.1%	17.1%	ND	ND	ND	27.6%	19.8%	19.3%	ND	28.2%	ND	ND	ND
Mobile Homes	1.1%	3.5%	ND	ND	ND	0.0%	0.0%	9.6%	ND	0.0%	ND	ND	ND
No Vehicle	2.3%	0.0%	ND	ND	ND	4.8%	0.0%	2.8%	ND	12.0%	ND	ND	ND

SOURCE: ESRI Data 2021. American Community Survey 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true

Exhibit 3: Social Vulnerability Index, Service Area Combined

	United States	New Hampshire	Hillsborough County	Monadnock Service Area
Population	324,697,795	1,397,908	413,035	38,816
Below Poverty	13.1%	7.6%	7.8%	6.4%
Unemployed	6.7%	3.8%	3.5%	3.6%
Median Income	$62,203	$75,181	$84,651	$75,683
Age 65+	16.6%	18.5%	15.2%	19.5%
Age 17 or Younger	21.9%	19.1%	20.7%	19.7%
Household with Disability	9.1%	9.5%	12.1%	8.6%
Single-Parent Household	29.0%	24.1%	23.8%	30.9%
Ethnic Minority	30.6%	8.4%	15.6%	4.7%
Do not Speak English	2.6%	0.4%	2.8%	0.0%
Multi-Unit Housing Structures	26.3%	23.7%	36.8%	21.5%
Mobile Homes	6.2%	5.5%	2.0%	2.4%
No Vehicle	8.6%	5.1%	5.7%	3.7%

SOURCE: ESRI Data 2021. American Community Survey 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true

Social Vulnerability Index Data Table Highlights

- The Monadnock service area is defined by its high senior citizen population. Nearly 20% (19.5%) of Monadnock service area residents are age 65 and over, a somewhat higher percentage than the state (18.5%) and county (15.2%) average.

- Median incomes are strong in the Monadnock service area ($75,683), and poverty rates are slightly lower (6.4%) than the Hillsborough County average (7.8%). By town, high poverty rates are noteworthy in Jaffrey (8.7%), Rindge (7.8%) Peterborough (7.5%), Greenfield (7.3%) and Antrim (7.3%). Poverty rates are low in Hancock (1.6%), Francestown (3.7%), and Sharon (3.8%).

- The number of single-parent households in the Monadnock service area is high – over 30% (30.9%). Single-Parent Households may indicate a vulnerable population, which may experience a lack of childcare options and/or a single source of income – contributing factors to the cycle of poverty

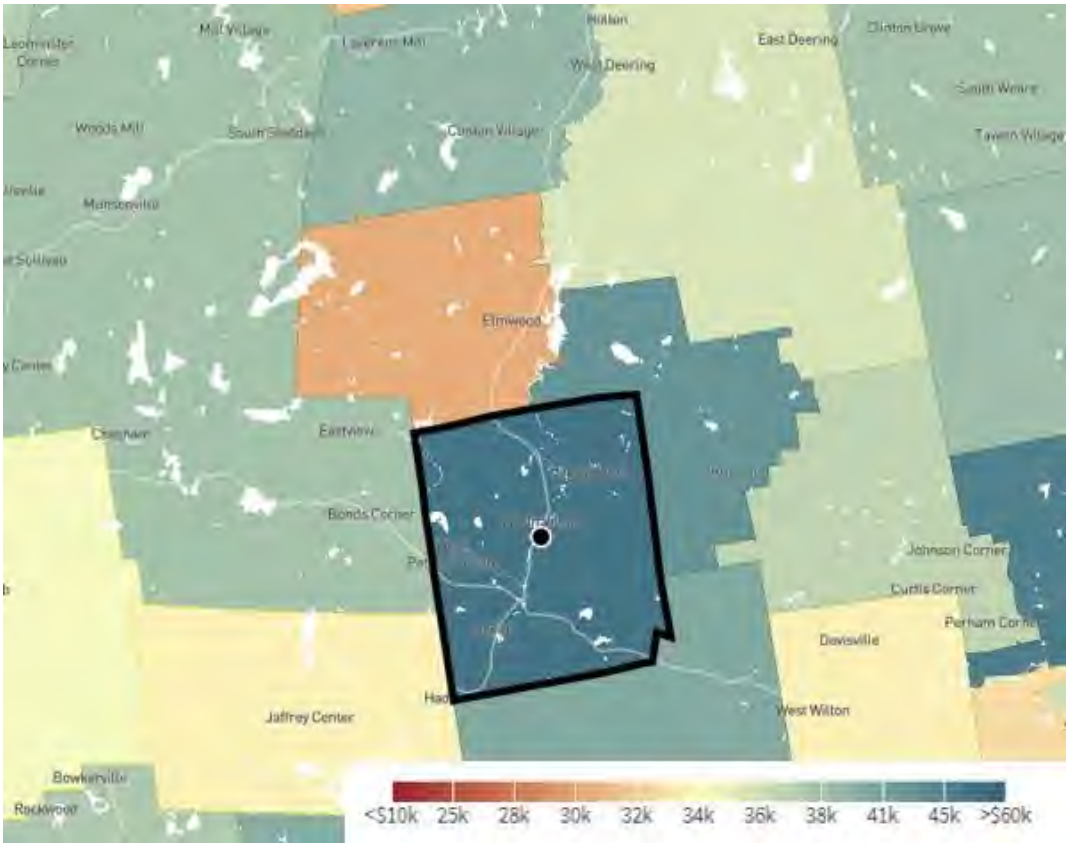
- While Hillsborough County experiences great population diversity compared with the New Hampshire average, that is not reflected in the Monadnock service area. Just 4.7% of the service area population identifies as an ethnic minority, well below county (15.6%) and state (8.4%) averages.

- Youth (i.e., age 17 or younger) make up nearly 20% of the Monadnock service area population (19.7%) – similar to state and county averages.

The Opportunity Atlas

To further illustrate the needs and disparities of the Monadnock service area, the Opportunity Atlas is an informative tool. The Opportunity Atlas analyzes census data and tax returns to track economic and social mobility among individuals born in distinct geographic regions.

Exhibit 4: The Opportunity Atlas, Peterborough, and Surrounding Service Areas



SOURCE: The Opportunity Atlas. https://www.opportunityatlas.org/

In Exhibit 4 above, the blue color represents higher income "opportunity" for children raised in a respective area, while orange and red indicate lower income "opportunity." Economic opportunity is most common in Peterborough and the immediate areas surrounding Monadnock Community Hospital (identified with a black dot). Relatively greater area of need can be seen in Jaffrey and Hancock.

Recap of 2019-2021 Community Health Needs

In 2018, the Monadnock Community Health Needs Assessment identified the following areas of need:

Exhibit 5: 2018 Community Health Needs Assessment Prioritized Needs

2018 Prioritized Community Needs	
Rank	**Need**
1	Behavioral health – early detection and intervention
2	Behavioral health care for adult social, emotional, and organically based illnesses
3	Drug and alcohol abuse treatment
4	Drug and alcohol education and early intervention
5	Affordable medical care for seniors and lower income households
6	Affordable Dental services for adults
7	Coordination of care
8	Coordination of care between provider organizations
9	Youth-oriented health programs
10	Services that provide transportation to medical appointments and the pharmacy

The top areas of need for the 2021-24 Community Health Needs Assessment are summarized below. Note that the highest priority needs are similar to the 2018 list, yet differences exist. The narrative following the table below provides insight regarding the collection of data, qualitative findings, and other material used to develop the 2021 list of prioritized needs.

Since the completion of the 2018 Needs Assessment, Monadnock Community Hospital has implemented the following action items to better serve community need:

- MCH provides a full-time athletic trainer to the ConVal and Conant Schools throughout the school year and offers a summer program to prepare student athletes for their season.
- MCH has an outpatient behavioral health department and subsidizes it over $500,000 per year. The MCH Emergency Department also always has a social worker on call 24/7.
- In late 2019 MCH signed a contract with Reality Check to offer a Recovery Coach program at MCH for patients both in the ED and in outpatient settings. Due to COVID-19 this was not utilized as expected and the contract was terminated. However, the partnership with Reality Check remains and if a patient needs a Recovery Coach, they can call Reality Check directly rather than having one show up to an appointment or the Emergency Room.

Exhibit 6: 2021 Community Health Needs Assessment Prioritized Needs

2021 Prioritized Community Needs	
Rank	**Need**
1	Affordable healthcare services
2	Funding for depression/anxiety
3	Early intervention for substance use
4	Crisis care programs for mental health
5	Domestic violence Resources
6	Transportation
7	Caring for aging parents
8	Dental care /Specialty services
9	Post addiction services
10	Prescription assistance

A prioritized community need that is new in this 2021 CHNA report is crisis care programs for mental health, which MCH CHNA Leadership Group agreed was pertinent to address. The ongoing mental health concerns in the Greater Monadnock region are in many ways linked to the unprecedented COVID-19 pandemic, which has impacted communities in a variety of ways.

Prioritized needs that are still impactful from the 2018 CHNA report and therefore identified again in 2021 include: the need for continued affordable healthcare services, dental and specialty care services, and additional services to support behavioral health and substance use disorder

For a detailed description of how the 2021 prioritized needs were determined, please see the Needs Prioritization report section on page 39.

Secondary Data Analysis

Population Demographics

Exhibit 7: Key Demographic Change Rates by Town, 2017-2019.

Trends and changes from 2017 to 2019 are noted by arrows ↑↓. An upward arrow (↑) indicates an increase of more than 10% from 2017, a downward arrow (↓) indicates a decrease of more than 10%. If no arrow is present, there is no identified change from 2018. Data presented is from 2019.

	Population	Median Age	Median Income ($)
Antrim	2,753	46.1	56,250
Bennington	1,568	39.2	71,667↑
Dublin	1,708	50	83,438
Francestown	1,626	50.9	103,588↑
Greenfield	1,837	45.3	77,059↑
Greenville	2,086	42.3	75,721
Hancock	1,665	54	56,458
Jaffrey	5,363	45.3	57,405
New Ipswich	5,399	38	80,882
Peterborough	6,566	49.1	60,324
Rindge	6,444	33.3	81,737↑
Sharon	369	49.0	78,750↑
Temple	1,432	49.0	82,917
Service Area	38,816	43.6	74,323
New Hampshire	1,397,908	42.3	76,768
U.S.	333,793,107	38.5	62,843

SOURCE: American Community Survey, 2017, 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true
https://data.census.gov/cedsci/table?q=age&g=1600000US3301620,3360500&tid=ACSST5Y2017.S0101&hidePreview=true&moe=false

- Since 2017, the Monadnock service area has seen notable income jumps in Bennington, Francestown, Greenfield, Rindge, and Sharon.
- There have been no other large (i.e., +/- 10%) data changes since 2017. For instance, the median age of the Monadnock service area decreased from 44.8 in 2017 to 43.6 in 2019 – not a change of more than 10%.

Exhibit 8: Educational Attainment

	United States	New Hampshire	Monadnock Service Area
Less Than 9th Grade	4.8%	2.4%	1.6%
9-12th Grade (No Diploma)	6.5%	4.3%	4.3%
HS Diploma	22.8%	23.5%	24.2%
GED/Alternative Credential	3.9%	4.2%	3.3%
Some College, No Degree	20.1%	18.3%	19.6%
Associate Degree	8.7%	10.3%	9.5%
Bachelor's Degree	20.2%	22.4%	22.5%
Graduate or Professional Degree	12.9%	14.7%	15.0%

SOURCE: ESRI Data, 2021.

- Educational attainment is typically a strong indicator of future economic status. The Bureau of Labor Statistics estimates Americans with a graduate or professional degree earn three times more than individuals without a high school diploma.[3]
- In the Monadnock Service area, where incomes are similar to the state average, the percent of individuals with a bachelor's degree is nearly identical to the state average. Educational attainment rates in the Monadnock service area are slightly better than those nationwide.

Exhibit 9: Unemployment

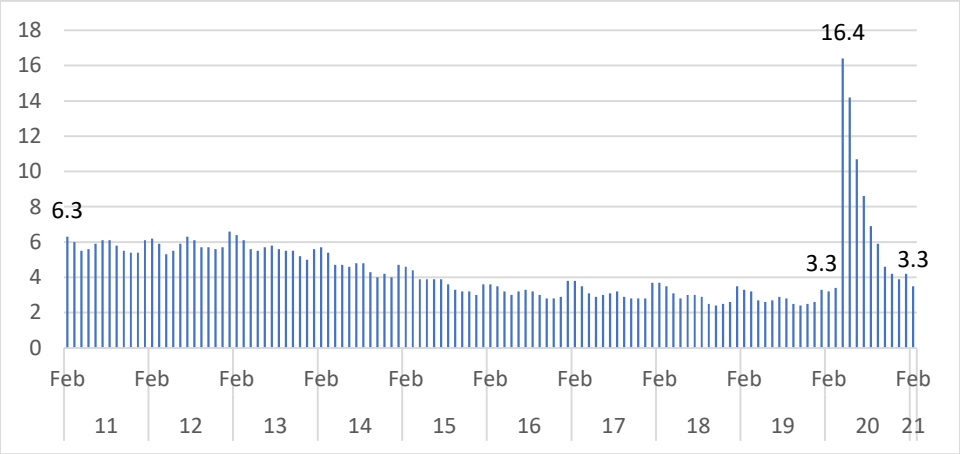
	United States	New Hampshire	Hillsborough County
February 2019	3.8%	2.6%	3.3%
February 2021	6.2%	3.3%	3.3%

SOURCE: Bureau of Labor Statistics. https://www.bls.gov/

- Unemployment increased sharply in the United States from February 2019 to February 2021. However, unemployment in Hillsborough County and the New Hampshire average has stabilized.

[3] US Bureau of Labor Statistics. https://www.bls.gov/careeroutlook/2016/data-on-display/education-matters.htm#:~:text=According%20to%20data%20from%20the,decreases%20as%20educational%20attainment%20rises.&text=That's%20more%20than%20triple%20the,than%20a%20high%20school%20diploma

Exhibit 10: Unemployment, Hillsborough County, 2011-2021 (Unemployment Rate as Percent)



SOURCE: Bureau of Labor Statistics. https://www.bls.gov/

- Unemployment in Hillsborough County was on a steady decline from 2011 to 2019, prior to the COVID-19 pandemic.
- Unemployment peaked in April 2020 (16.4%) and has been declining since then – returning to near pre-COVID levels. However, the labor participation rate is lower for Hillsborough County in March 2021 than February 2020 (pre-COVID-19) – 61.4% compared to 63.4%. The impact is that an additional nearly 2,000 people in Hillsborough County are without income (though not showing up in unemployment data).[4]

Exhibit 11: Disability Status by Age

	United States	New Hampshire	Hillsborough County
Overall	12.7%	13.1%	12.1%
Under 5 years	0.7%	0.8%	2.0%
5 to 17 years	5.6%	6.0%	6.5%
18 to 34 years	6.7%	8.5%	6.9%
35 to 64 years	12.4%	11.6%	10.6%
65 to 74 years	24.1%	21.2%	21.9%
75 years and over	47.1%	46.2%	47.8%

SOURCE: American Community Survey, 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true

- The age groups experiencing the highest rates of disability in Hillsborough County are seniors aged 65-74 (21.9%) and seniors aged 75 and over (47.8%).
- A slightly higher percentage of children in Hillsborough County experience some form of disability than the state average.

[4] U.S. Bureau of Labor Statistics. https://fred.stlouisfed.org/series/CIVPART

Exhibit 12: Disability Status by Type

	United States	New Hampshire	Hillsborough County
Overall	12.7%	13.1%	12.1%
With a hearing difficulty	3.6%	3.7%	2.9%
With a vision difficulty	2.3%	1.9%	1.4%
With a cognitive difficulty	5.2%	5.5%	5.1%
With an ambulatory difficulty	6.9%	6.2%	5.6%
With a self-care difficulty	2.6%	2.0%	2.3%
With an independent living difficulty	5.9%	5.3%	5.2%

SOURCE: American Community Survey, 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true

- The most common forms of disability in Hillsborough County are ambulatory difficulty (5.6%) and independent living difficulty (5.2%).
- Hillsborough County averages slightly lower overall rates of disability than the New Hampshire and National average.

Exhibit 13: Veteran Status

	United States	New Hampshire	Hillsborough County
Veteran Status	7.3%	8.8%	8.1%
Male	91.1%	92.0%	91.8%
Female	8.9%	8.0%	8.2%
Poverty Status	6.8%	4.6%	4.6%
Disability Status	29.3%	27.7%	27.1%

SOURCE: American Community Survey, 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=population&g=0100000US_0400000US33_0500000US33011&tid=ACSDT5Y2019.B01003&hidePreview=true

- Over one in four veterans in Hillsborough County experience some form of disability.
- Hillsborough County averages a slightly higher rate of Veteran population (8.1% of the total population) than the national average 7.3%.

Exhibit 14: Educational Attainment by Town

	Antrim	Bennington	Dublin	Francestown	Greenfield	Greenville	Hancock	Jaffrey	New Ipswich	Peterborough	Rindge	Sharon	Temple
>9th Grade	2.5%	1.8%	0.0%	0.6%	2.2%	1.4%	1.2%	1.4%	1.0%	0.2%	1.8%	3.6%	3.6%
9-12 Grade, No Diploma	6.0%	5.6%	3.7%	3.7%	6.5%	5.3%	1.2%	4.6%	5.4%	3.6%	3.7%	3.2%	3.2%
HS Diploma	22.7%	33.0%	24.1%	18.2%	34.1%	21.4%	15.4%	32.9%	27.9%	14.5%	32.5%	19.2%	19.3%
GED	7.0%	2.1%	2.0%	1.8%	5.0%	7.2%	1.9%	5.4%	2.5%	1.7%	4.2%	1.4%	1.3%
Some College, No Degree	26.5%	17.9%	13.5%	17.9%	19.1%	29.0%	14.8%	21.4%	23.0%	18.5%	19.6%	16.7%	16.6%
Associate Degree	13.4%	6.7%	4.0%	10.1%	8.8%	7.7%	12.4%	11.5%	12.0%	7.3%	13.2%	8.2%	8.1%
Bachelor's degree	14.6%	20.4%	33.4%	29.9%	12.6%	19.5%	24.7%	11.4%	17.4%	27.6%	16.2%	32.3%	32.2%
Graduate Degree	7.3%	13.3%	19.4%	17.9%	11.7%	8.6%	28.4%	11.4%	10.8%	26.6%	8.8%	15.6%	15.8%

SOURCE: Esri Data, 2021.

- Dublin and Temple have the highest rates of bachelor's degree completion in the Monadnock service area and are also two of the wealthiest towns in the Monadnock service area, drawing a clear parallel between educational attainment and income. Francestown, the service area's wealthiest town, also experiences high rates of educational attainment.
- There is a strong correlation between educational attainment and future earnings. A Bureau of Labor Statistics study found median weekly earnings for those with the highest levels of educational attainment—doctoral and professional degrees—were more than triple those with the lowest level, less than a high school diploma. [5]

[5] SOURCE: Bureau of Labor Statistics. Measuring the Value of Education. https://www.bls.gov/careeroutlook/2018/data-on-display/education-pays.htm#:~:text=Median%20weekly%20earnings%20in%202017,weekly%20earnings%20for%20all%20workers

Exhibit 15: Employment by Industry Type

	United States	%	New Hampshire	%	Hillsborough County	%
Civilian employed population 16 years and over	154,842,185		729,701		227,110	
Agriculture, forestry, fishing and hunting, and mining:	2,743,687	1.8%	5,504	0.8%	1,070	0.5%
Construction	10,207,602	6.6%	49,625	6.8%	13,864	6.1%
Manufacturing	15,651,460	10.1%	92,548	12.7%	31,762	14.0%
Wholesale trade	4,016,566	2.6%	19,290	2.6%	5,968	2.6%
Retail trade	17,267,009	11.2%	89,698	12.3%	27,852	12.3%
Transportation and warehousing, and utilities:	8,305,602	5.4%	27,974	3.8%	8,999	4.0%
Information	3,114,222	2.0%	14,937	2.0%	5,417	2.4%
Finance and insurance, and real estate and rental and leasing:	10,151,206	6.6%	45,841	6.3%	14,786	6.5%
Professional, scientific, and management, and administrative and waste management services:	17,924,655	11.6%	80,967	11.1%	29,970	13.2%
Educational services, and health care and social assistance:	35,840,954	23.1%	180,605	24.8%	52,795	23.2%
Arts, entertainment, and recreation, and accommodation and food services:	14,962,299	9.7%	62,668	8.6%	17,509	7.7%
Other services, except public administration	7,522,777	4.9%	31,355	4.3%	10,070	4.4%
Public administration	7,134,146	4.6%	28,689	3.9%	7,048	3.1%

SOURCE: American Community Survey, 2019 5-Year Estimates.
https://data.census.gov/cedsci/table?q=industry&g=1600000US3301620&tid=ACSST5Y2019.S2404&hidePreview=true&moe=false

- Educational Services, Health Care, and Social Assistance are the most common industry sectors in Hillsborough County. Agriculture, Forestry, Fishing, Hunting and Mining is the least common industry type.
- In Hillsborough County, a notably higher percentage of people work in Manufacturing (14.0%) than the national average (10.1%).

Population Health Measures

Exhibit 16: Leading Causes of Death[6]

	United States	New Hampshire	Hillsborough County
Total	728.8	711.9	710.3
Cancer	156.0	156.0	150.9
Heart Disease	166.0	148.9	148.0
Accidents	45.7	60.6	62.3
Chronic Lower Respiratory Disease	40.8	41.2	39.8
Stroke	37.3	27.9	25.4
Alzheimer's disease	29.4	29.4	24.4
Diabetes	21.2	18.0	18.8
Suicide	13.6	17.8	17.8

SOURCE: National Institutes of Health, Death Rate Report for New Hampshire by County. 2018.
https://hdpulse.nimhd.nih.gov/data/deathrates/index.php?stateFIPS=33&cod=247&year=0&race=00&sex=0&age=160&type=death&sortVariableName=name&sortOrder=desc

- Cancer is the leading cause of death in Hillsborough County, which differs from the national average, where Heart Disease is the leading cause of death.
- The Hillsborough County overall mortality rate is very similar to the state average and slightly lower than the national average.
- Heart disease, stroke, and Alzheimer's disease mortality rates in Hillsborough County are notably lower than the national average.

Exhibit 17: Chronic Disease Summary, Incidence Rate

	United States	New Hampshire	Hillsborough County
Heart Disease	26.8%	21.5%	21.7%
High Blood Pressure	57.2%	49.8%	51.6%
Asthma	5.0%	4.8%	5.6%
Diabetes	9.5%	8.0%	8.5%

SOURCE: Community Commons, National Center for Chronic Disease Prevention and Health Promotion.
https://www.communitycommons.org/entities/4c128e63-7457-4e58-84bb-ac161fa0277e
https://www.cdc.gov/chronicdisease/index.htm

- Chronic disease incidence rates are better (lower) than the U.S. average for most conditions. However, Hillsborough County has slightly higher rates of asthma than the New Hampshire and national average.

[6] Deaths per 100,000 population.

Exhibit 18: Health Status

	New Hampshire	Hillsborough County
Poor or Fair Health	13.0%	12.0%
Poor Physical Health Days	3.5	3.4
Poor Mental Health Days[7]	4.6	4.2

SOURCE: County Health Rankings, 2021. https://www.countyhealthrankings.org/

- Hillsborough County residents experience slightly fewer poor mental health days per month (4.2) than the New Hampshire average (4.6). Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population.[8]

Exhibit 19: Physical Health Indicators

	United States	New Hampshire	Hillsborough County
Adults who are Obese	29.5%	28.4%	28.2%
Current Smokers	15.7%	14.8%	13.5%
Physical Inactivity	22.1%	19.9%	21.2%

SOURCE: Community Commons, National Center for Chronic Disease Prevention and Health Promotion. 2019 https://www.communitycommons.org/entities/4c128e63-7457-4e58-84bb-ac161fa0277e https://www.cdc.gov/chronicdisease/index.htm

- Hillsborough County residents have slightly worse rates of physical inactivity than the state average. Slightly over one in five (21.2%) Hillsborough County residents does not get any form of physical activity. Physical activity may play an important role in the management of mild-to-moderate mental health conditions, especially depression and anxiety[9] -- in addition to general health and chronic medical conditions.
- There are slightly less smokers in Hillsborough County than the state and national average.

[7]Average number of mentally unhealthy days reported in past 30 days (age-adjusted).

[8] County Health Rankings. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes/quality-of-life/poor-mental-health-days

[9]Paluska, Schwenk. "Physical Activity and Mental Health." https://link.springer.com/article/10.2165/00007256-200029030-00003

Exhibit 20: Healthcare Providers

	United States	New Hampshire	Hillsborough County
Primary Care Physicians	2,648 to 1	1,100:1	1,160:1
Mental Health Providers	1,649 to 1	310:1	310:1
Dentists	2,911 to 1	1,300:1	1,210:1

SOURCE: County Health Rankings, 2021. https://www.countyhealthrankings.org/

- Hillsborough County and the State of New Hampshire have a much better ratio of providers compared to U.S. averages. For example, in Hillsborough County and New Hampshire, there is one mental health provider for every 310 residents – much better than the U.S. ratio of one provider for every 1,649 residents.
- Hillsborough County has similar rates of primary care, mental health, and dental providers per person compared with the New Hampshire average.

Exhibit 21: Maternal and Child Health

	United States	New Hampshire	Hillsborough County
Teen Birth Rate[10]	22.7%	10.6%	13.5%
Low Birth Weight	8.2%	6.8%	7.2%
Infant Mortality[11]	5.8%	3.7%	3.1%

SOURCE: Community Commons, National Center for Chronic Disease Prevention and Health Promotion. CDC Wonder Database. https://www.communitycommons.org/entities/4c128e63-7457-4e58-84bb-ac161fa0277e https://www.cdc.gov/chronicdisease/index.htm https://wonder.cdc.gov/

- Teen births are much less common in Hillsborough County (13.5%) than the national average (22.7%).
- Hillsborough County has a lower rate of infant mortality (3.1%) than the New Hampshire and national averages, but a slightly higher low birth weight percentage (7.2%) than the New Hampshire average (6.8%).

[10] Per 1,000 women aged 15-19

[11] Deaths per 1,000 live births

Exhibit 22: Insurance Status

	United States	New Hampshire	Hillsborough County
Uninsured Population	8.8%	5.9%	6.2%
Male (Uninsured)	9.9%	6.8%	7.2%
Female (Uninsured)	7.9%	5.1%	5.2%
Uninsured Seniors	0.8%	0.3%	0.4%
Uninsured Children	5.1%	2.8%	2.6%

SOURCE: County Health Rankings, 2021. https://www.countyhealthrankings.org/

- The uninsured rates in New Hampshire and Hillsborough County are lower than the national average.
- Men are slightly more likely than women to be uninsured across comparative regions.

Exhibit 23: Home Care Status, Rates Per 100,000 Population

	United States	New Hampshire
Adult-Day Services	4.1	3.7
Nursing Home	26.1	31.6
Residential Care Community	15.4	15.3
Home Health Agency	94.4	99.2
Hospice	28.4	23.7

SOURCE: National Center for Health Statistics, Long-Term Care Providers and Service Users in the United States, 2019. https://www.cdc.gov/nchs/npals/reports.htm

- Care services include a broad range of health, personal care, and supportive services that meet the needs of frail older people and other adults whose capacity for selfcare is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related conditions[12].

- New Hampshire residents have higher rates of home health agency use (99.2) and nursing home use (31.6) than national averages.

[12]National Center for Health Statistics, Long-Term Care Providers and Service Users in the United States, 2019. https://www.cdc.gov/nchs/npals/reports.htm

Behavioral Health and Risk Measures

Exhibit 24: Mental Health, Teens, 2019

	New Hampshire	Greater Monadnock
Felt Sad or Hopeless for Two Weeks in a Row	28.1%	32.0%
Seriously Considered Attempting Suicide	16.1%	19.4
Attempted Suicide One or More Times	5.9%	7.8%
Suicide Attempt Resulted in Treatment by Doctor or Nurse	1.9%	2.5%

SOURCE: NH WISDOM. https://www.dhhs.nh.gov/dphs/hsdm/documents/greater-monadnock-yrbs-results-2019.pdf

- Over 30% of Greater Monadnock area teens reported feeling sad or hopeless for two consecutive weeks in 2019, pre COVID-19 pandemic. Those numbers may be higher now.[13]
- Nearly one in five Greater Monadnock area teens seriously considered suicide. Over 7% reported a suicide attempt – with over 2% serious enough to warrant medical treatment. These may be small percentages, but the number of individual lives and families requires urgent attention.

Exhibit 25: Substance Use, Teens, 2019

	New Hampshire	Greater Monadnock
Drink Alcohol	29.6%	30.9%
Binge Drink	15.8%	17.1%
Use Marijuana	22.9%	25.3%
Ever Used Heroin	1.7%	2.3%
Ever Used Methamphetamine	1.7%	2.8%
Ever Used RX Without Prescription	11.3%	13.6%
Use RX Without Prescription	5.1%	6.1%

SOURCE: NH WISDOM. https://www.dhhs.nh.gov/dphs/hsdm/documents/greater-monadnock-yrbs-results-2019.pdf

- On average, Greater Monadnock area teens use substances at a slightly higher rate than their peers statewide.
- There is a small percentage of Greater Monadnock area high school students using hard drugs such as heroin (2.3%) and methamphetamine (2.8%).

[13] A U.S. Centers for Disease Control (CDC) study in June 2020 found 40.9% of respondents reported at least one adverse mental or behavioral health condition including symptoms of anxiety disorder or depressive disorder (30.9%). SOURCE: CDC, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm#:~:text=Overall%2C%2040.9%25%20of%205%2C470%20respondents,reported%20having%20started%20or%20increased

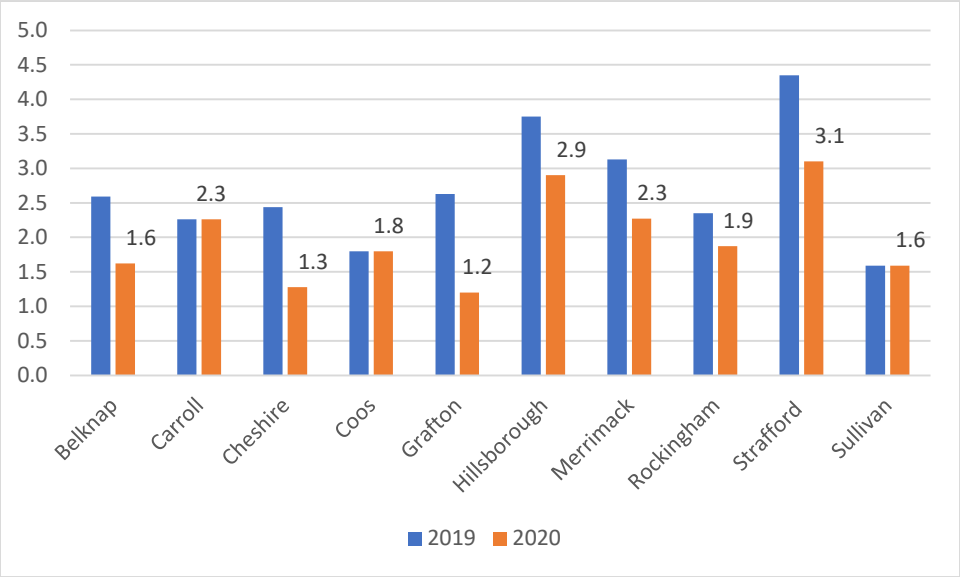
Exhibit 26: Nicotine Use, Teens, 2019

	New Hampshire	Greater Monadnock
Smoke Cigarettes	7.7%	10.3%
Use Vape or Electronic Cigarette	23.7%	18.3%

SOURCE: NH WISDOM. https://www.dhhs.nh.gov/dphs/hsdm/documents/greater-monadnock-yrbs-results-2019.pdf

- Around 10% of teens smoke cigarettes in the Greater Monadnock area, and around 20% use a Vape or Electronic Cigarette.
- Nicotine use in the Greater Monadnock region is varied compared with the state average – a higher percentage of Monadnock teens smoke cigarettes than the state average, but a lower percentage use a vape or electronic cigarette.

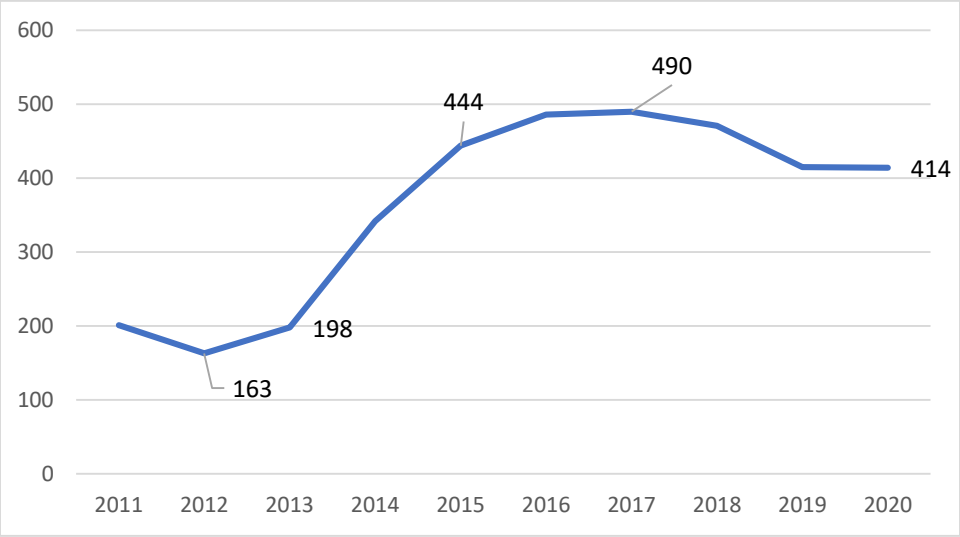
Exhibit 27: Drug Overdose Deaths per 10,000 Population, by County, 2019-2020



SOURCE: New Hampshire Drug Monitoring Initiative, 2020 Overview Report.
https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2020-overview.pdf

- Drug overdose deaths in New Hampshire fell from 2019 to 2020.
- Hillsborough County averages the second highest rate of drug overdose death statewide (2.9 per 10,000 population), second only to Strafford County.

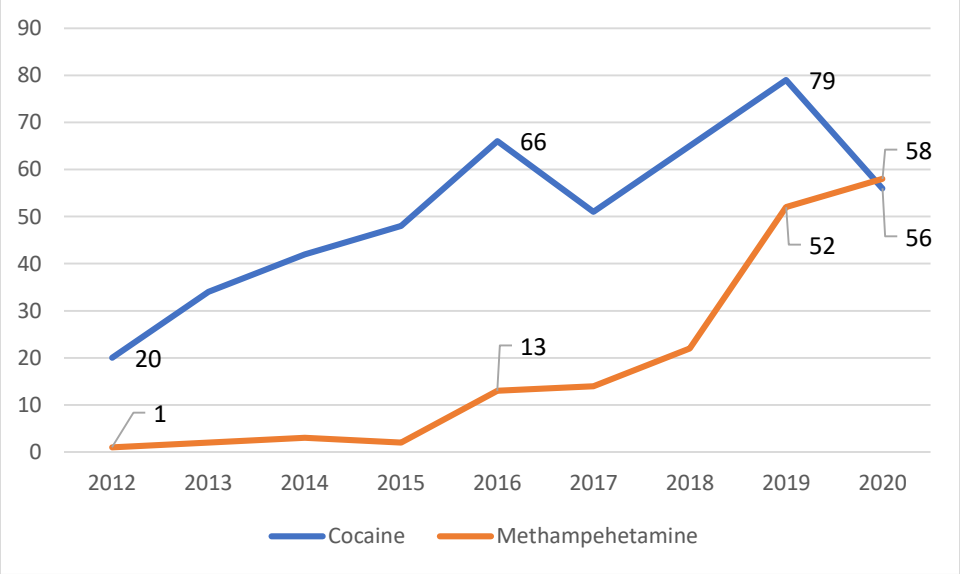
Exhibit 28: Total Overdose Deaths, New Hampshire, 2011-2020



SOURCE: New Hampshire Drug Monitoring Initiative, 2020 Overview Report.
https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2020-overview.pdf

- Statewide, overdose deaths appear to have peaked in 2017 (largely due to the opioid epidemic), but numbers remain high.

Exhibit 29: Total Overdose Deaths Involving Cocaine or Methamphetamine, New Hampshire, 2012-2020



SOURCE: New Hampshire Drug Monitoring Initiative, 2020 Overview Report.
https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2020-overview.pdf

- The rise in cocaine and methamphetamine involvement in drug overdose deaths illustrates how even though opioid overdoses are slightly down, drug mortality is still a statewide epidemic.

Qualitative Research Summary

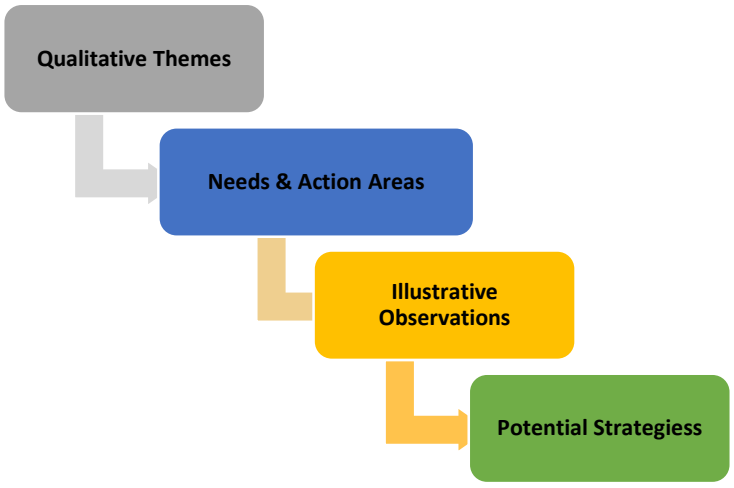
The qualitative primary research stage included stakeholder interviews and focus group discussions across the community. The 13 one-on-one interviews lasted approximately 30 minutes in length, although some community members chose to share a great deal of information, so some calls exceeded 30 minutes. The interviews provided the opportunity to have in-depth discussions about community, social, health, and service issues with individuals able to provide insight regarding health services and access needs. The stakeholder interview guide was designed to elicit respondents' opinions about community strengths and resources, health-related needs, the expected ongoing impact of the COVID-19 pandemic, the community-based strategies to address those needs, special insights from marginalized groups, and other topics.

The two focus group discussions (FGDs) – plus two MCH CHNA Leadership Group meetings – (held via Zoom) used a moderator's guide similar to the stakeholder interview guide (see Appendix). The FGDs enabled the participants to highlight areas of consensus as to what they see as the biggest health-related needs facing the community.

In total over 40 individuals provided input from the following segments:

- Healthcare service consumers
- General community members
- MCH CHNA Leadership Group
- Community service providers

The combination of qualitative individual interviews and focus the group discussions resulted in a consensus of several top areas of need that can be described as **Qualitative Themes.** Each of these themes cut across and impact the subsequent Needs & Action Areas. The Themes are identified in the following section with a short explanation for each.



The Needs & Action Areas include an overview of the subject and utilize de-identified **Illustrative Observations in italics** which are representative of respondents' consensus perspectives. The following needs and action areas were also used to guide needs prioritization with the MCH CHNA Leadership Group. See the graphic to the right that illustrates the hierarchical nature of the qualitative research section that follows.

Qualitative Discussion Themes

Qualitative research provided the basis for three, higher-level community needs themes.

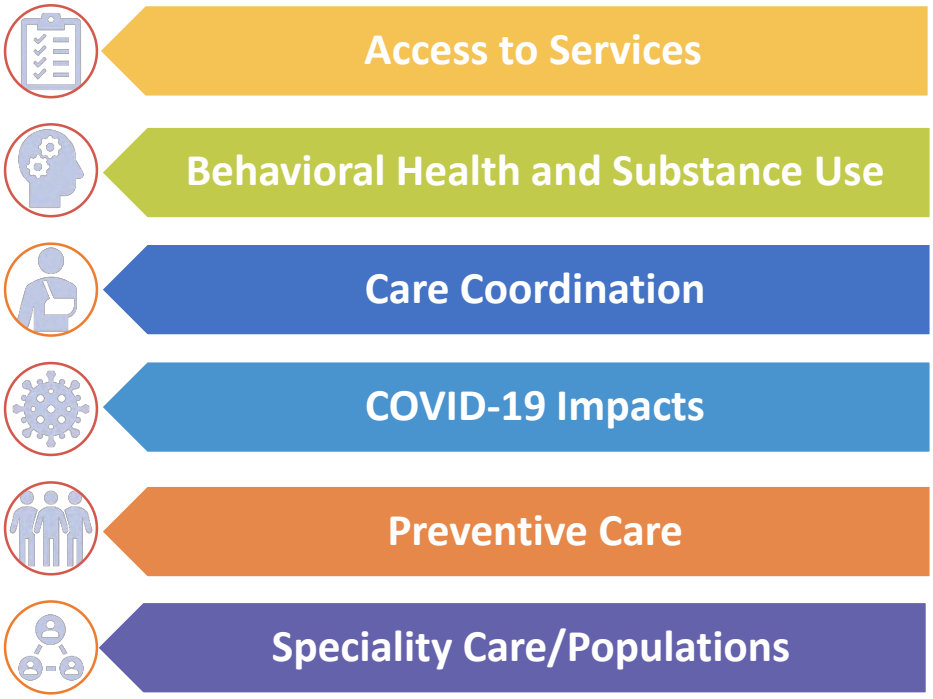
Monadnock's unique geographic and demographic challenges. *The need for improved care coordination, access to services, specialty care and preventive care all pertain to the unique challenges faced by Monadnock's rural, older, population, which require specific needs.*

Monadnock is well thought of and considered a community leader. *When sharing experiences with Monadnock Hospital, service providers and community members relayed a positive message. Constructive criticism centered on expanding community outreach.*

Improved community impact will be most likely achieved through a holistic approach. *The top action areas and observations (outlined below) are interwoven with one another. For instance – care coordination, identified as a top need, will improve access to services (another top need.) These can have a positive downstream effect to improve behavioral health care treatment (yet another top need).*

Needs, Action Areas and Observations

Key needs and areas and primary observations that are representative of respondents' consensus perspectives from the interviews are included below. Each ***theme*** above is embedded within the six key categories of ***needs*** listed below (presented alphabetically – not in order of priority):



Access to Services

Monadnock's geographic locale makes accessing services difficult for some communities, especially in outlying areas. Transportation and the cost of care are the two, most commonly noted "access to care" issues.

Transportation issues are a large barrier for many residents of the service area, where sometimes ambulances are the only methods of quickly accessing care. Cost barriers may arise when some individuals do not meet the requirements for services like Medicare, but do not have the means to pay for other forms of insurance.

- *"Convenient access to a hospital or healthcare is so important. Without Monadnock, we would have to drive about an hour to get anywhere."*
- *"We respond to 911 emergency calls, we are nondiscriminatory. I would say because we are a rural area, we are providing transportation that other people might be driving themselves."*
- *"You can have the greatest doctors, but if people think they won't be able to access it, what's the point? I will find myself frustrated with hoops to jump through, and I am someone who likes to work the system, talk to everyone. I think about - so many people aren't comfortable doing that, how will they ever understand what's happening? I will have an appointment - they schedule a follow up elsewhere, and I'll ask, 'What's the cheapest way to do this?' 'Is this covered?' and they don't know, that's not their job."*
- *"Choices for primary care are limited. I struggle finding a doctor I feel listens, really wants to work with me."*
- *"We do not have transportation. If we got a grant for a community bus or van or something, that would be huge. Children and adolescents and seniors especially do not have any access to services in this way."*
- *"Communication is so key and vital to this. For instance, a lot of people will mention transportation - there are some community transpiration options, but I guess people have not been able to easily understand or access that. I think service providers could do better outreach and update their websites more often."*

Behavioral Health and Substance Use

Behavioral health was reported to be a rising need in the Monadnock region where impacts of the COVID-19 pandemic (e.g., social isolation, economic insecurity, housing concerns, and other general anxiety and depression-related issues) have exacerbated underlying issues. Secondary data revealed that depression rates have risen during the COVID-19 pandemic: A CDC study in June 2020 found 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (30.9%).[14] Community members noted barriers such as access to care or overcoming stigma as factors for some populations unable to receive or seek treatment.

Substance Use Disorder (SUD) was also noted as a common issue. New Hampshire's substance use trends are well documented[15], and some stakeholders shared the opinion that although statistics around opioid related substance use are no longer as high as they once were, other substances (like methamphetamine) are now being used at a high rate in the region.

- *"There is still a mental health stigma. Not everyone is seeking (treatment) out. However, I do think there has been a lot of communication about self-care and that stigma has been somewhat reduced. I know there is a group called Reality Check in Jaffrey that focuses on substance use and abuse. There is certainly substance use in the schools."*
- *"I think behavioral health is the primary concern, and with COVID it feels like it's been even worse - and now we are not able to find practitioner for a prescription, etc. I've heard anecdotally, very long wait times. In the past, we had a therapist who would come see students. That is not happening at the elementary level anymore."*
- *"I think good behavioral health care is relationship based. I think getting out into the community to be a known commodity can be very helpful."*
- *"There is a long delay when setting up an appointment for mental health treatment. I think there is a dearth of providers."*
- *"I work with teens, there are high rates of substance use, many of them do not have great support systems or easy resources."*
- *"There may just not be enough patients to warrant numerous practitioners opening up shop in the area. But I think there is a real opportunity with telepsychiatry and telehealth."*

[14] Centers for Disease Control, Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

[15] https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2020-overview.pdf

Care Coordination

Many stakeholders and focus group participants spoke about the need to bolster care coordination. Stakeholders described the Monadnock administrative and medical staff in very positive terms, however, it was emphasized that many patients may not understand how to navigate through the medical system on their own. Current expert consensus suggests that such care coordination programs appear to improve quality of care (and there is a growing body of knowledge providing strong and consistent evidence of substantial financial savings).[16] Proposed actions to improve patient care coordination and improve the overall patient experience included access to health advocates, increased community collaboration, and patient education.

- *"Making connections between services would be helpful. Case management, connecting a patient from primary care to physical therapy, etcetera."*
- *"I think the hospital is a very good community collaborator, and helping patients navigate their way around the system is something (the hospital) can continue to build."*
- *"I would like to help our community understand they are their own best advocates for their well-being. They have a voice to make a difference and can advocate for their own best interests."*
- *"I think advocacy is important in-patient situations, there is not a system in place to provide advocacy in the room. System navigation could be helpful. Post check-up, that sort of thing."*
- *"Advocacy is so important - my dad went to the doctor and refused a test. Now he has to go back, it's another copay, and most people wouldn't even go in, or feel bad about refusing the test. So, providing an advocate is so important."*

COVID-19 Impacts

The COVID-19 pandemic has impacted the lives of all residents in the Monadnock region – some more than others. Service providers report augmenting the care they provided, and in some cases, temporarily eliminating some services. However, many community members reported an opinion that there was an increased level of community compassion and resolve in the face of difficulty, with food shelters remaining overstocked, and friends and neighbors helping one another. The physical impacts of the virus touched many, as did the mental toll. Moving community events to Zoom or other technology platforms was reported to be an inferior substitute for some, and the lack of time in schools stole precious time from young people. One stakeholder noted, "Parents are feeling stressed and anxious, and we know kids are like sponges – they are inheriting that."

[16]MedVision, 2018. Available at https://www.medvision-solutions.com/how-does-care-coordination-impact-healthcare-payer-organizations ; Science Direct, 2016. https://www.sciencedirect.com/science/article/abs/pii/S0891524517301797#:~:text=Hospital%20charges%20for%20patients%20who,of%20124%20pediatric%20tracheostomy%20patients; Institute for Healthcare Improvement, "Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs,: 2011. http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

- *"There is a drive though (vaccine) site at Keene State. Recently, we've seen Walgreens open up a site and the Laconia race track up north. But there was nothing locally. It could have been easy and so much more accessible if there were something local."*
- *"I would say people are uneasy about getting a vaccination. We are trying to talk them though the process, we are also trying to help them make an appointment, figuring out a way to get them a ride."*
- *"I think COVID exacerbated some existing needs and services. Transportation volunteers stopped. So that issue was significant. The need for more support caregivers cropped up. Some families refused care in this time, especially from those who were going house to house. I know childcare needs were difficult."*
- *"Not being able to be there from an advocacy standpoint in hospitals for friends and family - we couldn't get in the hospitals, couldn't hear about their care plans or make recommendations".*
- *"I am seeing a lot of challenges from the pandemic - frontline workers, especially. I am curious to see what happens with our kids coming out of this, but the adults and families are also not doing well. About 1/3 of our schools were free or reduced lunch and we lost that for a while. I think there is an idea this is a cute little town, but there is a lot need there."*
- *"It feels like it's taken the wind out of everyone's sails. (The community) really revolves around fellowship. This digital communication has created enough of a distance."*

Preventive Care

A crucial need in the Monadnock region is continued improvement of access to preventive care. Stakeholders cited the barriers of transportation, access (i.e., financial counseling and resources, awareness of ways to navigate the healthcare system, availability of providers in some medical specialties, and a lack of follow-up care and support services after an inpatient stay), and provider shortages that – in some cases – lead to preventable 911 calls and hospital visits. Stakeholders also noted that the COVID-19 pandemic halted elective procedures and other preventive care.

- *"I have direct medical practice through [name of provider), it is great. But so many do not."*
- *"This area may never be a place for providers to put down long roots, but I think it can still be an attractive place for young families for a while. We have outdoor recreation, natural beauty, and quality of life."*
- *"A lot of our people who are calling 911 - I think if they had home health care, or nurse visitation, they would not need our emergency treatment. Preventive care would be huge. These are people who simply never see a medical professional. We might say, get a call to Wal-Mart, to someone who is having a diabetic episode. That is preventable."*
- *"The COVID pause has been strange - it's like we've taken a pit stop. But we're not back in the race. It's such a part of preventive care, we need to get back on track. Maybe doctors need to go down their list, see who they need to call".*

Specialty Care/Populations

A distinguishing feature of the Monadnock region is its rural locale and high population percentage of seniors. Many stakeholders discussed the unique challenges faced by seniors, including a relative lack of specialty care – in particular geriatric medicine, dermatology, neurology / Alzheimer's care, behavioral health, and surgery. A related challenge exits around recruiting and retaining specialists, which leads to some healthcare consumers to the frustration of "starting over" with specialty care providers, or simply giving up on accessing care.

- *"I think geriatric medicine - we are an older state. I would like to see more emphasis on that. I think specialty services are important. Typically, we have to leave and go to Keene or Manchester, or even Boston."*
- *We have an older population, a lot of elderly living alone, I am definitely worried about their wellbeing."*
- *"The area has issues enlisting new doctors. I went to meet a surgeon when I was diagnosed, they said 'By the way, you have to find a new surgeon, we are not going to be here in a week.' Since then, there has been another new surgical group. I just want more stability when it comes to this. It is not the hospitals' fault, and I know they are frustrated. But communication could still be facilitated better."*
- *"I have to drive to Concord to see a dermatologist. We lack that specialty care. I am open to telehealth specialty care, but a lot of times, you go there to get something done, it's not always just a consult."*
- *"Programs for Alzheimer's are important. I think about how New Hampshire is one of the oldest populations in the United States, we see a lot of Alzheimer's and dementia. Those affiliated ailments may be heart surgery or a hip replacement. But we are trying to get physicians to identify all of the above, the holistic needs."*

Community Survey

A community wide survey was conducted in the Monadnock service area. The survey included representation from all thirteen Monadnock service area towns, with respondents completing the survey instrument online.

Total Sample

A total of 446 total respondents completed the community survey. The sample size yields a total margin of error +/- 4.6%, at the 95% confidence interval.

Survey Instrument

The questionnaire, offered in both Spanish and English, included closed-ended, need-specific evaluation questions; open-ended questions; and demographic questions. The responses were tabulated using SPSS (Statistical Package for the Social Sciences) and can be used to help provide directional support for the prioritized set of community health needs.[17]

Survey Data Collection

Monadnock Hospital facilitated survey advertising via internal and external communications lists and social media.

Top Needs

The top five community needs as identified by the survey were:

1. **Housing for all incomes/ages**
2. **Crisis care programs for mental health**
3. **Affordable healthcare services for people or families with low income**
4. **Counseling services for adolescents / children**
5. **Counseling services for depression or anxiety**

Note: Like many areas, housing was a highly ranked community need. However, when reviewing needs most central to the MCH's purview, housing is not among them.

For a thorough analysis of survey results, please see below:

[17] Research suggests that individuals sharing many of the demographic characteristics of the target population may provide socially desirable responses, and thus compromise the validity of the items. Special care was exercised to minimize the amount of this non-sampling error by a careful assessment design effects (e.g., question order, question wording, response alternatives).

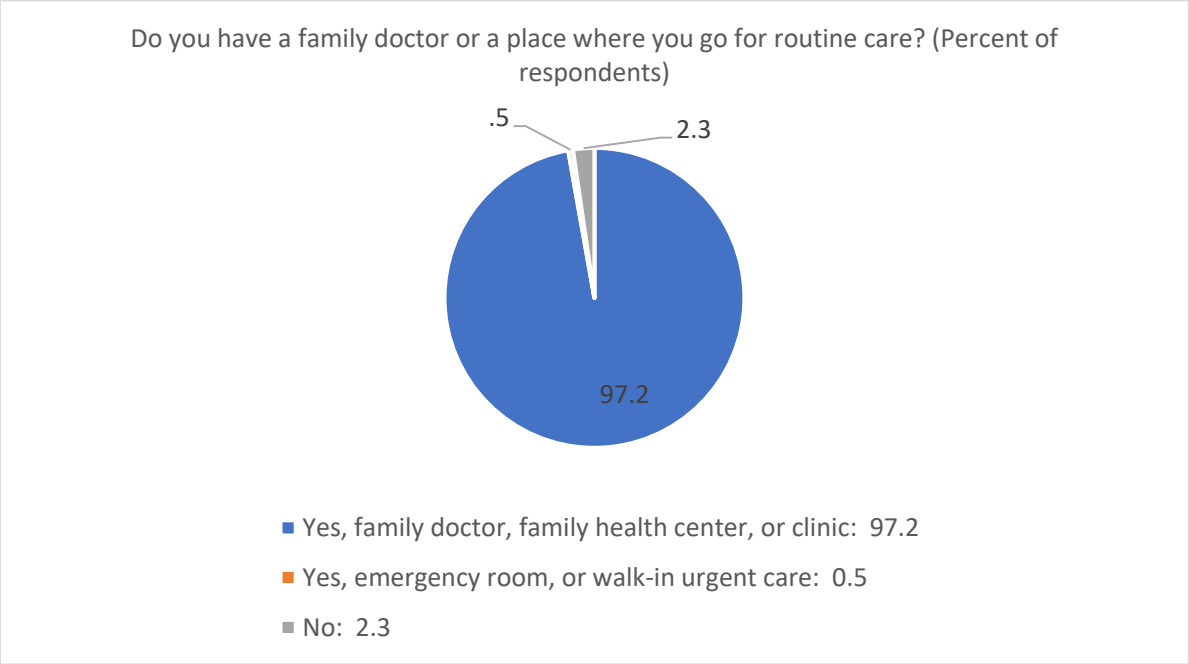
Exhibit 30: Community Needs Ranked by Community Response Categories

Rank	Need	"No more focus needed"	"Somewhat More Focus Needed"	"Much more focus needed"	Average Score[18]
1	Housing for all incomes/ages	6.1%	28.0%	66.0%	2.60
2	Crisis care programs for mental health	6.0%	28.9%	65.0%	2.59
3	Affordable healthcare services for people or families with low income	8.3%	28.2%	63.5%	2.55
4	Counseling services for adolescents / children	10.1%	28.6%	61.3%	2.51
5	Counseling services for depression or anxiety	8.5%	33.1%	58.5%	2.50
6	Affordable quality childcare	8.5%	33.8%	57.7%	2.49
7	Post-addictions treatment support programs	7.7%	38.3%	54.0%	2.46
8	Early intervention for substance use disorders	8.4%	37.5%	54.0%	2.46
9	Medical Assisted Treatment (MAT) for opioid addiction	10.1%	38.2%	51.7%	2.42
10	Caring for aging parents and resources to help	6.9%	49.5%	43.6%	2.37
11	Long-term care or dementia care	10.7%	42.0%	47.3%	2.37
12	Prescription assistance	14.3%	36.6%	49.1%	2.35
13	Homelessness	10.9%	45.3%	43.8%	2.33
14	Domestic Violence Resources	9.6%	49.0%	41.4%	2.32
15	Transportation	7.8%	53.5%	38.8%	2.31
16	Primary care services (such as a family doctor or other provider of routine care)	14.9%	41.6%	43.5%	2.29
17	Job readiness	11.4%	49.2%	39.4%	2.28
18	Programs for diabetes and/or obesity	11.6%	50.2%	38.2%	2.27
19	Transportation services for people needing to go to doctor's appointments or the hospital	9.7%	54.6%	35.7%	2.26
20	Specialty care services: Dermatology	16.7%	42.0%	41.3%	2.25
21	Secure sources for affordable, nutritious food	15.1%	47.8%	37.1%	2.22
22	Specialty care services: Cancer care	19.7%	41.8%	38.5%	2.19
23	Heart health or cardiovascular health	19.9%	49.8%	30.3%	2.10
24	Specialty care services: Cardiology	23.6%	45.2%	31.3%	2.08
25	Parenting classes	22.1%	49.3%	28.6%	2.06
26	Dental	35.9%	34.3%	29.8%	1.94
27	Emergency care and trauma services	34.0%	42.2%	23.8%	1.90
28	HIV AIDS testing	44.7%	42.0%	13.3%	1.69

[18] "No more focus needed" = 1, "Somewhat more focus needed" = 2, "Much more focus needed" = 3. "Average score" presented as composite weighted score.

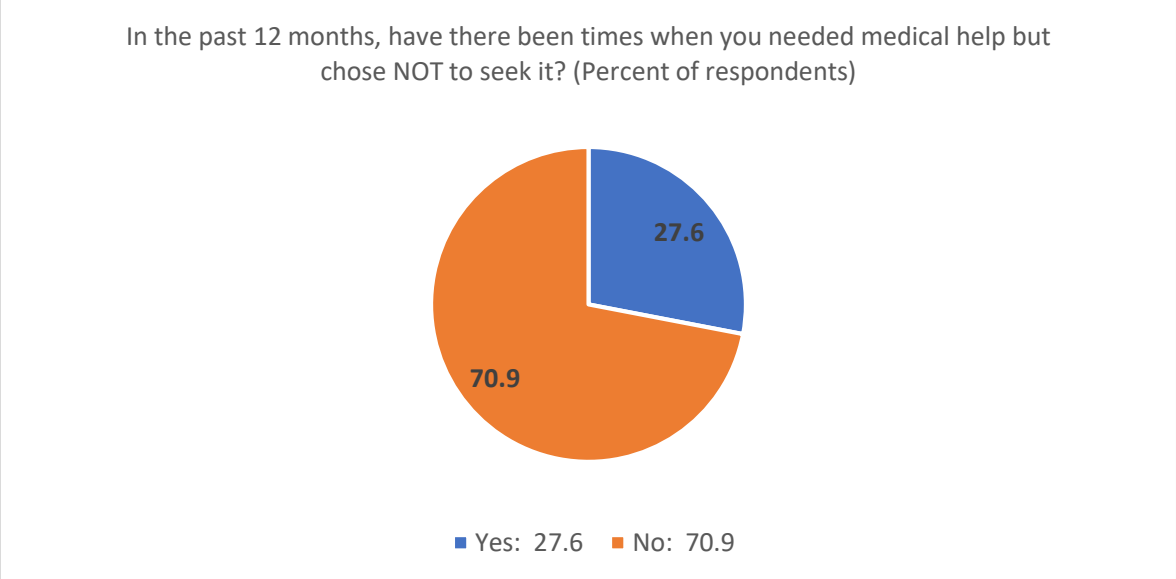
Survey respondent profiles skewed towards those who have a family doctor, family health center, or clinic they visit for routine care.

Exhibit 31: Access to Care



Over one quarter (27.6%) of survey respondents indicated there was a time in the past year they needed medical help and chose not to seek it.

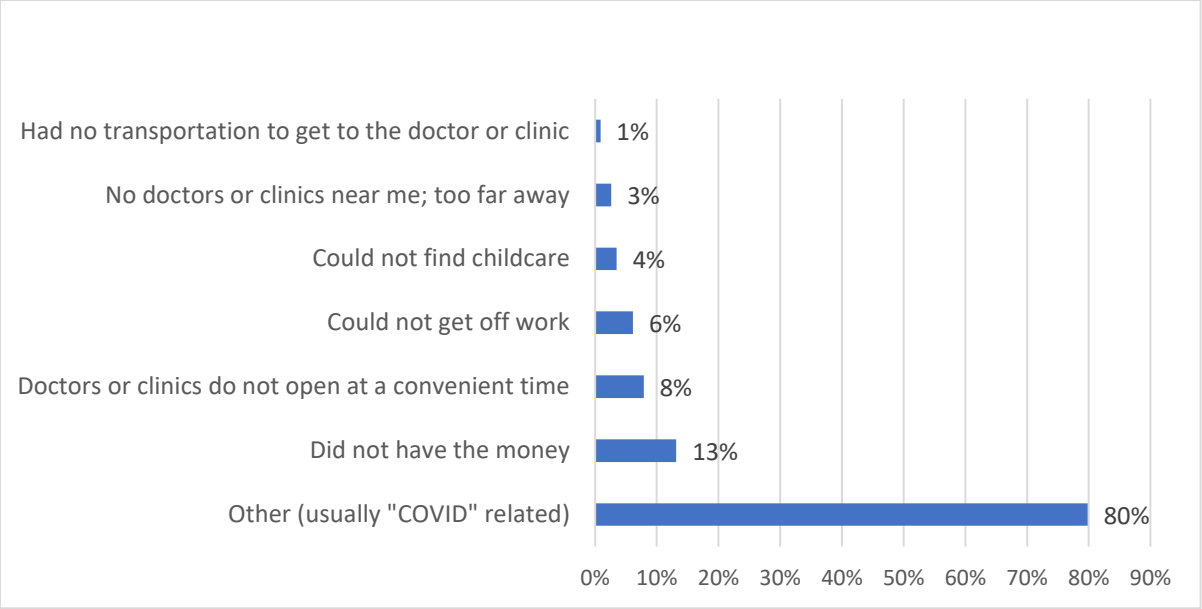
Exhibit 32: Seeking Care



Survey respondents overwhelmingly cited the COVID-19 pandemic as a reason for not seeking medical care in the past year.

Exhibit 33: Reasons for not Seeking Care

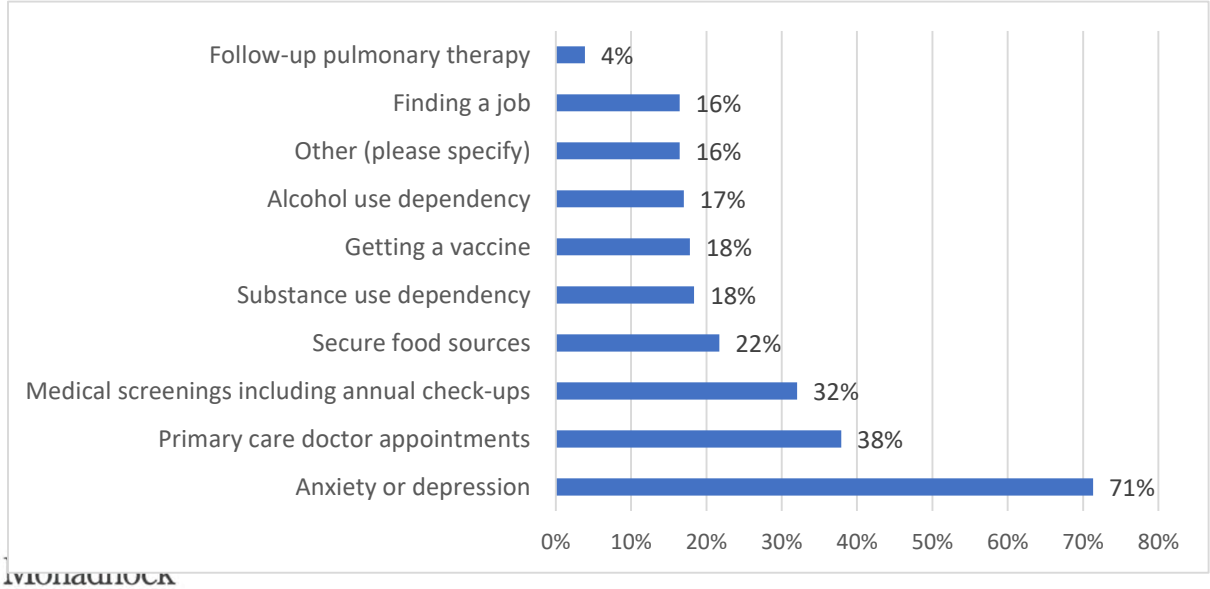
If you had a medical need but did not seek care, why did you NOT get care?



The COVID related issues with which people struggle most as identified by survey respondents were anxiety or depression, primary care doctor appointments, and medical screenings.

Exhibit 34: COVID Related Challenges

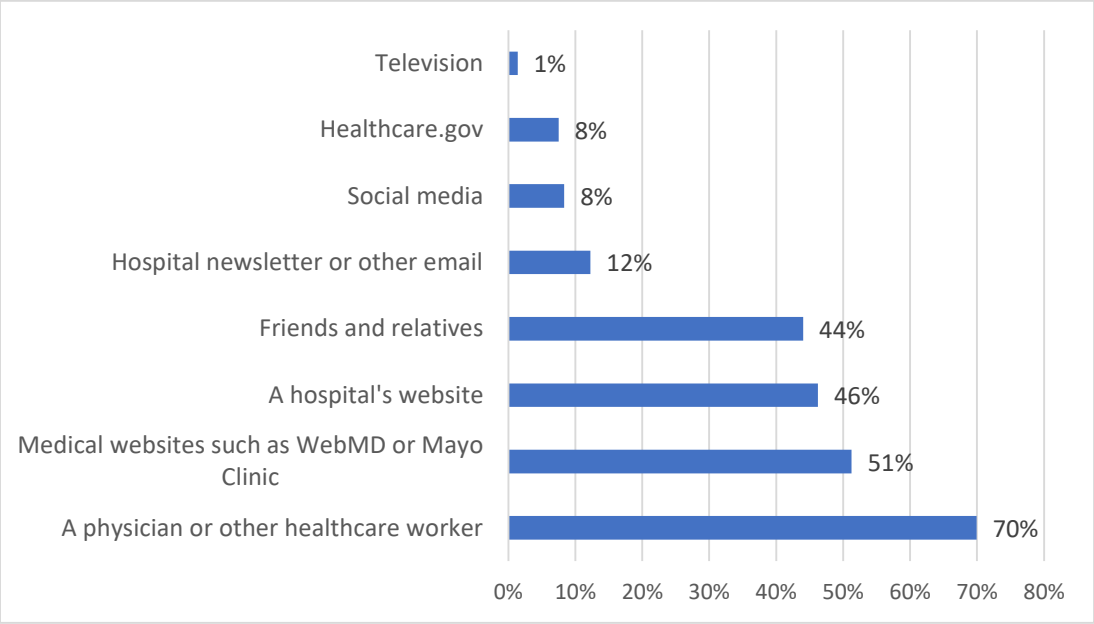
Since the beginning of the COVID-19 pandemic, which of the following are the top issues with which people struggle?



The most common sources of information used to find out about healthcare providers and health monitoring were physicians/healthcare workers, medical websites, hospital websites, and friends and relatives (word of mouth).

Exhibit 35: COVID Related Challenges

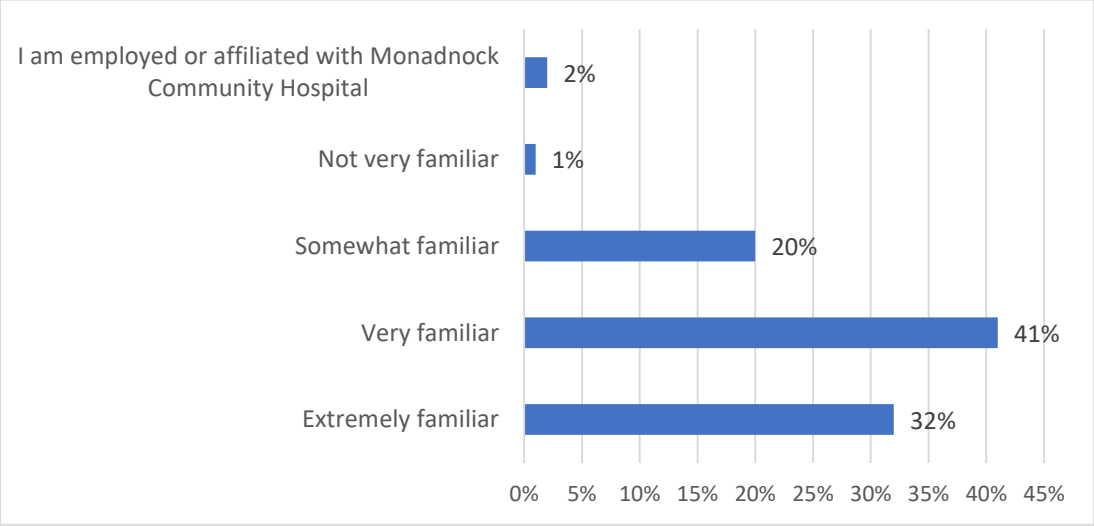
What sources do you normally use to find out about healthcare providers, hospitals, your own health, or to monitor your own health?



Most survey respondents had strong familiarity with Monadnock Hospital.

Exhibit 36: COVID Related Challenges

How familiar are you with Monadnock Hospital? (Percent of respondents)



Conclusions and Needs Prioritization

The secondary and primary research techniques generated an extensive list of community health needs, service gaps, barriers to healthcare, and recommendations to address them. In order to synthesize material and create consensus among Monadnock Community Hospital's leaders and other key stakeholders regarding the recommendations, MCH utilized the following prioritization approach.

Prioritizing the community needs involved two steps, or "rounds." The first utilized the community survey, which was disseminated electronically and with hard copies to the community at large, to identify approximately 28 community needs.

The second round was a prioritization process of the Hospital's CHNA Leadership Group. Leadership Group members were asked to determine if a given need falls within the Monadnock Community hospital purview to address, and to determine the hospital's "Locus of Control" to impact a need. For instance - affordable housing, while important, was decided not to be a within the purview of MCH to address. For needs that were determined to be within the MCH purview, Leadership Group members assigned a "Locus of Control" rating to determine how MCH can best make an impact. The explanation for Locus of Control scoring is outlined below:

1 = "We could do it ourselves"

2 = "We could do it with collaboration"

3 = "We could support, but others would need to lead."

The top prioritized results are as follows:

Exhibit 37: Prioritized Needs, 2021-2024[19]

Need	Locus of Control
Affordable healthcare services	1
Funding for depression/anxiety	1
Early intervention for substance use	1
Crisis care programs for mental health	1
Domestic violence Resources	2
Transportation	2
Caring for aging parents	2
Dental care /Specialty services	2
Post addiction services	2
Prescription assistance	2

[19] Additional prioritized needs that were identified within Locus of Control 3 ("We could support, but others would need to lead.") were "Long term dementia care" and "Medication Assisted Treatment (MAT)".

Implementation Strategy Considerations

The Implementation Plan to be developed by Monadnock Community Hospital is considered a required "next step" to follow the CHNA in which a prioritized list of community needs has been developed. As is seen above, the needs list includes a wide range of issues that fall into one of several categories:

- Community needs which MCH is already addressing but may enhance efforts
- Needs which MCH is already addressing to an appropriate degree
- Needs that are not part of MCH's purview (e.g., better addressed by other organizations), so an appropriate ongoing role for MCH may be minimal.

It is important to note though, that all of the identified needs are important, and MCH is dedicated to its mission of "Improving the health and well-being of our community" and vision of "Elevating the health of our community by providing accessible, high quality and value-based care." To each degree possible, MCH will continue working effectively and efficiently to strengthen the community.

To do so, MCH will develop the Implementation Plan that identifies which community needs MCH is already addressing, the degree of control it has over the ability to address each need, and the estimated timeline it would take to begin to address each need. The resulting Implementation Plan will show which of the CHNA prioritized needs MCH will address (and how, at a high level) and which ones it will not address (and why not).

The purpose of the Implementation Plan is to support the organization's efforts to efficiently and effectively deploy resources that address the most pressing community needs.

Appendices

Appendix A: Community Survey Instrument

Monadnock Community Hospital
Community Health Needs Assessment

Community Survey

Introduction and Objectives

We are conducting a very brief survey on behalf of Monadnock Community Hospital. The purpose is to better understand your perceptions of health needs and services in the area.

We have just a few short questions and would really value your input. The survey will take about 8 to 10 minutes, and your comments will be kept confidential.

Thank you for being willing to share your thoughts!

1. **Do you have a family doctor, or a place where you go for care?**
   - Yes, family doctor, family health center, or clinic
   - Yes, emergency room, or walk-in urgent care
   - No
   - Other (specify) _____

2. **In the past 12 months, have there been times when you needed medical help but chose NOT to seek it?**
   - Yes
   - No

3. **If YES, why did you NOT get care?**
   - Doctor might not know my language; difficult to communicate
   - Did not have the money
   - No doctors or clinics near me; too far away
   - Had no transportation to get to the doctor or clinic
   - Doctors or clinics do not open at a convenient time
   - Could not get off work
   - Could not find childcare
   - Other (please specify)

4. **How familiar are you with Monadnock Community Hospital?**
    - Very familiar
    - Somewhat familiar
    - Not very familiar
    - I am employed or affiliated with Monadnock Community Hospital

A healthy community can include different things such as the availability of healthcare services or behavioral health services. A healthy community many also include social, economic factors, environmental factors, or lifestyle topics such as obesity, smoking, substance abuse, and healthy living issues.

5. **Thinking broadly about health – mental, physical, or spiritual - when you hear a "healthy community" or "improving community health" what is the first thing that comes to mind?** OPEN ENDED:

The next few questions ask you about some issues in several areas. Please rate them on a 1 to 3 scale -- where 1 means that No More Focus is needed, 2 means Somewhat More Focus Needed, and 3 means Much More Focus Needed.

6. **Which of the following social or medical issues do you feel need more focus by the community?** (Circle your answers)

CATEGORY	NEEDS	No More Focus Needed (1)	Somewhat More Focus Needed (2)	Much More Focus Needed (3)	Do not know
Social, Economic, and Physical Environment Issues	Transportation services for people needing to go to doctor's appointments or the hospital	1	2	3	DK
	Secure sources for affordable, nutritious food	1	2	3	DK
	Affordable Quality Child Care	1	2	3	DK
	Transportation	1	2	3	DK
	Homelessness	1	2	3	DK
	Housing for all incomes/ages	1	2	3	DK
	Domestic Violence Resources	1	2	3	DK
	Job Readiness	1	2	3	DK
Medical / Health Issues	Primary Care Services (services (such as a family doctor or other provider of routine care)	1	2	3	DK
	Emergency Care and Trauma Services	1	2	3	DK
	Dental				
	Specialty Services, for example - cardiology - cancer care - dermatologists	1	2	3	DK
	Long Term Care or Dementia Care	1	2	3	DK
	Affordable healthcare services for people or families with low income	1	2	3	DK
	Prescription Assistance	1	2	3	DK

7. **Which of the following mental health or behavioral issues do you feel need more focus by the community?** (Circle your answers)

CATEGORY	NEEDS	No More Focus Needed (1)	Somewhat More Focus Needed (2)	Much More Focus Needed (3)	Do not know
Mental health and Substance Use Disorders	Counseling services for Depression or Anxiety	1	2	3	DK
	Counselling Services for adolescents / children	1	2	3	DK
	Early intervention for Substance use disorders	1	2	3	DK
	Medical Assisted Treatment for Opioid Addiction; suboxone	1	2	3	DK
	Post- Addictions Treatment Support Programs	1	2	3	DK
	Crisis Care Programs for mental health	1	2	3	DK
Lifestyle & Behaviors	Programs for Diabetes and/or Obesity	1	2	3	DK
	Caring for aging parents and resources to help	1	2	3	DK
	Parenting Classes	1	2	3	DK
	HIV AIDS Testing	1	2	3	DK
	Heart Health or Cardiovascular Health	1	2	3	DK

8. **Of all the issues, what do you think are the top one or two greatest health issues in the community?**
   OPEN ENDED:

9. **Since COVID, which of the following are the top issues with which people struggle?** (Please select two or three)
   - Finding a job
   - Getting a vaccine
   - Follow-up pulmonary therapy
   - Secure food sources
   - Anxiety or depression
   - Other _____

10. **Which of the following sources do you normally use to find out about healthcare providers, hospitals, your own health or to monitor your own health?** (Select all that apply)

    - **Healthcare.gov**
    - **A physician or other healthcare worker**
    - **Social media**
    - **A hospital's website**
    - **Medical websites such as WebMD or Mayo Clinic**
    - **Friends and relatives**
    - **Television**

The following are a few demographic questions that help us groups the responses later.

11. **In what year were you born?**
    OPEN ENDED:

12. **In what county do you live?**
    OPEN ENDED

13. **What is the highest grade or year in school you completed?**
    (CHECK ONE)
    - Less than high school
    - Graduated high school
    - Some college or vocational training
    - Graduated college (4-year bachelor's degree)
    - Completed Graduate or Professional school (Masters, PhD, Lawyer)

14. **What is your race?**
    (CHECK ALL THAT APPLY)
    - African American
    - American Indian
    - Asian
    - Caucasian
    - Hispanic
    - Mixed Race
    - Other

15. **Which of the following ranges best describes your total annual household income last year?** (CHECK ONE)
    - Less than $25,000
    - $25,000 to $50,000
    - $50,000 to $75,999
    - $75,000 to $100,000
    - $100,000 or more

16. **Gender: How do you identify?**
    - Male
    - Female
    - Non-binary/Other
    - _____

THIS COMPLETES THE STUDY – THANK YOU FOR YOUR PARTICIPATION!!

Monadnock
COMMUNITY HOSPITAL

Community Health Needs Assessment

Focus Group Discussion

Presented by crescendo

1

Discussion Questions

Monadnock COMMUNITY HOSPITAL

- Thinking broadly about the strengths of the Monadnock service area and its residents; what are some of the positive things about living here? What are some community strengths?

- How would you define community health? What does a healthy community look like to you?

Discussion Questions

Monadnock COMMUNITY HOSPITAL

What are the two or three greatest health related issues in the Monadnock service area?

What types of Healthcare services are generally available and what services do you think need more focus?

Are there any populations in the Monadnock service area that are especially vulnerable?

3

Discussion Questions

- What are the critical challenges or barriers to better addressing the needs we have just discussed? Are there ways Monadnock Hospital or community partners can help with this?
- In what ways has the COVID-19 pandemic affected the Monadnock community?

4

Discussion Questions

Monadnock COMMUNITY HOSPITAL

What are the most important non-healthcare related needs in the area?

How do consumers generally learn about access to and availability of services in the area?

5

Monadnock
COMMUNITY HOSPITAL

Magic Wand

- If there was one issue that you could personally change with the wave of a magic wand, what would it be?

crescendo

Questions?

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  JeremyV@CrescendoCG.com

Monadnock COMMUNITY HOSPITAL
a member of GraniteOne Health

Appendix E-3

Catholic Medical Center Community Needs Assessment Report

2022

GREATER MANCHESTER COMMUNITY HEALTH NEEDS ASSESSMENT

The City of Manchester Health Department

CMC
CATHOLIC MEDICAL CENTER

Dartmouth Health

The Elliot
A Member of SOLUTIONHEALTH

TABLE OF CONTENTS

INTRODUCTION

INTRODUCTION

The 2022 Greater Manchester CHNA is intended to fulfill the requirements for all Manchester area healthcare charitable trusts to conduct a periodic community health needs assessment as required by the Affordable Care Act, as well as State law. In addition, it serves as a common data source to inform community-level action and guide the development of implementation plans by the healthcare entities in compliance with applicable rules. This report was developed by the City of Manchester Health Department, which serves as the chief strategist for health-and wellness-related issues for the Greater Manchester Public Health Region, in partnership with Catholic Medical Center, Dartmouth Health, and Elliot Health System.
This report was produced with funding from the three health systems. Technical assistance was provided by JSI Research and Training Institute (JSI) in Bow, New Hampshire, in the collection and summary of Key Informant Interviews and Resident Surveys to provide resident input on major issues facing the Greater Manchester Region. Additional partners include Manchester Proud, LAUNCH Manchester, Makin' It Happen, Health Care for the Homeless, The Mental Health Center of Greater Manchester, Families in Transition, Manchester Food Collaborative, Neighborworks, and Amoskeag Health. The City of Manchester Health Department also secured the consultant expertise of Michelle Graham for much of the content. Reviewers of this report include Elaine Michaud and Victoria Adewumi. In addition, JSI contributed to the design and production of this report.

Data are drawn from national, state, and local sources, each offering different levels of geographic comparison. When possible, the data are drilled down to the neighborhood level using census tract maps. For some metrics, Manchester is compared to other towns within the Greater Manchester Region. This Region encompasses both the Greater Manchester Public Health Region (Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, New Boston, and Manchester) and the Greater Manchester Hospital Service Area (HSA), which includes the Public Health Region plus Londonderry. For data points obtained from the City Health Dashboard (see data sources), Nashua and the 500 cities are used as appropriate comparisons for Manchester.

Table 1 describes the demographics of cities and towns within the Greater Manchester HSA in terms of population size and by major racial categories and Hispanic/Latino concentration. The City of Manchester is by far the most racially/ethnically diverse in the region, with 26% of residents identifying as non-White. Manchester is also the largest city in New Hampshire, and the largest north of Boston, with more than 115,000 residents.

Table 1. Population Characteristics of Greater Manchester Hospital Service Area: Race/Ethnicity

City/Town	Total Population	White	Black	Asian	Other	Hispanic/ Latino
Auburn	5,946	92%	<1%	1%	4%	2%
Bedford	23,514	86%	1%	6%	4%	3%
Candia	4,013	92%	1%	1%	4%	2%
Deerfield	4,855	94%	<1%	<1%	4%	2%
Goffstown	18,577	90%	1%	1%	4%	3%
Hooksett	14,871	88%	1%	3%	5%	3%
Londonderry	25,829	89%	1%	1%	4%	4%
New Boston	6,108	92%	1%	<1%	5%	2%
Manchester	**115,644**	**74%**	**5%**	**4%**	**5%**	**12%**

Source: 2020 American Community Survey

Population distributions by age in the Greater Manchester Region are shown in Table 2. Candia and Bedford are home to the highest proportions of older adults, while Auburn and Bedford have the largest proportions of residents under 5 years of age. Bedford also has a uniquely high concentration of residents in the 30-49 year age range, at nearly 40%, while having the lowest percentage of residents in the 20-29 year age range, at just over 7%.

Table 2. Population Characteristics of Greater Manchester Hospital Service Area: Age

City/Town	Under 5	15-19	20-29	30-49	50-64	65 and up	Total Population
Auburn	6.3%	15.8%	11.7%	24.7%	27.9%	13.8%	5,946
Bedford	5.9%	21.4%	7.2%	39.4%	23.6%	16.6%	23,322
Candia	4.6%	12.9%	10.2%	21.9%	32.8%	17.7%	4,013
Deerfield	4.1%	18.1%	11.6%	24.7%	29.3%	15.0%	4,855
Goffstown	5.3%	22.2%	12.1%	24.8%	19.3%	16.4%	18,577
Hooksett	4.0%	19.2%	14.7%	26.3%	20.4%	15.4%	14,871
Londonderry	5.3%	19.7%	10.5%	25.8%	24.5%	14.1%	25,826
New Boston	5.1%	22.5%	10.1%	28.5%	22.4%	11.3%	6,108
Manchester	5.1%	14.2%	11.1%	27.1%	20.9%	14.6%	115,644

Source: 2020 American Community Survey

Table 3. Population Characteristics of Greater Manchester Region: Language Spoken at Home Other Than English

City/Town	Spanish		Other Indo-European Languages		Asian and Pacific Island Language		Other Languages		Total Population
	%	#	%	#	%	#	%	#	
Auburn	0%	0	2.1%	108	0%	0	0.2%	9	5,946
Bedford	1.2%	246	7%	1496	2%	432	0%	0	23,322
Candia	1.9%	69	3.1%	116	0%	0	0%	0	4,013
Deerfield	0.3%	12	1.6%	70	0.2%	9	0.3%	11	4,855
Goffstown	1.1%	193	6.2%	1067	0.7%	116	0%	0	18,577
Hooksett	0.8%	107	5.3%	740	0.7%	102	1.9%	267	14,871
Londonderry	2.4%	594	3.1%	761	0.7%	172	<0.1%	11	25,826
New Boston	0.3%	14	0.4%	21	0.1%	4	0%	0	6,108
Manchester	8%	8,555	8.2%	8,700	2.5%	2,656	2.4%	2,609	115,644

Source: 2020: ACS 5-Year Estimates Subject Tables

Language spoken at home other than English is shown in Table 3 above. The population in Manchester has a remarkably higher percentage of all languages spoken other than English than all other towns within the Greater Manchester HSA. Distinctively, Spanish and other Indo-European language speakers make up over 16% of Manchester's population.

Similar tables throughout this report illustrate regional differences in educational achievement, uninsurance rates, vehicle access, and other indicators of population health and well-being.

Definition of Community

While much of the data used in this assessment is based on cities, towns, and census tracts, it is important to recognize that a geographical unit is not the only method of measuring determinants of health and health outcomes. As defined by the Institute of Medicine, "community" includes individuals with shared affinity, and, in some cases, a shared geography, who organize around an issue, with collective discussion, decision making, and action.[1] As a result, community health is profoundly affected by the collective beliefs, attitudes, and behaviors of everyone who lives in the community.[2] Individual political affiliation, voting practices, volunteerism, engagement in faith and charitable giving are important elements of social capital and collective efficacy which warrant further study as to their connection and influence to health in Manchester.

[1] *Improving Health in the Community https://health.gov/healthypeople/tools-action/browse-evidence-based-resources/improving-health-community-role-performance-monitoring*
[2] *2000. Healthy people 2010, Volume I. Washington, DC: U.S. Dept. of Health and Human Services.*

Equity, Inclusion and Accessibility

Strong communities that demonstrate resilience and perseverance foundationally also strive for systemic equity, inclusion and accessibility in all that they do. This document, will reflect health disparities when data is available and statistically significant. Differences in health status can occur because of unequal access and discrimination on the basis of gender, race or ethnicity, education, income, disability, geographic location, and sexual orientation among others. Social determinants of health, which are socially-engineered conditions like poverty, unequal access to health care, lack of education, violence, stigma, and racism are linked to health disparities.[3] Furthermore, it is well documented that urban areas and mid to upper-sized cities are prone to higher rates of infectious disease, injuries and interpersonal violence, and noncommunicable diseases often linked to environment such as asthma, diabetes, depression, anxiety, and mental illness.[4] Interventions and policy change recommendations steered by authentic resident engagement will be necessary to combat these injustices and inequities and prevent social conditions from determining health winners and losers.

Neighborhoods of Opportunity

The neighborhoods people live in have a major impact on their health and well-being.[5] Furthermore, in almost all urban areas, serious health problems and unstable social conditions are highly concentrated historically, as well as through housing policy, in a fairly small number of distressed neighborhoods.[6] The U.S. Partnership on Mobility from Poverty defines opportunity neighborhoods as places where every family should be able to live and which support well-being and boost children's chances to thrive and succeed.

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[3] *https://www.cdc.gov/nchhstp/healthequity/index.html.*
[4] *https://www.who.int/news-room/fact-sheets/detail/urban-health.*
[5] *https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment*
[6] *https://aspe.hhs.gov/reports/neighborhoods-health-building-evidence-local-policy-1.*

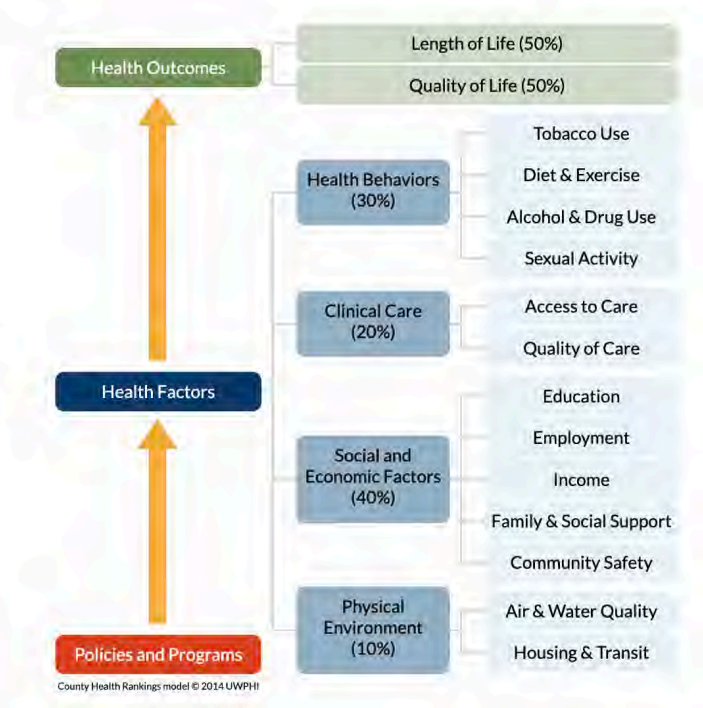
With this assessment, the City of Manchester and its partners share the commitment by the U.S. Partnership to foster neighborhoods of opportunity[7] which achieve:

- Economic success: Improvements in neighborhood quality and choice will lead to higher employment rates, higher incomes, and lower poverty.
- Power and autonomy: Communities will share a greater sense of agency, and indicators of civic activity, such as voting, will rise.
- Being valued in community: Residents of all races and ethnicities will report a greater sense of belonging and higher standing in the community and society. Experiences of discrimination and racial resentment should fall.

Strategic Framework

The City of Manchester and its partners embrace a broad definition of health as more than the presence or absence of disease, but rather a state of well-being and resilience. Health is rooted in interactions among characteristics of an individual and their environment. The County Health Rankings Model (Figure 1), developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, provides a framework for population health that emphasizes the many factors that, if improved, help make communities healthier places to live, learn, work, and play. These factors fall into four domains—health behaviors, clinical care, social and economic factors, and physical environment—which together encompass all of the modifiable factors influencing individual and community health.

Figure 1. County Health Rankings Model



Source: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

[7] *https://www.mobilitypartnership.org/opportunity-neighborhoods.*

This report uses the County Health Rankings framework at its chapter outline, focusing first on the factors that have the greatest overall impact on health outcomes—social and economic factors—and ending with health outcomes and opportunities. The framework uses the following descriptions to define each of its four domains influencing health:

- **Social and Economic Factors** (also call social determinants of health) include income, education, employment, community safety, and social supports that can significantly affect how well and how long an individual lives. These factors impact the ability to make healthy choices, afford medical care and housing, manage stress, and more. The Model estimates that 40% of an individual's health status is determined by social and economic factors.
- **Health Behaviors** include actions individuals take that affect their health, such as eating well and being physically active. Health behaviors also include actions that increase one's risk of negative health outcomes, including smoking and substance misuse. The Model estimates that 30% of an individual's health status is determined by their health behaviors.
- **Clinical Care** includes the extent to which residents have access to affordable, quality, and timely health care that can help prevent disease and detect health conditions early, enabling individuals to live longer, healthier lives. The Model estimates that 20% of an individual's health status is determined by access to quality and timely clinical care.
- **Physical Environment** includes characteristics of the environments in which individuals live, work, play, and worship that can have an impact on their overall health. A poor physical environment, such as substandard housing and poor walkability, can affect the ability to live long and healthy lives. The Model estimates that 10% of an individual's health status is determined by the characteristics of their physical environment.

This report also references the benchmarks outlined in Healthy People 2030, which includes 355 core objectives for improvements within each of the domains listed above.[8] It places a special emphasis on Social Determinants of Health as major influencers of the health status of individuals, communities, and populations (Figure 2).

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[8] *Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health*

Figure 2. The Five Social Determinants of Health, Healthy People 2030

1. **Healthcare Access and Quality**
2. **Neighborhood and Built Environment**
3. **Social and Community Context**
4. **Economic Stability**
5. **Education Access and Quality**

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

Chapter Outline

Within the strategic framework outlined above, this report focuses on six priority areas identified in the 2019 Greater Manchester Community Health Needs Assessment: Manchester's Urban Advantage. Key indicators and outcomes are described within each priority area, with the aim of informing rather than prescribing local action. The report is organized as follows:

- Chapter 1: Introduction
- Chapter 2: Social and Economic Factors
  - Priority: Improve Educational Outcomes
- Chapter 3: Health Behaviors
  - Priority: Reduce and Prevent Substance Misuse
- Chapter 4: Clinical Care
  - Priority: Improve Access to Quality Preventive Healthcare
- Chapters 5 and 6: Nutrition and Food Security and Healthy Homes and Neighborhoods
  - Priority I: Improve Access to Healthy Foods
  - Priority II: Improve Access to Healthy, Affordable Housing
- Chapter 7: Trauma and Health Outcomes
  - Priority: Prevent and Address Trauma
- Chapter 8: Conclusion
- Chapter 9: Resident Input Summary

Each chapter includes data on key indicators associated with its priority area along with a narrative describing the relevance of each indicator and interpretation of the data. Where appropriate, Healthy People 2030 targets are included as benchmarks in charts and tables. Relevant findings from the key stakeholder interviews and resident surveys are included at the end of each chapter. Finally, "community spotlights" have been added to each chapter to highlight important action being taken to address each of the six priorities. References within each chapter offer readers an opportunity to take a "deeper dive" into each of the topics presented.

Data Sources

As mentioned above, this report pulls data from a variety of national, state, and local resources. While all sources are referenced throughout the report, some of the more commonly cited are described below.

City Health Dashboard

The City Health Dashboard serves as a central repository for data on more than 40 indicators associated with health and wellness. The site was launched in 2018 with funding from the Robert Wood Johnson Foundation, and included data on the 500 largest cities in the US, including Manchester. The Dashboard calculates averages on each indicator across those 500 cities to provide a common measure against which individual municipalities can assess their performance. Most metrics on the Dashboard are available to view as maps detailing census tract-level variation in indicators and outcomes. For more information or to explore metrics not included in this report, visit: https://www.cityhealthdashboard.com/

US Census Bureau

The Census Bureau's new data exploration site allows users to view data across years and from several geographic perspectives, allowing comparisons across the Greater Manchester Region and with the State of NH as a whole. The site includes results from a large selection of federally-sponsored surveys, including the American Community Survey. For more information or to explore data points not included in this report, visit: https://data.census.gov.

NH DHHS Data Portal

The NH Department of Health and Human Services data portal includes state, regional and, when possible, local data on a variety of health-related outcomes and indicators. The site includes data from the Youth Risk Behavior Surveillance System and the Behavioral Risk Factor Surveillance System, two important surveys that measure youth and adult health-related risk factors across the US. Data not accessible through the portal were directly requested for use in this report by the City of Manchester Health Department. For more information or to search for additional data, visit: https://wisdom.nh.gov/wisdom/

Resident Input

Local input on the priorities and issues outlined in this report was gained through interviews with key community stakeholders conducted by JSI in March and April of 2022 and resident surveys conducted online and through direct outreach to minority populations by Community Health Workers at the Manchester Health Department. Results from both sources are summarized in the final chapter of this report. The full thematic analysis and report from JSI is available on the City of Manchester Health Department's website: https://www.manchesternh.gov/departments/health/

A Note About COVID-19

The two years preceding this report have been unlike any other in this generation's history. Public health strategies put in place to contain the COVID-19 pandemic led to vast disruptions in everyday life locally, nationally, and worldwide. School closures and stay-at-home orders interrupted routine data collection, impacting several data systems that provide critical information on health and human services.[9] The National Health and Nutrition Examination Survey missed a complete cycle of data collection. The Behavioral Risk Factor Surveillance System survey was conducted entirely by phone for the first time in history. Data collection for the most recent cycle of the Youth Risk Behavior Surveillance System was delayed by a year.

The impact of COVID-19 on this report goes beyond data collection. "Various data indicate that in 2021, relief measures reduced poverty, helped people access health coverage, and reduced hardships like inability to afford food or meet other basic needs," according to the Center on Budget Policies and Priorities.[10] Yet these efforts did not provide the ongoing support families need, particularly in the face of rising inflation. More than 26,000 New Hampshire families were behind on rent in the third quarter of 2021 as eviction protections expired.[11] In addition, Supplemental Nutrition Assistance benefit increases were discontinued in September, 2021. Equitable economic recovery post-COVID must be the community's priority and may take decades to achieve as neighborhood vulnerabilities persisted in Manchester prior to the pandemic.

These rapid and consequential changes in social policy cannot easily be reflected in the data sources utilized in this report, as State and Federal data often lag by 1-2 years between the date of collection and the time of reporting. It is important to keep these limitations in mind when reviewing this report and monitoring trends in the health and well-being of Manchester residents.

[9] *https://aspe.hhs.gov/reports/covid-19-impacts-hhs-data*
[10] *https://www.cbpp.org/sites/default/files/2-24-2022pov_1.pdf*
[11] *Ibid*

SOCIAL AND ECONOMIC FACTORS

PRIORITY: IMPROVE EDUCATIONAL OUTCOMES

The association between education and health is well-established and persistent over the lifespan. Higher education attainment is linked to lower morbidity from chronic and acute conditions, lower prevalence of chronic disease, reduced age-adjusted mortality from all causes, and increased physical and mental functioning.[1] While some of this relationship can be explained by healthier lifestyle choices, other factors associated with employment, income, and environment also contribute to better overall wellbeing.

Research consistently demonstrates that high school graduates obtain higher income jobs and, therefore, gain access to better living conditions.[2] Individuals who drop out of high school are more likely to report overall poor health and suffer from at least one chronic health condition.

> ***"Educational attainment is a particularly profound predicator of length of life, now surpassing both race and gender in importance in the United States."***

COVID-19 Response

The COVID-19 pandemic has had a dramatic negative impact on child development, health, and wellbeing across the country. With a switch from in person to online learning, student educational outcomes have been greatly impacted. In Manchester, the school district proactively implanted measures to protect students including a new policy dictating smaller class sizes, standardized new curriculum, integrated English learning programing, increased number of guidance counselors, a targeted approach to seniors who are at risk of graduating, improved internet connectivity, a layered mitigation plan to safely allow for students to return to in person learning, enhanced ventilation and cleaning in schools, free tutoring services in person and online, continued Social Emotional Learning (SEL) resources, continued Multi-Tiered System of Supports (MTSS) that supports students where they are at, strengthened professional development for students, and the district continued to deepen community partnerships to support children.

National studies on educational assessments following the COVID-19 pandemic show Manchester's consistency with national trends. Recognizing the impact, supplementary measures implemented by the Manchester school district include partnerships with GEAR UP, a program that supports low-income students to help prepare them to succeed in post-secondary education. Furthermore, the school district is utilizing data from standardized testing to help in fully understanding student growth as well as informing instruction moving forward.

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[1] *Cutler, D.M. & Lleras-Muney, A. (July 2006). Education and health: evaluating theories and evidence. National Bureau of Economic Research, Working Paper 12352. doi: 10.3386/w12352.*

[2] *https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/high-school-graduation*

In addition to these measures the district created a daily data dashboard that was specific to the Manchester school district. The dashboard was a decision making dashboard that was based on risk correlated to district action levels. This dashboard facilitated the driving forward of the strategic plan and helped the City of Manchester reach a renewed place where student health and safety were the main priority.

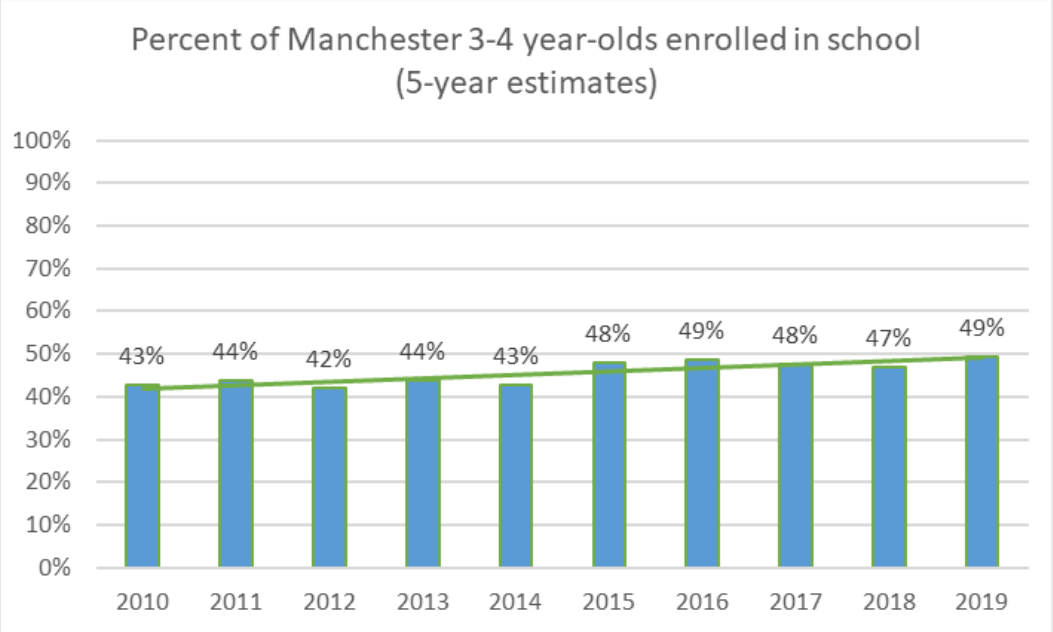
Early Access to Learning and School Readiness

Improving educational outcomes starts with ensuring children enter school ready to learn. Participation in early education opportunities helps to minimize the gaps in school readiness related to income and race. Enrollment in Kindergarten, while not mandatory in the State of New Hampshire, ensures children have an opportunity to transition from the preschool to elementary school environments in a structured learning environment.

Preschool Enrollment

Data from the American Community Survey suggest that the proportion of Manchester 3- and 4-year-olds who are enrolled in preschool has risen over the past decade, though the absolute gains are small (Figure 1). Between 2010 and 2019, the percent of children enrolled in preschool increased by approximately 16%, from 42.6% to 49.4%.

Figure 1. Preschool Enrollment on Slow But Steady Rise in Manchester



Source: American Community Survey, 5-year Estimates

Preschool enrollment rates vary widely among towns within the Greater Manchester Region, as illustrated in Table 1. In 2019, Goffstown and Hooksett had the highest rates of preschool enrollment, at about 80%, while Londonderry had the lowest enrollment rate at only 41.3%. Fewer than half of Manchester 3- to 4-year-olds were enrolled in preschool in 2019, falling below the averages for both the Greater Manchester Region and the State of New Hampshire as a whole. By comparison, preschool enrollment in the City of Nashua reached 59.7% that same year (data not included in table).

Table 1. Fewer than Half of Manchester 3-4-year-olds Enrolled in Preschool
Preschool Enrollment by Town in Greater Manchester Region, 2019 (5-year estimates)

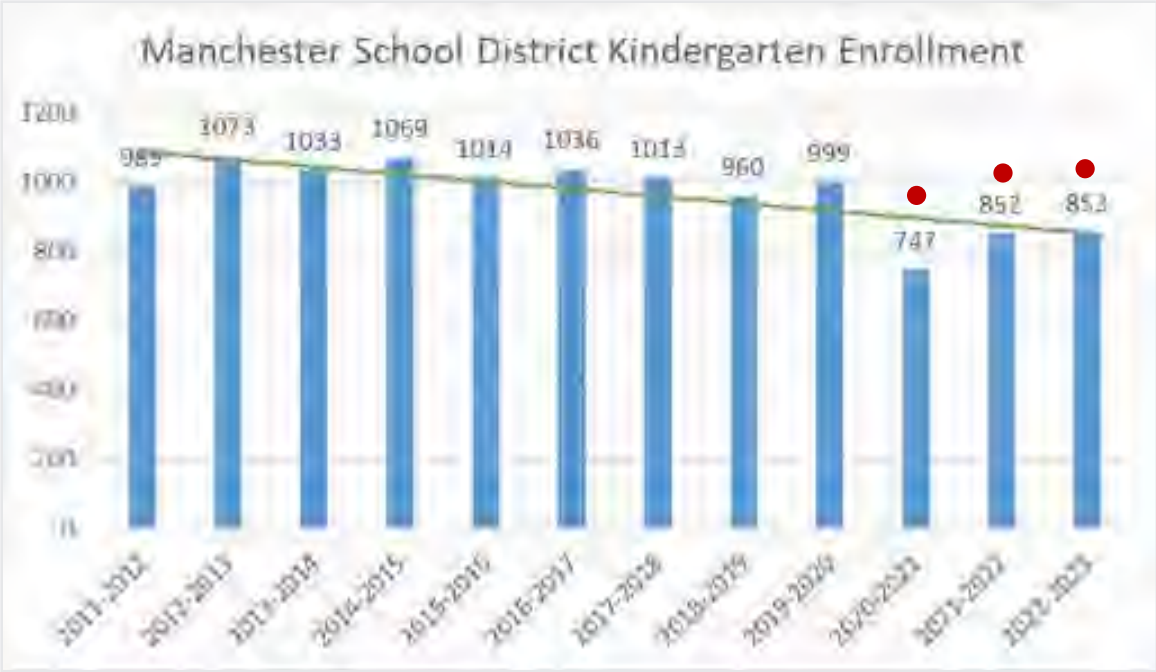
Town	Percent of 3-4 Year-Olds Enrolled in School
Manchester	49.4%
Auburn	55.7%
Bedford	49.2%
Candia	59.6%
Deerfield	59.8%
Goffstown	80.0%
Hooksett	79.5%
New Boston	57.7%
Londonderry	41.3%
Nashua	75.9%
State of NH	53.1%

Source: American Community Survey, 5-year Estimates

Kindergarten Enrollment

While all New Hampshire school districts are required to offer at least part-time kindergarten to children aged 5 and up, attendance is not mandatory. Not surprisingly, school districts across the state saw dramatic drops in kindergarten enrollment because of the COVID-19 pandemic. In Manchester, the number of students enrolled in kindergarten dropped by more than 25% in 2020-2021 compared with 2019-2020 (Figure 2). While numbers rebounded somewhat during the current school year, they have not returned to pre-pandemic levels.

Figure 2. Manchester School District Kindergarten Enrollment



Source: NH Department of Education

Academic Growth

3rd Grade English Language Arts (ELA) Proficiency

The percent of students who are reading on grade-level by Grade 3 is a widely accepted indicator of future academic achievement. Third grade marks the transition when children switch from learning to read, to reading to learn.[3] As such, children who reach fourth grade without reading proficiency are more likely than others to struggle academically.

The data in Figure 3 indicate that 3rd grade ELA proficiency is trending in the wrong direction in Manchester. Between the 2015-2016 and 2020-2021 school years, the percent of 3rd graders who scored at or above proficient in ELA declined from 29% to 19%, a drop of nearly 35%.

According to the City Health Dashboard, Manchester's 3rd graders scored, on average, at a 1.4-grade reading level in 2017-2018. Male students scored at the 1st-grade level, while female students scored close to 2nd-grade level.

While assessment data for 2019-2020 are not available due to COVID-19 restrictions, numerous studies have shown that pandemic-related school closures had a negative impact on school achievement, particularly for younger students, and likely caused a widening in the achievement gap for students living in poverty.[4]

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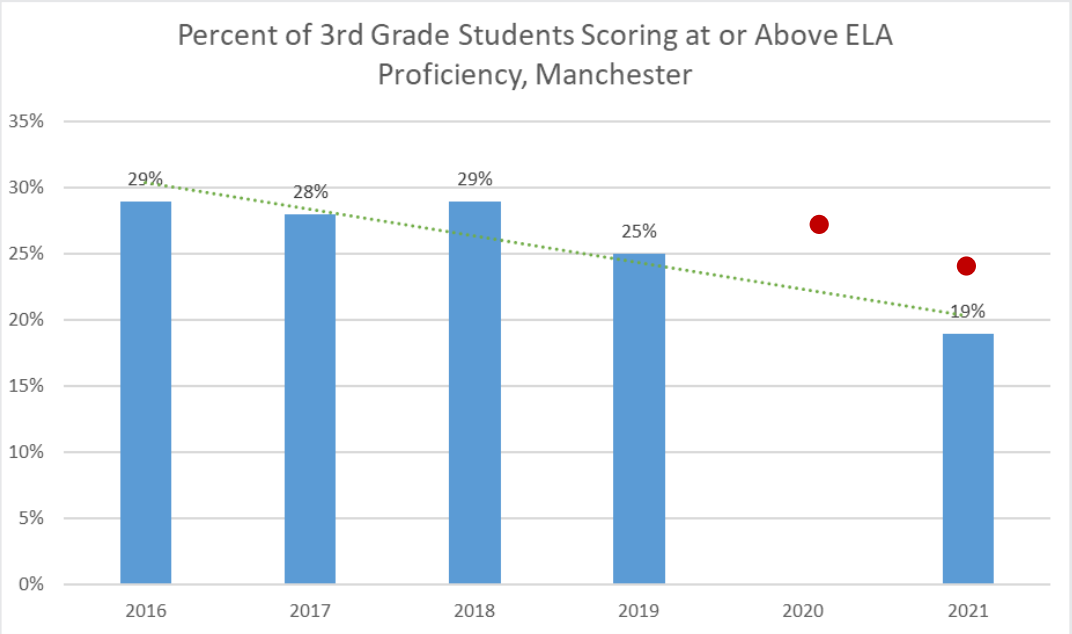
[3] https://cityhealthdashboard.com/metric/15 achievement: a systematic review. Frontiers in Psychology, 16, 1-8.
[4] Hammerstein, S., Konig, C., Dreisorner, T., & Frey, A. (2021). Effects of COVID-19-related school closures on student

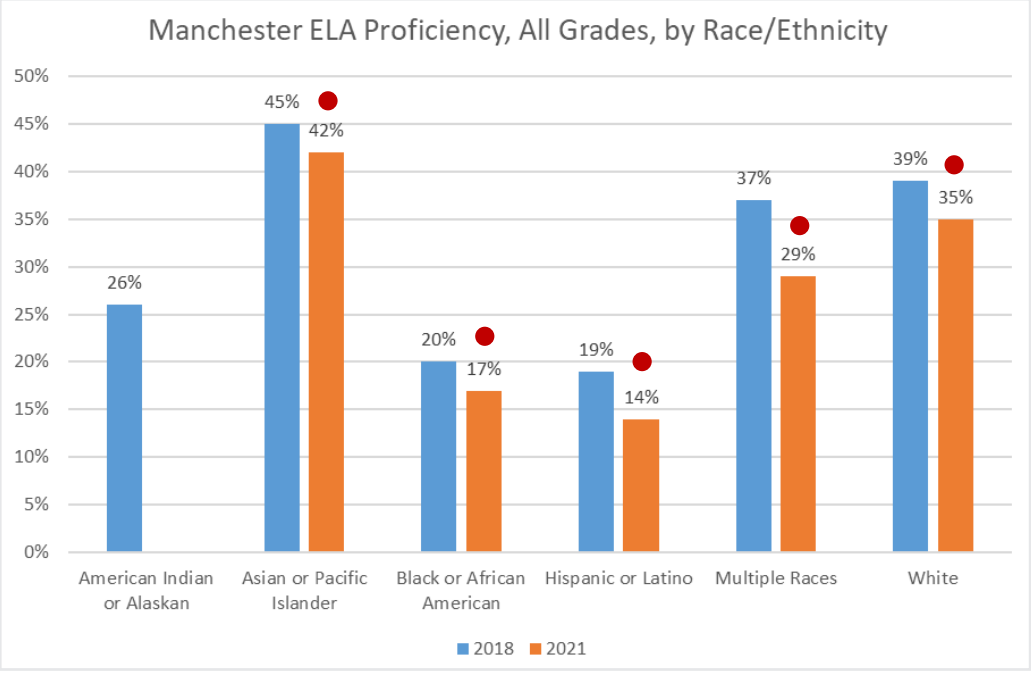
Figure 3. Manchester 3rd Grade ELA proficiency down 35% since 2016



Source: NH Department of Education
**data unavailable for 2020 due to pandemic school closures*

Figure 4 shows the racial/ethnic differences in ELA proficiency among students in all grades in Manchester between 2018 and 2021. At both time points, Asian/Pacific Islander and White students have the highest levels of ELA proficiency, while Black and Hispanic/Latino students have the lowest levels of proficiency. The gap in achievement between white and black students increased from 48.7% in 2018 to 51.4% in 2021, while the gap between white and Hispanic/Latino students increased from 51.3% to 60.0%

Figure 4. Racial/Ethnic Differences in ELA Proficiency Expanding



Source: NH Department of Education
**Note: data for American Indian/Alaskan students suppressed in 2021 due to low numbers*

Reading and Math Proficiency

Seventh grade math proficiency is another important predictor of later academic growth and economic stability.[5] According to the Bureau of Labor and Statistics, students who do well in math are more likely to graduate from a 4-year college and achieve financial success.[6]

As Table 2 demonstrates, Manchester students are scoring well below students in other Greater Manchester towns on both 3rd grade ELA and 7th grade math proficiency tests. For example, students in Bedford, Deerfield, Goffstown, Hooksett and Londonderry are achieving 3rd grade ELA proficiency at or above state averages. Students in Auburn, Bedford, Candia, and Hooksett are achieving 7th grade math proficiency above the state rate of 47%. By comparison, Manchester 3rd graders were less than half as likely to score proficient in ELA as students in the State of New Hampshire as a whole. Manchester 7th graders were less than one-quarter as likely as students across the state to score proficient at math.

Table 2. Manchester Students Score Well Below State Average on ELA, Math Proficiency Tests

Town	ELA Proficiency, 3rd Grade	Math Proficiency, 7th Grade
Manchester	19%	12%
Auburn	46%	60%
Bedford	76%	64%
Candia	50%	68%
Deerfield	58%	44%
Goffstown	52%	41%
Hooksett	52%	50%
New Boston	50%	N/A
Londonderry	52%	37%
Nashua	30%	23%
State of NH	52%	47%

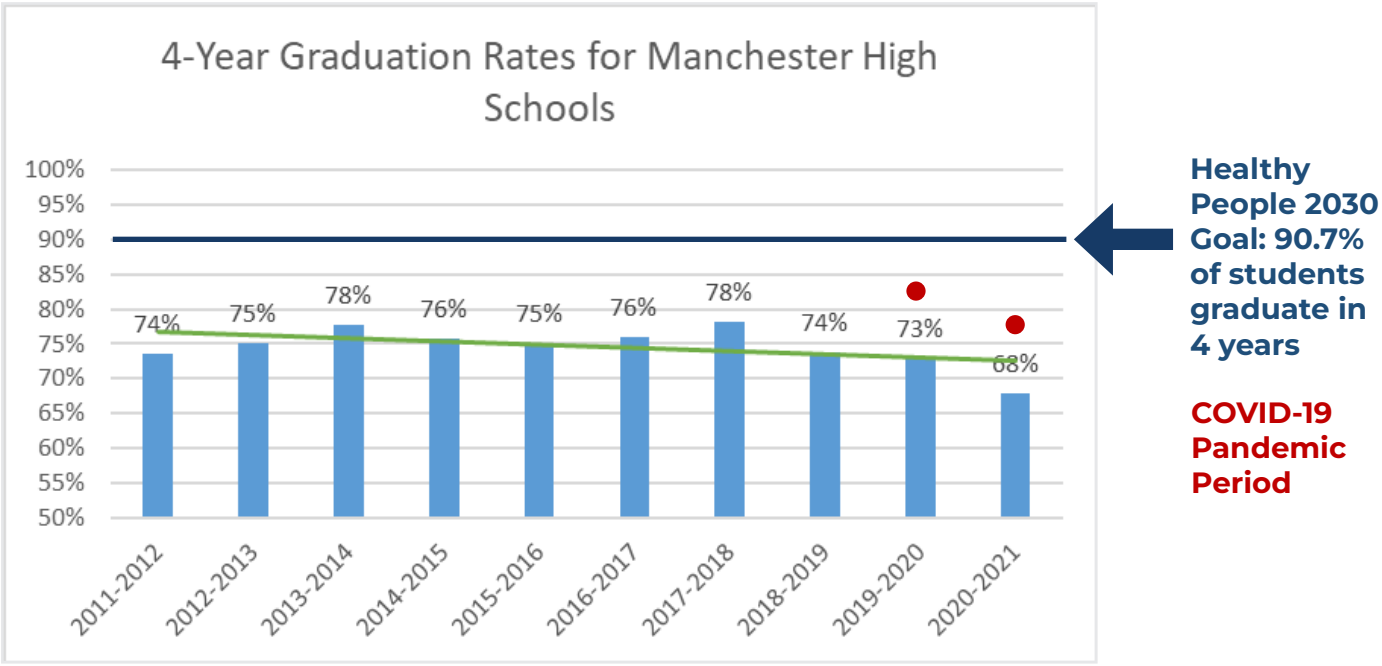
Source: NH Department of Education

On-time Graduation

According to Figure 5, high school graduation rates in Manchester have been on the decline for several years. While this trend was apparent before the onset of the COVID-19 pandemic, the larger-than-predicted drop in graduation rates between 2019-20 and 2020-21 suggest that the pandemic likely exacerbated an already negative trend.

[5] *https://www.iyi.org/wp-content/uploads/2021/06/EducationSpotlight.pdf*
[6] *https://www.mathnasium.com/math-proficiency-predicts-financial-success*

Figure 5. Manchester On-Time Graduation Rates Down for Fourth Year in a Row

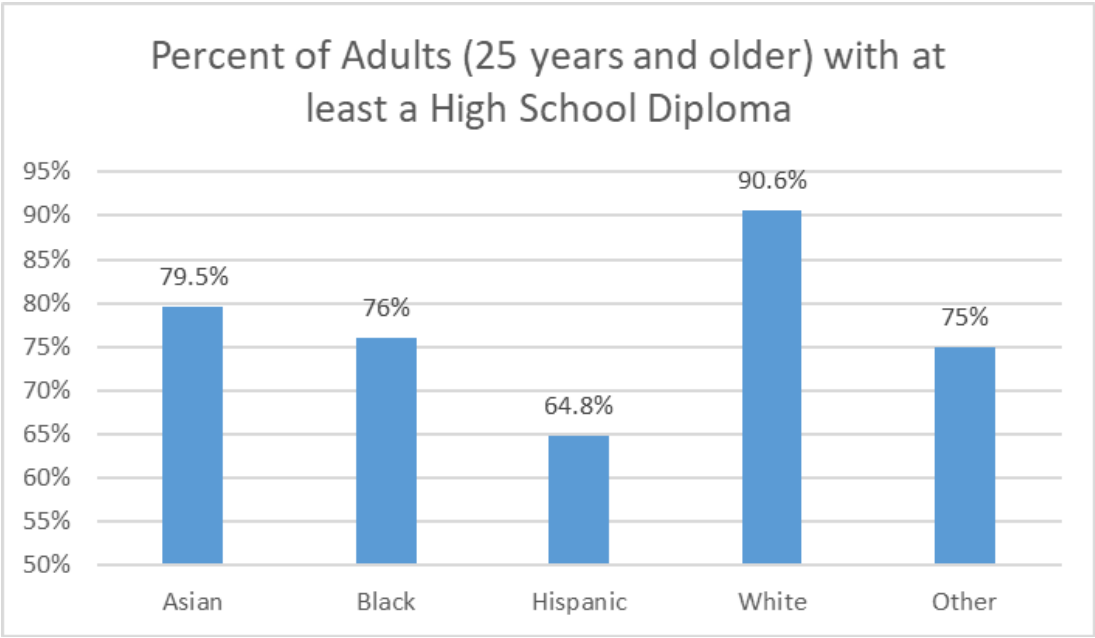


Source: NH Department of Education

High School Completion

In 2020, the high school completion rate (percent of adults aged 25 years or older with at least a high school diploma or equivalent) was 87.5% in Manchester. However, this rate varied widely among racial and ethnic groups, as achievement barriers contributed to 64.8% of Hispanic adults completing high school compared with 90.6% of white adults (Figure 6). Overall, Manchester's high school completion rate was similar to the average for the 500 largest cities in the US (88.5%), but lower than Nashua's rate of 91.2% in 2020.

Figure 6. Manchester Mirrors National Disparities in High School Completion by Race/ Ethnicity



Source: City Health Dashboard

Workforce Readiness and Success

Post-secondary Education

According to the US Bureau of Labor Statistics, workers with a bachelor's degree earned an average of $524 per week more than those with only a high school diploma or equivalent in 2020.[7] Moreover, a study published by the Center for Society and Health in 2014 demonstrated clear links between higher education and longer life expectancy, lower rates of chronic disease, fewer health risk factors, and a lower likelihood of diminished physical abilities or disabilities.[8]

In 2019, a little more than 30% of Manchester adults aged 25 years and older had a bachelor's degree or higher level of educational attainment, compared with 37% of adults in the State of New Hampshire as a whole (Figure 7). The proportion of Manchester adults with less than a high school diploma or equivalent was nearly twice as high as the state rate in 2019, at 12.7% and 6.9%, respectively. By comparison, 36.2% of Nashua adults had a bachelor's degree or higher and 9.2% had less than a high school diploma that same year.

Figure 7. Fewer Than One-Third of Manchester Adults Have Bachelor Degree or Higher

Source: US Census Bureau, American Community Survey, 2019 5-year Estimates

[7] *https://www.bls.gov/emp/chart-unemployment-earnings-education.htm*
[8] *file:///C:/Users/mgraham/Downloads/rwjf409883.pdf*

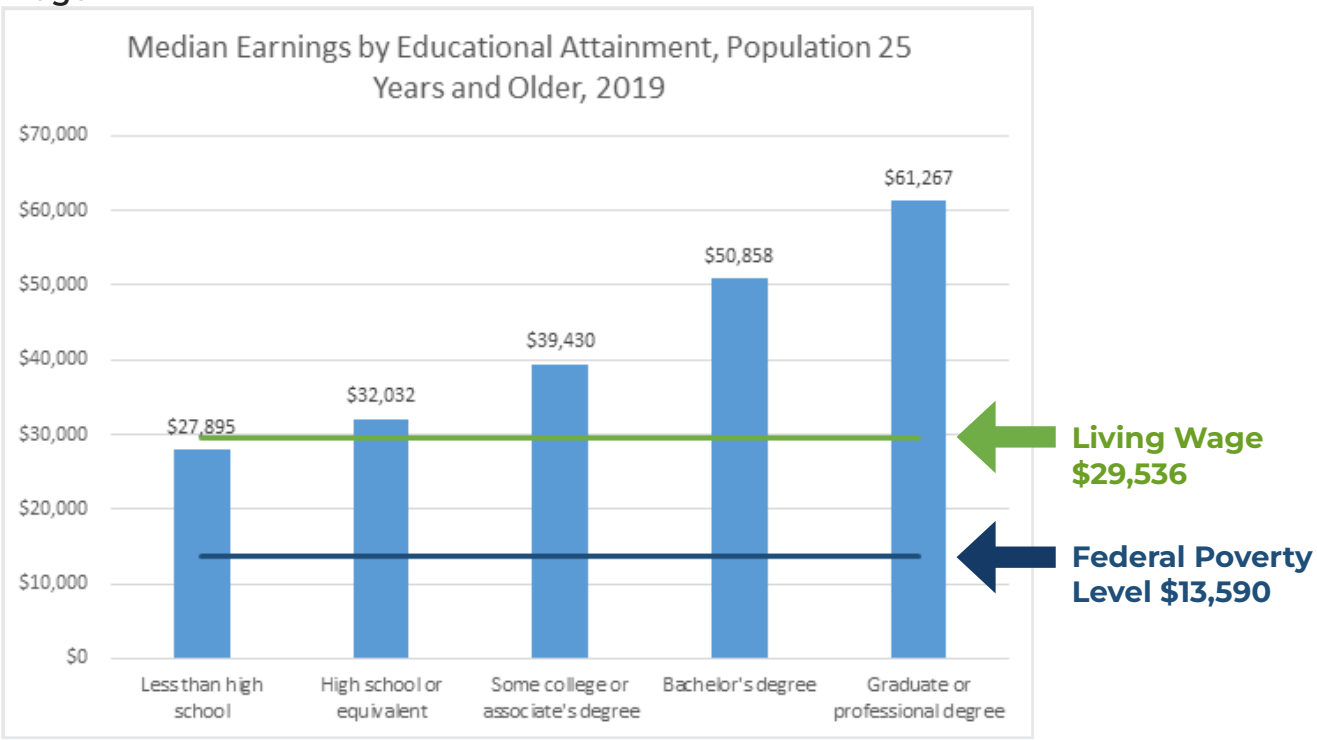
Wages and Income

The Living Wage calculator, created by the Massachusetts Institute of Technology (MIT), uses publicly available data to estimate the current cost of living in a community. They define a living wage as one that "allows residents to meet minimum standards of living," including adequate shelter, food, healthcare, transportation, and other basic needs.[9] According to the calculator, the current living wage for an individual living alone in Manchester is $16.96/hour or $35,276 annually. For a Manchester family of four with 2 adults working and 2 children, the living wage rises to $50,502 for each adult.

In contrast to the living wage, the Federal Poverty Level is calculated based only on the cost of a "minimum food diet" and is used as the threshold for eligibility for certain welfare benefits.[10] The Federal Poverty Level has been set at $13,590 for a single adult in 2022, and a combined household income of $27,750 for a family of four.[11]

As illustrated in Figure 8, the average Manchester adult with less than a high school education earned below a living wage in 2019. Adults with a high school diploma or equivalent but no college earned just 8% above a living wage. The greatest jump in earnings was between those with some college and those with a bachelor's degree, with the latter group earning nearly 30% more than the former.

Figure 8. Manchester Adults with Less Than High School Diploma Earning Below Living Wage



Sources: US Census Bureau, American Community Survey, 2019 5-year Estimates; Living Wage Calculator, https://livingwage.mit.edu/metros/31700

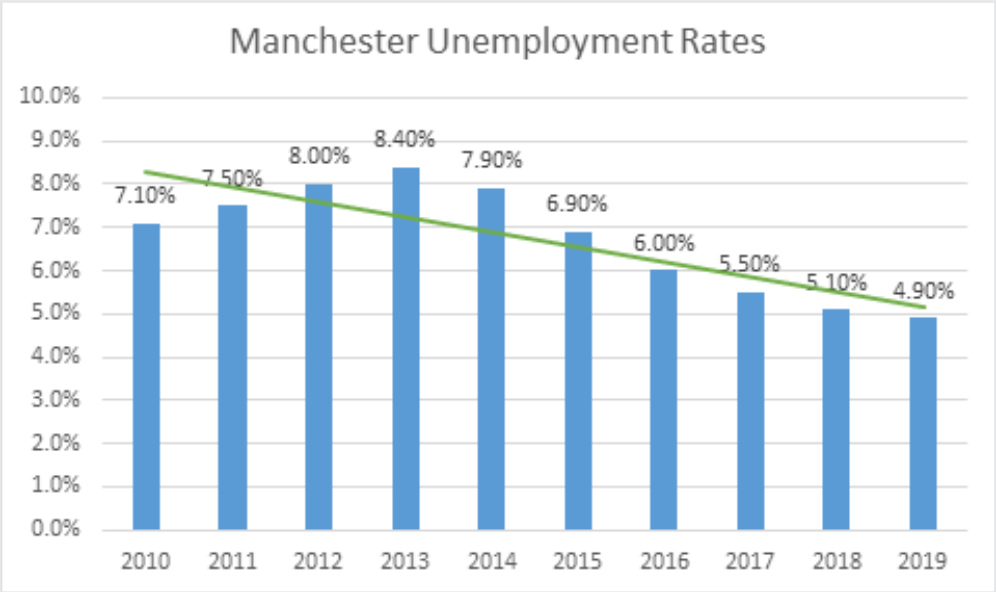
[9] *https://livingwage.mit.edu/pages/about*
[10] *https://www.irp.wisc.edu/resources/how-is-poverty-measured/*
[11] *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines*

Unemployment

According to the US Bureau of Labor Statistics, as individuals achieve higher levels of education, both wages and employment rates improve.[12] In 2015, the rate of unemployment was 16 times higher across the US among individuals with less than a high school diploma or equivalent than in those with a professional degree.

As shown in Figure 9, unemployment has been on a decline since 2013 in Manchester, following similar trends nationally.[13] As of October 2021, unemployment in the city was only 2.3%, much lower than the average rate of 4.6% across the 500 largest cities in the US.[14]

Figure 9. Manchester Unemployment Rates by Race/Ethnicity



Source: US Census Bureau, American Community Survey, 2019 5-year Estimates

Despite these encouraging trends, Manchester residents remain more likely to be unemployed compared with residents of other towns in the Greater Manchester Region (Table 3). There is even greater geographic variability within the City of Manchester, with unemployment rates ranging from less than 1% in census tracts 1.01, 7 and 12, to over 10% in census tracts 16, 17, 19, and 21—all located within the center of the city (Figure 10).

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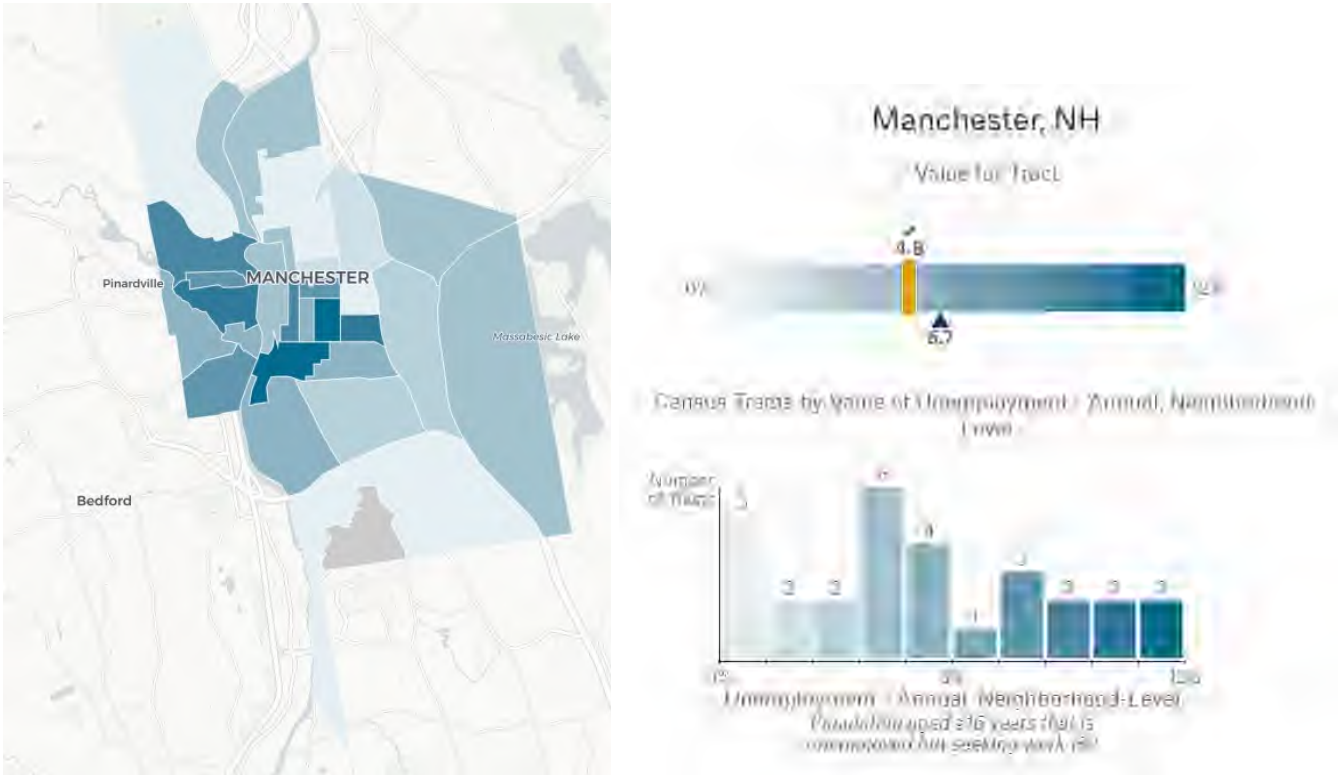
[12] *https://www.bls.gov/careeroutlook/2016/data-on-display/education-matters.htm*
[13] *https://www.bls.gov/charts/employment-situation/civilian-unemployment-rate.htm*
[14] *https://www.cityhealthdashboard.com/nh/manchester/metric-detail?metric=1483&metricYearRange=10-2021&dataRange=national*

Table 3. Unemployment Low, but Higher than State Average in Manchester
Unemployment in the Greater Manchester Region, 2019 5-year Estimates

Town	Percent of Civilian Labor Force, 16 years and older, Unemployed
Manchester	4.9%
Auburn	2.7%
Bedford	3.5%
Candia	2.1%
Deerfield	2.0%
Goffstown	3.2%
Hooksett	3.9%
New Boston	1.3%
Londonderry	3.0%
Nashua	4.4%
State of NH	3.6%

Source: US Census Bureau, American Community Survey, 2019 5-year Estimates

Figure 10. Manchester Unemployment Rates by Census Tract
Manchester Annual Unemployment Rate by Census Tract, 2019 5-year Estimates

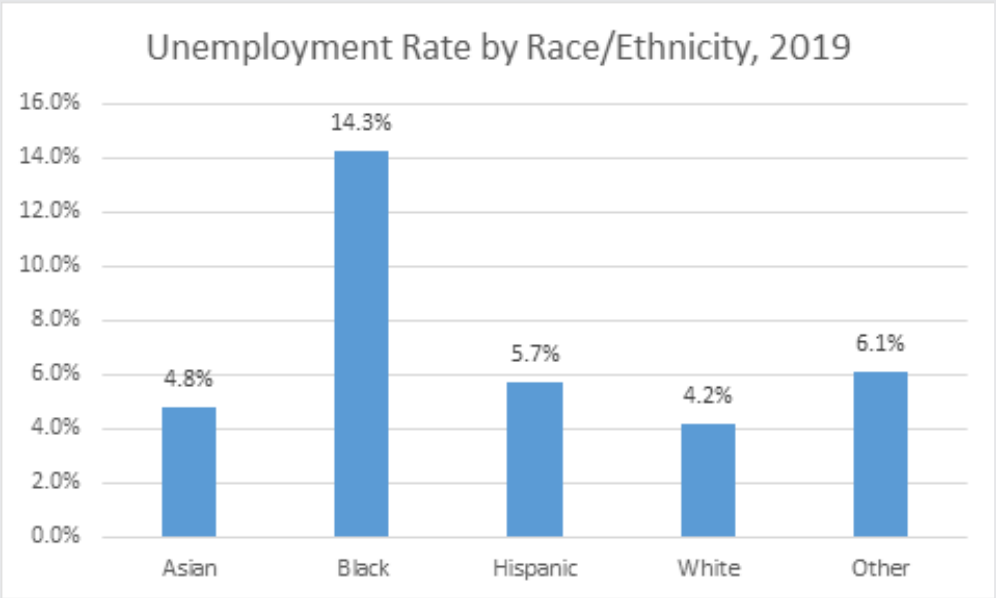


Source: City Health Dashboard

According to the National Equity Atlas, "in an equitable economy, everyone who wants to work would have a good job."[15] However, there is clear racial and ethnic variation in unemployment, both nationally and in Manchester.

Figure 11 shows annual unemployment by race/ethnicity in Manchester in 2019. Persistent racial inequalities contributed to Black residents being twice as likely as any other racial or ethnic group to be unemployed in 2019.

Figure 11. Unemployment Rates by Race/Ethnicity



Source: City Health Dashboard

Attendance

Average Daily Attendance

A missed day of school is a missed day of learning. Young children who are frequently absent from school are less likely to read at grade level and risk falling behind both academically and socially. Older students who are chronically absent are at increased risk for substance use, violence, and delinquency.[16]

Table 4 shows average daily attendance rates for Manchester schools compared with schools statewide for the past 10 school years. While there is no doubt that the recent decline in school attendance across the state is the result of the COVID-19 pandemic, students in Manchester are consistently absent from school more often than the state average.

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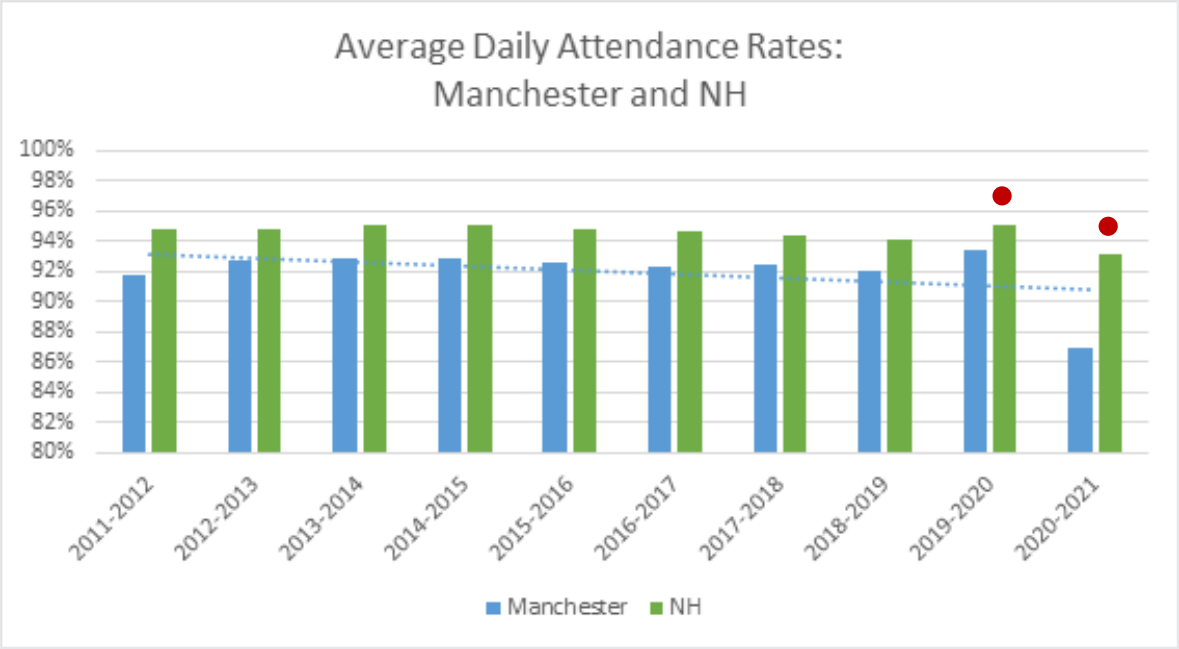
[15] *https://nationalequityatlas.org/indicators/Unemployment#/*
[16] *https://www.cityhealthdashboard.com/metric/52*

Table 4. Manchester Schools See Dramatic Drop in Daily Attendance Following the COVID-19 Pandemic



Source: NH Department of Education

Table 5 shows the average daily attendance rates reported for schools in the Greater Manchester Region during 2020-2021. While Bedford and New Boston schools maintained attendance levels at rates of 97% or higher, Manchester's rate was only 87%, well below the state average of 93.1% and Nashua's rate of 90.5%. While it is likely this difference is the result of difficulties with remote learning during school closures, it is nevertheless an indicator that, without intervention, gaps in learning outcomes may widen between Manchester students and those attending schools in other towns in the region.

Table 5. Manchester Schools Have the Lowest Attendance in Greater Manchester Region
Average Daily Attendance Rate in the Greater Manchester Region, 2020-21

Town	Average Daily Attendance Rate
Manchester	87.0%
Auburn	95.5%
Bedford	97.6%
Candia	95.0%
Deerfield	94.2%
Goffstown	92.9%
Hooksett	95.6%
New Boston	97.0%
Londonderry	95.1%
Nashua	90.5%
State of NH	93.1%

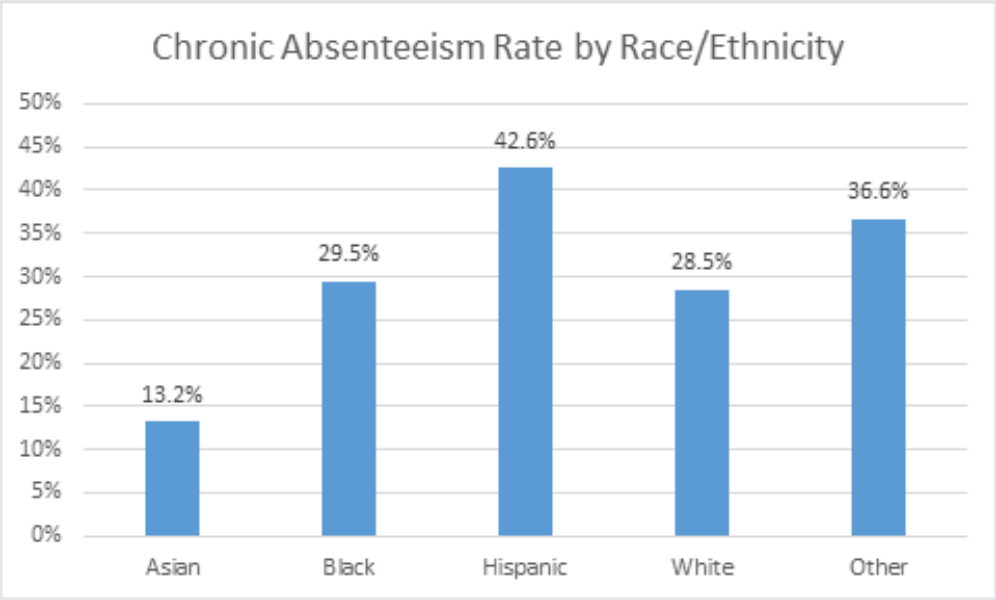
Source: NH Department of Education

Chronic Absenteeism

Studies show that students who have regular school attendance achieve at higher levels than those who are chronically absent (15 or more missed days of school in an academic year). While there are many causes of chronic absenteeism, systemic inequities by race and ethnicity play an important role.[17] In turn, frequent absences lead to widening gaps in educational achievement between racial/ethnic groups.

According to City Health Dashboard, 31.5% of Manchester's public-school students were chronically absent in 2018. By comparison, only 18.3% of students across the country's largest cities and 19.7% of Nashua students were chronically absent that year. Figure 12 shows that chronic absenteeism was much higher among Hispanic and other racial/ethnic groups similar between White and Black students, and lowest among Asian students.

Figure 12. Chronic Absenteeism Highest Among Hispanic/Latino Students



Source: City Health Dashboard

Free/Reduced School Lunch Eligibility

The National School Lunch Program provides subsidized meals to income-eligible students each school day. The proportion of students who qualify for this program is often used as an indicator of overall poverty within a school district. Children with household incomes at or below 130% of the Federal Poverty Level are eligible for free school lunch, while those with household incomes between 130% and 185% of the Federal Poverty Level are eligible for reduced-price lunch.[18] This measure is also a strong indicator of food insecurity, discussed in Chapter 4 of this report.

The percentage of students eligible for free or reduced-price school lunch is substantially higher in Manchester than in other districts within the Greater Manchester Region (Table 6). In fact, Manchester's rate is more than twice that in every district in the region.

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[17] *https://www.cityyear.org/national/stories/education/how-a-focus-on-equity-can-help-address-chronic-absenteeism-in-schools/*

[18] *https://fns-prod.azureedge.net/sites/default/files/resource-files/NSLPFactSheet.pdf*

Table 6. Nearly Half of Manchester Students Qualify for Free/Reduced Price Meals
Free/Reduced School Lunch Eligibility by District in Greater Manchester Region, 2021-22

Town	% of Students Eligible
Manchester	44.0%
Auburn	5.9%
Bedford	4.5%
Candia	13.8%
Deerfield	7.9%
Goffstown	9.1%
Hooksett	15.0%
New Boston	6.6%
Londonderry	11.1%
Nashua	35.6%
State of NH	20.9%

Source: NH Department of Education

WHAT DO MANCHESTER RESIDENTS THINK?

Of 204 Manchester residents surveyed, 89.4% said that it is "very important" for Manchester to take action on improving educational outcomes, including ensuring children are ready for school, students graduate on-time, and the community has high paying jobs.

Key stakeholders interviewed said that, while things are improving, Manchester public schools remain underfunded. They suggested looking to the Community Schools Model, already articulated in the school district's strategic plan, as an option for addressing many of the priority areas described in this report.

Community Spotlight

LAUNCH Manchester

Amoskeag Health serves as the lead agency for LAUNCH Manchester, an early childhood initiative that promotes the overall health and well-being of children birth through 8 years and their families, utilizing a cross-sector team focused on improving access to high-quality early education and care, empowering families, identifying and mitigating the effects of Adverse Childhood Experiences, and improving access to health, behavioral health, and specialized medical services. A current priority of LAUNCH Manchester is the Early Learning Collaborative, a partnership among early childhood programs, both public (Manchester School District) and private, in Greater Manchester.

The Collaborative encourages child care and preschool programs to work together, share resources and training, connect with the school district on screenings and transitions and prepare all young children to enter kindergarten ready to learn. Its current key focus is implementation of the Pyramid Model, an evidence-based practice that promotes social-emotional competence, preventing challenging behavior, and addressing challenging behavior appropriately, if it does occur. The programs are able to rely on each other and work together to solve everyday problems that each of them is dealing with, including staffing shortages, waitlists for enrollment and the new Quality Rating and Improvement System.

Manchester Proud

Manchester Proud is a city-wide movement to unite and engage Manchester in the making of exceptional public schools. We believe that great public schools are essential to all of our futures and can only be achieved through broad and sustained community support.

Since Manchester Proud's founding in 2018, more than 10,000 voices and 300 working volunteers have contributed to the creation and implementation of Manchester School District's Strategic Plan, Our Community's Plan for Manchester's Future of Learning: Excellence and Equity for ALL Learners.

Today, in partnership with the Manchester School District, Manchester Proud's work continues:

- Making progress on the strategic plan's goals – to Grow Our Learners, Grow Our Educators, and Grow Our System;
- Cultivating and aligning school-community partnerships with our youth serving organizations and businesses;
- Building The Compass, Manchester Proud's community portal with a broad range of student and family services and supports: www.manchesterproudcompass.org;
- Planning CelebratED! 2022, our second annual city-wide festival to celebrate our public schools and community.

To learn more or become involved, please visit: www.manchesterproud.org

HEALTH BEHAVIORS

PRIORITY: REDUCE AND PREVENT SUBSTANCE MISUSE

Health behaviors account for 30% of an individual's health status, according to research conducted through the County Health Rankings and Roadmaps project.[1] Negative health behaviors, such as tobacco, alcohol, and drug use, account for as many as 40% of premature deaths in the US each year.[2]

The opioid crisis remains, rightfully, at the forefront of public health issues in Manchester as well as the country as a whole. The city has received national attention as "ground zero" for opioid-related deaths in the US.[3]

Despite this fact, tobacco use is the leading cause of preventable deaths in the US, accounting for approximately 1 in every 5 preventable deaths in the US each year.[4] Smoking reduces average life expectancy by 10 years, but smoking cessation is effective at reducing the risk of dying from tobacco-related illness by up to 90%.5 [5]

As the third leading cause of preventable deaths, excessive alcohol use causes more than 95,000 deaths each year in the US. More than half of these deaths are due to health effects of alcohol misuse over time, including cancer, liver disease, and heart disease.[6]

Opioid Overdose

Substantial gains have been made in Manchester, New Hampshire, and across the US in the reduction of opioid-related deaths through widespread harm-reduction interventions in the past 5 years. Unfortunately, opioid overdose deaths increased significantly across the US because of the COVID-19 pandemic. This increase, influenced by decades of concentrated poverty and both racial and economic segregation, was most dramatic in "poor, urban neighborhoods, affecting Black and Hispanic communities," according to a recent report in the Journal of Urban Health.[7]

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[1] *https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model*
[2] *Committee on Population; Division of Behavioral and Social Sciences and Education; Board on Health Care Services; National Research Council; Institute of Medicine. Measuring the Risks and Causes of Premature Death: Summary of Workshops. Washington (DC): National Academies Press (US); 2015 Feb 24. Available from: https://www.ncbi.nlm.nih.gov/books/NBK279971/doi: 10.17226/21656*
[3] *https://www.usnews.com/news/best-states/articles/2017-06-28/why-new-hampshire-has-one-of-the-highest-rates-of-opioid-related-deaths*
[4] *U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2015 Aug 17].*
[5] *https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm*
[6] *https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html*
[7] *Ghose R, Forati AM, Mantsch JR. Impact of the COVID-19 Pandemic on Opioid Overdose Deaths: a Spatiotemporal Analysis. J Urban Health. 2022 Feb 18:1–12. doi: 10.1007/s11524-022-00610-0. Epub ahead of print. PMID: 35181834; PMCID: PMC8856931.*

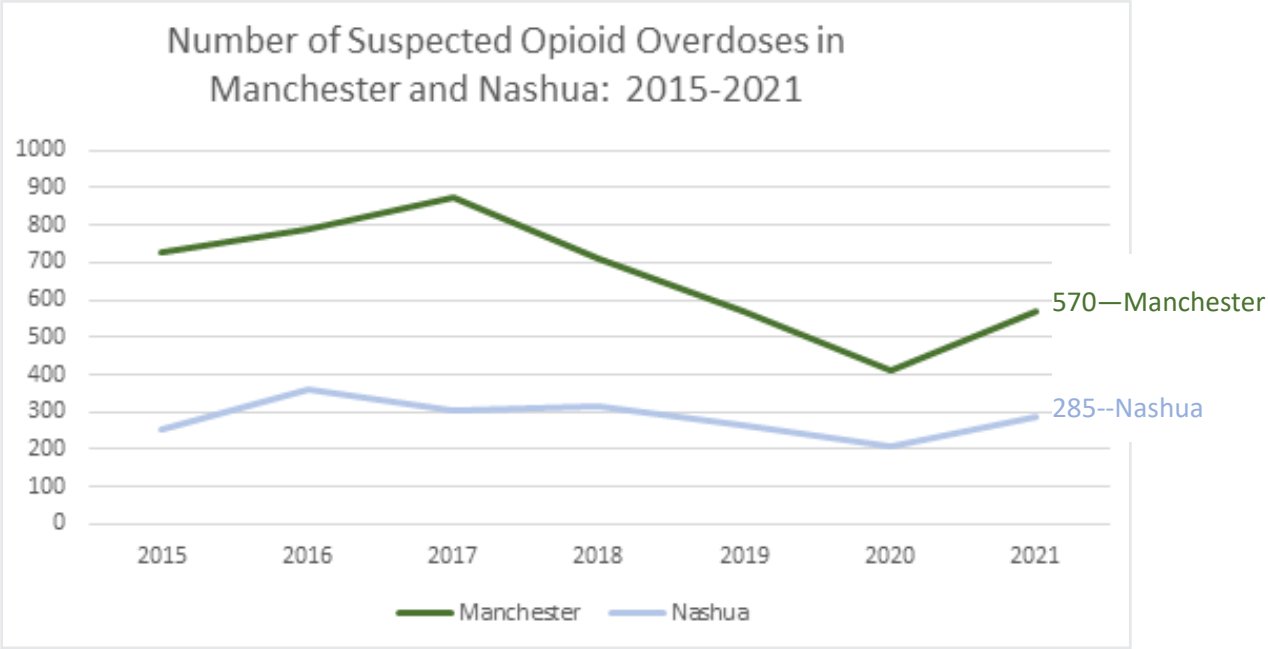
Manchester, the largest city in the state, continues to be at the epicenter of New Hampshire's opioid crisis, with the highest number of deaths due to overdose in the state. Trends in opioid-related emergency department visits in Manchester reflect those across the state as a whole (Figure 1).

Figure 1. Opioid-related Emergency Department Visits on the Rise Again in New Hampshire and Manchester

Source: NH Department of Health and Human Services

Rates of suspected opioid overdose are consistently two- to three-times higher in Manchester compared with Nashua, the city with the next highest rate of opioid overdoses in the State of New Hampshire (Figure 2). There were 161 more suspected opioid overdoses in Manchester in 2021 compared with 2020 -- a 39% increase. Individuals with suspected opioid overdoses in Manchester were three times more likely to be men than women (77% versus 23%, respectively), and had an average age of 39 years. Across both Manchester and Nashua, nearly half (49%) of all opioid overdoses were labeled as repeat encounters by first responders.

Figure 2. Twice as Many Opioid Overdoses in Manchester than in Nashua in 2021



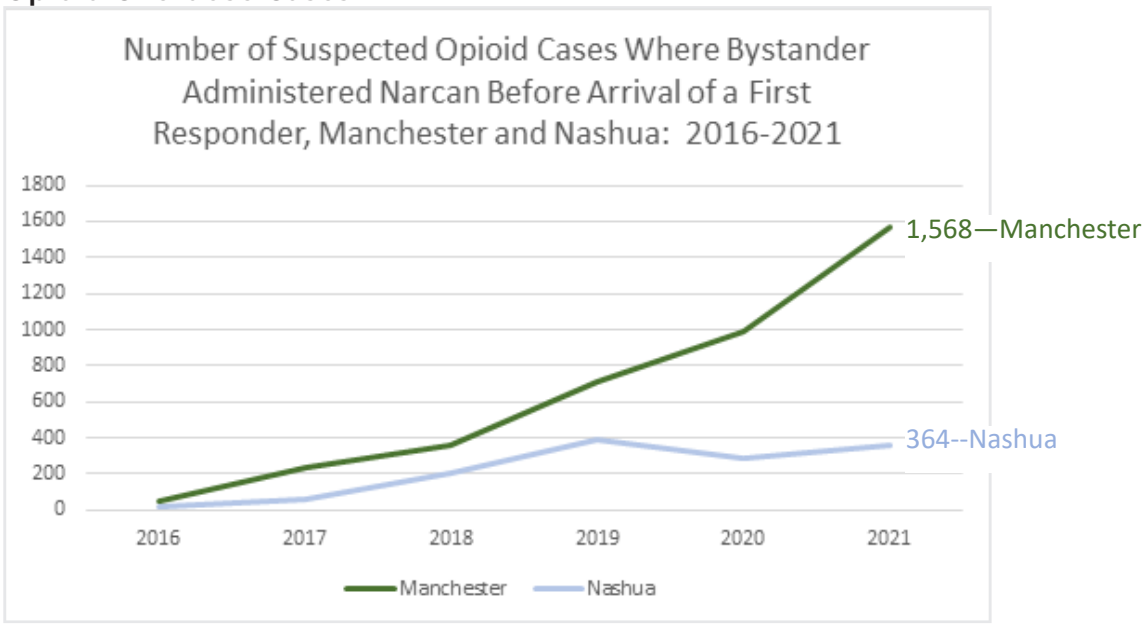
Source: American Medical Response

In 2021, bystanders administered Narcan (naloxone) in a third of all opioid overdoses in Manchester and Nashua combined. Narcan, often administered as a nasal spray, rapidly reverses the effects of opioids, including fentanyl, heroin, and prescription opioid medications. The CDC reports that approximately 27,000 opioid overdoses were reversed by bystanders administering Narcan between 1996 and 2014, demonstrating the impact of this harm-reduction measure.[8]

Figure 3 illustrates a sharp incline in public use of Narcan in cases of suspected opioid overdose in Manchester over the past 5 years. Between 2020 and 2021 alone, the use of Narcan by bystanders increased by more than 58% in Manchester. By comparison, Narcan use prior to the arrival of a first responder increased by only about 25% in Nashua during the same period.

[8] *https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm?s_cid=mm6423a2_e*

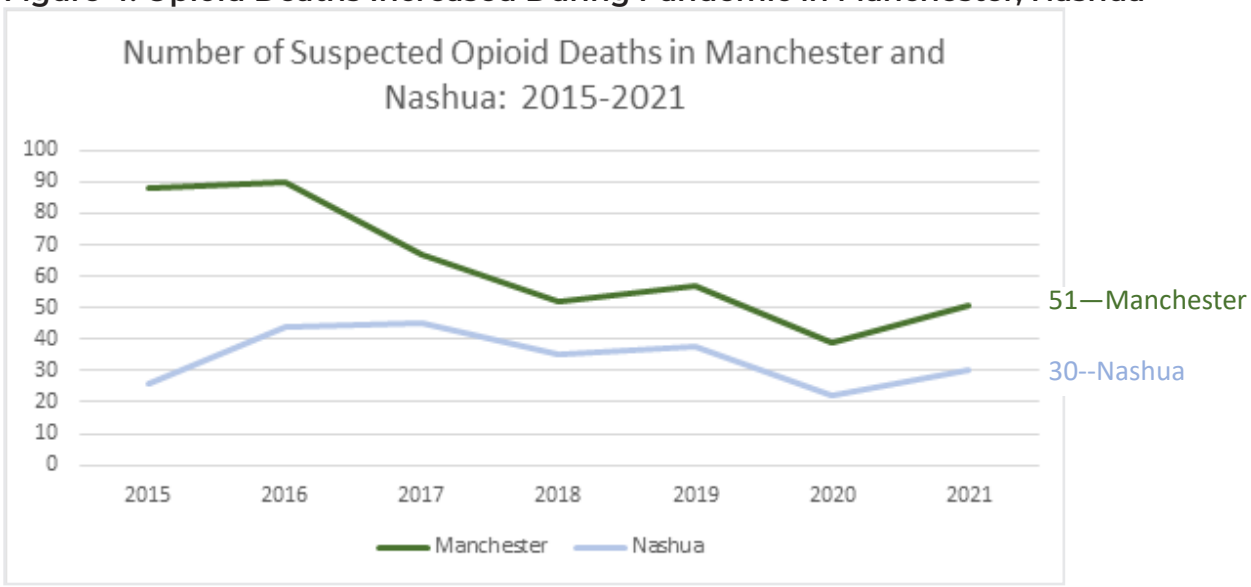
Figure 3. Use of Narcan by a Bystander Increasing Dramatically in Manchester Suspected Opioid Overdose Cases



Source: American Medical Response

Unfortunately, suspected opioid overdose deaths also increased in Manchester and Nashua between 2020 and 2021, marking an end to the steady decline in opioid-related deaths in both cities that occurred in the 4 previous years (Figure 4). Between 2020 and 2021, the number of suspected opioid deaths increased by 31% in Manchester and 36% in Nashua. Notably, from 2019 to 2020 in Manchester there was a 28% decrease in opioid overdoses and a 32% decrease in opioid overdose deaths. Additionally, from 2017 to 2019 there was a 34% decrease in opioid overdoses, and a 15% decrease in opioid overdose deaths in Manchester.

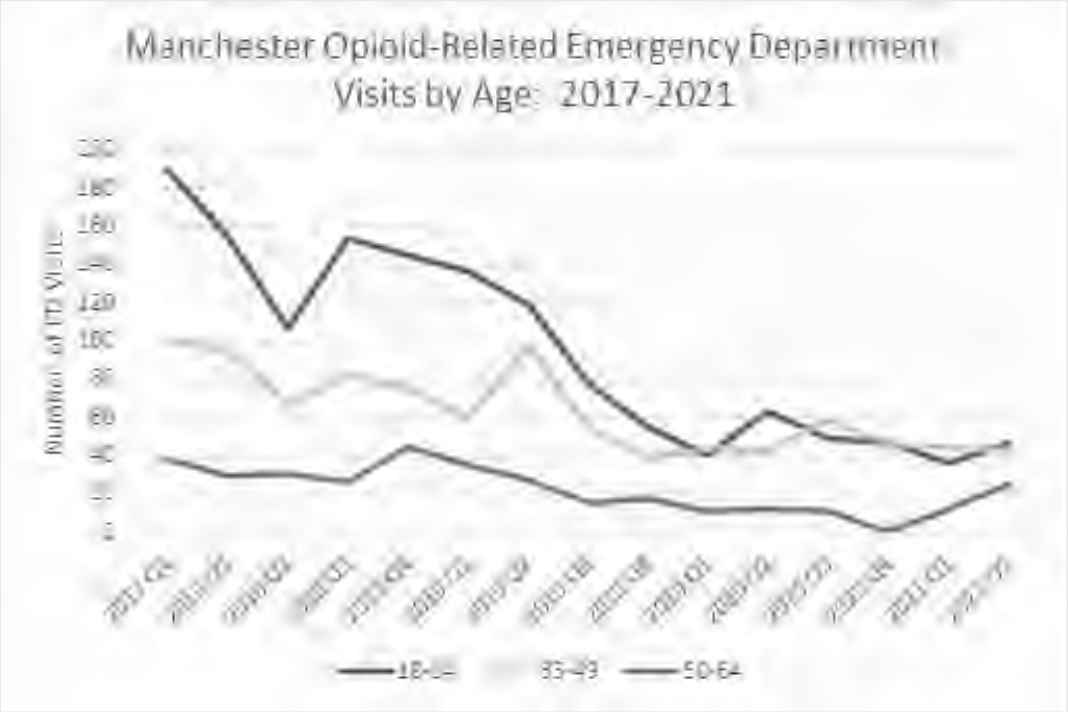
Figure 4. Opioid Deaths Increased During Pandemic in Manchester, Nashua



Source: American Medical Response

While most opioid-related deaths occur in the 25- to 54-year-old age group nationally, deaths among individuals aged 55 and older are on the rise.[9] In Manchester, the number of opioid-related emergency department visits in this older age group is on the rise, according to Figure 5. The absolute numbers of events are low, but the trend deserves attention as it may be an early indication of growing opioid-misuse concerns among seniors.

Figure 5. Sharpest Increase in Opioid-Related ED Visits Among 50-64-year-olds in Manchester



Source: NH Department of Health and Human Services

Both statewide and in Manchester, treatment for substance use disorder relies heavily on Medication-Assisted Treatment (Figure 6), which is considered the most effective treatment for opioid addiction.[10] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Medication-Assisted Therapy is a "whole patient" approach to the treatment of substance use disorder that includes medications to help reduce withdrawal and dependence symptoms in combination with both counseling and behavioral therapies.[11]

The relationship between overdoses and brain injury is being explored by the SUD/Brain Injury & Mental Health Task Force which was formed in 2019 by the Brain Injury Association of New Hampshire. During an overdose, the brain can be deprived of oxygen for several minutes,

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[9] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Multiple Cause of Death 1999-2020 on CDC WONDER Online Database. Data from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[10] National Academies of Sciences, Engineering, and Medicine, "Medications for Opioid Use Disorder Save Lives" (2019), https://doi.org/10.17226/25310.

[11] https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions

which can lead to brain injury.[12] If sustained, brain injuries following an overdose can alter recovery and treatment plans as well as an individual's cognitive function.

In Manchester, as well as the state as a whole, opioid use disorder treatment is primarily paid for through Medicaid, supporting calls for commercial insurance companies to play a stronger role in the fight against opioid addiction (Figure 6).[13] Recent increases in opioid-related ED visits, overdoses and deaths, will continue to stretch existing capacity limits on inpatient and outpatient treatment in New Hampshire. With Safe Station closing in Manchester in late 2021, the Doorway was opened to assist residents who would like to seek treatment for substance use. Manchester has several outreach teams including a partnership team between the Health Department and the Police Department which was formed to aid residents who have recently experienced an opioid overdose by offering support and recovery resources.

Figure 6. Medication-Assisted Therapy Most Widely-Used Service for Substance Use Disorder in Manchester

Source: NH Department of Health and Human Services

Adolescent Drug Misuse: Illegal and Prescription Drugs

Adolescence is a critical period for the initiation of drug use, with higher risks of developing drug dependence compared with those who initiate use in adulthood.[14] As such, many drug abuse prevention programs target adolescents with the aim of delaying or preventing use.[15] Even occasional substance use by teens can impact brain development, increase participation in other risky health behaviors, and contribute to the development of high blood pressure and heart disease.[16]

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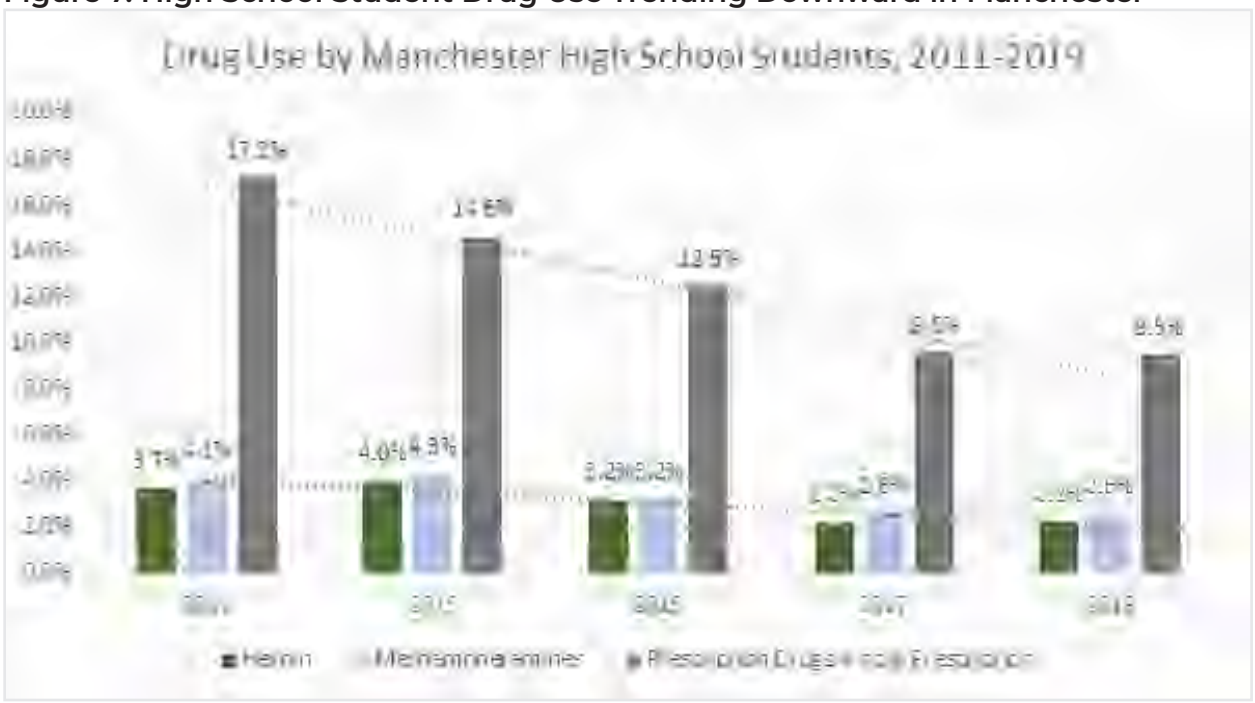
[12] *Brain Injury & Substance Use Disorder: "Understanding The Connection" PowerPoint Presentation, Brain Injury Association of New Hampshire*
[13] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7546457/*
[14] *https://www.samhsa.gov/data/sites/default/files/WebFiles_TEDS_SR142_AgeatInit_07-10-14/TEDS-SR142-AgeatInit-2014.pdf*
[15] *https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0225384&type=printable*
[16] *https://www.cdc.gov/ncbddd/fasd/features/teen-substance-use.html*

The percentage of Manchester high school students reporting use of illegal and prescription drugs has declined steadily in the past decade, as shown by the trend lines in Figure 7. Between 2011 and 2019, the proportion of high school students reporting heroin use dropped by more than 40%, from 3.7% to 2.2%. The decline in reported methamphetamine use was similar, at 37% during the same period. While use of prescription drugs without a prescription was the highest reported drug use type across the entire period, it also experienced the greatest reduction from 17.2% of all students in 2011 to 9.5% of students in 2019—a 45% difference.

Figure 7. High School Student Drug Use Trending Downward in Manchester



Source: NH DHHS, Youth Risk Behavior Surveillance Survey 2011-2019

Trends in reported drug use by high school students were similar in Manchester, Greater Manchester, and the State of New Hampshire between 2011 and 2019 (Table 1). However, while Manchester and Greater Manchester students reported similar rates of ever having used heroin in 2019, students in the City of Manchester were nearly 1.5 times more likely to report ever using heroin compared with students in the state as a whole. Manchester students were more than 1.5 times more likely than those across the state to report ever having used methamphetamine in 2019, and nearly 1.4 times more likely than students in the Greater Manchester Region. On the other hand, rates of prescription drug use without a prescription were somewhat lower in Manchester and Greater Manchester high school students than in the state as a whole in 2019.

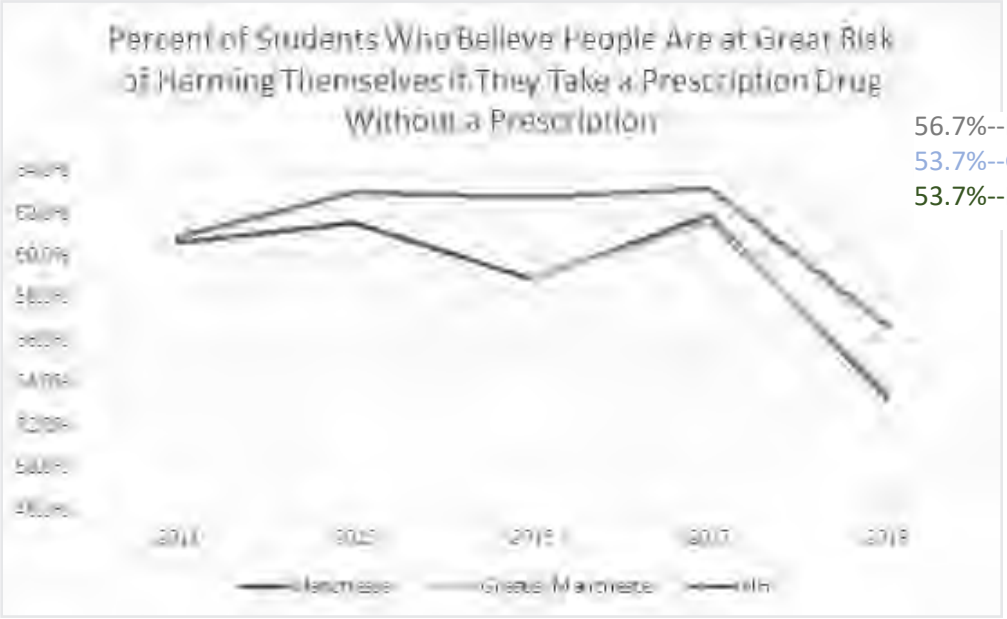
Table 1. Teen Drug Use On the Decline Across State, Greater Manchester and City of Manchester

Percent of students who reported ever using heroin (one or more times)					
City/Region	**2011**	**2013**	**2015**	**2017**	**2019**
Manchester	3.7%	4.0%	3.2%	2.2%	2.2%
Greater Manchester	--	--	3.2%	2.7%	1.9%
NH*	3.6%	2.7%	2.4%	1.8%	1.5%
Percent of students who reported ever using methamphetamines (one or more times)					
City/Region	**2011**	**2013**	**2015**	**2017**	**2019**
Manchester	4.1%	4.3%	3.2%	2.6%	2.6%
Greater Manchester	--	--	3.0%	3.1%	1.9%
NH*	4.2%	2.9%	2.5%	1.8%	1.7%
Percent of students who reported ever using prescription drugs w/o prescription (one or more times)					
City/Region	**2011**	**2013**	**2015**	**2017**	**2019**
Manchester	17.2%	14.6%	12.5%	9.6%	9.5%
Greater Manchester	--	--	13.0%	10.5%	8.9%
NH*	20.8%	16.5%	13.4%	11.5%	10.0%

Source: NH DHHS, Youth Risk Behavior Surveillance Survey 2011-2019
Note: access to regional-level results is not available prior to 2015
** NH includes data for entire state*

"The likelihood for drug abuse increases as the population perceives little or no harmful risks associated with the drugs," according to a recent article published in BMC Public Health.[17] Figure 8 shows that only a little more than half of high school students in Manchester, Greater Manchester, and NH believe that people are a great risk of harm if they use prescription drugs without a prescription. Moreover, this percentage is on the decline. In both Manchester and Greater Manchester, the proportion of students who perceived great risk from using prescription drugs without a prescription dropped 13% between 2017 and 2019, from 61.6% to 53.7%. Across the state, the decline was marginally smaller, at 10%, from 63.2% of students in 2017 to 56.7% in 2019.

Figure 8. High School Students Perceive Less Harm Associated with Prescription Drug Misuse than 2 Years Ago



Source: NH DHHS, Youth Risk Behavior Surveillance Survey 2011-2019

In 2019, Manchester high school students were 20% less likely to report exposure to some form of public messaging to avoid drugs or alcohol compared with students statewide (Figure 9). While these rates were similar in 2017, the percentage of high school students who reported exposure to anti-drug or -alcohol use messaging decreased in Manchester and Greater Manchester while remaining steady in the state overall. Between 2017 and 2019, reported exposure to messaging to avoid drugs or alcohol dropped by 13% among Manchester high school students and by 10% among those in the Greater Manchester Region.

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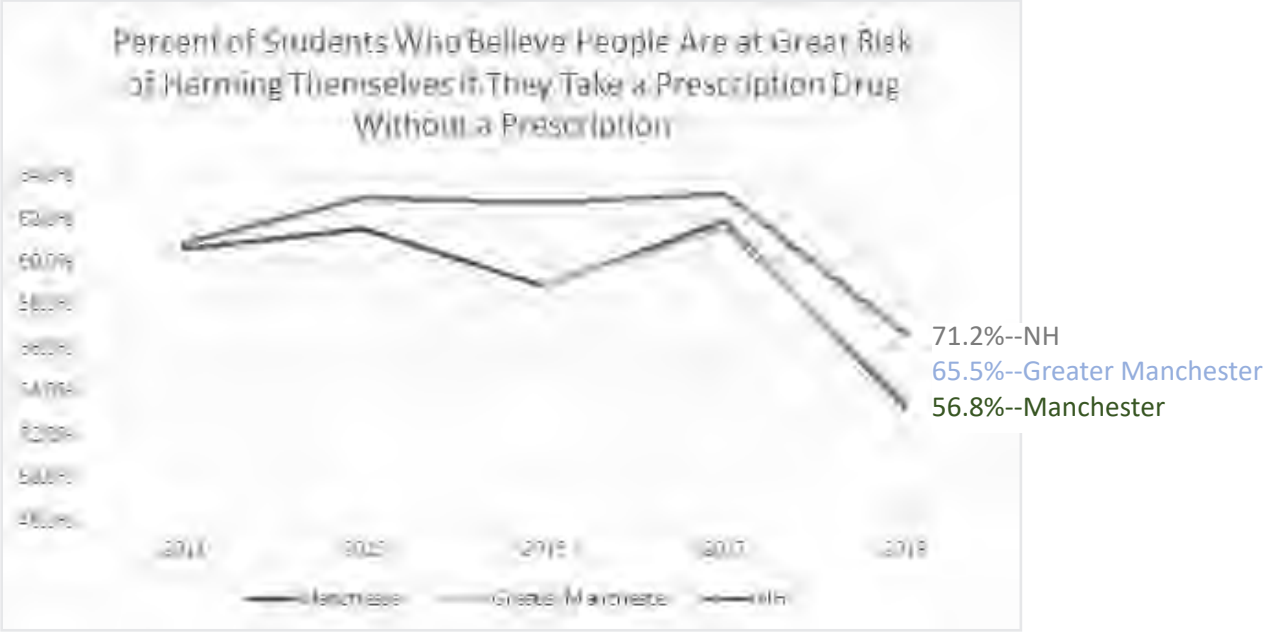
[17] *Nawi, A.M., Ismail, R., Ibrahim, F. et al. Risk and protective factors of drug abuse among adolescents: a systematic review. BMC Public Health 21, 2088 (2021). https://doi.org/10.1186/s12889-021-11906-2*

Figure 9. Manchester High School Students Less Likely to be Exposed to Public Messaging About Alcohol or Drugs



Source: NH DHHS, Youth Risk Behavior Surveillance Survey 2011-2019

Binge Drinking

Alcohol misuse has both long-term and short-term negative impacts on health. In the long-term, excessive alcohol use shortens life expectancy by an average of 29 years in those who die of alcohol-related disorders.[18] In the short-term, binge drinking—defined as 4 or more drinks in a row for females and 5 or more drinks in a row for males—increases the risks of injuries, violence, risky sexual behaviors, and alcohol poisoning.[19] Binge drinking is associated with significant economic, criminal justice, and workplace productivity costs in the United States.[20]

Binge drinking is one of the Leading Health Indicators defined in Healthy People 2030. Among other criteria, leading health indicators are described as those that "address *high-priority public health issues* that have a major impact on public health outcomes."[21] Based on data showing that 26.6% of adults in the United States aged 21 years and older reported binge drinking in the past 30 days, Healthy People 2030 sets a target of reducing this number to 25.4% in the next decade.[22]

According to City Health Dashboard, the percent of Manchester adults who reported binge drinking in the last 30 days in 2019 was lower than the Healthy People 2030 target but higher than the average rate across the 500 largest cities in the US in 2018 (Figure 10). The percentage of adults who reported binge drinking in the last 30 days was similar between Manchester and Nashua (18.8% and 18.6%, respectively.)

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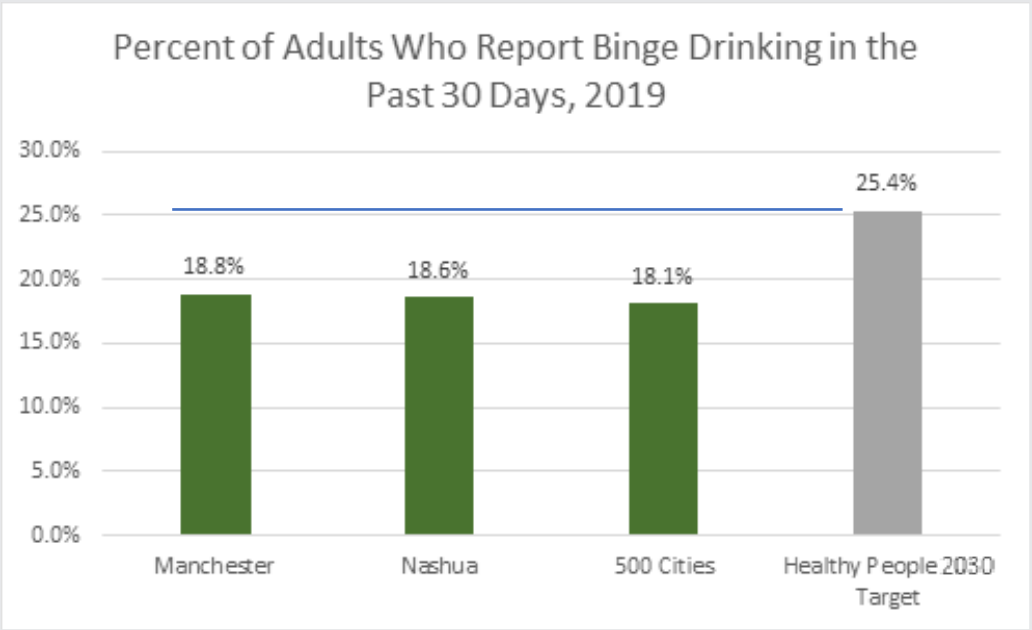
[18] *https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html*
[19] *https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm*
[20] *https://www.cityhealthdashboard.com/metric/24*
[21] *https://health.gov/healthypeople/objectives-and-data/leading-health-indicators*
[22] *https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-proportion-people-aged-21-years-and-over-who-engaged-binge-drinking-past-month-su-10*

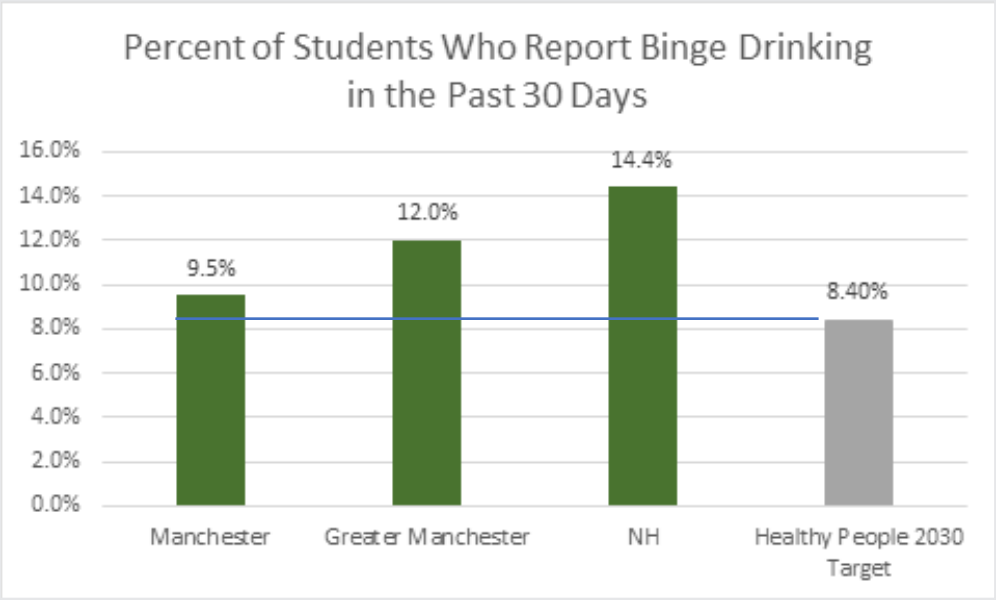
Figure 10. Adult Binge Drinking Similar Across Manchester, Nashua, State



Source: City Health Dashboard

Based on previous data, Healthy People 2030 sets a target of 8.4% for students who report binge drinking in the past 30 days. In 2019 (the first year for which these data are available), 14.4% of students statewide reported binge drinking at least once in the past 30 days (Figure 11). Manchester students were a third less likely to binge drink, at 9.5%. Across the Greater Manchester Region, high school students reported binge drinking at rates between the two, at 12.0%. Importantly, all three groups of students reported binge drinking at rates exceeding the Healthy People 2030 benchmark.

Figure 11. Manchester High School Students Less Likely to Binge Drink than Teens Statewide



Source: NH DHHS, Youth Risk Behavior Surveillance Survey 2011-2019
**The YRBS defines binge drinking as 4 or more drinks of alcohol in a row for females and 5 or more drinks of alcohol in a row for males.*

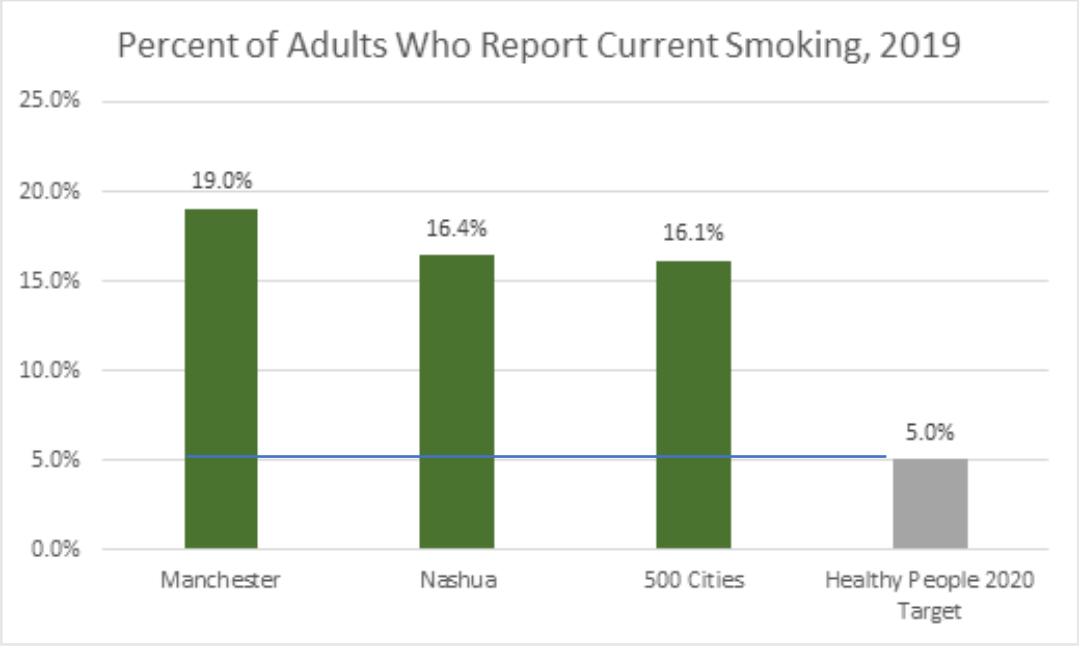
Relative risk perception is one of the strongest predictors of binge drinking among adolescents, according to a recent study published in the journal, Substance Use and Misuse.[23] In 2019, more than two-thirds (69.6%) of Manchester students said people are not at great risk of harming themselves (physically or in other ways) from binge drinking once or twice a week. This proportion was similar among students in the Greater Manchester Region (29.1%) and those in NH overall (27.3%).

Tobacco Use and Vaping

Cigarette smoking in adults and use of any tobacco products in adolescents are leading health indicators for the US, according to Healthy People 2030. The US Government aims to eliminate the initiation of smoking and other forms of tobacco use among adolescents by the year 2030 and reduce the proportion of adults who smoke to 5.0% during that same timeline.[24]

In 2019, 19.0% of Manchester residents reported being current smokers, nearly four times the Healthy People 2030 benchmark (Figure 11). Manchester adults were also 16-18% more likely to smoke than adults in Nashua and in the 500 largest cities in the US combined.

Figure 11. Manchester Adult Smoking Rates Nearly 4-Times the National Target



Source: City Health Dashboard

Residents in Manchester's Center City neighborhoods had particularly high rates of current smoking, with 28.4% of adults living in census tract 14 reporting current smoking (Figure 12). More than a quarter of adults reported current smoking in three Center City census tracts: 14, 15, and 20.

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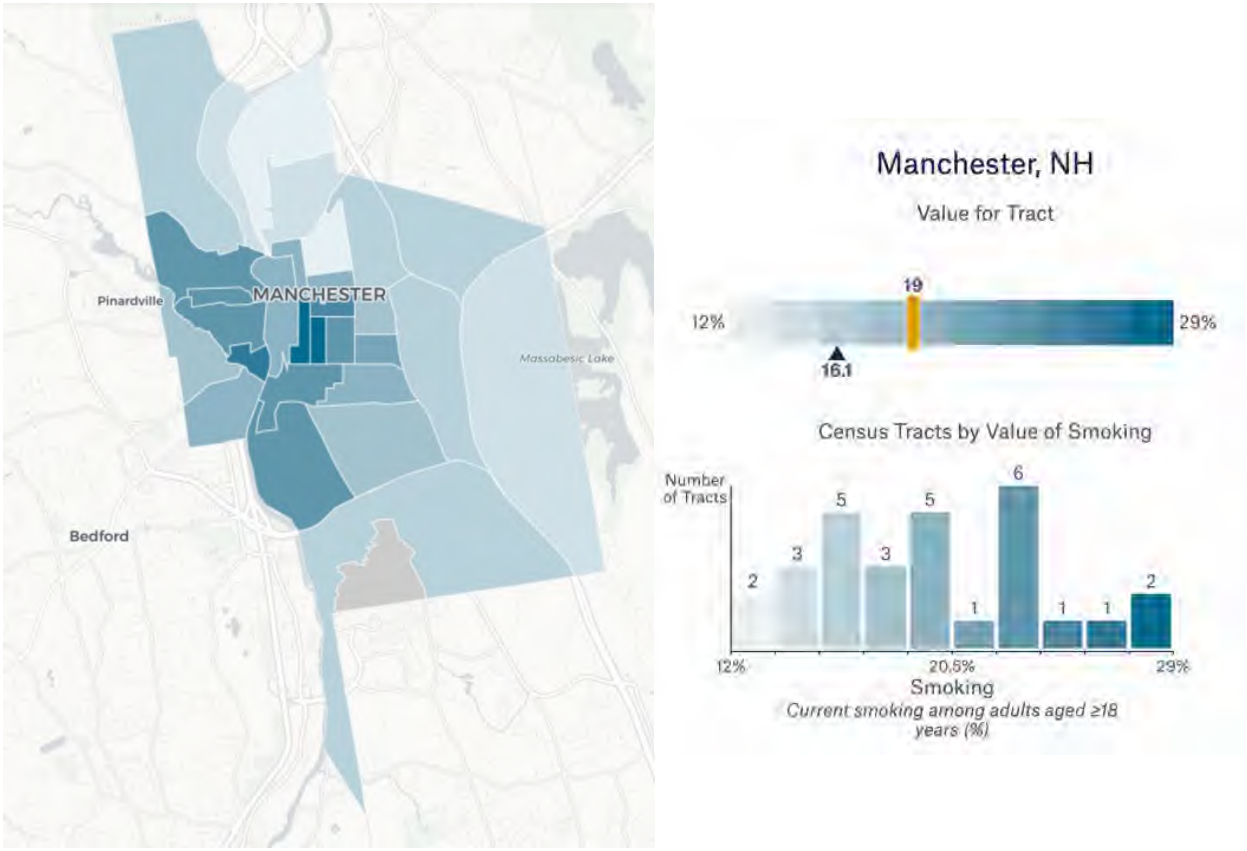
[23] Dennis Grevenstein, Christoph Nikendei & Ede Nagy (2020) Alcohol Use, Binge Drinking, and Drunkenness Experience in Adolescence: Complex Associations with Family, Peers, Social Context, and Risk Perceptions,Substance Use & Misuse, 55:11, 1834-1845, DOI: 10.1080/10826084.2020.1766504

[24] https://health.gov/healthypeople/objectives-and-data/browse-objectives/tobacco-use/eliminate-cigarette-smoking-initiation-adolescents-and-young-adults-tu-10

Figure 12. Adult Cigarette Smoking Highest in Manchester's Center City Neighborhoods

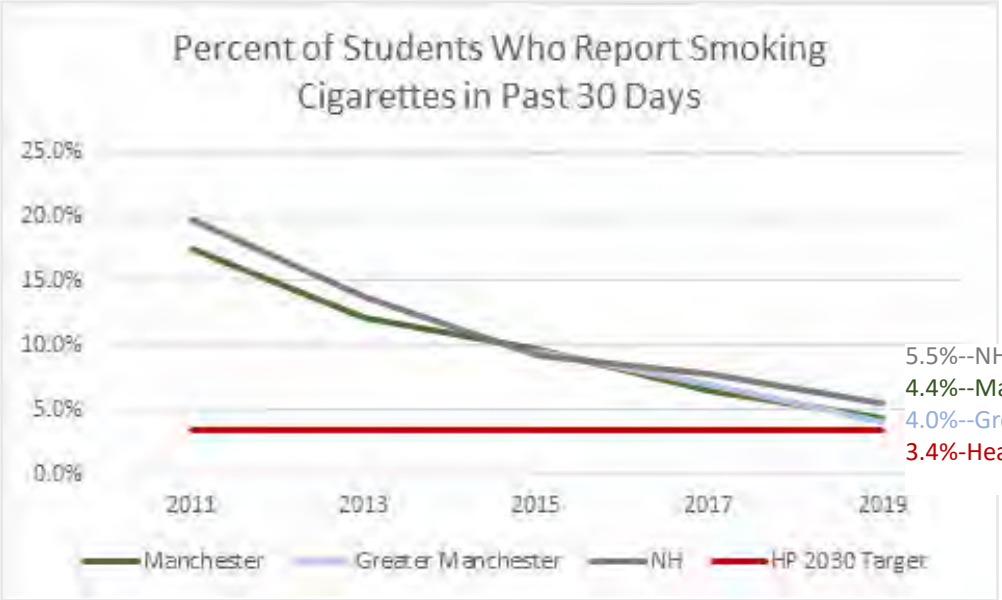


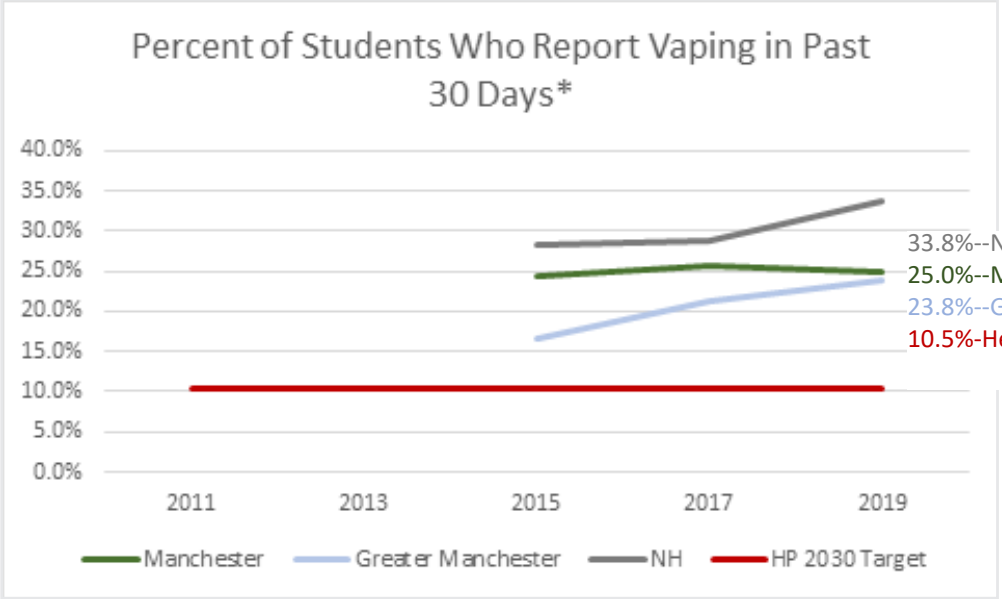
Source: City Health Dashboard

Figure 13 shows the rates of self-reported smoking and vaping during the past 30 days among students who participated in the NH Youth Risk Behavior Survey. While significant gains have been made across the state in reducing youth cigarette smoking since 2011, it is clear that vaping among high school students in on the rise.

In Manchester, the proportion of students who report smoking cigarettes in the past 30 days dropped nearly 73% between 2011 and 2019. However, the percent of Manchester students who report vaping in the past 30 days is now far above the 2011 rate of smoking in this population. In 2011, 17.5% of Manchester students reported current use of cigarettes, while in 2019 4.4% of students reported smoking and 25.0% reported current vaping. In both cases, Manchester's 2019 rates of youth tobacco use exceed the targets set by Healthy People 2030. Of note, 11.9% of Manchester students who reported current vaping in 2019 said they had purchased vaping products themselves in stores. Comparable rates in Greater Manchester and New Hampshire were 15.6% and 10.6%, respectively.

Figure 13. Smoking Cigarettes Down, but Vaping Up in Manchester, Greater Manchester and NH Teens





Source: NH DHHS, Youth Risk Behavior Surveillance Survey 2011-2019
**data on this indicator not available prior to 2015*

WHAT DO MANCHESTER RESIDENTS THINK?

Manchester residents identified substance use as their third priority for action by the city, with 92.4% saying that it is "very important" to reduce and prevent substance misuse, including overdoses and deaths due to drugs, tobacco use and vaping, binge drinking, and youth risk behaviors.

Substance misuse was tied with trauma as the top priority for action among key stakeholders in Manchester. They described substance misuse as a "highly visible" challenge in Manchester, with not enough services available to meet the high demand. Some called for dedicated housing units for those in recovery, while others suggested diversion programs for youth and hiring more program staff who are themselves in recovery. Stakeholders highlighted the stigma associated with substance misuse as an important barrier to addressing this issue.

Community Spotlight

The Doorway of Greater Manchester

The Doorway has changed how New Hampshire helps people with opioid use disorder or other substance use disorders. There are nine Doorway locations, providing single points of entry for people seeking help for substance use. The Doorway of Greater Manchester is administered by Catholic Medical Center. Services offered include screening and evaluation; treatment, including Medication Assisted Treatment; prevention, including naloxone; supports and services to assist in long-term recovery; and peer recovery support services. On average, The Doorway of Greater Manchester consistently served approximately 200 unique individuals per month for substance use disorder throughout 2021. In addition, from October 2021 – April 2022, the Doorway of Greater Manchester distributed nearly 5,000 Naloxone kits to community partners for public use.

The Doorway of Greater Manchester is located at 60 Rogers Street, Suite 210, and is open Monday-Friday, 8 AM-5 PM. 24/7 access to services is also available by dialing 211. To learn more: https://www.thedoorway.nh.gov/doorway-greater-manchester

Manchester Crisis Response Unit (CRU)

The CRU conducts post-overdose outreach focused on harm reduction and secondary prevention by targeting high-risk/influencer populations to reduce the risk of repeat overdose and the overall rate of overdose deaths. During outreach visits, the CRU:

- Provides linkages to care and resources, including access to the Doorway, Medication Assisted Treatment, physical and mental health care, food, housing and other immediate needs as determined by the individual;

- Provides naloxone, overdose prevention training and overdose prevention materials ("Leave Behind Kits") to loved ones/family/friends; and
- Reduces stigma about substance use disorder through education and offering hope about recovery.

The Crisis Response Team's goal is to inform and motivate participants, and ultimately, prevent future overdoses through compassionate outreach. Through proactive and reactive interactions, the team, composed of 2 police officers, a community health worker from the Manchester Health Department and peer outreach specialists, has been able to support individuals recently affected by overdose as well as those who are in their social networks. Since the start of the program, there have been 580 outreach attempts resulting in 189 successful contacts..

Harm Reduction

Harm reduction (HR) is programs, policies, and practices that aim to minimize negative health impacts. They include things like using a seatbelt, wearing a motorcycle helmet, or applying sunscreen. Currently, common harm reduction practices include wearing a face covering, social distancing, and hand washing to reduce the risks of contracting and being harmed by COVID-19.

For those with Substance Use Disorder, harm reduction services save lives. When using clean needles, people avoid spreading infectious diseases, such as HIV and Hepatitis. In addition, the following are also important elements of a strong HR model. Other harm reduction services include:

- Connecting people to primary care and mental health services
- Giving them access to Naloxone (Narcan)
- Providing treatment instead of incarceration
- Offering screening and vaccinations for treatment for sexually transmitted diseases
- Helping people enroll in health insurance

According to the CDC, over the past 30 years, harm reduction programs have had the following benefits:

- Harm reduction services save lives by lowering the likelihood of deaths from overdoses.
- Providing testing, counseling, and sterile injection supplies helps prevent outbreaks of other diseases. For example, Harm reduction services are associated with a 50% decline in the risk of HIV transmission.
- Users of harm reduction services were three times more likely to stop injecting drugs.
- Law enforcement benefits from reduced risk of needle sticks, no increase in crime, and the ability to save lives by preventing overdoses.
- When two similar cities were compared, the one with harm reduction services had 86% fewer syringes in places like parks and sidewalks.

In early 2021, the Greater Manchester Region rolled out a Harm Reduction Strategy document. It can be viewed on makinithappen.org.

CLINICAL CARE

PRIORITY: IMPROVE ACCESS TO QUALITY PREVENTIVE HEALTHCARE

People have the best overall health outcomes when they have the ability to obtain the right care, at the right time, and in the right setting. Unfortunately, many people face barriers that prevent or limit their access to needed clinical services, leading to poorer health outcomes and contributing to racial and ethnic disparities in wellbeing.[1]

The most common barrier to healthcare access is cost. Either people lack health insurance or their deductibles and copays are so high that they would need to forgo other basic needs—like utilities or food—in order to pay for clinical services. Other common barriers include transportation and/or lack of providers in a geographic area and language. Importantly, those without regular access to quality providers and care are often diagnosed at later, less treatable stages of a disease than those with insurance. Overall, those who lack access to quality healthcare have worse health outcomes, lower quality of life, and higher mortality rates.

Access to Medical Care

Uninsured

Health insurance status is a key indicator of a population's access to care. The unequal distribution of health insurance coverage is a major contributor to health disparities in the US.[2] Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and heart disease, while uninsured children are less likely to receive routine well-child visits to track developmental milestones, timely immunizations, and other important preventive services. According to the US Census Bureau, individuals without health insurance were nearly three times more likely than the insured to have medical debt exceeding 20% of their household's annual income.[3]

The proportion of Manchester residents who lack health insurance has decreased steadily since 2013 (Figure 1). Specifically, the percent of uninsured dropped more than 30% in Manchester, from 16% of residents under the age of 65 (when universal Medicare coverage begins) in 2013 to 11% of residents in 2019. While this trend is encouraging, the percent of Manchester residents without health insurance remains higher than the Healthy People 2030 goal of 7.9%.

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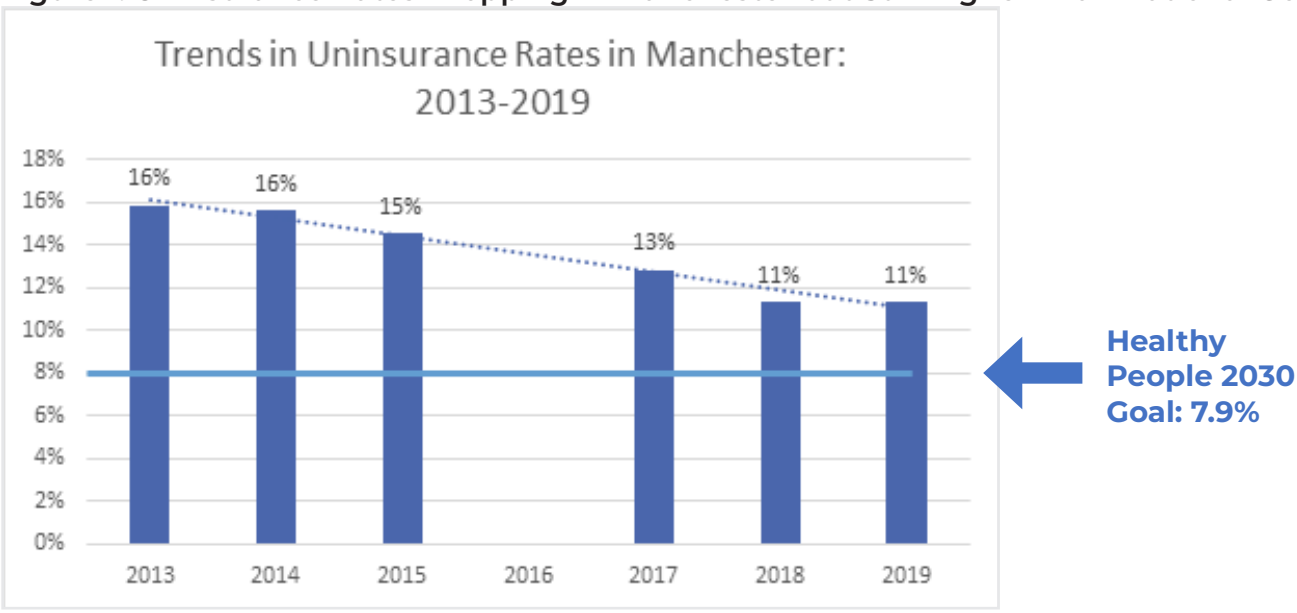
[1] *https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/access-health-services*
[2] *Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: confronting racial and ethnic disparities in health care. Washington (DC): National Academies Press (US); 2002.*
[3] *https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html*

Figure 1. Uninsurance Rates Dropping in Manchester but Still Higher Than National Goal



Source: City Health Dashboard

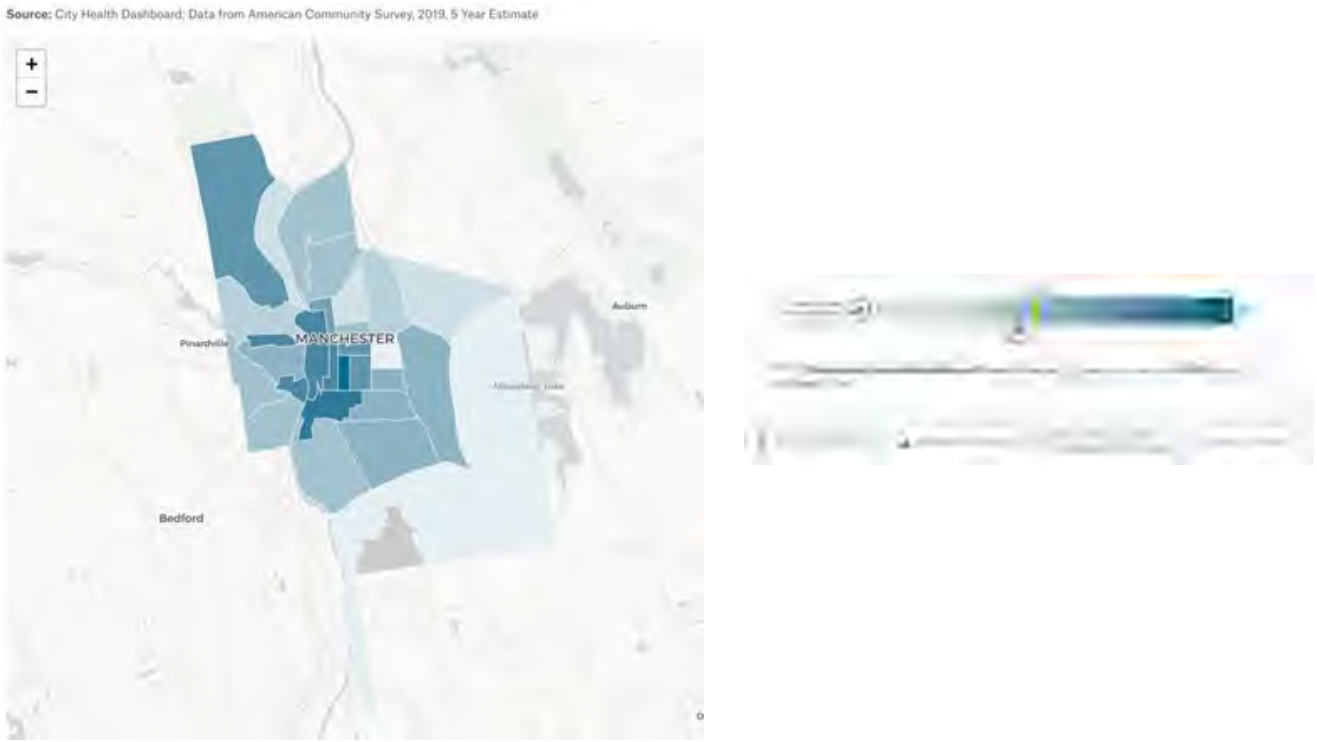
The vast majority of towns in the Greater Manchester Region have rates of uninsured well below the Healthy People 2030 Goal of 7.9%. (Table 1) One notable exception is Candia, which has the highest rate in the region, at 13.1% in 2020. The percent of Manchester residents who are uninsured is more than 63% higher than in the State of NH and 48% higher than in Nashua.

Table 1. Candia has Highest Uninsured Rate in Greater Manchester Region
Uninsured Rates by Town in Greater Manchester Region, 2020 (5-year estimates)

Town	Percent of Residents Uninsured
Manchester	9.8%
Auburn	4.4%
Bedford	1.7%
Candia	13.1%
Deerfield	5.2%
Goffstown	4.8%
Hooksett	4.3%
New Boston	4.3%
Londonderry	3.2%
Nashua	6.6%
State of NH	6%

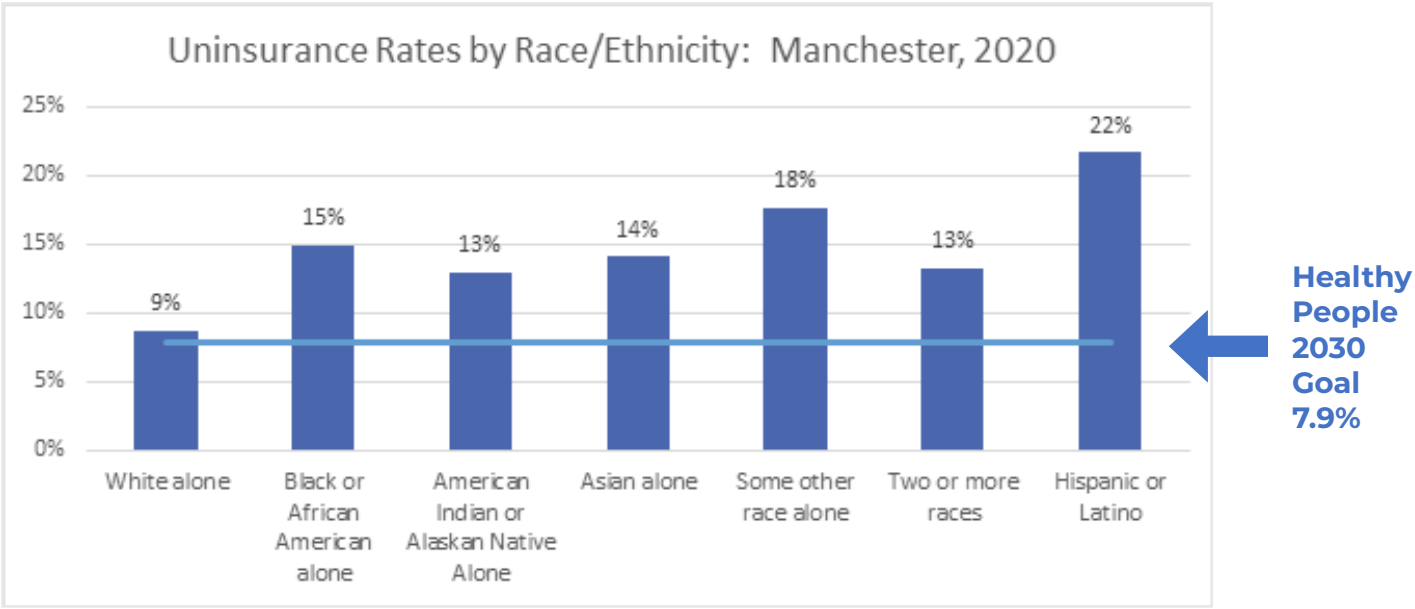
Source: 2020: ACS 5-Year Estimates

Figure 2. Manchester's Center City Residents Most Likely to be Uninsured



The proportion of Manchester residents who lack health insurance varies widely by census tract, from a low of 3% to as much as 23%--nearly three times the Healthy People 2030 Goal of 7.9%. Residents of Manchester's center-city neighborhoods are particularly more likely to be uninsured, with more than one in five residents in center city tracts 15 and 19 having no health insurance in 2019 (22.2% and 20.9%, respectively).

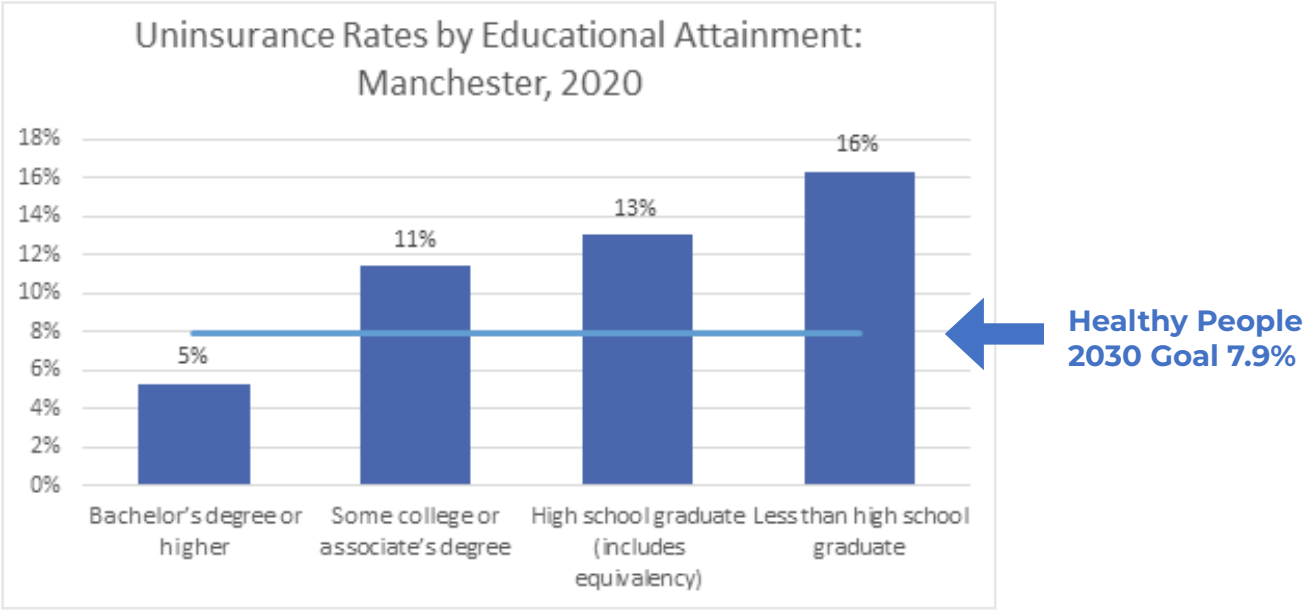
Figure 3. Hispanic/Latino Residents Most Likely to be Uninsured in Manchester



Source: US Census Bureau, ACS 5-year estimates

Figure 3 illustrates the variation in insurance rates by race and ethnicity in Manchester in 2020. These differences largely reflect national disparities in health insurance coverage, with people of Hispanic or Latino origins having some of the highest rates of uninsurance nationwide (20% in 2019), and individuals identifying as white having some of the lowest rates (7.8%).[4] Of note, Asian people may face unique barriers that make them more likely to lack health insurance in New Hampshire than in the country as a whole where they have the lowest uninsurance rate nationally at 7.2%. Conversely, American Indians have the highest rate of uninsurance nationally, at 21.7%, compared with much lower rates in NH.

Figure 4. Higher Education Associated with Lower Uninsurance Rates



Source: US Census Bureau, ACS 5-year estimates

The likelihood of being uninsured also varies substantially by educational attainment (Figure 4). In Manchester, residents with less than a high school diploma or equivalent are more than three times more likely than those with a Bachelor's degree or higher to lack health insurance.

Medically-Underserved Areas

The federal government provides two designations for geographic areas lacking adequate access to preventive healthcare services: Medically-Underserved Areas (MUAs) and Medically-Underserved Populations (MUPs). MUAs have a shortage of primary care providers within a geographic area that can be defined as large as a county or as small as a census tract. MUPs have a shortage of primary healthcare services available to a specific subpopulation, such as persons experiencing homelessness, the elderly, and individuals or families living below the federal poverty level. Often, these groups face additional economic, structural, cultural, and/or language barriers to health care.

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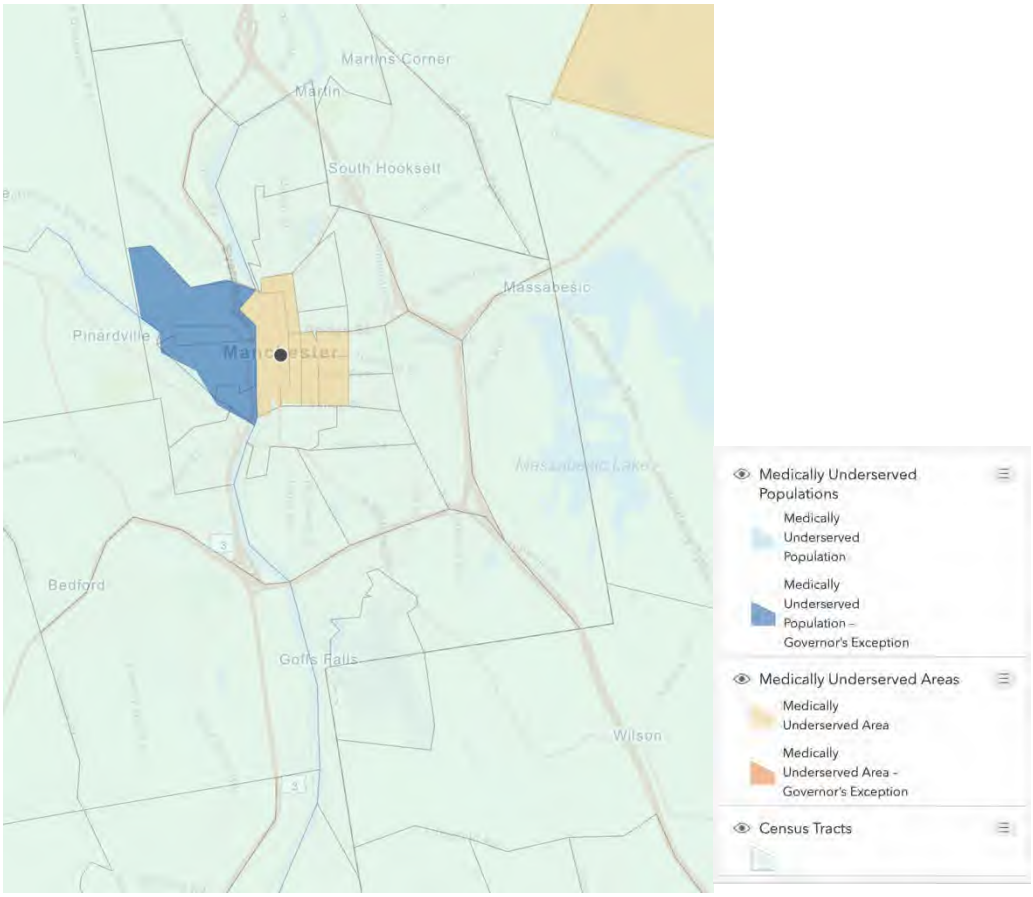
[4] *https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/*

Figure 5. Manchester's Center City Neighborhoods Designated as Medically Underserved



Source: US Health Resources and Services Administration, https://data.hrsa.gov/maps/map-tool/

Much of Manchester's center city is designated as Medically underserved. Six east-side census tracts are designated as Medically Underserved Areas: 6, 13, 14, 15, 16, and 2004. In addition, four census tracts on the City's west side are designated as Medically Underserved Populations: 2.02, 3, 20, and 21.

Prevention Quality Indicators (PQIs)

Prevention Quality Indicators (PQIs) are clinical conditions or complications that typically result from inadequate access to quality primary care services. Hospital admissions for these conditions can generally be avoided through appropriate access to quality, outpatient care. As such, the PQIs are an important indicator of both healthcare access and overutilization of hospitals for chronic disease management.[5]

PQIs are similar to ambulatory-care sensitive conditions, an indicator used in previous Greater Manchester Community Health Needs Assessments, but represent a more robust measure of access to quality outpatient care.

[5] *https://qualityindicators.ahrq.gov/measures/pqi_resources*

The Chronic Conditions composite measure for PQIs includes hospital visits for certain short- and long-term complications of diabetes, chronic obstructive pulmonary disease or asthma, hypertension, and heart disease. The Acute Conditions composite measure for PQIs includes hospital visits for dehydration, bacterial pneumonia, and urinary tract infection. A detailed list of PQIs can be found at: https://qualityindicators.ahrq.gov/measures/pqi_resources.

Table 2. Drop in Emergency Department Visits for PQIs Could Mean Better Access to Preventive Care

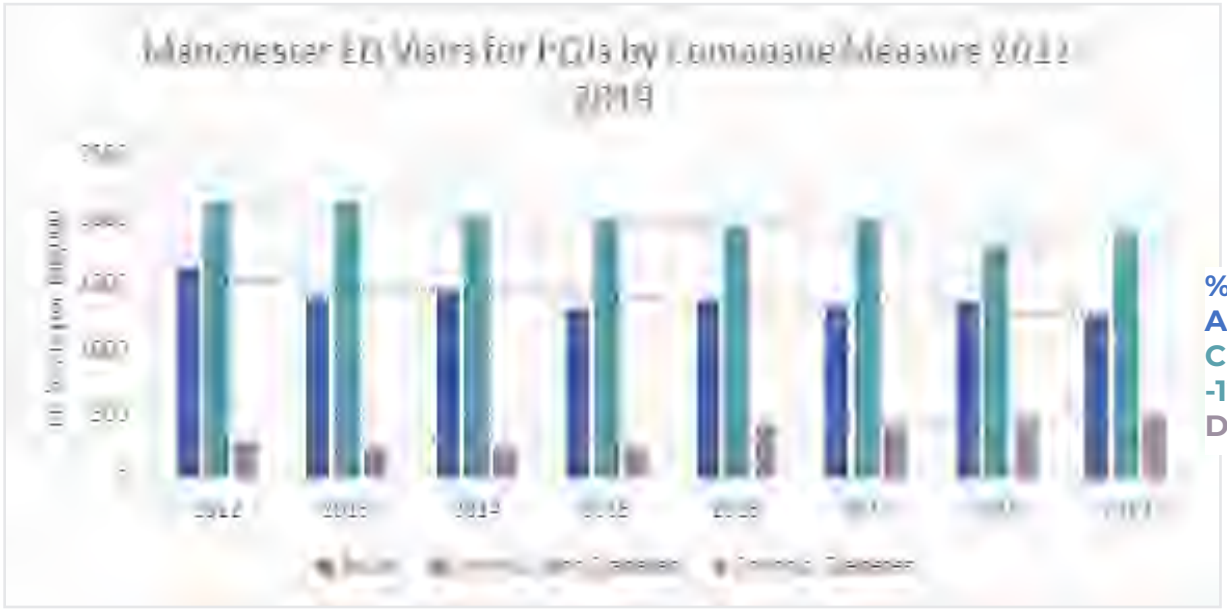
Trends in Emergency Department Visits for PQIs, Age-Adjusted Rates per 100,000

Emergency Department Visits for PQIs per 100,000: All Conditions, 2012-2019									
City/Region	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**% Change**
Manchester	4071	3779	3731	3553	3760	3769	3625	3620	-11.1%
Greater Manchester	3262	2986	2928	2839	2889	2916	2859	2841	-12.9%
NH	2876	2654	2587	2403	2443	2492	2489	2560	-11.0%
Emergency Department Visits for PQIs per 100,000: Acute Conditions, 2012-2019									
City/Region	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**% Change**
Manchester	1636	1412	1460	1313	1401	1325	1357	1243	-24.0%
Greater Manchester	1388	1163	1196	1084	1101	1065	1086	1019	-26.6%
NH	1374	1204	1152	1109	1122	1120	1105	1129	-17.9%
Emergency Department Visits for PQIs per 100,000: Chronic Conditions, 2012-2019									
City/Region	2012	2013	2014	2015	2016	2017	2018	2019	% Change
Manchester	2435	2367	2272	2241	2358	2444	2268	2377	-2.4%
Greater Manchester	1873	1822	1732	1755	1788	1851	1773	1822	-2.8%
NH	1502	1450	1434	1294	1321	1372	1383	1432	-4.7%

Source: NH Department of Health and Human Services

Table 2 details rates of Emergency Department (ED) visits for PQIs per 100,000 residents between 2012 and 2019. ED admissions for all PQIs have been declining slowly, but steadily, in Manchester, Greater Manchester and the State of NH since 2012. When broken down into admissions for either Acute or Chronic PQIs, it is clear that this decline is due in large part to reductions in ED admissions for Acute PQIs between 2012 and 2019. During this period, admissions for Acute PQI's dropped by 24% among Manchester residents, while visits for Chronic PQIs declined only slightly, by 2.4%.

Figure 6. Preventable ED Visits for Diabetes-Related Conditions on the Rise in Manchester



Source: NH Department of Health and Human Services

Figure 6 further breaks down trends in ED admissions for PQI Chronic Conditions in Manchester into those that are diabetes-related and non-diabetes-related. While ED visits for PQIs unrelated to diabetes declined by 12% between 2012 and 2019, those for diabetes-related chronic conditions increased by 64%.

Table 3. Hospital Inpatient Visits for Preventable Acute Causes Down More than 25% in Past 7 years

Trends in Hospital Inpatient Visits for PQIs, Age-Adjusted Rates per 100,000

Hospital Inpatient Visits for PQIs: All Conditions, 2012-2019									
City/Region	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**% Change**
Manchester	1730	1522	1480	1561	1482	1565	1503	1620	-6.3%
Greater Manchester	1447	1312	1229	1334	1227	1291	1262	1337	-7.6%
NH	1054	981	937	965	931	975	933	920	-12.7%
Hospital Inpatient Visits for PQIs: Acute Conditions, 2012-2019									
City/Region	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**% Change**
Manchester	520	479	429	432	387	297	377	379	-27.2%
Greater Manchester	474	431	378	383	346	280	314	334	-29.5%
NH	378	336	302	309	287	266	269	250	-33.9%
Hospital Inpatient Visits for PQIs: Chronic Conditions, 2012-2019									
City/Region	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**% Change**
Manchester	1210	1043	1050	1129	1094	1267	1126	1242	+2.6%
Greater Manchester	973	881	851	951	881	1011	948	1003	+3.0%
NH	675	646	634	657	644	709	664	670	-0.8%

Source: NH Department of Health and Human Services

Table 3 shows similar trends in Manchester, Greater Manchester and the State of NH when measuring rates of hospital inpatient admissions for PQIs over time. While inpatient admissions for Acute PQIs dropped by approximately one-quarter to one-third in all three regions, admissions for Chronic PQIs changed little, or even increased slightly, during the same period.

Figure 7. Hospital Admissions for Preventable Diabetes Complications Up 35% in Past 7 years

% Change:
Acute, -27%
Chronic, ND, -3%
Chronic, Diabetes, +35%

Source: NH Department of Health and Human Services

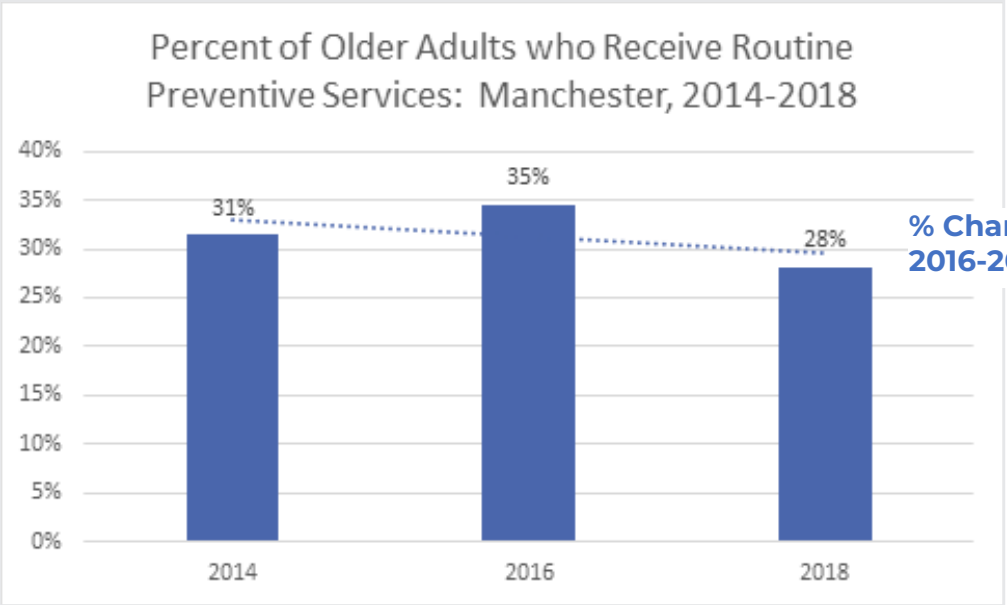
When inpatient hospital admissions for Chronic PQIs are further broken down into those that are diabetes-related and those that are non-diabetes-related, we see that admissions for Chronic Diabetes PQIs are again on the rise in Manchester, while those for non-diabetes-related Chronic PQIs are relatively unchanged. These data point to a disturbing trend in Manchester residents being hospitalized for diabetes-related complications that could be prevented with better access to outpatient diabetes management services. Further attention to this trend is warranted to identify potential barriers to accessing care by this population and potential solutions to improving outpatient diabetes management in Manchester.

Routine Preventive Health Screenings, Ages 65+

The Centers for Disease Control and Prevention estimate that preventive care, including immunizations and routine cancer screenings, could save an estimated 100,000 lives in the U.S. per year.[6] Yet, each year, millions of people do not receive the preventive services recommended by national experts for their age group.

The City Health Dashboard created a metric to monitor access to preventive healthcare among older adults, ages 65 and older. The metric measures the percentage of older adults who are up-to-date on a core set of preventive services that are widely recommended for their age and gender.[7] Though small gains were made in the percent of older adults receiving core preventive services in Manchester between 2014 and 2016, Figure 8 illustrates an overall reduction between 2014 and 2018. Between 2016 and 2018, the proportion of older adults receiving core preventive services dropped by 20% in Manchester.

Figure 8. Utilization of Preventive Care Services Down Among Manchester's Older Adults



Source: City Health Dashboard

[6] *Centers for Disease Control and Prevention. CDC Prevention Checklist. https://www.cdc.gov/prevention/. Updated May 31, 2017. Accessed February 26, 2018.*
[7] *https://www.cityhealthdashboard.com/metric/32*

A similar, though less dramatic, decline was observed across the 500 Cities included in the City Health Dashboard, and in Nashua during the same period (Table 4). Additional attention to barriers to preventive care access among older adults in Manchester is warranted.

Table 4. Routine Health Screenings by Older Adults Drop More in Manchester than in Other Cities

Percent of Older Adults Who Receive Routine Health Screenings: Manchester, Nashua and 500 Cities

Region	2014	2016	2018	% Change
Manchester	31%	35%	28%	-11%
Nashua	33%	36%	30%	-9%
500 Cities	31%	32%	30%	-2%

Source: City Health Dashboard

Late or No Prenatal Care

One of the best ways to ensure a healthy pregnancy, and therefore a healthy birth, is through early and adequate prenatal care. The American College of Obstetricians & Gynecologists (ACOG) recommends that prenatal care services begin in the first trimester of pregnancy and continue throughout the pregnancy until birth.[8] Early initiation of care allows clinicians to identify risk factors for poor birth outcomes and facilitates intervention as needed.

Table 5. Majority of Manchester Women Receive Early Prenatal Care During Pregnancy

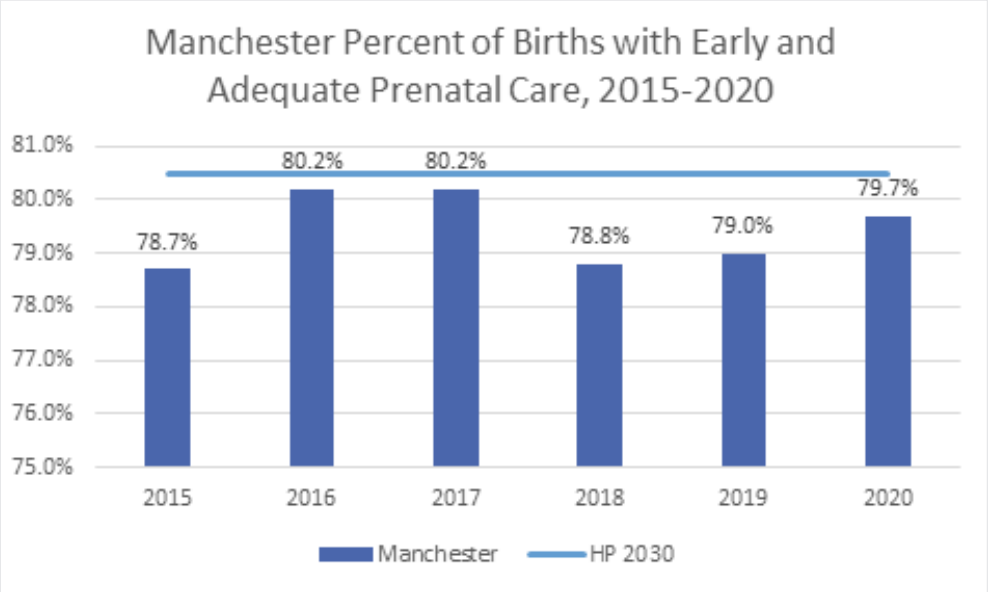
Early prenatal care: started in 1st/2nd trimester	
Manchester	94.1%
Greater Manchester PHR	94.8%
State of NH	95.4%
Late prenatal care: started in the 3rd trimester	
Manchester	4.5%
Greater Manchester PHR	3.9%
State of NH	3.2%
No prenatal care	
Manchester	1.0%
Greater Manchester PHR	0.9%
State of NH	0.6%

Source: NH Department of Health and Human Services

[8] *https://www.acog.org/clinical-information/physician-faqs//media/3a22e153b67446a6b31fb051e469187c.ashx*

Table 5 indicates that the vast majority of births to women in Manchester, Greater Manchester, and the State of NH had prenatal care initiated in the first trimester of pregnancy in the years 2016-2020 combined. However, 4.5% of births did not initiate prenatal care until the third trimester in Manchester, a rate that is 41% higher than in the State of New Hampshire and 15% higher than in the Greater Manchester Region. Overall, 5.5% of births had either late or no prenatal care in Manchester in the 5-year period.

Figure 9. Manchester Births with Early and Adequate Prenatal Care Approaching National Target



Source: City Health Dashboard

ACOG stresses the importance of both early and adequate prenatal care during pregnancy, defined as care initiated during the first trimester and includes nine or more visits for a pregnancy lasting 36 weeks or longer. Healthy People 2030 uses this definition for reaching its goal of achieving early and adequate prenatal care of 80.5% of births by the year 2030. Data from the City Health Dashboard indicates an upward trend toward reaching this goal in Manchester. In 2020, 79.7% of births to Manchester women included early and adequate prenatal care, higher than the average of 77.8% of births across the 500 Cities project.

Figure 10. Teen Births in Manchester per 1,000 Females

Teen births have been on a steady decline in Manchester as well as the 500 largest cities in the US. From 2012 to 2020, the teen birth rate per 1,000 females between the ages of 15-19 in Manchester have decreased by nearly half from 32.3 to 17.2 per 1,000 females. Measuring and monitoring the teen birth rates help in identifying need for evidence-based interventions. These interventions can include sexual health education and promotion of contraceptive use, as well as social, economic, and health care support for teen parents.[9]

Access to Behavioral/Mental Healthcare

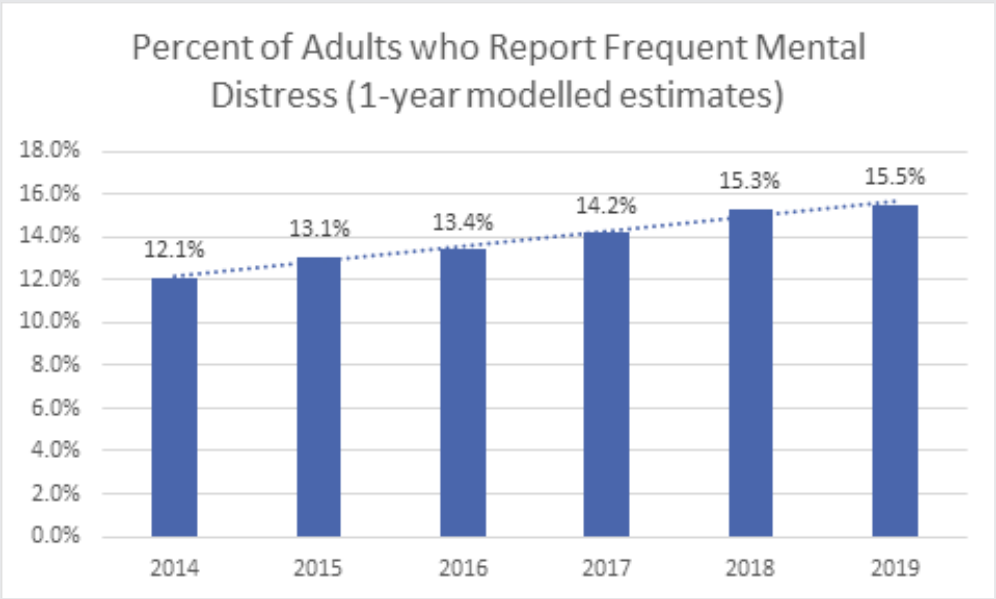
Health-related quality of life is measured by asking people how they would characterize their physical and mental health in the past month. Frequent mental distress is defined as experiencing 14 or more days of poor mental health in the prior 30 days.[10] Consistently poor mental health is linked to difficulties in daily life activities, like work or school, and an increased risk of behaviors that can have a negative impact on overall health and wellbeing.

The proportion of Manchester adults aged 18 years and older who report frequent mental distress is on a steady rise, according to data reported by City Health Dashboard (Figure 11). Between 2014 and 2019, the proportion of adults experiencing frequent mental distress increased by more than 28%, from 12.1% to 15.5%. A similar trend is occurring in Nashua and across the 500 Cities. However, rates of frequent mental distress have been consistently higher in Manchester than in the other two regions.

[9] *Centers for Disease Control and Prevention. Social Determinants and Eliminating Disparities in Teen Pregnancy. https://www.cdc.gov/teenpregnancy/about/social-determinants-disparities-teen-pregnancy.htm*

[10] *https://www.cityhealthdashboard.com/metric/30*

Figure 11. Frequent Mental Distress on the Rise in Manchester Adults



Source: City Health Dashboard

Table 6. Manchester, Nashua Adults Report Similar Increase in Rates of Frequent Mental Distress

Percent of Adults Who Report Frequent Mental Distress, 2014-2019

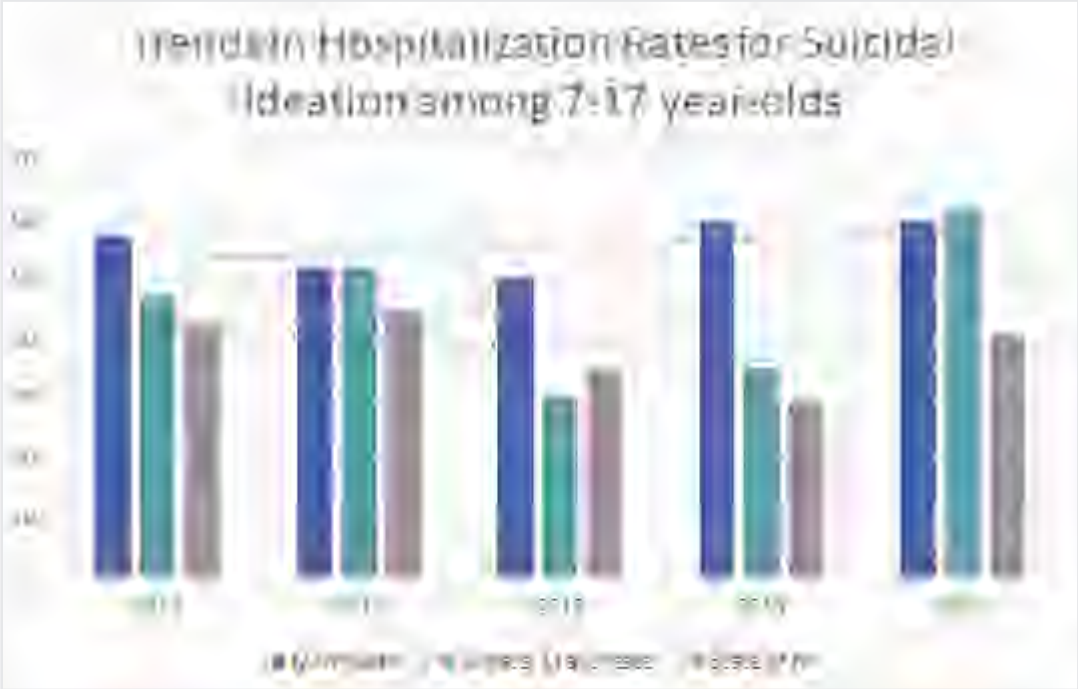
Region	2014	2015	2016	2017	2018	2019	% Change
Manchester	12.1%	13.1%	13.4%	14.2%	15.3%	15.5%	+28.1%
Nashua	11.0%	11.8%	12.1%	12.8%	13.7%	13.8%	+25.5%
500 Cities	12.3%	12.6%	12.8%	13.7%	14.0%	14.5%	+17.9%

Source: City Health Dashboard

Youth Hospitalized for Suicidal Ideation

Suicide attempt or suicidal ideation has been among the top five reasons for hospital admission among 7-17 year-olds in New Hampshire since 2016. In 2019, it was the 2nd most common reason for hospital admission in this age group in Manchester, the 4th most common in the Greater Manchester Public Health Region, and the 3rd most common reason for hospitalization in the State of New Hampshire.

Figure 12. Hospitalization Rates for Suicide Attempt/Suicidal ideation/Self-harm Jump 75% among Greater Manchester 7-17 year-olds



% Change:
Manchester, +4%
Greater Manchester, +31%
State of NH, -3%

While the rate of hospitalizations for suicidal ideation/suicide attempt/self-harm in 7–17-year-olds is on the decline across the State of New Hampshire as a whole, this rate is on the rise among Greater Manchester youth (Figure 12). Rates of hospitalization increased by more than 30% in Greater Manchester between 2016 to 2020, with an increase of 75% in the last year of that period. In the City of Manchester, this increase was much smaller, at only 4% from 2016 to 2020.

Table 7. Greater Manchester Shows Sharp Increase in Suicide-Related Hospitalizations Among Youth Compared with Manchester, State of NH

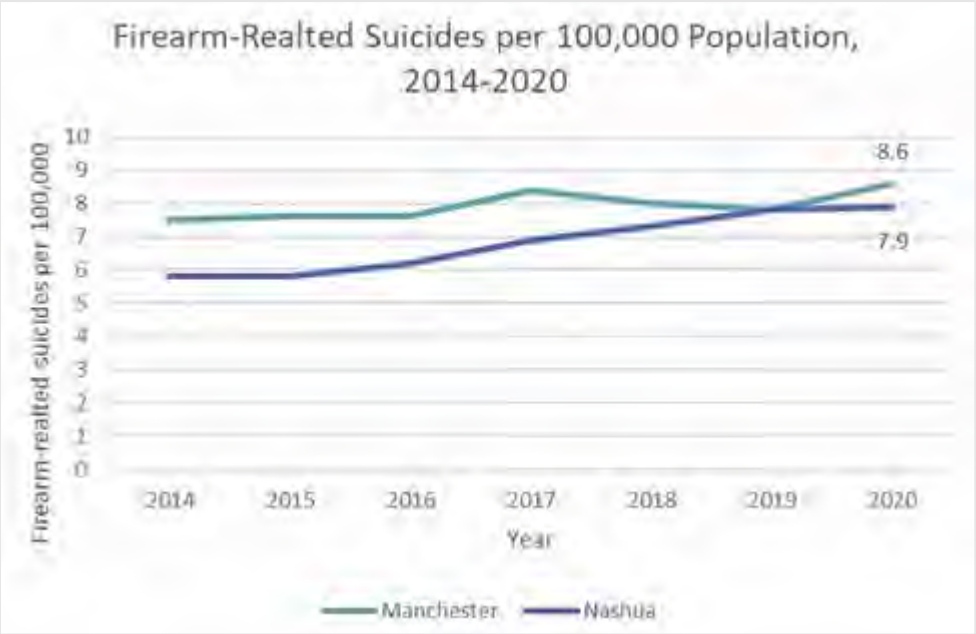
Region	2016	2017	2018	2019	2020	% Change
Manchester	57.6	41.8	50.6	59.8	59.8	+4%
Greater Manchester	47.4	52.3	30.6	35.4	61.9	+31%
State of NH	**42.5**	**44.8**	**35.3**	**29.6**	**41.1**	**-3%**

Source: NH Department of Health and Human Services

Table 7 further details the recent upward trend in hospital admissions for suicidal ideation/suicide attempt/self-harm among Manchester youth. These data provide a clear indication that increased mental health services are needed for youth in Manchester.

Manchester had 8.6 firearm suicides per 100,00 population compared to an average of 7.9 in Nashua, and 7.3 across the 500 largest cities in the US in 2020. While the amount of firearm related suicides has stayed fairly constant in Manchester since 2014, there was an increase from 7.8 to 8.9 per 100,000 from 2019 to 2020.

Figure 13: Firearm Related Suicides in Manchester per 100,000 Population



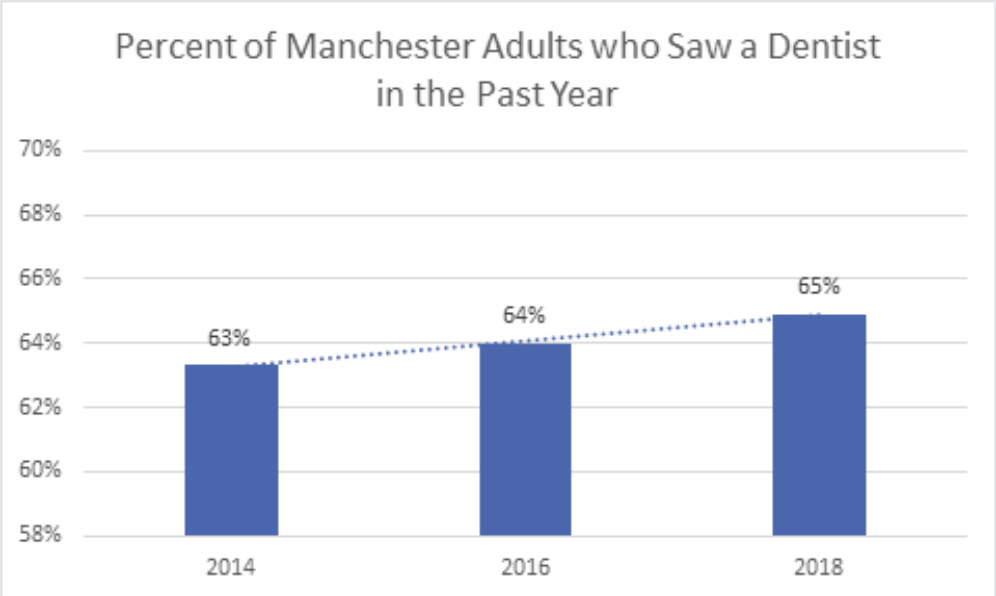
Access to Oral Healthcare

Routine oral healthcare is important to maintaining a healthy mouth, teeth and gums. Diseased or missing teeth not only affect your appearance and self-esteem, but can also make chewing your food properly difficult and painful, leading to malnutrition and digestive problems. Oral infections and inflammation have been linked to endocarditis, cardiovascular disease, pneumonia, and certain complications of pregnancy.[11] Moreover, "children with tooth decay might have noticeable difficulty in eating, speaking, and sleeping, experience distress and pain, and smile less—which in turn affect their development, wellbeing, family and social life, and school performance," according to an article recently published in The Lancet Child and Adolescent Health.[12]

Routine Dental Care

The US Department of Health and Human Services has prioritized access to oral health care in Healthy People 2030, with a goal of reducing the number of people who are unable to obtain or delay needed dental care to fewer than 4.1% by the year 2030.[13]

Figure 14. Only Two-Thirds of Manchester Adults Saw a Dentist in the Past Year



Source: City Health Dashboard

The proportion of Manchester adults who report visiting a dentist in the past year for any services has been rising incrementally since 2014, according to data reported by City Health Dashboard (Figure 14). The percent of adults with routine dental visits have been similarly steady in Nashua and across the Dashboard's 500 Cities. In 2018, the proportion of adults who reported at least one dental visit in the past year was slightly lower in Manchester than in Nashua (65% versus 67%, respectively), but slightly higher than in the 500 Cities combined (64%).

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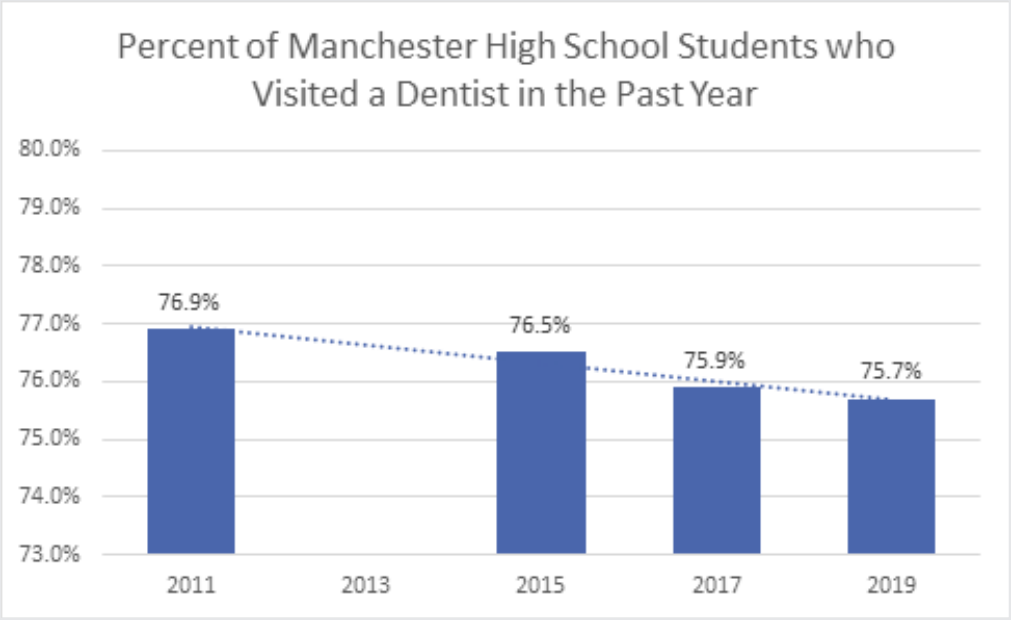
[11] *https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475*
[12] *https://www.thelancet.com/action/showPdf?pii=S2352-4642%2819%2930275-5*
[13] *https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/reduce-proportion-people-who-cant-get-dental-care-they-need-when-they-need-it-ahs-05*

Figure 15. 25% of Manchester High School Students Say They Did Not See a Dentist in the Past Year



Source: NH Department of Health and Human Services

Conversely, data from the Youth Risk Behavior Surveillance Survey indicate that Manchester high school students were somewhat less likely to have a recent dental visit in 2019 compared with earlier years (Figure 15). Between 2011 and 2019, the proportion of Manchester high school students who said they had seen a dentist in the past year decreased slightly, from 76.9% to 75.7%.

Table 8. Manchester Teens Less Likely to Visit a Dentist than Nashua, State of NH as a Whole

Percent of High School Students Who Report Visiting a Dentist in the Past Year, 2011-2019

Region	2011	2013	2015	2017	2019
Manchester	76.9%	**	76.5%	75.9%	75.7%
Greater Manchester PHR	**	**	80.3%	82.3%	82.6%
State of NH	**79.6%**	****	**82.7%**	**82.8%**	**83.6%**

Source: NH Department of Health and Human Services
***data not available*

By comparison, the percentage of high school students reporting routine oral health care appears to be on the rise in the Greater Manchester Region and the State of NH. Between 2015 (the earliest year for which data are available) and 2019, the percent of students in the Greater Manchester Public Health Region who had a dentist visit in the past year increased from 80.3% to 82.6%. In the State of NH, the proportion of students reporting a recent visit to the dentist increased from 79.6% in 2011 to 83.6% in 2019.

WHAT DO MANCHESTER RESIDENTS THINK?

More than 9 in 10 Manchester residents surveyed said that it is “very important” for Manchester to take action to improve access to quality, preventive health care, including primary care, prenatal care, dental care, and mental health services. Almost one-quarter said they had trouble accessing dental care for adults in the past 3 years and 13% said they had trouble accessing mental health services for adults in the same period.

Key stakeholders interviewed identified the number of healthcare facilities in Manchester as an asset but described access to dental and mental health services as poor in the city. Some pointed to the state’s Integrated Delivery Networks as a model for coordinating care but expressed concern about the sustainability of those networks now that funding has ended. Others pointed to insurance coverage and reimbursement practices as important barriers to expansion of services that could be overcome with legislative action.

Community Spotlight

NH Rapid Response Mobile Crisis Response Team

For adults and seniors experiencing a time of crisis, a Rapid Response Team deploys mental health clinicians and peer support and recovery coaches directly to the individual, or individuals, in need.
Rapid Response is a 24/7/365 service providing direct access to risk assessment, crisis intervention, stabilization, and connection to a comprehensive array of mental health and substance misuse treatment. The goal of Rapid Response is to assist community members with these services outside of a hospital or emergency room whenever possible.

The Mobile Crisis Response Team (MCRT) is now a part of the larger statewide Rapid Response system. Calls are triaged through the Rapid Response Access Point, and Mobile Crisis Teams are deployed to the community through the Access Point. The Mobile Crisis Response Team through The Mental Health Center of Greater Manchester works closely with the Manchester Police Department, Manchester Fire, and AMR, as well as our many community partners. The Manchester team facilitates Crisis Intervention Training (CIT) and Certification to members of the Manchester Police Department, and a CIT officer is embedded within the mobile team seven nights per week. The mobile crisis team serves community members of all ages and responds to homes, community based settings, schools, community partner settings, etc.

The MCRT has served over 1,000 individuals in the first 5 months of 2022, with 28% of those individuals being children and youth under the age of 18. In 2020 and 2021, the team served 4,785 Manchester residents, of whom 942 were children and youth.

To learn more please visit www.mhcgm.org or www.nh988.com

The 24/7/365 number for NH Rapid Response is 1-833-710-6477

Healthcare for the Homeless

Health Care for the Homeless (HCH) is a program of the Manchester Health Department based at Catholic Medical Center. HCH is a designated Federally Qualified Health Center for men, women, teens, and children in the City of Manchester who do not have a regular or adequate place to call home.

HCH offers a variety of services including primary medical care, medical case management, chronic disease management, integrated behavioral health services, counseling and medication-assisted treatment for substance use disorders, easily accessible clinics, outreach, and street medicine, testing and treatment for STD/HIV, health screenings and phlebotomy, prescription medication assistance, telehealth, transportation coordination, referrals to specialty care, and social work/case management.

In 2021, HCH served 1,283 total patients, with 7,284 total visits (medical, mental health, oral health, substance use disorder treatment, and enabling service visits). All people experiencing homelessness in the City of Manchester are welcome--no one is turned away due to an inability to pay.

Heath Care for the Homeless has three locations across Manchester:

- Adult Emergency Shelter Practice/Families in Transition located at 199 Manchester Street, Manchester, NH 03103 (603)-663-8718
- The Family Place Practice/Families in Transition located at 177 Lake Avenue, Manchester, NH 03103 (603)-782-7414
- Wilson Street Integrated Health Practice located at 293 Wilson Street, Suite 102, Manchester, NH 03103 (603)-665-7450

The City of Manchester Health Department Oral Health Program

The Manchester Health Department's School-Based Oral Health Program provided complete preventative dental services. It is the largest program in NH, serving an average of 600 students each school year at all 21 public schools in Manchester. Students who qualify for the program receive a dental screening, fluoride treatment, sealants and temporary fillings (as needed), oral health education, and a referral for additional and regular dental care. This care is provided by a public health dental hygienist on the mobile dental van during school hours, and when billable, Medicaid reimbursement is processed. In order to qualify for services through this program, families must not have a current dental home and must meet financial eligibility criteria. For more information, call the Manchester Health Department at 603-624-6466.

NUTRITION AND FOOD SECURITY

PRIORITY: IMPROVE ACCESS TO HEALTHY FOODS

Each year, chronic diseases account for 70% of all deaths in the United States.[1] In New Hampshire, the five major diet-related chronic diseases—cardiovascular disease, diabetes, hypertension, stroke, and cancers—accounted for more than 6,500 deaths in 2020.[2,3]

A healthy diet includes "a variety of fruits, vegetables, grains, protein foods, and dairy and fortified [dairy] alternatives," according to the US Department of Agriculture.[4] However, many NH residents, particularly those in low-income and minority communities, lack access to fresh, healthy nutritious food. When healthy foods are not available, people often settle for foods that are higher in calories and lower in nutritional value.

Limited Access to Healthy Foods

Living in a "food desert" is strongly associated with higher levels of obesity and nutrition-associated chronic diseases. Food deserts are neighborhoods with limited access to affordable healthy foods due to low income, low proximity to a full-service grocery store, or both. The USDA considers individuals who live less than ½ mile from a supermarket or grocery store to have limited access to healthy foods.

Figure 1 shows that nine of Manchester's center city census tracts were considered food deserts in 2019: 6, 8, 13, 16, 18, 20, 21, 24, and 25. These neighborhoods have both significant rates of poverty and are at least ½ mile from the nearest grocery store. Without easy access to a vehicle or public transportation, families living in these communities end up paying higher prices for produce at a corner store or choosing less-healthy options to stretch their food budgets.

Overall, 63.1% of Manchester residents had limited access to healthy food in 2019, down almost 20% from 77.4% of residents in 2015. Manchester residents are less likely to have limited access to healthy food than Nashua residents, 73.5% of whom had limited access in 2019.

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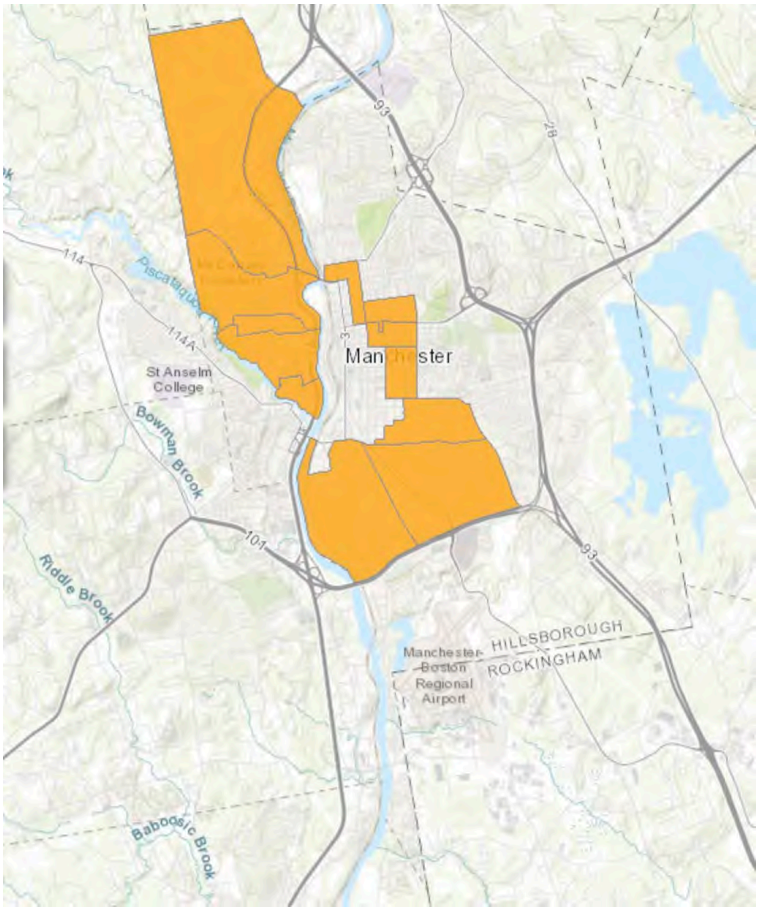
[1] *https://www.cdc.gov/nutrition/healthy-food-environments/improving-access-to-healthier-food.html*
[2] *https://www.cdc.gov/nchs/pressroom/states/newhampshire/nh.htm*
[3] *http://journals.sagepub.com/doi/pdf/10.1177/156482650102245209*
[4] *https://ask.usda.gov/s/article/What-is-a-healthy-diet*

Figure 1. Many Manchester Center-City Neighborhoods Are Food Deserts



LI (low income): census tracts with 20% or more residents living in poverty or where the median family income is less than 80% of the state average.

LA (low access): distance to the closest grocery store for urban (½ mile) and rural (10 miles) communities.

Source: USDA Food Atlas

Food access is closely tied to vehicle access in communities without a close full-service grocery store. In Manchester, 8.3% of households had no access to a vehicle in 2020, while another 40.6% of households shared one vehicle among all residents. City residents were much less likely to have access to a vehicle compared with households in the Greater Manchester Area, as shown in Table 1. The percentage of households with no access to a vehicle was 66% higher in Manchester than in the state as a whole in 2020.

Table 1. More than 8% of Manchester Households have No Vehicle Access

Percent of Occupied Housing Units with no Vehicle Access, Greater Manchester, 2020

Town	Households with no Vehicle	Sharing one Vehicle
Manchester	8.3%	40.6%
Auburn	0.0%	14.1%
Bedford	4.1%	16.3%
Candia	1.0%	17.7%
Deerfield	4.2%	12.9%
Goffstown	4.3%	35.3%
Hooksett	0.0%	33.4%
New Boston	0.0%	0.0%
Londonderry	2.6%	23.2%
Nashua	7.9%	35.2%
State of NH	*5.0%*	*29.7%*

Source: US Census Bureau, 2020 5-year estimates

Factors Associated with Food Insecurity

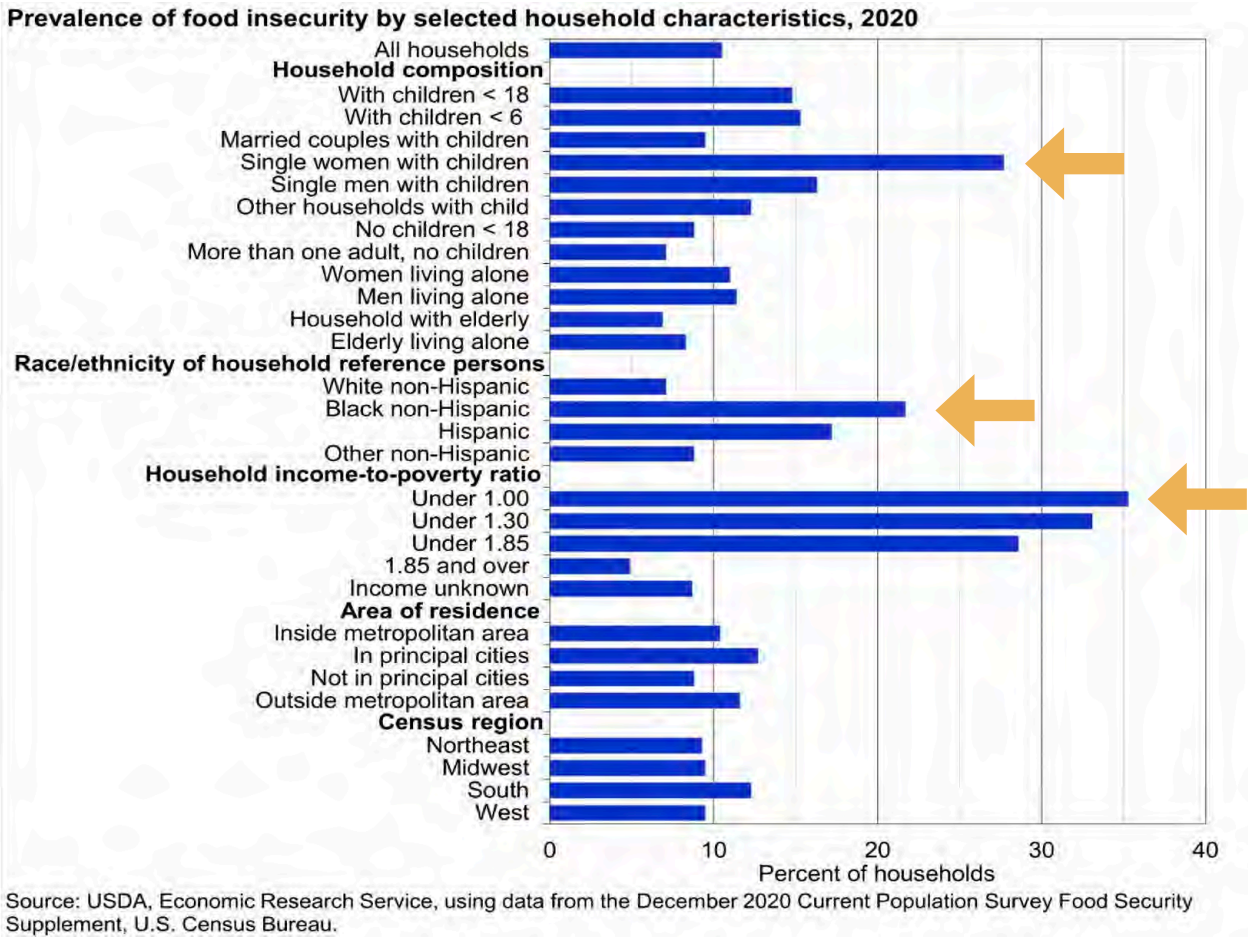
Several household characteristics are consistently associated with higher rates of food insecurity, according to research conducted by the USDA. Female-headed households with children, black- and Hispanic-headed households, and households with a low income-to-poverty ratio are at particular risk of food insecurity. (Figure 2). Job segregation, gender and economic inequality, and racial/ethnic discrimination all increase the likelihood that women will be poor.[5]

In 2020, there were 4,980 female-headed households with children in Manchester, representing nearly one-quarter (24.3%) of all households with children. Overall, 26.8% of households in Manchester were female-headed with no spouse or partner present that year. In addition, 20.7% of Manchester households had income-to-poverty ratios below 185% in 2020—the standard criteria used for many food insecurity benefits including free school meals—with 9.3% of households living below 100% the national poverty rate.

[5] *https://www.projectbread.org/research/barriers-to-snap*

Figure 2. Single Moms with Children, Black and Hispanic Households Most Likely to Experience Food Insecurity

Prevalence of Food Insecurity by Selected Household Characteristics in the US, 2020



Source: USDA Economic Research Service

Supplemental Nutrition Assistance Program (SNAP)

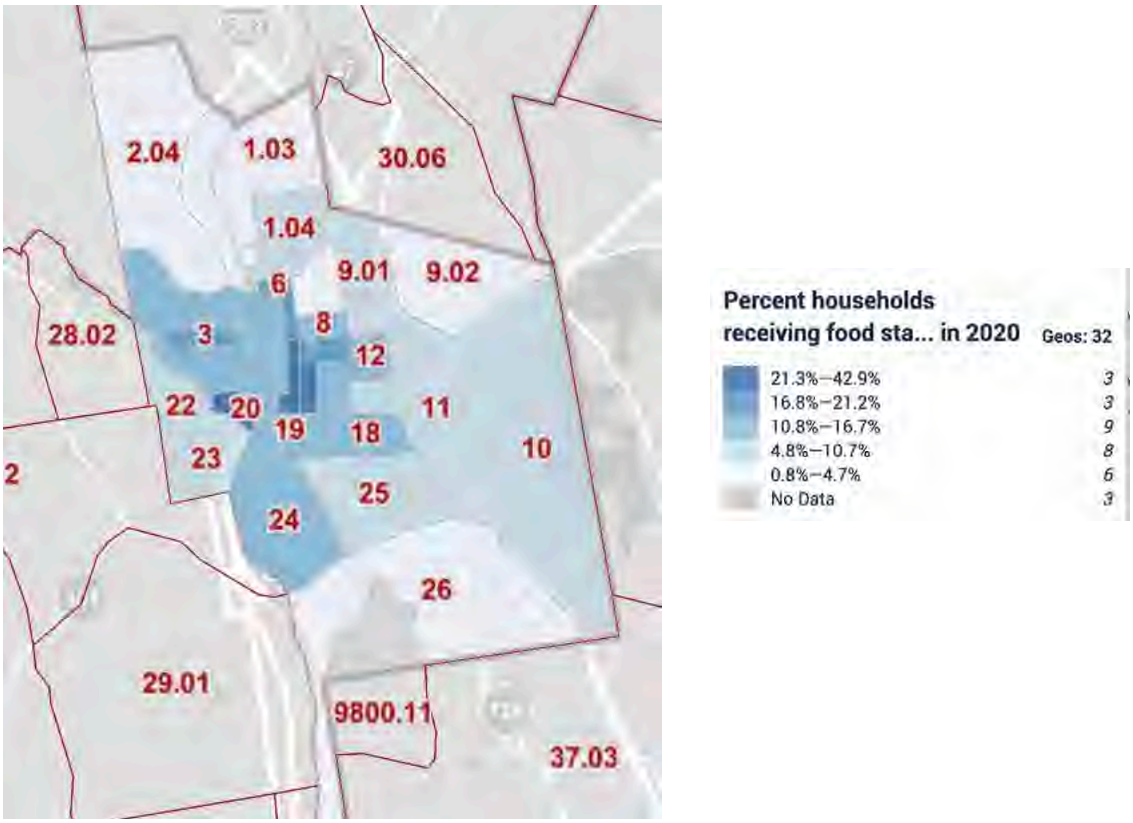
The SNAP program, also known as food stamps, is the national food insecurity safety net for low-income households. While other criteria apply, households generally must have net incomes at or below 100% of the federal poverty level to qualify. Importantly, not everyone who qualifies for SNAP actually receives those benefits, with computer access, stigma, and application difficulties cited as the most prominent barriers to participation.[6]

Overall, 11.5% of Manchester households received SNAP benefits in 2020 (Table 2). However, the proportion of families receiving food assistance was twice this rate in three center city census tracts—14, 15, and 20—where up to 42.9% of households were receiving SNAP assistance that year (Figure 3).

[6] *https://www.projectbread.org/research/barriers-to-snap*

Figure 3. Up to 40% of Families Receive SNAP Benefits in Manchester Center-City Neighborhoods

Percent of Households Receiving SNAP Benefits, Manchester, 2020



Source: US Census Bureau

Manchester residents were 80% more likely to be receiving SNAP benefits in 2020 than residents across the State of New Hampshire as a whole (Table 2). Participation in this program also varied widely among towns in the Greater Manchester Area, with rates ranging from a low of 0.0% in New Boston to a high of 5.7% in Candia. Manchester families were 35% more likely than those living in Nashua (8.5%) to be receiving food stamps in 2020.

Table 2. Percent of Households Receiving Food Assistance Varies Widely in Greater Manchester

Percent of Households Receiving SNAP Benefits, Greater Manchester, 2020

Town	Households Receiving SNAP/Food Stamps
Manchester	11.5%
Auburn	1.9%
Bedford	1.5%
Candia	5.7%
Deerfield	3.3%
Goffstown	3.5%
Hooksett	2.3%
New Boston	0.0%
Londonderry	4.4%
Nashua	*8.5%*
State of NH	*6.4%*

Source: US Census Bureau, 2020 5-year estimates

Obesity

Residents of neighborhoods with lower access to healthy foods have higher rates of obesity than those living in neighborhoods with easy access to a grocery store.[7] Obesity increases the risk of other nutrition-associated chronic diseases, poor mental health, and overall reduced quality of life.[8] Rates of obesity are increasing across the nation in all age groups—children, adolescents and adults. Reversing this trend is a top objective in Healthy People 2030.

Figure 4 shows that obesity rates among Manchester adults are below the Healthy People 2030 goal of 36.0%, but will not be for long if current trends continue. Between 2014 and 2019, the percent of Manchester residents who are obese increased by 10%, from 30.9% to 34.0% (Figure 3). While the proportion of Manchester adults with obesity was lower than the national target in 2019, it was higher than in Nashua (32.5%) and across the City Health Dashboard's 500 cities (30.8%).

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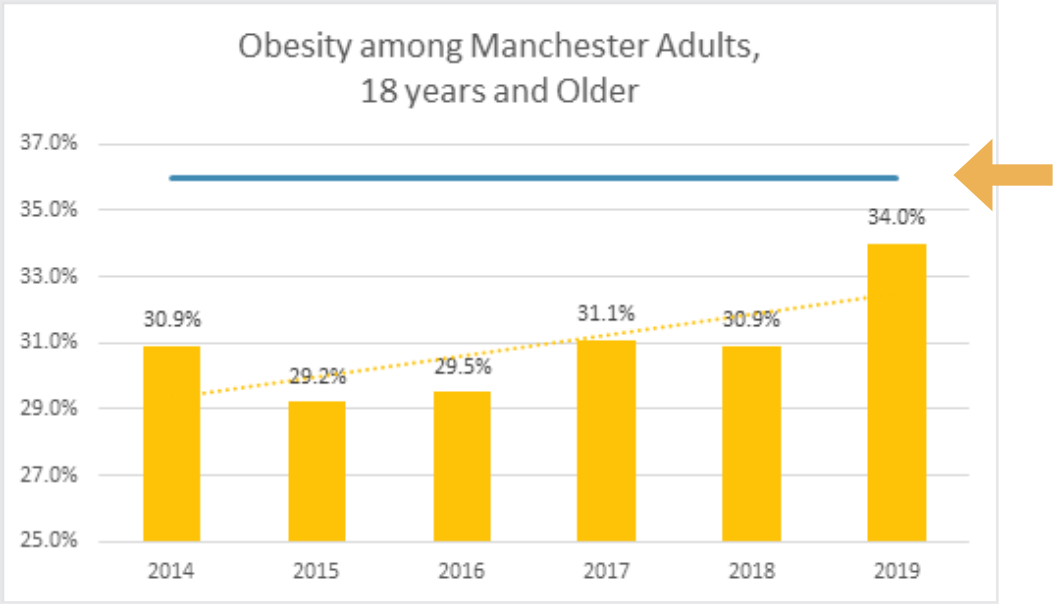
[7]Babey SH, Diamant AL, Hastert TA, Harvey S. Designed for disease: the link between local food environments and obesity and diabetes. Los Angeles: UCLA Center for Health Policy Research; 2008 Apr 1.
[8] Centers for Disease Control and Prevention. Adult Obesity Causes & Consequences. https://www.cdc.gov/obesity/adult/causes.html. Updated August 29, 2017. Accessed February 16, 2018.

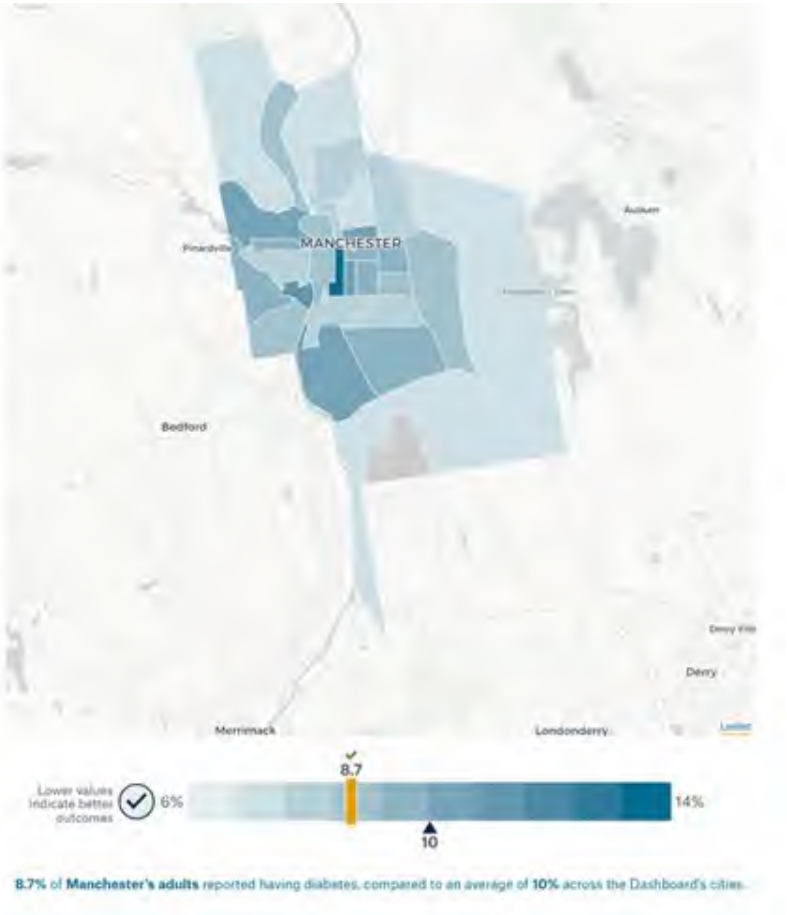
Figure 4. Obesity Rates Rising, but Lower than National Target among Manchester Adults



Source: City Health Dashboard

As shown in Figure 5, obesity rates are higher in Manchester's center city than in the surrounding areas. The highest proportions of adults with obesity are located in census tracts 14 and 15, where the obesity rates were 42.1% and 40.8%, respectively, in 2019.

Figure 5. Adult Obesity Rates Highest in Manchester's Center City Neighborhoods



Source: City Health Dashboard

Brain Health

Research shows that longitudinal brain health is closely linked to a healthy diet. Incorporating leafy greens and healthy fats while simultaneously reducing consumption of red meat and processed sugars is associated with reduced cognitive decline and reduced risk of dementia.[9] Research suggests that dietary changes that reduce the risks of developing a chronic illness such as type 2 diabetes and heart disease have considerable benefits to brain health.

Alzheimer's is the most common form of dementia and has consistently been in the top ten leading causes of death in Manchester. From the years 2000 to 2016, the rate of Alzheimer's disease deaths was 26.7 per 100,000 in Manchester.[10] Notably, the rate of Alzheimer's mortality for females was slightly higher than males in Manchester during this time period at 28.9 and 21.5 per 100,000 respectively.

Nutrition-related Chronic Disease: Diabetes

Diabetes was the 8th leading cause of death in New Hampshire in 2020, with a rate of 19.2 deaths per 100,000 residents.[11] Diabetes is closely tied to obesity, with approximately 90% of adults with diabetes also diagnosed as obese or overweight.[12] People with diabetes have an increased risk of complications associated with reduced quality of life, including eye damage, foot ulcers, and amputations. Complications of diabetes are responsible for a considerable proportion of preventable emergency department and hospital admissions in Manchester (see Access to Clinical Care).

Figure 6 shows an increase in the prevalence of diabetes among adults living in Manchester from 2014 to 2018, followed by a decline from 2018 to 2019. Overall, the proportion of adults with diabetes declined 2.2% during this period in Manchester and 4.5% in Nashua, while rising slightly (1.0%) across the 500 Cities.

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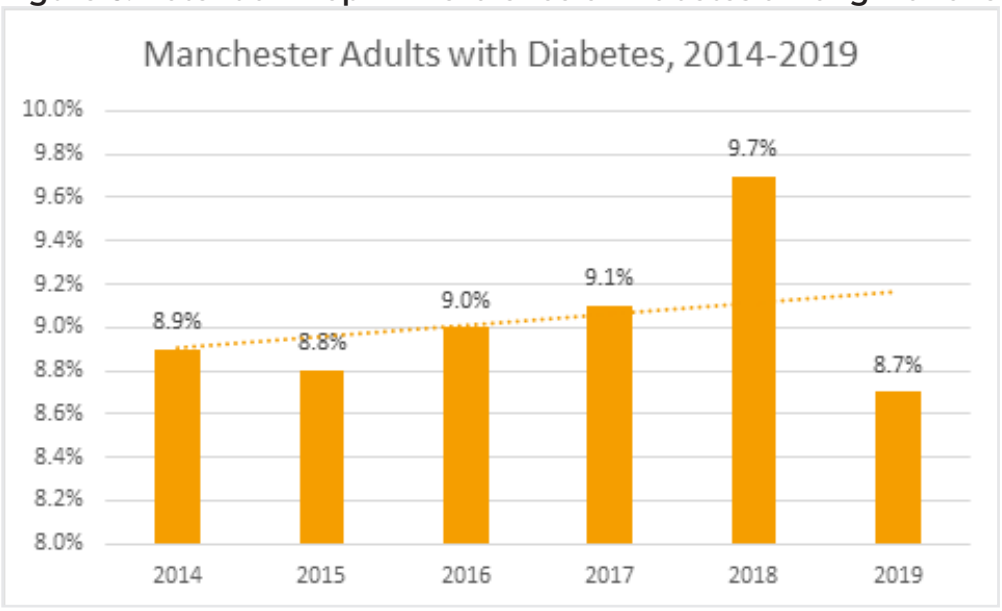
[9]Flanagan, Emma, et al. "Nutrition and the ageing brain: Moving towards clinical applications." Aging Research Reviews, vol. 62, Sept. 2020, doi:https://doi.org/10.1016/j.arr.2020.101079
[10] https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?category=chronic-health-conditions&topic=heart-disease-and-stroke&subtopic=leading-causes-of-death&indicator=death:-leading-causes-(all-ages)
[11] https://www.cdc.gov/nchs/pressroom/sosmap/diabetes_mortality/diabetes.htm
[12] Dutko, Paula, Michele Ver Ploeg, and Tracey Farrigan. Characteristics and Influential Factors of Food Deserts, ERR-140, U.S. Department of Agriculture, Economic Research Service, August 2012.

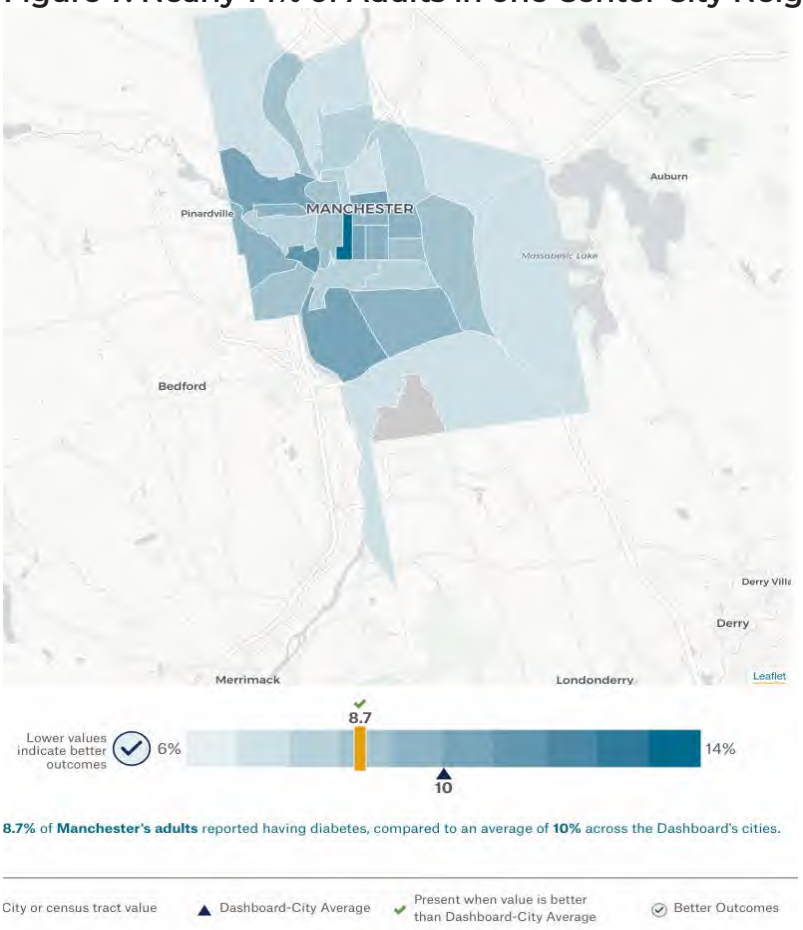
Figure 6. Potential Drop in Prevalence of Diabetes among Manchester Adults



Source: City Health Dashboard

Like obesity, diabetes prevalence is highest in Manchester's center city neighborhoods (Figure 7). Six census tracts—2.02, 8, 14, 15, 20, and 24—have diabetes rates above 10% of adults, with the highest rate seen in tract 14, at 13.7%.

Figure 7. Nearly 14% of Adults in one Center City Neighborhood have Diabetes



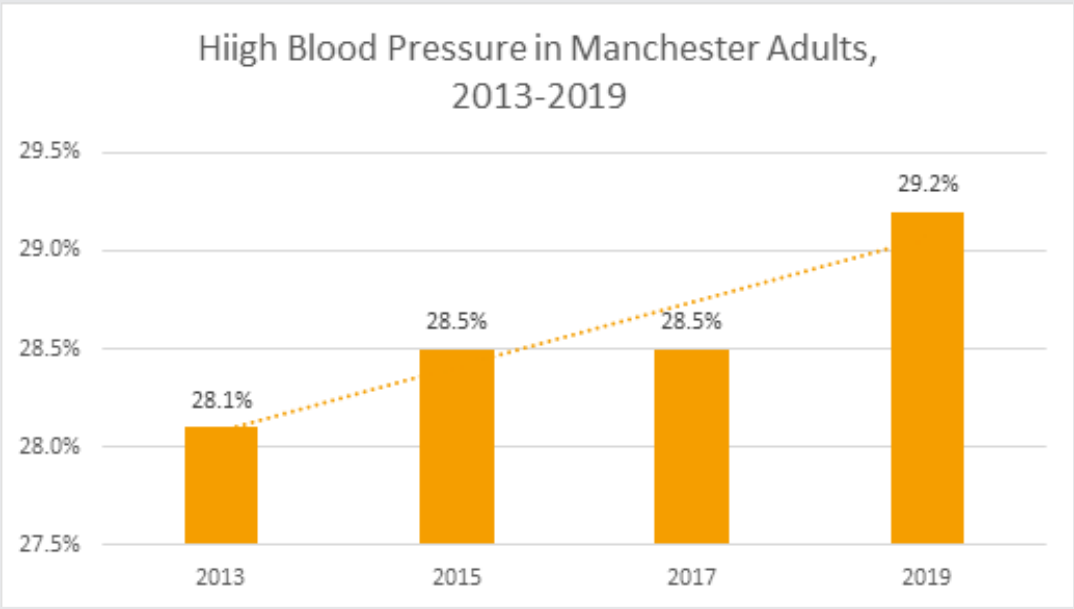
Source: City Health Dashboard

Nutrition-related Chronic Disease: High Blood Pressure

A diet low in fats and sodium and high in fiber is key to maintaining a healthy blood pressure. This translates to more fresh fruits and vegetables and fewer processed foods, which are typically high in sodium, saturated fat, and sugars. Poorly managed blood pressure increases the risk of heart attack, stroke, kidney disease, and vision loss.[13]

Unfortunately, the proportion of Manchester adults with a diagnosis of high blood pressure has risen slowly but consistently in the past several years (Figure 8). Between 2013 and 2019, the prevalence of high blood pressure in Manchester rose by 4%, while declining slightly (1%) across the 500 Cities, and remaining the same over time in Nashua. The US Department of Health and Human Services has set a goal of lowering the rate of adult high blood pressure to 27.7% by 2030.

Figure 8. Hypertension on the Rise in Manchester Adults

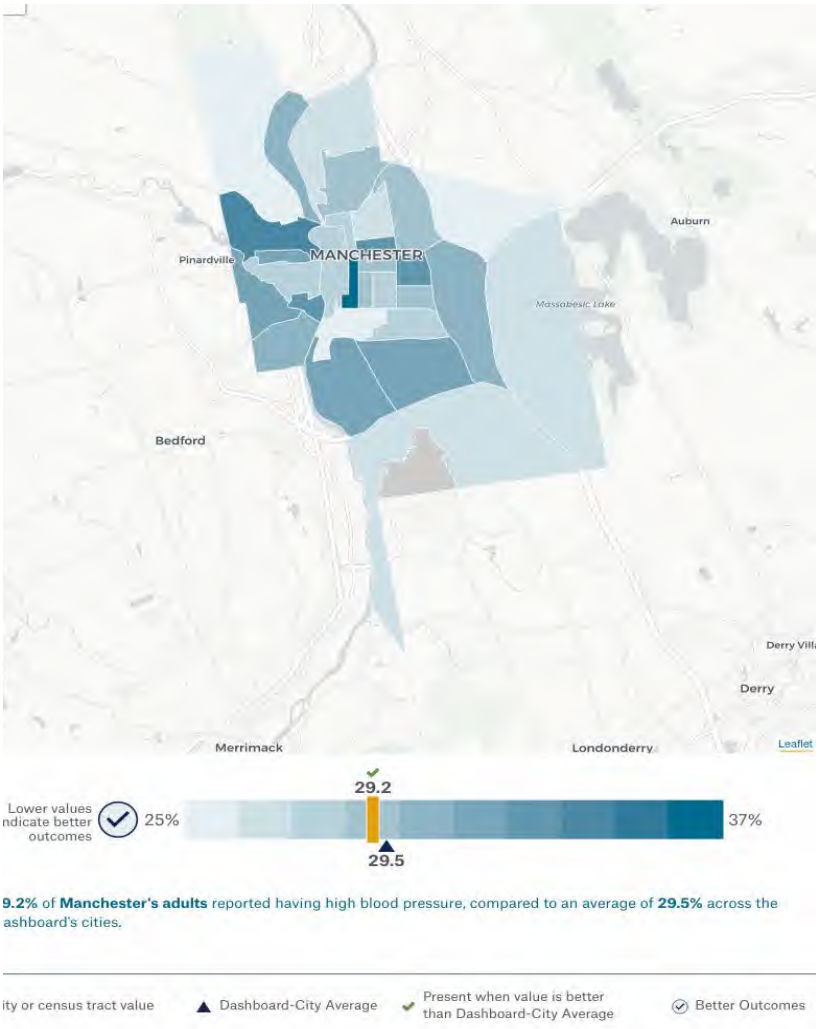


Source: City Health Dashboard

Figure 9 demonstrates that the prevalence of high blood pressure varies throughout Manchester, from a low of 25.2% in census tract 9.02 to a high of 36.2% in center city census tract 14—a 44% difference.

[13] *https://www.heart.org/en/health-topics/high-blood-pressure/health-threats-from-high-blood-pressure*

Figure 9. High Blood Pressure Rates Highest in Center City and West Side Neighborhoods



Source: City Health Dashboard

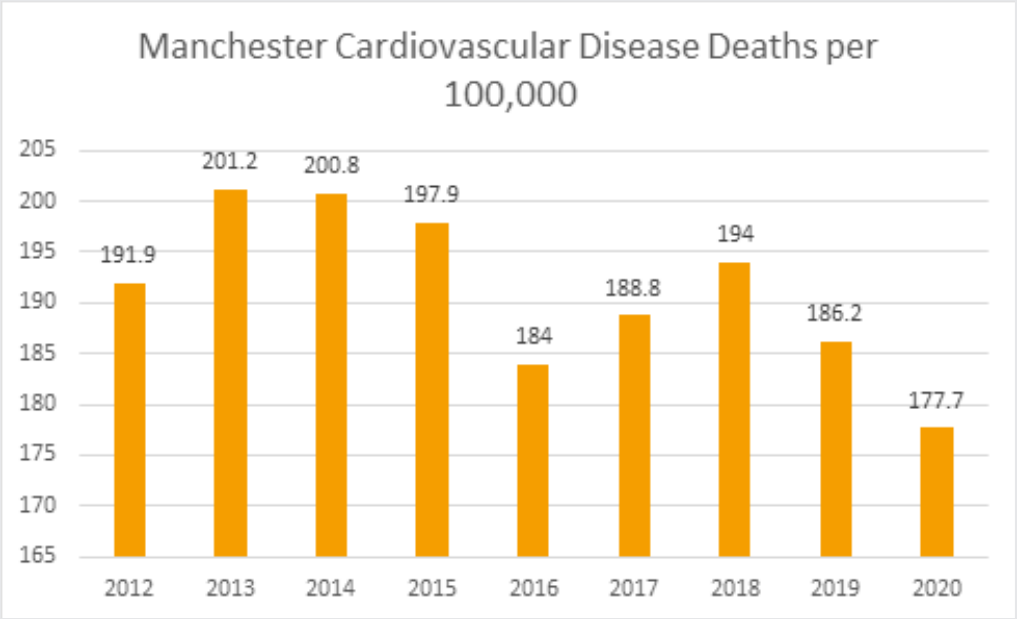
Nutrition-related Chronic Disease: Cardiovascular Disease

Cardiovascular disease is the leading cause of death in Manchester, the State of New Hampshire, and the country as a whole. However, the City of Manchester accounts for a disproportionate fraction of the state's deaths due to heart disease, with 12% of deaths occurring in Manchester while the city's residents represent only 9% of the state's population.[14]

The rate of deaths due to cardiovascular disease in Manchester was 177.7 per 100,000 in 2020, continuing a multi-year decline in rates starting in 2018 (Figure 10). The cardiovascular disease death rate for Manchester in 2020 was 17% lower than the 500 Cities average (211.5 deaths/100,000), but notably 30% higher than Nashua (131.4 deaths/100,000).

[14] *https://www.manchesternh.gov/Departments/Health/Services/Chronic-Disease-Prevention#:~:text=Heart%20disease%20is%20the%20number,the%20State%20of%20New%20Hampshire*

Figure 10. Cardiovascular Disease Deaths per 100,000 May be Decreasing in Manchester



Source: City Health Dashboard

WHAT DO MANCHESTER RESIDENTS THINK?

More than 91% of Manchester residents survey said that it is “very important” for Manchester to take action to increase access to healthy, affordable food sources, including addressing health conditions such as obesity and diabetes, lack of access to fresh fruits and vegetables, and food deserts. More than one in ten residents (11.3%) reported having trouble getting access to food/meals in the past 3 years.

Key stakeholders pointed to the Organization for Refugee and Immigrant Success (ORIS) as a key leader in addressing healthy food access in Manchester. Though food has not historically been a priority for funding in the city, they noted that the COVID-19 pandemic raised awareness of food insecurity and brought funding and other resources to address this issue. Several stakeholders pointed to Manchester’s West Side as a food desert, lacking both full-service grocery stores and adequate transportation. Some suggested a model of subsidized grocery stores to help encourage development in targeted neighborhoods.

Community Spotlight

Manchester Food Collaborative

Manchester has high rates of food and nutrition insecurity with over 46% of Manchester students in grades K-12 qualifying for free and reduced school meals. As a result of the pandemic, Manchester community organizations led by Families in Transition and Dartmouth Health created the Manchester Food Collaborative (MFC) to address food and nutrition insecurity when people were losing income and feeling unsafe to go to the grocery store. The pandemic highlighted the need for collaboration around food and nutrition supports in Manchester. MFC was able to address the immediate needs of pantries, because of increased demand, through small grants provided by funds from Dartmouth Health. These funds have also provided staff time for NH Hunger Solutions to coordinate and facilitate MFC and co-create a strategic plan to address food and nutrition insecurity in Manchester.

MFC's Vision: We envision a future where all of Manchester can access nutritious, affordable, culturally relevant, and sustainable food in a dignified way. A future where people's needs are met. A future where communities and a resilient local food system provide a strong foundation that allows everyone to thrive.

MFC's Mission: To increase food security through sharing resources, expanding equitable access, providing nutrition education, reducing food waste, eliminating stigma, and empowering communities to shape our food system. MFC meets the 4th Tuesday of the month 10:30am-12pm.

To learn more and get involved visit: https://nhhungersolutions.org/

Fresh Choice Manchester, The City of Manchester Healthy Corners Program

The purpose of the Healthy Corners Program is to expand healthy food access in Manchester with a focus on areas known as "food deserts" where the nearest grocery store is more than a half mile away. We will work with corner and convenience stores throughout the City that accept Supplemental Nutrition Assistance Program (SNAP) benefits, thereby helping low-income families afford healthier food. In partnership with Organization for Refugee and Immigrant Success (ORIS) and Fresh Start Farms who will serve as the Food Hub, the program will provide:

- Fresh produce and healthy snacks at wholesale prices (with an emphasis on culturally appropriate foods);
- Training and technical assistance to storeowners;
- Marketing and merchandising support;
- Infrastructure, equipment, and produce displays; and
- Nutrition education for shoppers.

We are currently working with six pilot stores with food deliveries beginning Summer 2022.

For more information, please contact the Manchester Health Department at 603-624-6466.

HEALTHY HOMES AND NEIGHBORHOODS

PRIORITY: IMPROVE ACCESS TO HEALTHY, AFFORDABLE HOUSING

"Overall, the research supports the critical link between stable, decent, and affordable housing and positive health outcomes," according to the Center for Housing Policy in Washington, DC.[1] Their research identifies numerous pathways through which quality, affordable housing can have a positive impact on health. For example, affordable housing makes more household financial resources available to pay for healthy food and health care services. Stable housing results in fewer household moves and related stressors that take a significant toll on mental health.

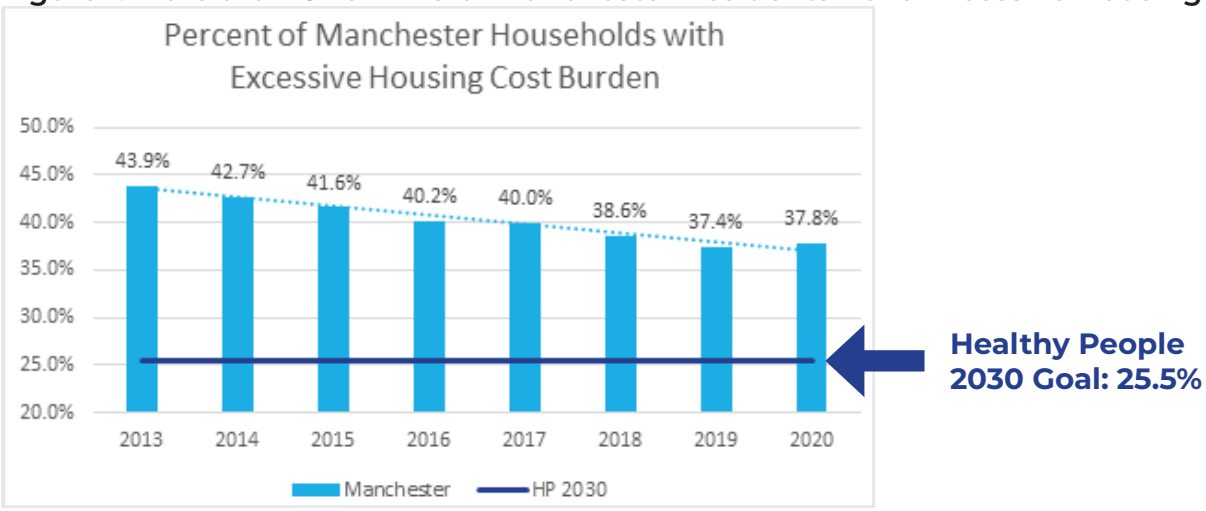
Overcrowding, such as "doubling up" two families in a housing unit intended for one family, increases the spread of respiratory illnesses like COVID-19 and influenza. Poorly maintained housing can expose residents to toxins such as lead or environmental allergens, including mold and pests.

Excessive Housing Cost Burden

Families with excessive housing costs have fewer resources to support healthy living and are often forced to make difficult choices between paying for rent and utilities or healthcare and healthy food. The US Department of Housing and Urban Development (HUD) defines excessive housing cost burden as spending more than 30% of a household's combined income on housing.[2] As housing prices climb across the country, this threshold is becoming increasingly more difficult for many families to achieve.

While Figure 1 shows a decline in the proportion of households with excessive housing cost burden in Manchester, the rate remains well above the Healthy People 2030 goal of 25.5%. In addition, 2020 5-year estimates from the US Census Bureau indicate that the percent of Manchester renters whose gross rent payments exceed 30% of their income topped 50% in 2020. Rates of excessive housing cost burden were similar, though somewhat lower, in Nashua and the 500 Cities in 2020 (34.9% and 34.2%, respectively).

Figure 1. More than One-Third of Manchester Residents Have Excessive Housing Cost



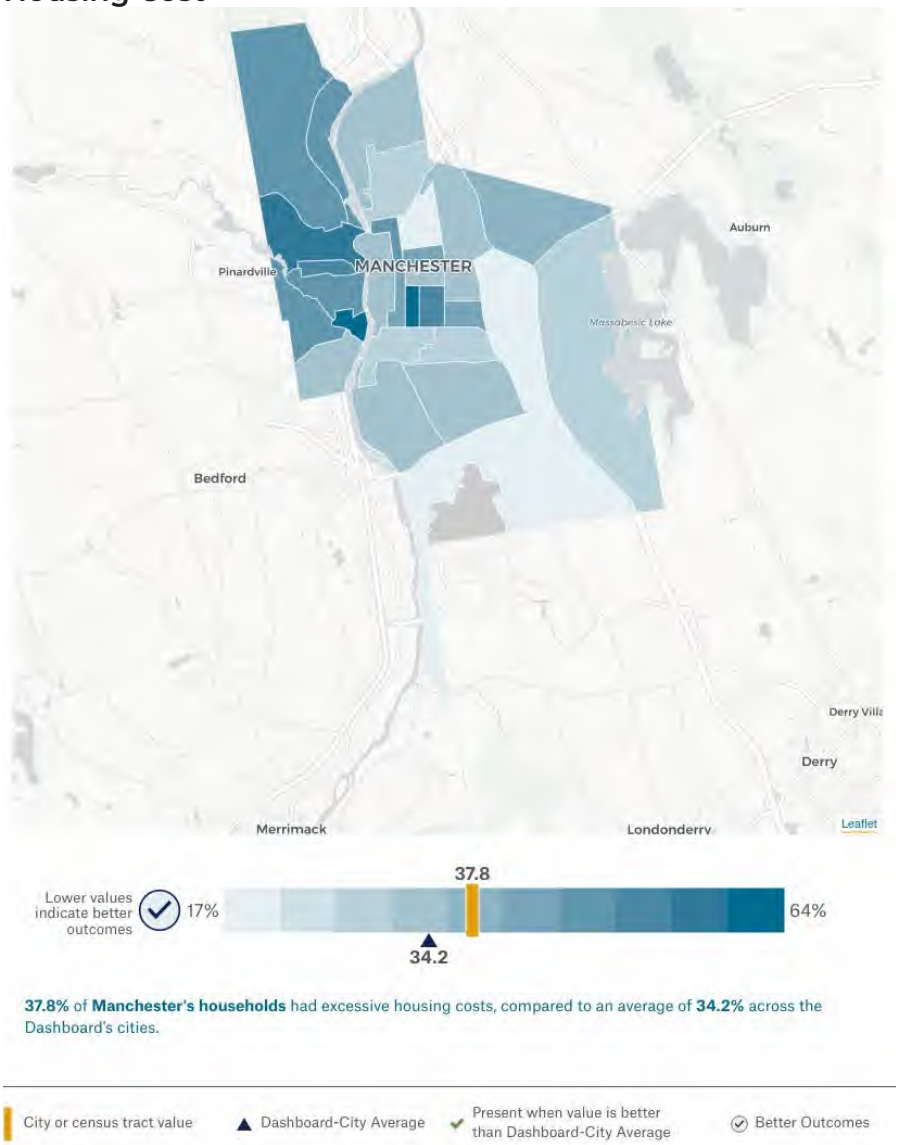
Source: City Health Dashboard

[1] *https://nhc.org/wp-content/uploads/2017/03/The-Impacts-of-Affordable-Housing-on-Health-A-Research-Summary.pdf*

[2] *https://www.huduser.gov/portal/pdredge/pdr_edge_featd_article_092214.html*

Figure 2 illustrates the variability in excessive housing cost by neighborhood in Manchester, with the highest rates seen in the center city and west side. More than 60% of residents living in census tract 15 have excessive housing cost, while in three census tracts—2.02, 6 and 20—between 50% and 60% of residents have excessive housing costs.

Figure 2. More than Half of Residents in Some Center-City Neighborhoods Have Excessive Housing Cost



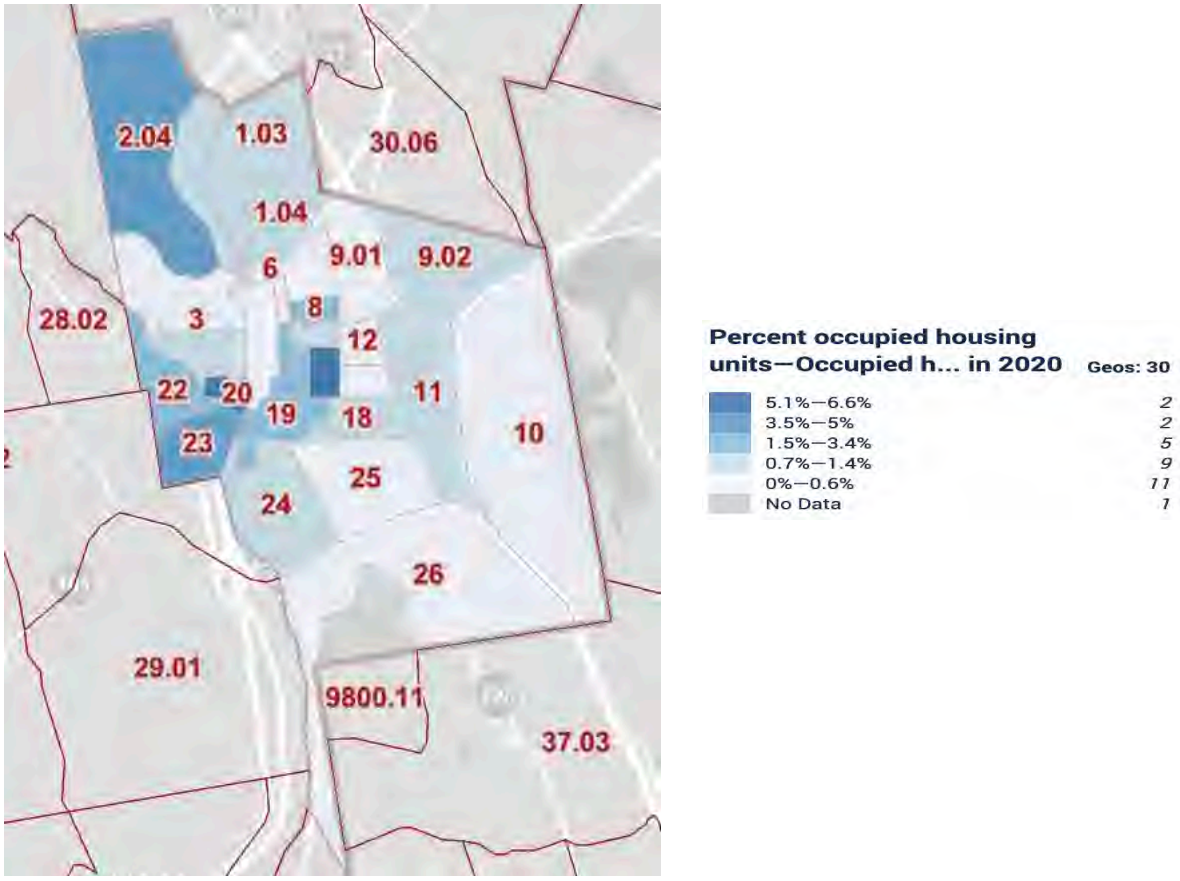
Source: City Health Dashboard

Overcrowded Housing

Living in overcrowded housing is associated with poor mental health, higher rates of asthma and infectious diseases, and overall physical stress. In children, a higher risk of childhood injuries and poor school performance can be added to this list of negative impacts.[3] The most common definition of overcrowding is based on the persons-per-room living in a housing unit. Crowding is defined as more than one person per habitable room (excluding bathrooms, balconies, porches, foyers, hallways, and half-rooms), while severe crowding is defined as more than 1.5 persons per habitable room.[4]

In 2020, 2.6% of Manchester housing units were crowded or severely crowded. Renter-occupied units were 7 times more likely to be crowded or severely crowded than owner-occupied units, at 4.9% and 0.7% of units, respectively. Figures 3 and 4 show the distribution of crowded and severely crowded housing in Manchester by census tract in 2020. Two census tracts—16 and 20—had the highest rates of crowding in Manchester, at 6.6% and 6.3%, respectively. Three census tracts—20, 15, and 2004--were in the highest fifth of severely crowding rates in 2020, at 6.5%, 4.2%, and 4.5%, respectively. Notably, census tract 20 topped both of these lists, with a combined total of 12.8% of housing units characterized as crowded or severely crowded in 2020.

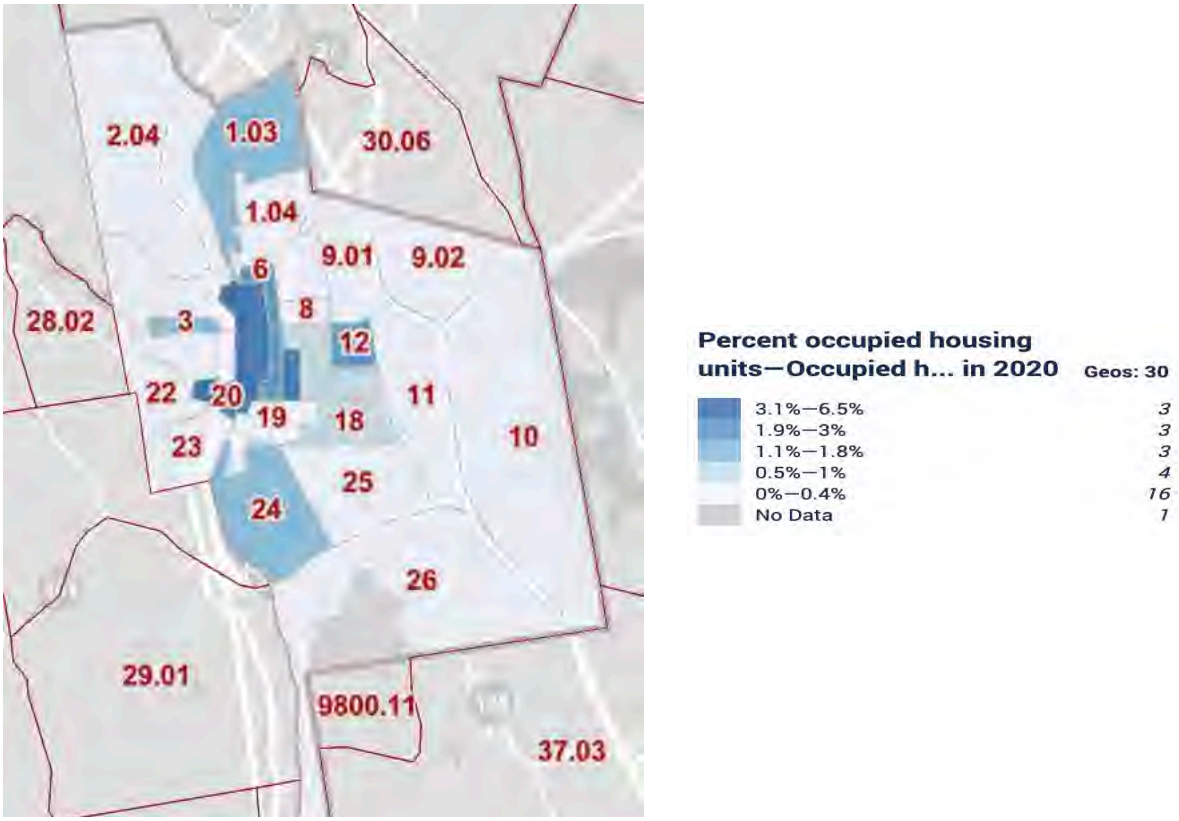
Figure 3. Center-City, West Side Residents More Likely to Live in Crowded Housing Units



Source: US Census Bureau

[3] *Inglis D. J. (2015). Crowding as a possible factor for health outcomes in children. American journal of public health, 105(2), e1–e2. https://doi.org/10.2105/AJPH.2014.302458*
[4] *WHO Housing and Health Guidelines. Geneva: World Health Organization; 2018. Table 3.1, Measures of crowding. Available from: https://www.ncbi.nlm.nih.gov/books/NBK535289/table/ch3.tab2/*

Figure 4. Severely Crowded Housing Concentrated in Manchester's Center City



Source: US Census Bureau

Credit Insecurity

In general, people who own their homes have better physical and mental health outcomes than those who rent.[5] For the vast majority of individuals, buying a home means borrowing money from a mortgage lender. Credit insecurity can be a critical barrier to borrowing, resulting in lower buying power and higher interest rates. The City Health Dashboard recently started reporting the Credit Insecurity Index, which "reflects the proportion of local residents who have limited access to credit, either because they have no credit history or have negative credit outcomes."[6] The Index is a community-based measure, with a higher score indicating that the community is more credit constrained.

In 2020, Manchester had a Credit Insecurity Index of 19.5, slightly lower than the average of 20.5 across the Dashboard's 500 cities. Concentrations of people with limited access to credit may also be indicative of communities that are under-resourced as a whole. These communities often have fewer opportunities for economic mobility and financial resilience.[7] Manchester's index was nearly 25% higher than Nashua's, indicating that Nashua residents, in general, have better access to credit than those in Manchester. Credit insecurity is highest in Manchester's center city neighborhoods, with the highest Index scores in census tracts 14, 19, 15, and 16, at 57.2, 49.1, 45.6, and 42.7, respectively (Figure 5).

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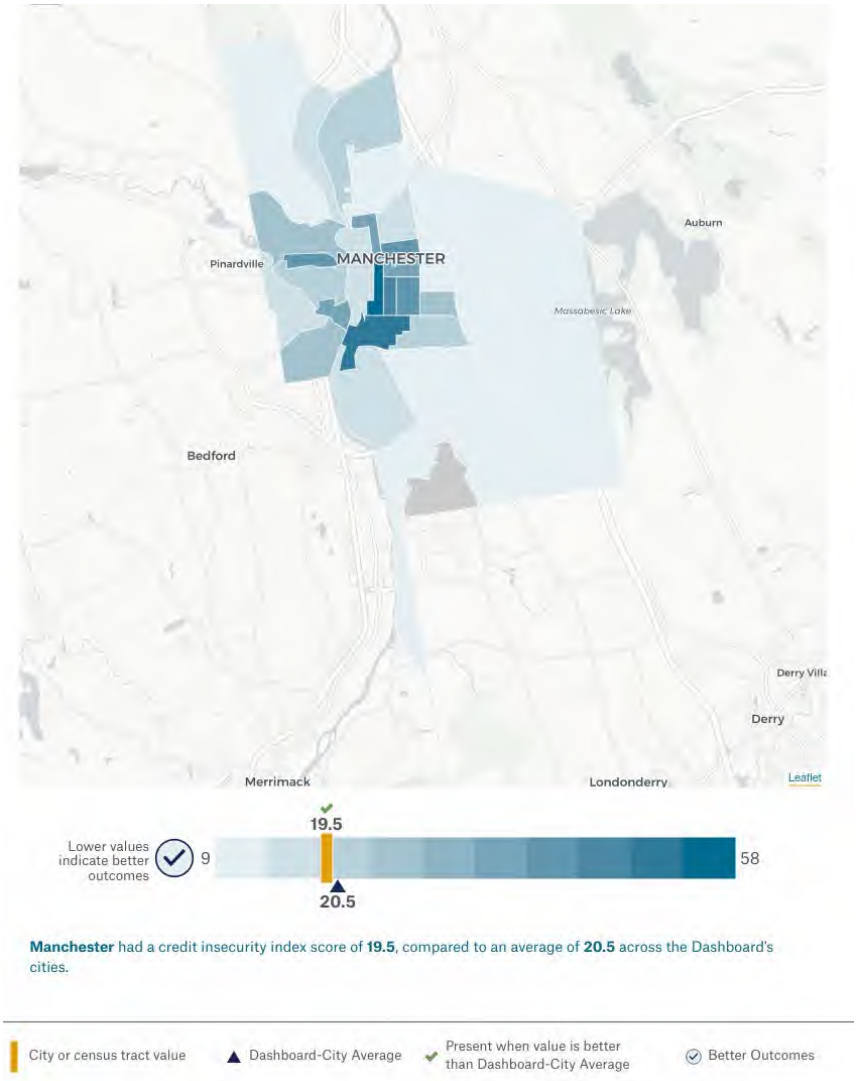
[5] *https://nhc.org/wp-content/uploads/2017/03/The-Impacts-of-Affordable-Housing-on-Health-A-Research-Summary.pdf*
[6] *https://www.cityhealthdashboard.com/metric/1608*
[7] *https://www.newyorkfed.org/outreach-and-education/community-development/unequal-access-to-credit-hidden-impact-credit-constraints*

Figure 5. Many Center-City Residents Experience Credit Insecurity



Source: City Health Dashboard

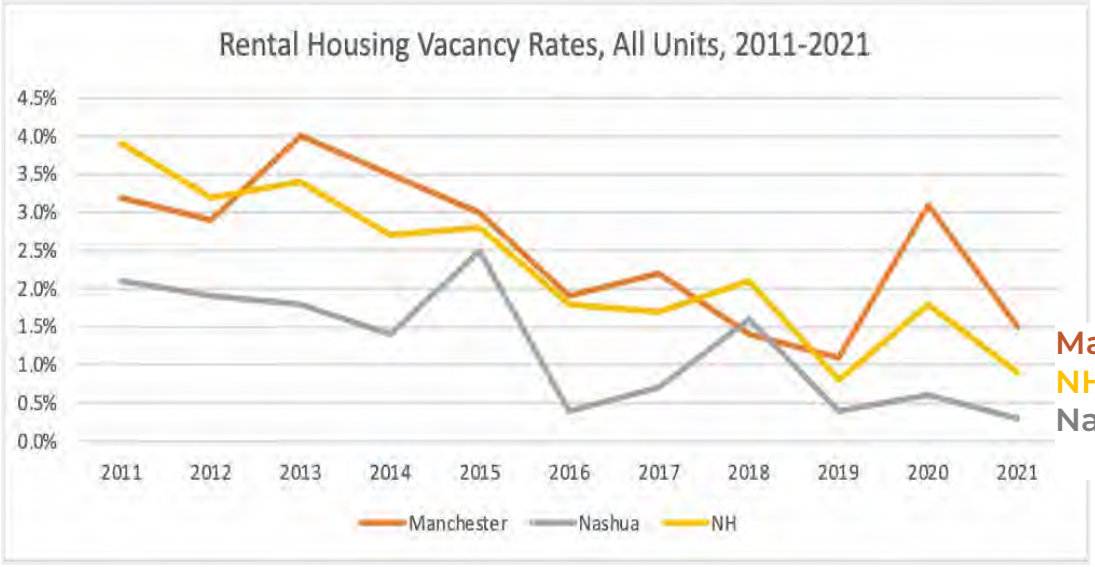
Rental Vacancy Rate and Cost

The rental vacancy rate is the fraction of homes for rent that are not occupied. In a "balanced" rental market, the vacancy rate is approximately 5.0%, according to NH Housing.[8] In a limited rental market with few affordable vacancies, low-income households may be forced to rent substandard housing, such as that with high lead risk, mold, or pests. A low rental vacancy rate can also lead to housing instability, as families face excessive housing costs or overcrowding.[9]

The proportion of rental units available for rent dropped by more than 50% in Manchester during the past decade, from 3.2% in 2011 to 1.5% in 2021 (Figure 6). During the same period, vacancy rates across the state dropped by more than 85%, from 3.9% to 0.9%. In 2021, the rental housing vacancy rate was approximately 50% higher in Manchester than in the State, and five times higher than in Nashua.

[8] *https://www.nhhfa.org/wp-content/uploads/2021/07/NH-Housing-Rental-Survey-Report-2021.pdf*
[9] *https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability*

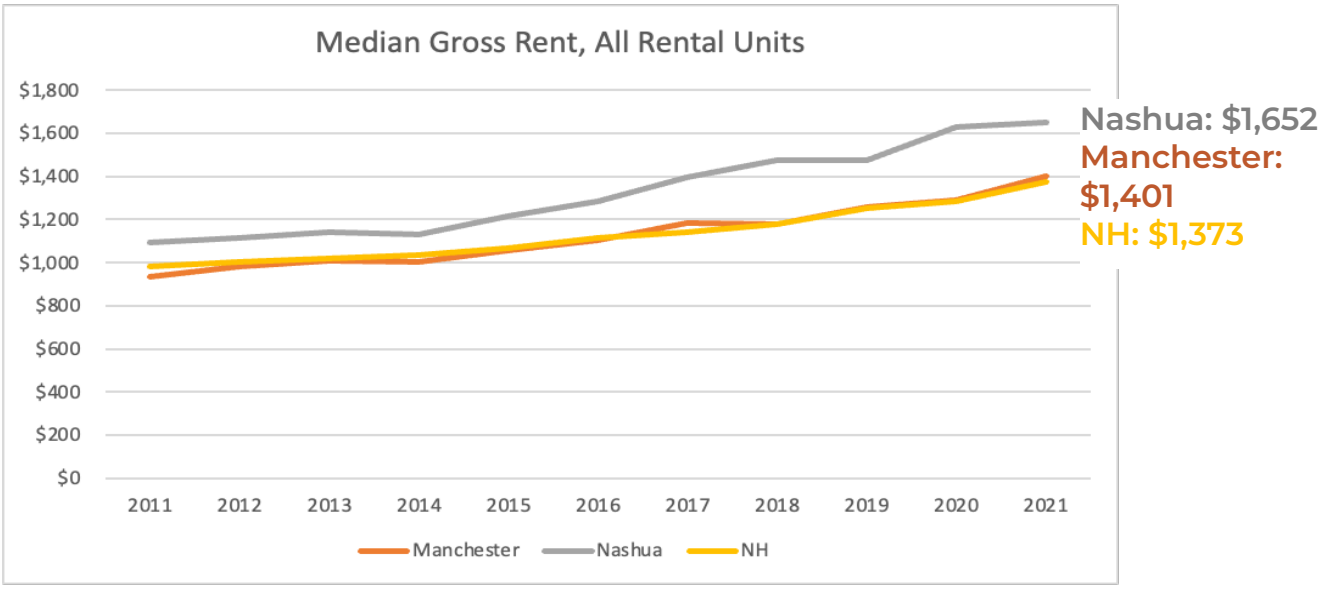
Figure 6. Rental Market Far from Ideal in Manchester



Source: NH Housing

At the same time vacancy rates have dropped across the state, median rent costs have risen (Figure 7). In both Manchester and Nashua, rent prices increased by 50% between 2011 and 2021, from $935/month to $1,401/month in Manchester and from $1,095/month to $1,652/month in Nashua. In contrast, the average monthly rent was $1,373 in NH, during that same year.

Figure 7. Rental Costs up 50% in Last Decade



Source: NH Housing

Subsidized Housing

In a rental market with low vacancy and high cost, subsidized housing assistance can make a critical difference between finding a stable, healthy home and housing instability. Unfortunately, as of February 2020, the waiting list for housing cost vouchers was more than six years in Manchester, according to the Manchester Housing and Redevelopment Authority (MHRA).[10] When families do receive Section 8 Housing Vouchers, their options may be limited as New Hampshire law permits landlords to consider income source when determining whether to rent a unit to a particular family.

MHRA prioritizes Veterans and their families, people with disabilities, and families who are currently considered homeless and unsheltered for housing assistance.

Housing Stock with Potential Lead Risk

In a market with low available housing and high rental costs, low-income families may be forced to accept low quality housing as an alternative to homelessness. Oftentimes, this means older, poorly maintained homes with a higher risk of lead exposure.

According to the CDC, there is no safe blood lead level for children.[11] Children are most likely to be exposed to lead in older housing with lead-based paint. Lead can permanently damage children's kidneys and brains, resulting in slowed development, behavior problems, and poor academic achievement. At high levels, lead poisoning can result in coma, seizures, and death.[12]

City Health Dashboard reports on two metrics correlated with the risk for elevated blood lead levels in children: the percent of housing stock with potential lead risk and the lead exposure risk index.

The "housing with potential lead risk" metric takes into account the relative proportions of older housing units—those most likely to have lead paint—and newer units. Housing units are categorized by five time periods, and then counts of those built within each period are weighted by the likelihood of lead exposure in housing during that era.[13]

Figure 8 shows that nearly one-third of Manchester's housing stock has a high potential lead risk. This proportion was 49% higher than in Nashua and 73% higher than in the Dashboard's 500 Cities in 2020. While the proportion of Manchester housing stock with high lead risk declined by 12% between 2013 and 2020, more needs to be done to ensure Manchester children have safe places to live.

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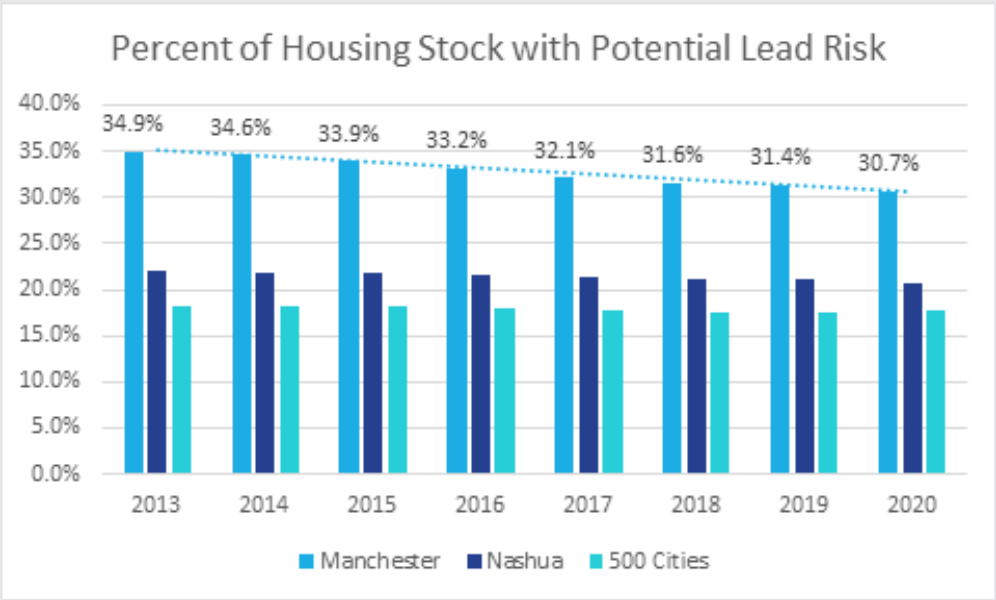
[10] *https://manchesterhousing.org/waiting-lists/*
[11] *https://nchh.org/resource-library/fact-sheet_childhood-lead-poisoning_what-you-should-know_english.pdf*
[12] *https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-blood-lead-levels-children-aged-1-5-years-eh-04*
[13] *https://www.cityhealthdashboard.com/metric/46*

Figure 8: One-third of Manchester Housing Stock has High Lead Risk



Manchester: 30.7%
Nashua: 20.6%
500 Cities: 17.7%

Source: City Health Dashboard

The proportion of housing stock with potential lead risk varies widely by census tract in Manchester, from a low of 5.9% to a high of 58.5%--a 10-fold difference. The highest concentrations of housing with lead risk are in Manchester's center-city neighborhoods, with four east-side census tracts and 2 west-side census tracts having levels above 50%.

Figure 9: Housing with Potential Lead Risk Concentrated in Center-City

Source: City Health Dashboard

The “lead exposure risk index” score is calculated by combining the housing with potential lead risk information with the percent of people who live in poverty in the city or census tract, since both housing age and poverty are major predictors of lead exposure.[14] Scores range from 0 (lowest risk) to 10 (highest risk).

As expected, the lead exposure risk index scores follow the same pattern as housing with potential lead risk, with the highest scores seen in Manchester’s center-city census tracts (Figure 10). In 2020, Manchester overall had a lead exposure risk index of 8, compared with 5 in Nashua and 5.5 in the Dashboard’s 500 cities. Six center-city census tracts—3, 8, 13, 14, 15, and 20—received scores of 10, indicating the “highest risk” of lead exposure.[15]

Figure 10. Center City Neighborhoods Receive “Highest Score” for Lead Exposure Risk

Source: City Health Dashboard

Homelessness

Homelessness is a complex social problem with a variety of underlying economic and social factors such as poverty, lack of affordable housing, uncertain physical and mental health, addictions, and community and family breakdown. It may be people living unsheltered, “doubling up” with family and friends, or moving back and forth between shelters and transitional housing. It takes on many forms and is related to a number of structural, individual, and systemic factors. There is a well-established link between homelessness and health, with poor health increasing the risk of homelessness, and homelessness exacerbating existing health conditions and increasing the risk of exposure to infectious disease.[16]

[14] *https://www.cityhealthdashboard.com/metric/46*
[15] *https://www.cityhealthdashboard.com/metric/46*
[16] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3766254/*

In New Hampshire, like elsewhere, the COVID-19 pandemic compounded this problem. As the number of shelter spaces decreased due to social distancing requirements, the number of unsheltered homeless increased.[17] This was particularly evident in Manchester, as officials repurposed old buildings to increase available beds and found creative ways to improve access to basic hygiene with handwashing stations and portable bathrooms at existing encampments.

Between 2018 and 2020, the number of homeless individuals increased by 16% in New Hampshire, from 1,450 to 1,675, according to point-in-time counts. Unsheltered individuals accounted for 86% of this increase. In 2020, nearly 40% of homeless individuals in the state fell within the Manchester Continuum of Care (CoC), while only 17% fell within the Greater Nashua Continuum of Care (Table 1). The proportions of individuals with chronic homelessness—who "utilize the costliest crisis services, including emergency rooms, jails, and prisons"—were similar, with 36% of chronic homeless within the state residing in Manchester's CoC, compared with only 13% living in Greater Nashua's CoC.[18] In 2020, 40% of the State's unsheltered homeless also lived in Manchester, compared with only 3% of that population living in Greater Nashua.

Table 1. Manchester Home to a Disproportionate Number of State's Homeless

Continuum of Care (CoC) Region	Overall Homeless	Chronic Homeless	Unsheltered
Manchester CoC	1,739	211	164
Greater Nashua CoC	778	78	14
Balance of NH CoC	2,139	308	233
Statewide Total	**4,451**	**580**	**411**

Source: NH Coalition to End Homelessness

Significant proportions of New Hampshire's homeless families also call Manchester their residence, with 33% of people in homeless families living in Manchester and 19% living in Greater Nashua (Table 2). A lower proportion, one-in-four, of the state's homeless students live in Manchester, compared with 16% living in Nashua and the vast majority, 60%, living outside these two urban areas. Importantly, student homelessness decreased by nearly 20% in New Hampshire between the 2018-19 and 2019-20 school years. In Manchester, the number of homeless students decreased by 15% during that period, while the number increased slightly, by 5%, in Greater Nashua. As of April 25, 2022, the count of homeless students in the Manchester School District was 706, comprising 297 (42%) elementary school students, 183 (26%) middle school students, and 226 (32%) high school students.

[17] *https://www.nhceh.org/wp-content/uploads/2021/03/2020-State-of-Homelessness-in-NH-Report-Online-Final-compressed-1.pdf*
[18] *https://www.nhceh.org/wp-content/uploads/2021/03/2020-State-of-Homelessness-in-NH-Report-Online-Final-compressed-1.pdf*

Table 2. Majority of NH's Homeless Students Live Outside Urban Areas

Continuum of Care (CoC) Region	Family Homelessness	Student Homelessness
Manchester CoC	516	797
Greater Nashua CoC	304	501
Balance of NH CoC	758	1,918
Statewide Total	**1,577**	**3,216**

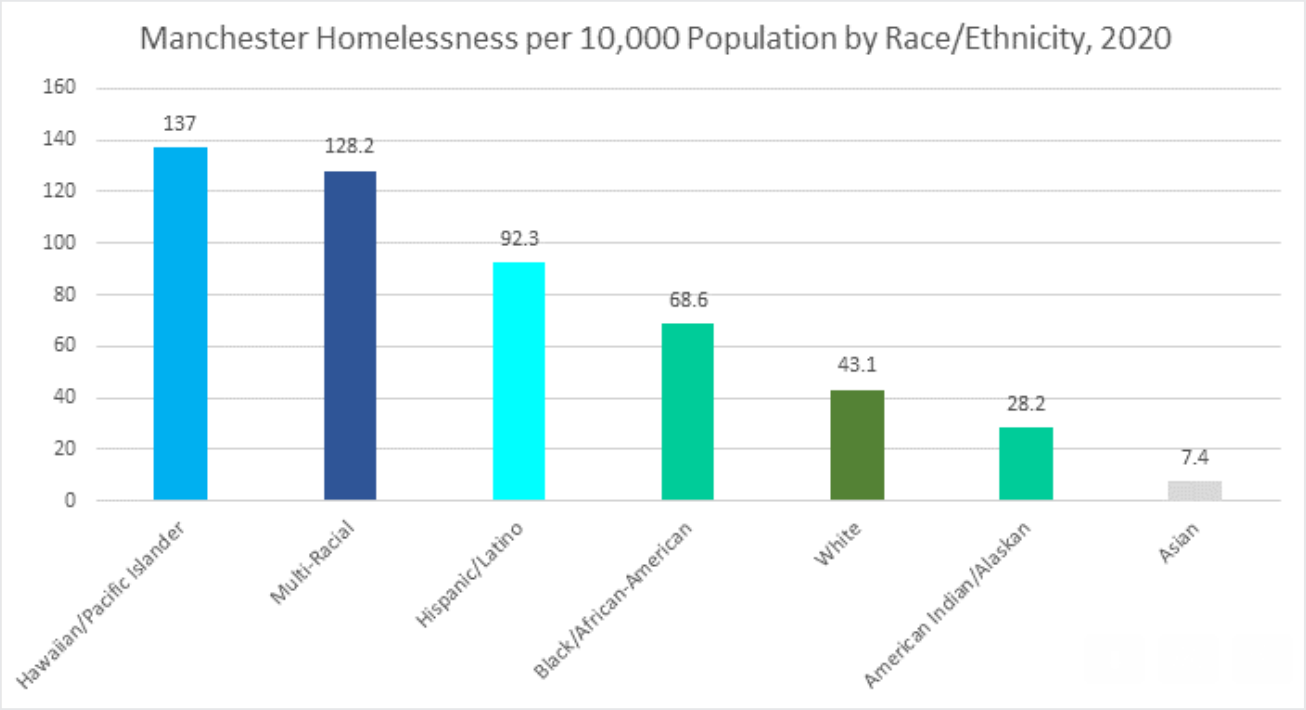
Source: NH Coalition to End Homelessness

In 2020, the State of New Hampshire counted 348 homeless veterans, of whom the vast majority were living in transitional housing where they were connected to critical support services.[19] Approximately one-third of these veterans were living in Manchester.

Figure 11 shows a comparison of homelessness rates by racial and ethnic groups in Manchester in 2020. As with the State of New Hampshire as a whole, non-Hispanic Whites and Asian-Americans have the lowest per capita rates of homelessness. Homelessness rates are highest among Native Hawaiian/Pacific Islanders in Manchester, New Hampshire, and across the US. In addition, those who identify as multi-racial, Hispanic-Latino, and Black/African American have higher rates of homelessness than Whites and Asian-Americans. Structural and economic inequities often mean that Hispanic-Latino and Black/African American populations are disproportionally represented in these figures as compared to the rest of the state.

[19] *https://www.nhceh.org/wp-content/uploads/2021/03/2020-State-of-Homelessness-in-NH-Report-Online-Final-compressed-1.pdf*

Figure 11. Manchester Homelessness by Race/Ethnicity



WHAT DO MANCHESTER RESIDENTS THINK?

Housing was the #1 priority for Manchester residents surveyed, with 93.4% agreeing that it was "very important" for Manchester to increase access to quality, affordable housing, identifying housing conditions such as crowding, environmental concerns such as lead exposure, rental costs for housing, and lack of supportive/transitional housing. Just over 14% of residents reported having trouble getting access to programs to help with paying for housing and utilities in the past 3 years.

Many stakeholders interviewed identified homelessness as a top priority in Manchester. They pointed out that homelessness places a large strain on the city's resources and projects a negative image of the city. Several stakeholders looked to other cities and states leveraging public-private partnerships for housing development as a promising practice that should be pursued in Manchester. Others suggested that a coordinated plan was needed to bring community resources together to work toward a common vision.

Community Spotlights

Families in Transition

Families in Transition is committed to preventing and breaking the cycle of homelessness, offering programs and services to assist families and individuals through integrated case management, affordable housing, emergency homelessness services, food programs, and substance use treatment. As a state-wide 501c3 non-profit, Families in Transition has headquarters and operations in Manchester, NH, and locations in Concord, Dover, and Wolfeboro.

The organization provides a continuum of housing and emergency shelter in Manchester, including the State's largest adult emergency shelter, a family emergency shelter, and over 200 affordable and permanent supportive housing units. Utilizing a housing-first approach to assist people experiencing homelessness, they use a proven model pairing housing with case management and other supportive services. A recently completed project in Manchester features 11 apartment units offering permanent supportive housing prioritized for individuals utilizing emergency shelter services.

To learn more or get involved, visit www.fitnh.org or call (603) 641-9441

Neighborworks Southern New Hampshire

NeighborWorks Southern New Hampshire impacts positive health by offering quality, well-maintained, safe housing that is affordable to income level and also providing education and counseling services to help individuals/households understand the homeownership process and prepare for home purchase in stronger financial position so they are better able to maintain and retain a home. Neighborworks also offers financial education and counseling services for those seeking to move out of a pattern of financial instability and struggle in their daily lives.

Neighborworks has a total of 267 affordable rental apartments in Manchester, and deliver unbiased programs and services relative to homeownership and financial education that help participants adopt practices that will lead to improved financial health and sustained financial stability. For more information about renting an apartment or registering for a homeownership or financial confidence workshop, visit www.nwsnh.org.

TRAUMA AND HEALTH OUTCOMES

PRIORITY: PREVENT AND ADDRESS TRAUMA

Trauma has biological effects, causing the body to produce adrenaline and cortisol—the "fight or flight" neurochemicals. Over time, repeated trauma can actually change brain chemistry and result in the development of anxiety and depression, as well as chronic stress-related illness, such as hypertension, diabetes and cancer. People who are repeatedly exposed to trauma often develop unhealthy coping mechanisms, such as overeating, alcohol misuse, and drug and tobacco use.

Persistent trauma also impacts an individual's ability to engage with healthcare. People under chronic stress often miss medical appointments and may lack trust in the healthcare system. Individuals living in poverty are more likely to experience multiple forms of trauma, further eroding their ability to prioritize their health.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[1] Trauma is often categorized into three main types: acute (a single incident), chronic (prolonged and repeated trauma), and complex (exposure to multiple traumatic events).

Poverty

"Beginning before birth and continuing throughout an individual's life, poverty can significantly impact health and health outcomes," according to a position paper by the American Academy of Family Physicians.[2] People living in impoverished neighborhoods are at increased risk of mental illness and chronic disease and have overall higher mortality and lower life expectancy.[3]

People living in poverty are more likely than others to experience multiple forms of trauma. However, poverty can be a form of trauma in and of itself, particularly among children.[4] Children who are born into poverty are more likely than others to be poor as adults, drop out of high school, and become teen parents.[5]

Figure 1 shows that child poverty is on a slow decline in Manchester, with rates decreasing by 11% between 2013 and 2019. However, child poverty remains high in Manchester, at nearly 20% in 2019, compared with 12% in Nashua and 19% across the 500 Cities. Child poverty is also declining at a higher rate in Nashua, dropping by 25% between 2013 and 2019.

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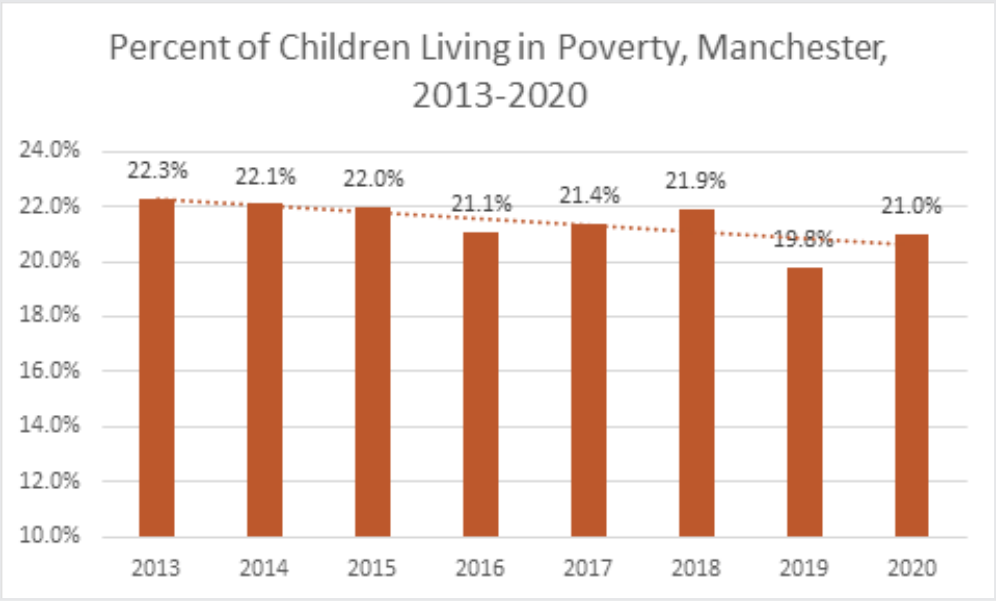
[1] *https://www.samhsa.gov/trauma-violence*
[2] *https://www.aafp.org/about/policies/all/poverty-health.html*
[3] *https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty*
[4] *https://www.nctsn.org/sites/default/files/resources/resource-guide/understanding_impact_trauma_urban_poverty_family_systems.pdf*
[5] *https://www.urban.org/sites/default/files/publication/32926/412126-childhood-poverty-persistence-facts-and-consequences.pdf*

Figure 1. Slow Decline in Child Poverty in Manchester



Source: City Health Dashboard

While child poverty rates are dropping in Manchester as a whole, this is not the case in many neighborhoods (Table 1). In fact, child poverty increased in 11 of the City's 29 census tracts between 2013 and 2020.

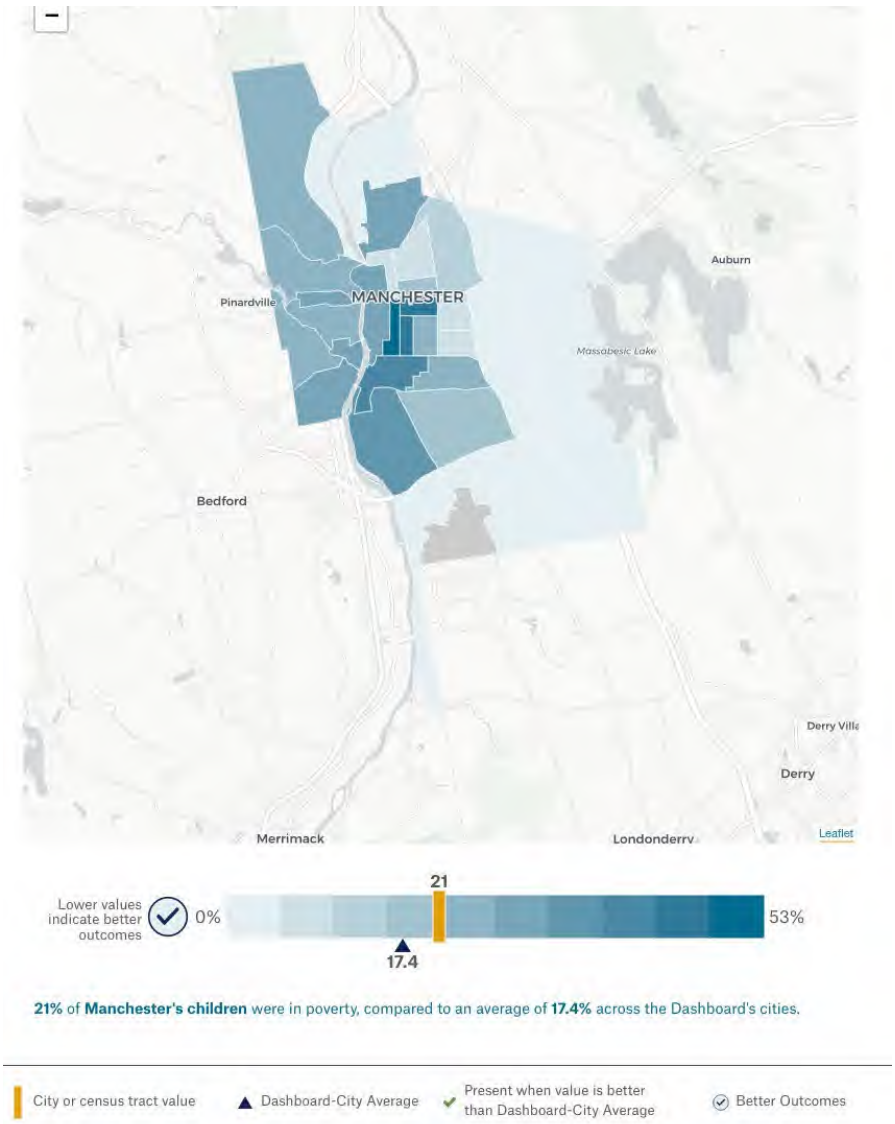
Table 1. Child Poverty on the Rise in 11 Census Tracts

Census Tract	2013	2020
2.04	17.0%	22.8%
8	6.7%	16.5%
9.01	9.8%	12.6
10	0.0%	1.7%
13	32.2%	43.6%
14	33.1%	52.1%
18	20.4%	26.3%
19	37.1%	39.5%
22	19.7%	22.5%
23	1.0%	26.8%
24	18.1%	36.9%

Source: City Health Dashboard

Figure 2 shows that the highest rates of child poverty were concentrated in Manchester's center-city neighborhoods in 2020, with more than half of the children in census tract 14 (52.1%) living in families with incomes below the federal poverty level.

Figure 2: Child Poverty Concentrated in Manchester's Center City (2020)



Source: City Health Dashboard

Geographic areas in which 20% or more of the population lives in poverty are considered high poverty areas. Persistent poverty exists when a community experiences high poverty for 30 years or more.[6] Several of Manchester's center-city neighborhoods meet this definition of persistent poverty (Table 2), putting residents at risk of even greater morbidity and mortality compared with areas without sustained high poverty.[7]

[6] *https://www.transit.dot.gov/02-what-%E2%80%9Carea-persistent-poverty%E2%80%9D#:~:text=An%20area%20of%20persistent%20poverty,recent%20Small%20Area%20Income%20and*
[7] *https://aacrjournals.org/cebp/article/29/10/1949/124425/Persistent-Poverty-and-Cancer-Mortality-Rates-An*

Table 2. Residents of Manchester's Center City Experiencing Persistent Poverty

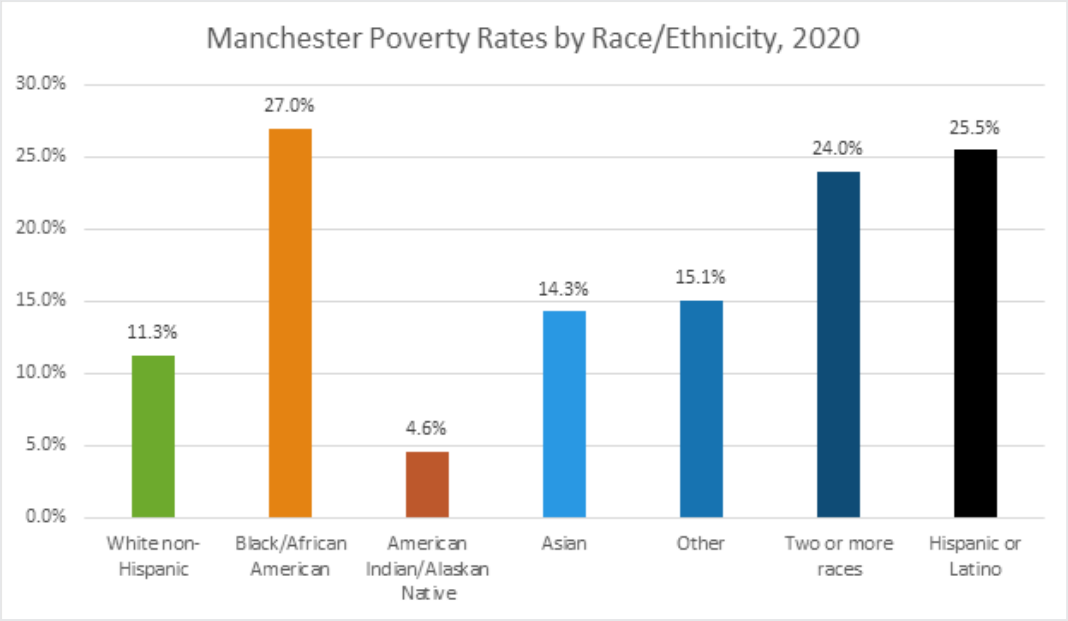
Manchester census tracts with 20% or more residents living in poverty, 1990-2020				
Census Tracts	1990 Census	2000 Census	2010 Census	2020 Census
14	X	X	X	X
2004	X	X	X	
6		X	X	
15		X	X	X
20		X	X	X
13			X	X
16			X	
3			X	
2.02				
21				
19				

Source: US Census Bureau

Note: The highlighted cells in yellow signify census tracts that are persistently impoverished.

Deep racial and ethnic disparities in poverty are related to social class stratification through mechanisms like societal disadvantage and discrimination. These disparities exist in poverty in Manchester, as in the rest of New Hampshire and the country as a whole. In 2020, American Indian/Alaskan Natives, non-Hispanic Whites, Asians, and "other" races had the lowest poverty rates in Manchester (Figure 3). Compared with non-Hispanic Whites, Black/African American residents were 2.4 times more likely to be living in poverty, multiracial residents were 2.1 times more likely, and Hispanic/Latino residents were 2.3 times more likely to be living in households with incomes below the federal poverty level. This disproportionate racial makeup in neighborhoods with high levels of poverty suggest that societal factors beyond income contribute to how poverty is "produced" both locally and nationally.[8]

Figure 3: Manchester's Black, Hispanic/Latino and Multi-Racial Residents are More Than Twice as Likely as Whites to Live in Poverty



Source: US Census Bureau

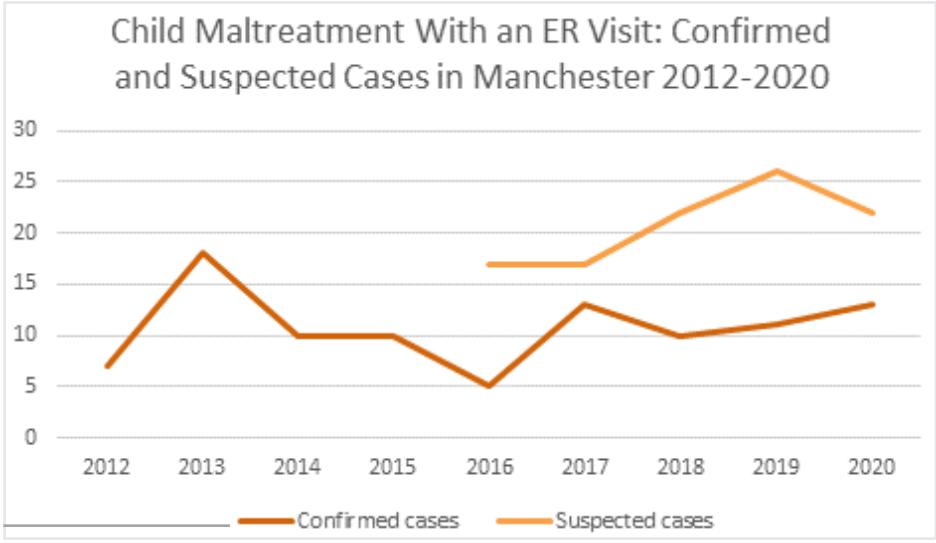
Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are traumatic events that occur in childhood that include exposure to violence, mental illness, and substance use, having a family member incarcerated, emotional or physical neglect, and divorce.[9] According to the CDC, 5 of the 10 leading causes of death in the US are linked to toxic stress associated with ACEs.[10] Adults with a history of ACEs are also at higher risk of mental illness and substance misuse.

[8] *Lin, Ann Chih, and David R. Harris. "The colors of poverty: Why racial & ethnic disparities persist." Ann Arbor 1001.48109 (2009): 43091.*
[9] *https://acestoohigh.com/got-your-ace-score/*
[10] *https://www.cdc.gov/vitalsigns/aces/index.*html

The Pair of ACEs tree model was designed to specifically articulate the difference between addressing individual trauma and community/neighborhood level trauma.[11] Adverse childhood experiences are stressors that can increase a person's risk of developing heart disease, chronic depression, obesity, and substance misuse disorders. ACEs are often chronic but can be acute. They include events such as parental divorce, incarceration, physical and emotional neglect, substance abuse, and domestic violence. ACEs are portrayed as the part of the tree that is above ground—its leaves, stems, and trunk. These are not the only kind of adverse experiences that can affect outcomes. There are also adverse community environments, which represent the roots and soil in which our 'tree' is planted. When the tree is planted in nutrient poor soil steeped in systemic inequities such as discrimination, violence, poor housing quality, and lack of opportunity, it creates poorer community resilience and increases ACEs for the community. It is crucial to address both individual trauma as well as community level trauma to prevent a community from repeating the negative cycles of ever worsening adversity.

Figure 4. Child Maltreatment Cases in Manchester



[11] *https://publichealth.gwu.edu/sites/default/files/downloads/Redstone-Center/Resource%20Description_Pair%20of%20ACEs%20Tree.pdf*

[12] *https://www.cdc.gov/brfss/index.html*

Cases and suspected cases of child maltreatment in Manchester from 2012-2020 are shown in the figure above. This data only includes children that visited the emergency department or were hospitalized due to maltreatment. This data does not capture all cases of maltreatment, and does not capture all injuries. These data show a steady incidence of confirmed child maltreatment in Manchester with an average of 10 confirmed cases and 20 suspected cases a year.

BRFSS ACEs and Mental Health

The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collects state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.[12]

The most recently available BRFSS data for Manchester regarding ACEs indicates that, from 2015 to 2016, 8.9% of Manchester adults (who responded to the BRFSS survey) reported being hit, beat, kicked, or physically hurt by a parent or adult in the home more than once when they were under the age of 18, while 68% of respondents reported never being physically hurt by a parent or adult in their home. In addition, from 2015 to 2016, 12% of respondents reported that, on more than one occasion when they were under the age of 18, parents or adults in their home slapped, hit, kicked, punched, or beat each other up.

In Manchester, the Adverse Childhood Experiences Response Team (ACERT) is a partnership between the Police Department, YWCA-NH, and Amoskeag Health working collaboratively to provide assistance to families and their children who have had recent police involvement. ACERT has connected a total of 1,660 children and 887 families to services. Slightly over 35% of ACERT's referrals were Domestic Violence related, which is the most common incident type to which Manchester children are exposed. So far in 2022, ACERT has connected 88 families with 140 children to support and services.

Additionally, BRFSS collects data on mental health, specifically poor mental health days. BRFSS describes poor mental health days as a quality of life measure which documents the average number of mentally unhealthy days reported in the past 30 days (age-adjusted).

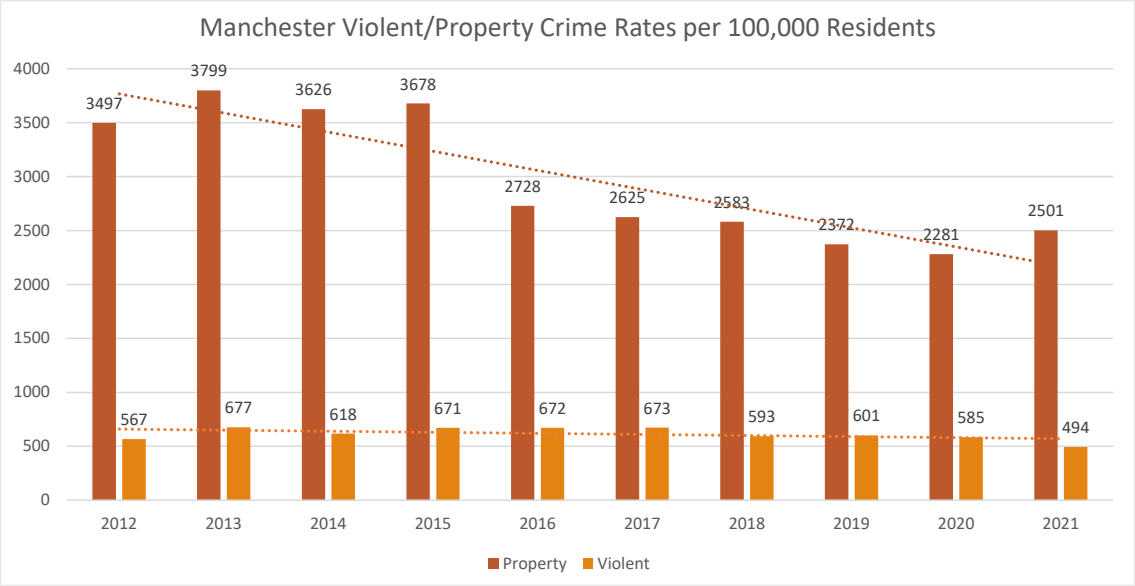
From 2014 to 2019, an average of 15% of Manchester residents reported experiencing 14 to 30 days of poor mental health over the past 30 days, 23% reported 1 to 13 days of poor mental health, and, on average, 59% of residents reported having no poor mental health days within the past 30 days.

ACEs: Community Crime and Violence

The impact of community violence extends beyond the immediate victims and perpetrators. Living in a high-crime neighborhood is a significant source of toxic stress, which has long-term effects on neural development resulting in poorer overall health and well-being.[13] Exposure to community violence is associated with a range of adverse health consequences, including increased risks of cancer, chronic lung disease, diabetes, hepatitis, gastrointestinal disorders, heart disease, hypertension, and stroke.[14]

Crimes are typically categorized as either violent crimes or property crimes. Violent crimes include murder, aggravated assault, robbery, and rape, while property crimes include those in which someone's property is stolen or destroyed without any threat of direct force against the victim.[15] The violent crime rate has been on the decline in Manchester since 2019, dropping nearly 18% between 2019 and 2021 (Figure 5). Figure 5 also shows a downward trend in the rate of property crimes in Manchester, though the past year saw a small uptick in property crimes from 2,281 per 100,000 population in 2020 to 2,501 in 2021. The overall crime rate in Manchester has been showing a slow but steady decline since 2016, according to the Manchester Police Department.

Figure 5. Manchester Violent Crime Rate Drops for Second Year in a Row

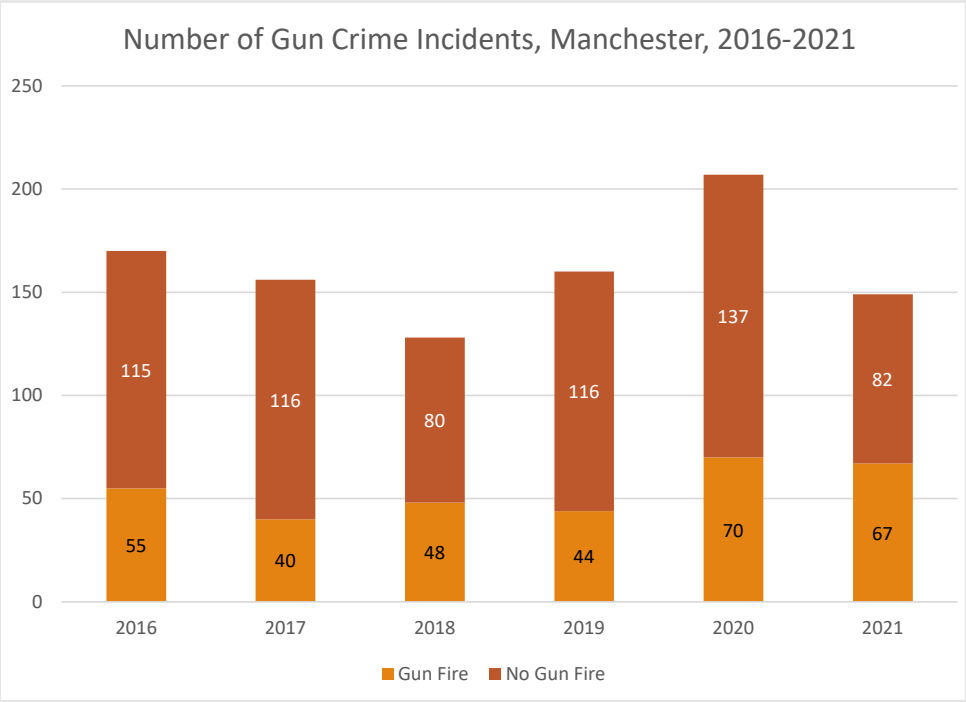


Source: Manchester Police Department Annual Report 2021

More than 45,000 people were killed by gun violence across the US in 2020—the highest number of gun fatalities in any year on record.[16] While the overall crime rate is decreasing in Manchester, 2020 marked the second year in a row of increasing numbers of gun crimes, with an overall increase of 62% between 2018 and 2020 (Figure 6). This trend began to reverse in 2021, with a 28% drop in the number of overall gun crimes. However, this decline was largely due to a drop in gun crimes in which firearms were not discharged, as the proportion in which a firearm was discharged increased from 34% to 45%.

[13] *Violence Policy Center. (July, 2017). The Relationship Between Community Violence and Trauma: How violence affects learning, health, and behavior. Available at: https://vpc.org/studies/trauma17.pdf.*
[14] *Violence Policy Center. (July, 2017). The Relationship Between Community Violence and Trauma: How violence affects learning, health, and behavior. Available at: https://vpc.org/studies/trauma17.pdf.*
[15] *https://nij.ojp.gov/topics/crime/property-crimes*
[16] *https://www.bbc.com/news/world-us-canada-41488081*

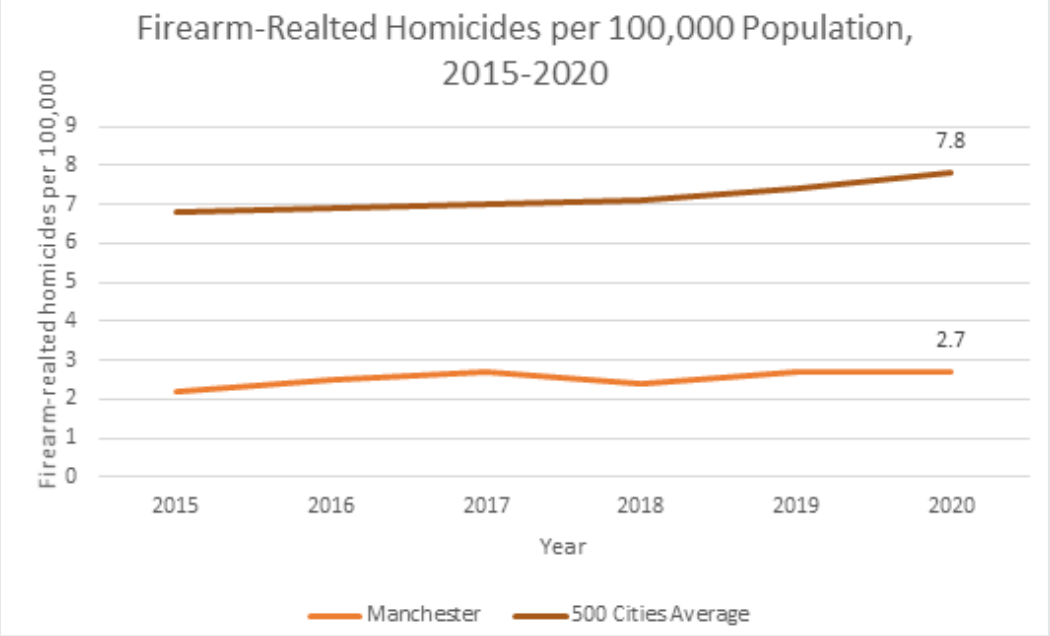
Figure 6. Manchester Gun Crimes Down 28% in 2021



Source: Manchester Police Department Annual Report 2021

Manchester's firearm related homicides have consistently been lower that the average for the 500 largest cities in the US. With the most recent data indicating that in 2020 Manchester had 2.7 firearm related homicides per 100,000 compared to an average of 7.8 per 100,000 across the 500 largest cities.

Figure 7: Firearm Related Homicides in Manchester per 100,000 Population



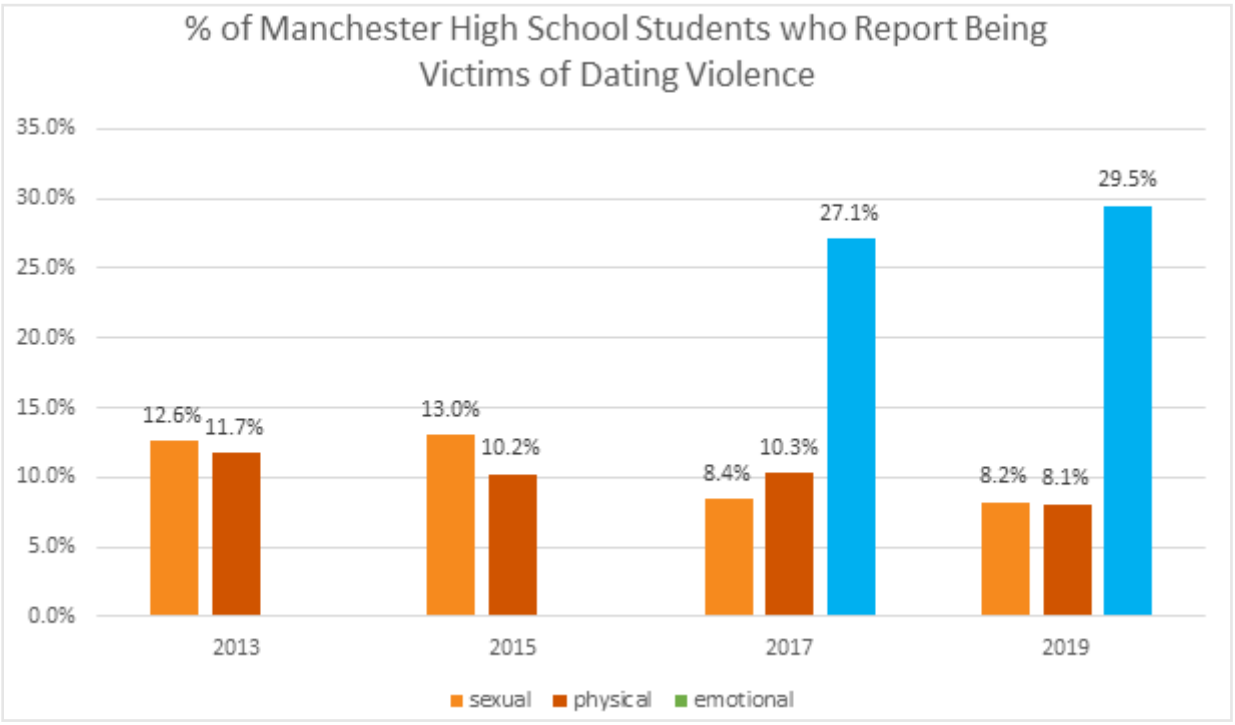
ACEs: Dating violence

Exposure to ACEs in childhood has been linked to an increased risk of later violent experiences in adulthood. In particular, several studies have demonstrated a higher risk of dating violence victimization and perpetration among youth exposed to ACEs.[17]

In 2019, nearly one-third of Manchester high school students reported that a dating partner had "purposely tried to control them or emotionally hurt them" in the past year, according to the Youth Risk Behavior Surveillance Survey (Figure 8). This proportion was approximately 11% higher than reported by high school students across the state as a whole (26.5%). While only two years of data are available on this outcome measure, it appears that emotional dating violence is on the rise in both Manchester and the state.

More than 8% of students reported having been victims of physical dating violence in Manchester in 2019, compared with 7% of high school students across the state, a 12.5% difference. The proportion of students reporting having experienced sexual dating violence in the past year was slightly higher, at 8.2% in Manchester and 7.8% in the state (5% difference). Reports of physical and sexual dating violence decreased in both Manchester and the state as a whole between 2013, with rates dropping by 30% and 36%, respectively, in Manchester.

Figure 8. Nearly One-third of Manchester Teens Report Emotional Abuse by a Dating Partner



Source: NH DHHS

[17] *Davis, J.P., Ports, K.A., Basile, K.C. et al. Understanding the Buffering Effects of Protective Factors on the Relationship between Adverse Childhood Experiences and Teen Dating Violence Perpetration. J Youth Adolescence 48, 2343–2359 (2019). https://doi.org/10.1007/s10964-019-01028-9*

Social Vulnerability Index

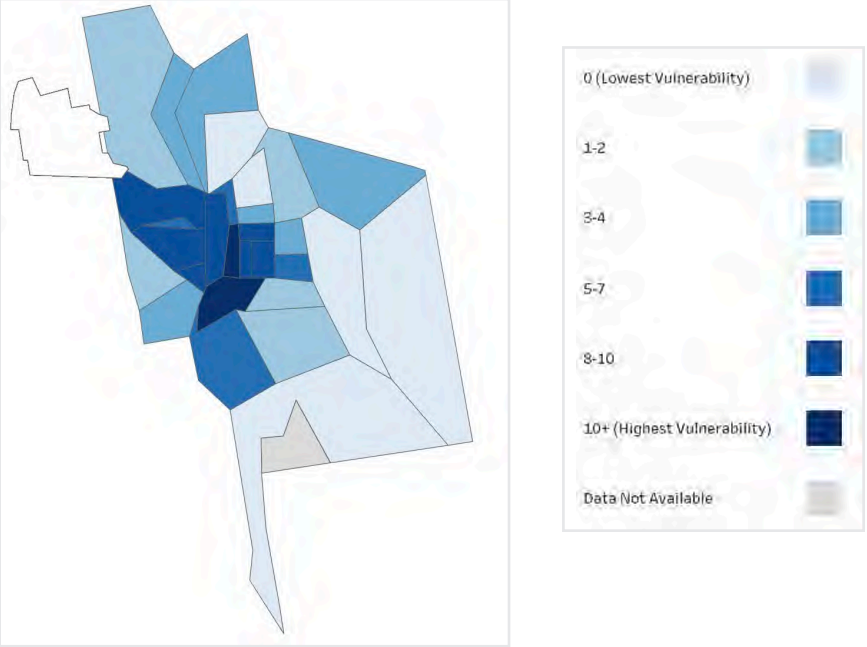
The Federal Emergency Management Agency (FEMA) uses the Social Vulnerability Index to identify communities likely to suffer "disproportionate death, injury, loss, or disruption of livelihood," as a result of natural or human-caused disasters, or disease outbreaks.[18] These communities have fewer resources available to aid in responding to emergencies, such as transportation, financial resources, and access to healthcare. Residents of communities with a high Social Vulnerability Index are also more likely to die from traumatic events, such as incidents of violence, and experience higher levels of psychological stress and stress-related illness than those living in higher-resourced areas.[19,20]

"The Social Vulnerability Index uses NH population data from the U.S. Census and American Community Survey to calculate a summary index score for 16 measures to assess the social vulnerability of every Census Tract," according to NH Health Wisdom.[21] The Index is a count of the number of these measures that score above the 90% percentile for vulnerability, with a maximum Social Vulnerability Index Score of 16.

During the 3-year period of 2015-2018, nine Manchester neighborhoods scored at or above 90% on at least half of the measures in the Social Vulnerability Index (Figure 7). Four center-city census tracts scored in the highest range of social vulnerability, with at least 10 of 16 measures scoring at or above the 90th percentiles: tracts 13, 14, 15, and 19.

Figure 7. Manchester Center-City Neighborhoods Have Highest Rates of Social Vulnerability

Manchester Social Vulnerability Index by Census Tract, 2015-2018



Source: DHHS, NH Wisdom

[18] *https://hazards.fema.gov/nri/social-vulnerability*
[19] *Phelos, Heather M. MPH; Deeb, Andrew-Paul MD; Brown, Joshua B. MD, MSc Can social vulnerability indices predict county trauma fatality rates?, Journal of Trauma and Acute Care Surgery: August 2021 - Volume 91 - Issue 2 - p 399-405. doi: 10.1097/TA.0000000000003228*
[20] *Basile Ibrahim, B., Barcelona, V., Condon, E. M., Crusto, C. A., & Taylor, J. Y. (2021). The Association Between Neighborhood Social Vulnerability and Cardiovascular Health Risk Among Black/African American Women in the InterGEN Study. Nursing research, 70(5S Suppl 1), S3–S12. https://doi.org/10.1097/NNR.0000000000000523*
[21] *https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?category=community-health&topic=social-determinants-of-health&subtopic=social-determinants-of-health&indicator=social-vulnerability-index-(svi)*

WHAT DO MANCHESTER RESIDENTS THINK?

Trauma was the second highest priority among Manchester residents surveyed, with 92.9% saying that it is "very important" for Manchester to address and prevent trauma, including persistent poverty, adverse childhood experiences such as abuse and neglect, mental/physical distress and suicide, and neighborhood crime and family violence.

Trauma was tied with substance misuse as the top priority for key stakeholders interviewed. Many pointed to the Adverse Childhood Experiences Response Team (ACERT) as a national model for reducing the long-term impact of traumatic experience on youth. However, several pointed to the need to invest in universal, primary prevention approaches, including family supports and programs promoting positive child development. Key stakeholders also identified the rise in poor mental health and suicidality, particularly among Manchester's youth, as a significant concern.

Community Spotlight

Adverse Childhood Experiences Response Team (ACERT)

The Adverse Childhood Experiences Response Team (ACERT) is a multi-disciplinary, collaborative approach to addressing the negative effects of childhood trauma. The ACERT model acts as a referral mechanism that connects families and their children to local trauma-informed mental health services and social supports. In Manchester, the ACERT core partnership includes the Police Department, YWCA-NH, and Amoskeag Health who work collaboratively to provide assistance to families, and their children, who have had recent police involvement. This referral program is voluntary and offers connections to a variety of therapies, youth support groups, domestic violence services, athletic enrichment programs, home visiting, and many other child/family-based resources. The ACERT model has been touted as a best-practice secondary health prevention program by former California Surgeon General Dr. Nadine Burke-Harris and has been replicated in multiple other communities across New Hampshire. To learn more, please visit our website at www.acert.us. If you have questions for the team, please contact ACERT@AmoskeagHealth.org.

Public Health and Safety Team (PHAST)

The Manchester Health Department's Public Health and Safety Team's Community Health Workers (CHWs) address public safety and health issues within the City's 12 Wards through a partnership with the Manchester Police Department. The CHWs assist the MPD in addressing repeat "check condition" calls for service, of which most of these calls are more related to health, social and economic issues than crime or violence. CHWs are also working towards increasing neighborhood-based resident engagement via improvement projects and events.

In addition to working directly with the MPD, the CHW team:

- Serves as a City point of contact for policy makers and residents with neighborhood concerns, such as crime and safety issues.
- Assists residents in linking with services and local resources to meet their needs, such as food, jobs, and health care; and
- Connects with community groups to support neighborhood enhancement and engagement projects, such as clean-up or block party events.

Care coordination services by the CHW team include but are not limited to:

- Access to basic resources, such as food, navigating health care and other support services,
- Assistance with basic housing and safety concerns, and
- Help with enrolling in programs/services.

The team is multicultural and collectively speaks 12 languages, in addition to English (Spanish, French, Nepali, Hindi, Swahili, Kinyarwanda, Kirundi, Lingala, Mandinka, Fula, Wolof, and Yoruba). The Community Health Workers serve the entire City and the program does not have eligibility criteria, such as income or age. The team has the desire to assist those in need, leading them to work for equity and social justice or equal access to essential health resources, such as housing, healthy food, education, employment, and health care.

To learn more please visit https://www.mymanchesternh.com/Resources/PHAST

Manchester Gun Violence Reduction Strategy

The Manchester Gun Violence Reduction Strategy is a community centered approach to identifying, analyzing, and developing evidence-based responses to the gun violence public safety issue in the Manchester community. Through work with community stakeholders, a problem solving team identifies the circumstances and conditions that could be influencing the gun violence problem.

Manchester Police partnered with the National Policing Institute to adopt the CompStat360 problem solving model in an attempt to integrate these community needs and feedback on public safety issues. This process began with a community assessment conducted by the Policing Institute, which identified several priority areas. The issue of gun violence and fear of gun violence was identified as the most significant problem area.

Through this work, four focus areas were identified: Focus on Youth, Focus on Place, Building Community, and Focused Policing.

Community-based interventions and responses were identified for each focus area and a data-informed strategy to reduce gun violence and fear of gun violence in Manchester was created. This strategy strives to incorporate on-going services coupled with new programs and resources. Through focusing efforts on youth, the community, neighborhoods, and precision policing, Manchester can become safer and healthier for all members of the community.

Read more about the Manchester Police Department's Gun Violence Reduction here.

CONCLUSION

CONCLUSION

Next steps

Improving health in the community is fundamentally a shared responsibility and often takes comprehensive, multifaceted approaches to quantifiably change neighborhood conditions and opportunities for the better. The City of Manchester has a long standing history of valuing a commitment to health for its constituents and has benefited from many stakeholders who have come together to positively affect population health. Community leaders have collaboratively tackled tough issues such as decreasing adolescent pregnancy, increasing access to oral health care, preventing childhood lead poisoning, asthma, and violence in center city neighborhoods. The 2022 Community Health Needs Assessment should serve as a call to action by the community, including the residents who make Manchester or its region their home, to build neighborhoods of opportunity and resilience. Our success will be measured when all Manchester families and individuals thrive and give back to the greater good. Next steps include:

1. Reconvene a leadership council comprised of key community stakeholders dedicated to improving health that meets regularly to set long-term health improvement goals and monitor short-term metrics between community needs assessments.
2. Practice authentic resident engagement in finding and implementing community solutions.
3. Adopt a unified theory of change such as results-based accountability and train community leaders and stakeholders in its application.
4. Institute community performance monitoring to include data dashboards to advance health and equity.
5. Update the Community Health Improvement Plan to address the priority areas identified in the Community Needs Assessment and develop issue-specific action plans for unmet needs that warrant unique exploration.
6. Harness the use of technology to expand the reach of public health through real-time surveillance, program management and communication. This includes the use of forecasting techniques and predictive analytics in decision making for health.
7. Form a funding hub with health care charitable trusts, banks and funding agencies to co-fund, blend and braid investments what can bring neighborhood health improvement strategies to scale.
8. Transform the City of Manchester Health Department into a local academic/teaching health department and provide real-world learning opportunities for current and future public health professionals.
9. Establish an Urban Health Research Institute with academic partners to contribute to the science and evidence base of neighborhood health improvement.
10. Strengthen evaluation on public health intervention strategies to determine which program variants work best, whether the public is getting the best possible value for its investment, and how to increase the impact of existing programs.[1]

[1] *https://samples.jblearning.com/0763738425/38425_CH18_495_544.pdf*

RESIDENT INPUT SUMMARY

RESIDENT INPUT SUMMARY

Key leaders reported that, in terms of health and wellness, Manchester is doing the same or worse than it was 5 years ago. Overall, they believe the COVID-19 pandemic exacerbated and/or highlighted inequities among city residents associated with housing, food security, technology access for educational and other domains, and substance misuse. Despite these impacts, more than one-third of Manchester residents scored as "thriving" in the wellness assessment, with only 10.5% scoring in the lowest, "suffering," range on this measure. In fact, Manchester residents rated their overall physical and mental health as positive, with few reporting health-related limitations on their daily activities.

Both residents and key leaders ranked housing as the highest priority for action in Manchester. Education and healthcare were the next two highest priorities for key leaders, while trauma and substance misuse were among the top priorities for residents. Residents identified crime and safety, racism, transportation, and climate considerations as additional priorities for action. Key leaders also noted challenges with transportation and racism. Leaders also recommended more attention to effective partnerships to develop and implement solutions, wrap-around care models, the needs of older adults, and workforce development.

Key leaders identified access to health care from high-quality service providers as assets in Manchester, with few residents reporting an inability to access healthcare services in the city. Leaders reflected on the opportunities that have arisen due to strong partnerships between community leaders in areas such as housing and family support. Named health care partners included the Manchester Health Department, area hospitals, and primary care clinics. However, many residents reported barriers to accessing adult dental care, with the expense being the primary barrier.

Unfortunately, many health and wellness measures have worsened in the city over the last five years. Though COVID-19 is one of the most significant factors in this change, city politics, financial constraints, and a limited and strained workforce are also affecting health and wellness. Key leaders identified both short-term COVID-19 impacts on financial and food security, as well as longer-term impacts as concerns. Long-term and potentially far-reaching negative impacts of the pandemic included child safety, stress and mental health, substance misuse, drug overdose, housing accessibility and affordability, educational disparities, food access, and transportation. In addition to COVID, racism was also noted as a key concern impacting the wellness of Manchester residents, with several key leaders reporting its pervasiveness at all levels of the community and its systems of care.

Key leaders suggested increased funding, expanded and more effective partnerships, wrap-around and community-centered approaches, workforce investments, private-public partnerships for housing expansion, and more supportive housing models as opportunities for improvements across the priorities outlined in this report.

Methods

The Manchester Health Department in Manchester, New Hampshire, contracted with a public health consulting firm, JSI Research and Training Institute, Inc. (JSI), to collect community input as a component of their community health needs assessment (CHNA). Data were collected from two groups: key community leaders and local residents. Key leaders were recruited through community partnerships and were invited to participate in two data gathering activities: a pre-interview survey and an interview conducted via video conference over the internet. Local residents were invited to participate in a 32-question survey that was available online or in person with the guidance of a community health worker who was provided a script to assist residents with accessing and completing the online survey. Residents were offered a $10 gift card as an incentive for their participation. Data collection focused on perspectives associated with well-being and with the six priority areas established during the 2019 Manchester CHNA.

Twenty (20) leaders and 204 residents provided their perspectives on health and wellness in Manchester. Overall, leaders felt that housing was the highest priority currently impacting health and wellness in the city, followed by education and food. Residents ranked access to dental care and childcare as their greatest challenges now, with the most common barriers across multiple services and supports being cost and a lack of awareness of how to access the particular service or support.

The full report from JSI is available from the Manchester Health Department.

Key Stakeholder Interviews

Twenty key leaders were interviewed. These interviewees were chosen by the Manchester Health Department as representatives of the six priority areas. Table 1 shows the number of key leader interviewees representing each priority area. Note that some interviewees represented more than one priority area.

Table 1. Key Leader Priority Areas

Number of Key Leader Interviewees Representing Priority Areas	
Education	7
Health Care	5
Substance misuse	3
Food	2
Housing	4
Trauma	5

Key leaders were asked to rank order the six priority areas of the Manchester Health Department. Many people struggled with this activity and noted that the priorities were interrelated. Key leaders' rankings of the priority areas were averaged and organized from highest priority (average ranking closest to 1) to lowest priority (highest average ranking). Table 2 features the results of the ranking analysis from highest priority (housing) to lowest priority (substance misuse and trauma tied).

Table 2. Housing the Top Priority for Manchester Key Stakeholders

Priority Area Rankings	
Priority Area	Average Ranking
Housing	2.2
Education	3.2
Health care	3.3
Food	3.6
Substance misuse	4.3
Trauma	4.3

Within each priority area, leaders were asked to describe current assets, challenges and opportunities, as well as the impact they felt COVID had on that priority area. Results of these interviews area summarized above.

As only 12 of the 20 Key Leaders interviewed responded to the pre-interview survey (60%), the results are not broadly representative and, therefore, not included in this summary.

Resident Surveys

The resident survey was designed to gather information on resident priorities for action, barriers to accessing services related to the social determinants of health, and overall wellness. A web link to the survey was shared with the Manchester Health Department who provided it to community health workers for dissemination. A flyer in English and Spanish that included a QR code was also used to promote the survey. The survey was limited to participants who were at least 18 years of age and currently living in Manchester. The first 200 residents to complete the survey received a $10 gift card as an incentive.

Community health workers were allowed to capture the participants' answers and enter them on-line as needed. The Manchester Health Department set a goal of 200 residents participating in the survey. Between April 11 and May 17, 2022, there were 204 completed responses. The survey was then closed since the goal for the total number of respondents was reached.

Characteristics of Respondents

Table 3 shows the self-reported race/ethnicity of respondents. While more than one-quarter of respondents choose not to disclose their race or ethnicity, the results indicate a diverse sample. Of those who indicated their gender, 63% were female. Most residents who responded to the survey lived in Manchester for more than 3 years (63%). The average age of respondents was 38.

Table 3. Respondent Race/Ethnicity

Race	
White	27%
Black	30%
Asian	14%
American Indian/Alaskan Native	1%
Choose not to disclose	28%
Ethnicity	
Hispanic/Latino	28%
Non-Hispanic/Latino	45%
Choose not to disclose	28%

Resident Priorities

Residents were asked to rank each of the following priority areas as Not very Important, Somewhat Important, or Very Important for Manchester to take action. Residents were not limited in the number of priorities they could rate as Very Important. Table 4 summarizes resident responses. While residents clearly thought all six priority areas addressed in this report were very important for Manchester to take action, they rated safe and affordable housing the highest, with 93.4% of residents saying this was a very important priority for action.

Table 4. Residents Rate Housing as Highest Priority for Action

Please tell us how important you think it is for Manchester to take action in the areas below. (n=198)			
	Not very important	Somewhat important	Very important
Improve educational outcomes, including ensuring children are ready for school, students graduate on-time, and the community has high paying jobs.	1.5% (N=3)	9.1% (N=18)	89.4% (N=177)
Improve access to quality, preventive health care, including primary care, prenatal care, dental care, and mental health services.	<1% (N=1)	8.1% (N=16)	91.4% (N=181)

Reduce and prevent substance misuse, including overdoses and deaths due to drugs, tobacco use and vaping, binge drinking, and youth risk behaviors.	1.0% (N=2)	6.6% (N=13)	92.4% (N=183)
Increase access to healthy, affordable food sources, including addressing health conditions such as obesity and diabetes, lack of access to fresh fruits and vegetables, and food deserts.	0% (N=0)	8.6% (N=17)	91.4% (N=181)
Increase access to quality, affordable housing, including housing conditions such as crowding, environmental concerns such as lead exposure, rental costs for housing, and lack of supportive/ transitional housing.	<1.0% (N=1)	6.1% (N=12)	93.4% (N=185)
Address and prevent trauma, including persistent poverty, adverse childhood experiences such as abuse and neglect, mental/physical distress and suicide, and neighborhood crime and family violence.	1.0% (N=2)	6.1% (N=12)	92.9% (N=184)

Residents were also asked to identify top priorities not included in the above list. Participants identified the following additional priorities for action:

- Crime and safety
- Transportation
- Recycling/access to clean communities and green spaces
- Support for small businesses
- Elderly assistance
- Racism
- Access to domestic violence shelters
- Climate health
- Cost of utilities

Resident Barriers to Services

Residents were asked to list which items, services, or programs they or their families have had trouble getting in the last three years. Whenever respondents answered yes, they were given a list of specific types of barriers and asked to select all that applied. Table 5 lists the top 10 services residents reported having trouble getting in the past 3 years, with adult dental care and childcare topping that list. Table 6 shows that the most common barriers to getting services were “I don’t know where to go to get the services I need” and “services were too expensive.”

Table 5. Nearly One-Quarter of Manchester Adults Have Trouble Getting Dental Care

Top 10 items, services, or programs Manchester residents had trouble getting in the last three years.	% of Responses	# of Responses
Dental care for adults	23.7%	42
Childcare	15.8%	28
Scholarships or financial help for college	14.7%	26
Programs to help with paying for housing and utilities (gas, electric, oil)	14.1%	25
Help finding work	13.6%	24
Health insurance	13.6%	24
Mental health counseling/therapy for adults	13.0%	23
After school programs and sports for children and teens	12.4%	22
Job training programs	11.3%	20
Help with accessing food/meals	11.3%	20

Table 6. Many Manchester Residents Don't Know Where to Go to Get Services They Need

What were the barriers to getting this item/service/program?	Most Frequently Selected Barriers - # of Responses
Dental care for adults	Services were too expensive (32) No health insurance (14)
Childcare	Services were too expensive (15) I do not qualify for the services that I need (7)
Scholarships or financial help for college	I don't know where to go to get the services that I need (15) I do not qualify for the services that I need (3)
Programs to help with paying for housing and utilities (gas, electric, oil)	I don't know where to go to get the services that I need (16) I do not qualify for the services that I need (7)
Help finding work	I don't know where to go to get the services that I need (7) I do not qualify for the services that I need (7)
Health insurance	I do not qualify for the services that I need (11) Services were too expensive (9)
Mental health counseling/therapy for adults	I don't know where to go to get the services that I need (12) Services were too expensive (5)
After School programs and sports for children and teens	Services were too expensive (8) I don't know where to go to get the services that I need (7)
Job training programs	I don't know where to go to get the services that I need (9) I do not qualify for the services that I need (4)
Help with accessing food/meals	I don't know where to go to get the services that I need (10) I don't have transportation (7)

Resident Well-Being

Resident well-being was assessed using the 100 Million Healthier Lives 12-item Adult Well-Being Assessment.[1] This tool provides two composite measures, Life Evaluation and Affect Balance, as well as 8 individual measures of overall well-being.

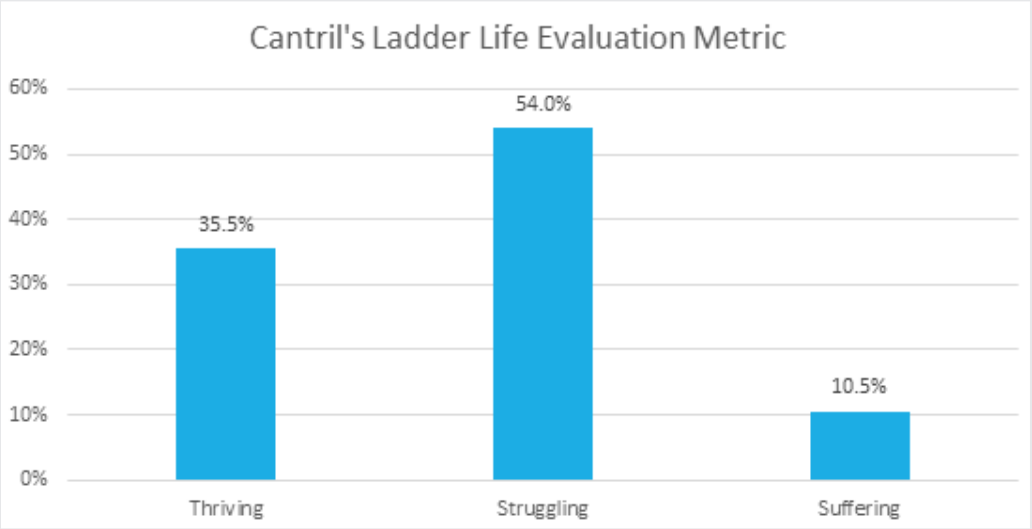
The first composite measure uses the Cantril Self-Anchoring Scale, known as Cantril's Ladder, to measure present and future overall well-being. These two measures are scored together to reveal an overall Life Evaluation Well-Being Score with three categories of well-being: Thriving, Struggling, and Suffering.[2] While Figure 1 shows that most Manchester residents scored

[1]*Stiefel MC, Riley CL, Roy B, McPherson M, Nagy JM. Health and Well-being Measurement Approach and Assessment Guide. Boston: 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement; 2020. (Available at www.ihi.org/100MLives)*

[2]*https://news.gallup.com/poll/122453/understanding-gallup-uses-cantril-scale.aspx*

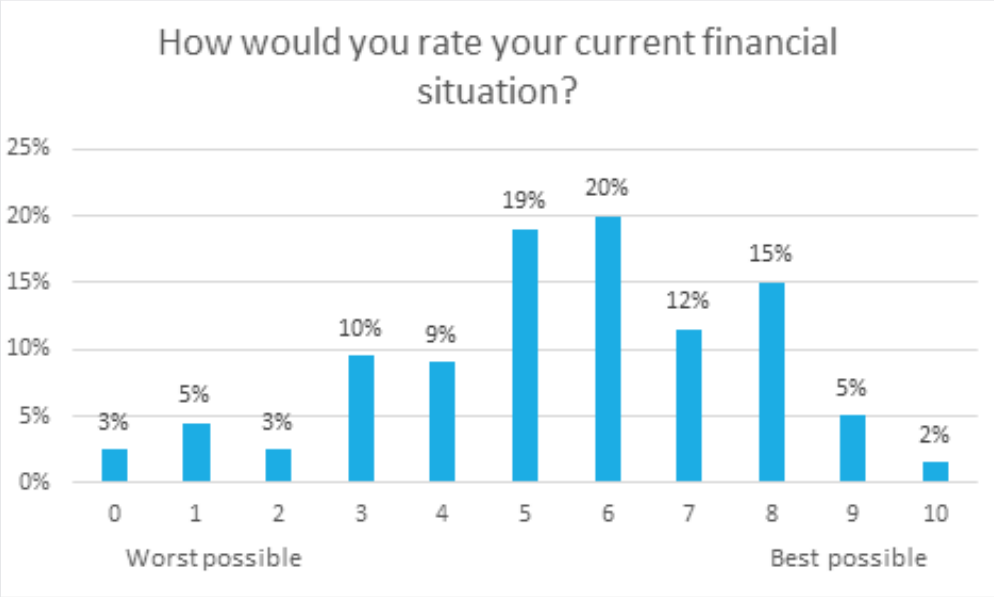
within the Struggling range (well-being that is moderate or inconsistent), more than one-third scored as Thriving (well-being that is strong, consistent, and progressing). One in ten residents scored at the lowest rating of Suffering on this metric (well-being that is at high risk).

Figure 1. One-Third of Manchester Residents Report They are Thriving



The Cantril's ladder scale was also used to assess Manchester residents' views of their current financial situation. Most residents scored in the middle of the range from "worst possible" financial situation to "best possible" (Figure 2). However, 30% of residents characterized their current financial situation as below the midpoint (5) of the scale.

Figure 2. Most Manchester residents feel their current financial situation is neither the "best", nor the "worst"



The second composite measure, Affect Balance, is measured by two items drawn from the Scale of Positive and Negative Experiences that measure the frequency of positive and negative emotions in the past two weeks.[3] To calculate the overall Affect Balance score, the negative emotions rating is subtracted from the positive emotions rating. Higher scores represent a stronger prevalence of positive emotions to negative ones.

Manchester residents scored 0.24 overall for Affect Balance, suggesting they are experiencing positive emotions only slightly more frequently than negative ones (Figure 3). The average score on a range from 0 to 10 for the frequency of positive emotions in the past 2 weeks was 6.59 among Manchester residents, while the average score for the frequency of negative emotions was 6.34.

Figure 3. Manchester Residents Experience Similar Levels of Positive and Negative Emotions

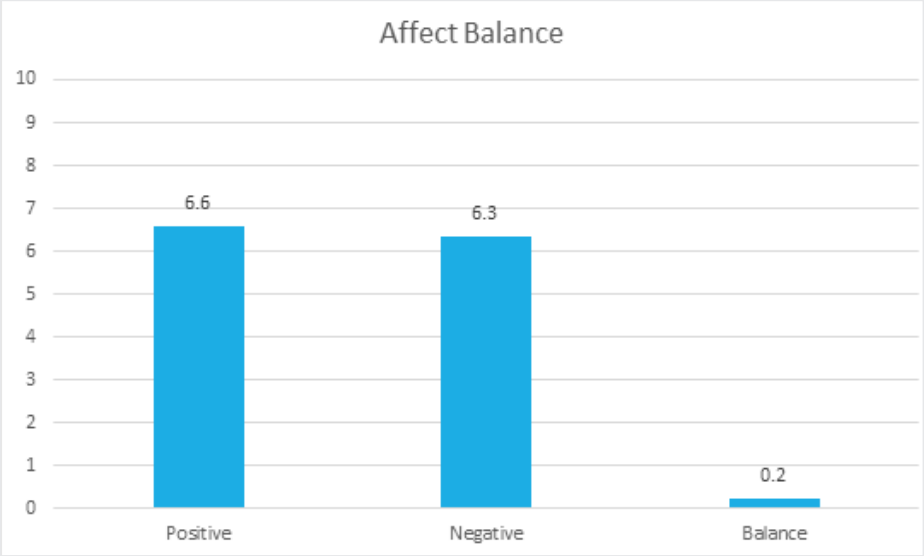


Figure 4 shows that most Manchester residents rate their physical and mental health as excellent or close to excellent. The following figure (5) indicates that very few of the respondents feel their normal activities are limited by a health problem.

[3]Li, F., Bai, X., & Wang, Y. (2013). The Scale of Positive and Negative Experience (SPANE): psychometric properties and normative data in a large Chinese sample. PloS one, 8(4), e61137. https://doi.org/10.1371/journal.pone.0061137

Figure 4. Physical/ Mental Health

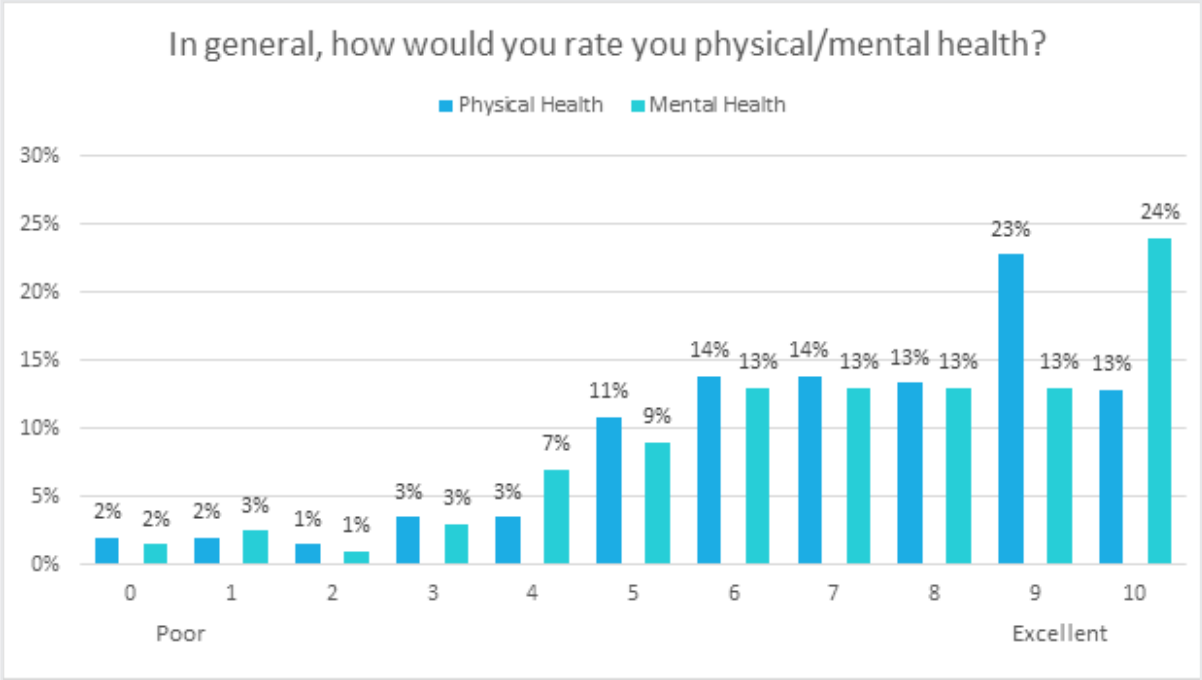
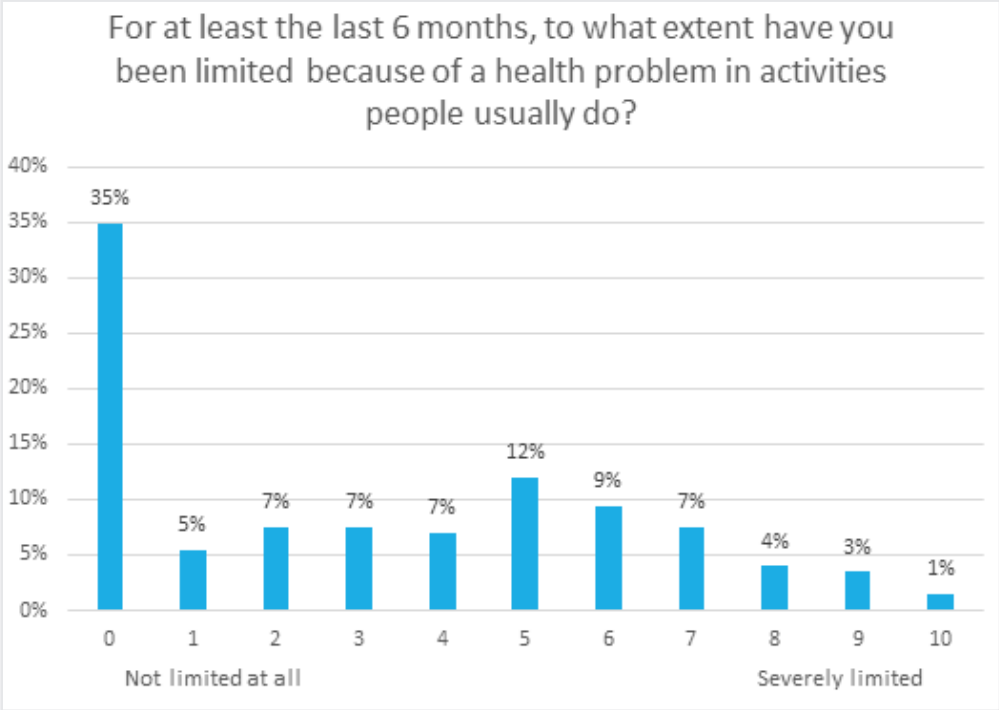


Figure 5. Few Manchester Residents Feel Limited by Health Problems



Figures 6 through 9 show residents' responses to questions about their overall social and emotional well-being. The results paint an overall positive picture, with most residents feeling like they have a purpose in life and few residents reporting feeling lonely all or most of the time. While there is a range in residents' reports of community belonging, most residents feel they have someone who can help them when they are in need.

Figure 6. Most Manchester Residents Feel They Have Purpose in Life

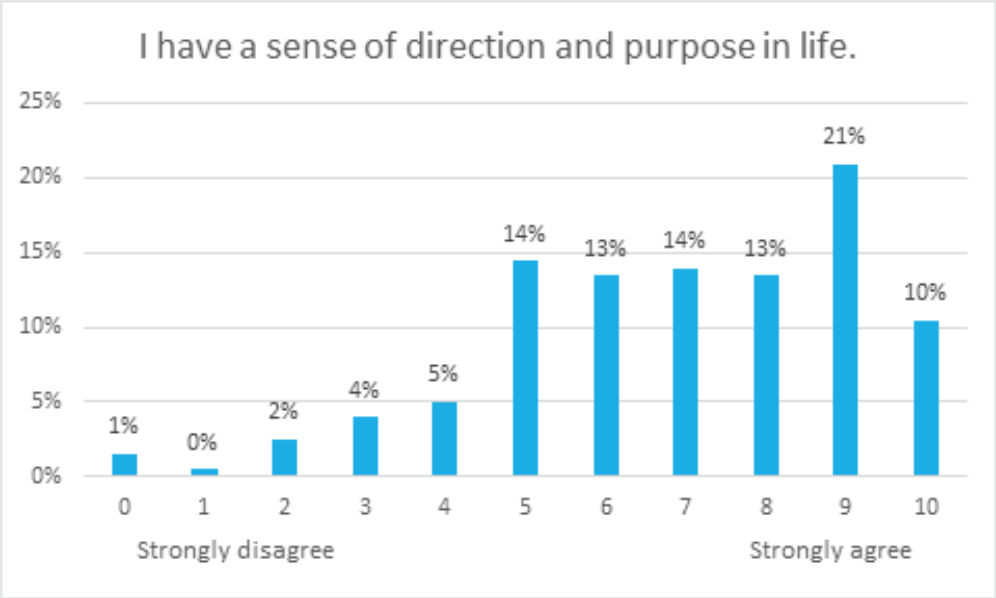


Figure 7. Few Manchester Residents Feel Lonely Always

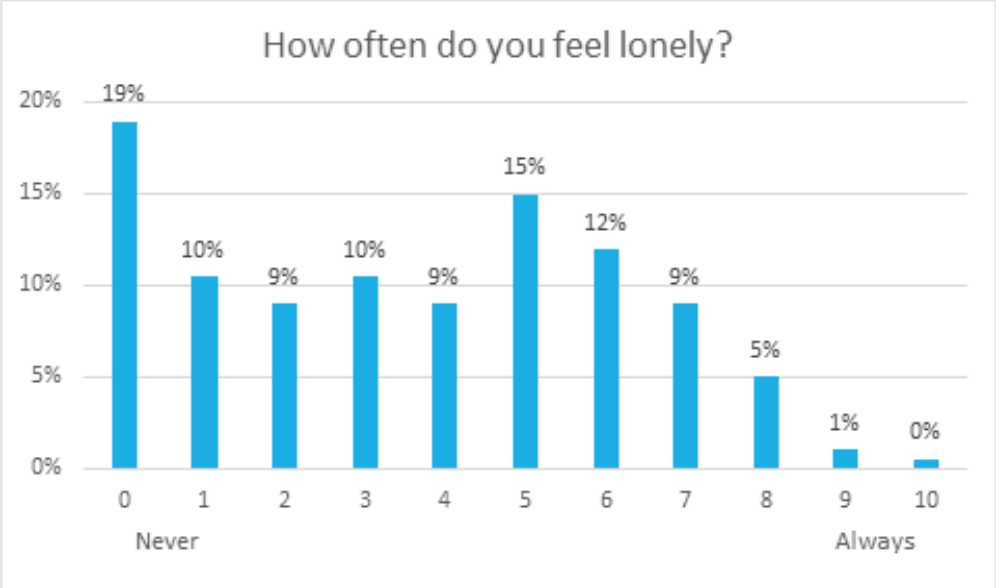


Figure 8. Manchester Residents Report a Range of Belonging to their Communities

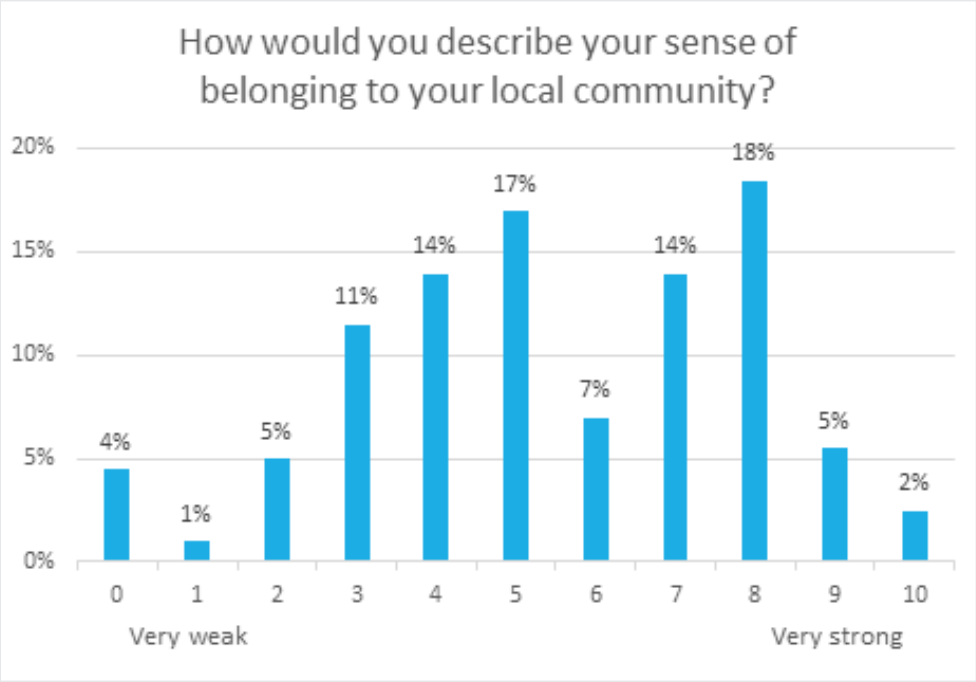
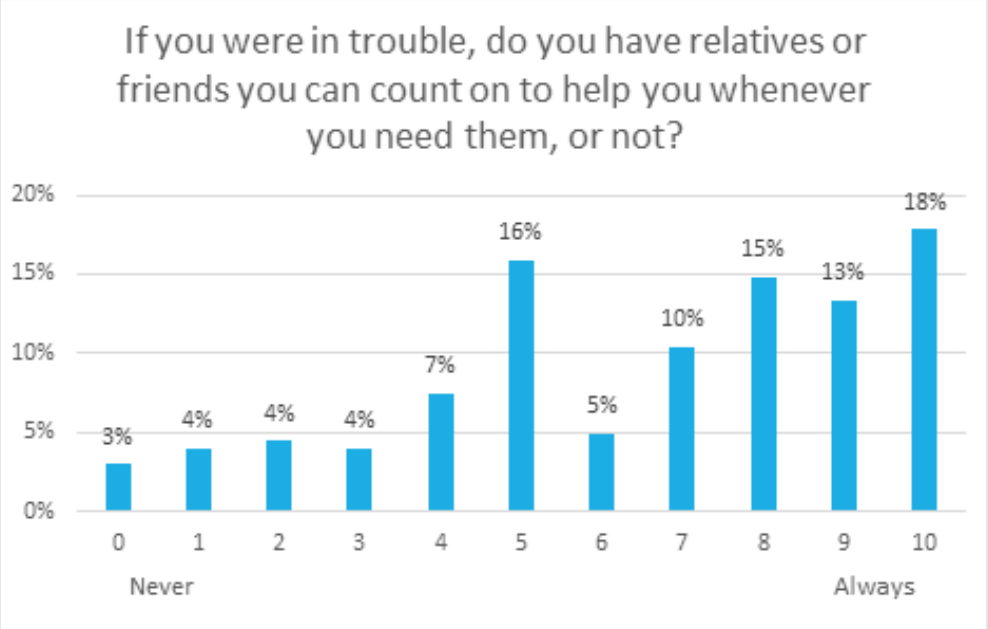


Figure 9. Manchester residents have people they can count on, more often than not



The final two questions on resident well-being, shown in Figures 10 and 11, were not part of the 100 Million Healthier Lives assessment but were added by the Manchester Health Department. Only 15% of respondents said they do not ever worry about safety, food, or housing, while 4% said they worry all the time about these issues. The average score on this question was 5.9. Twelve percent of residents said they do not every worry about meeting their regular monthly living expenses, while 6% said they worry about this all the time. The average score on this question was 5.6.

Figure 10. Most Manchester Residents Worry Sometimes about Safety, Food, or Housing

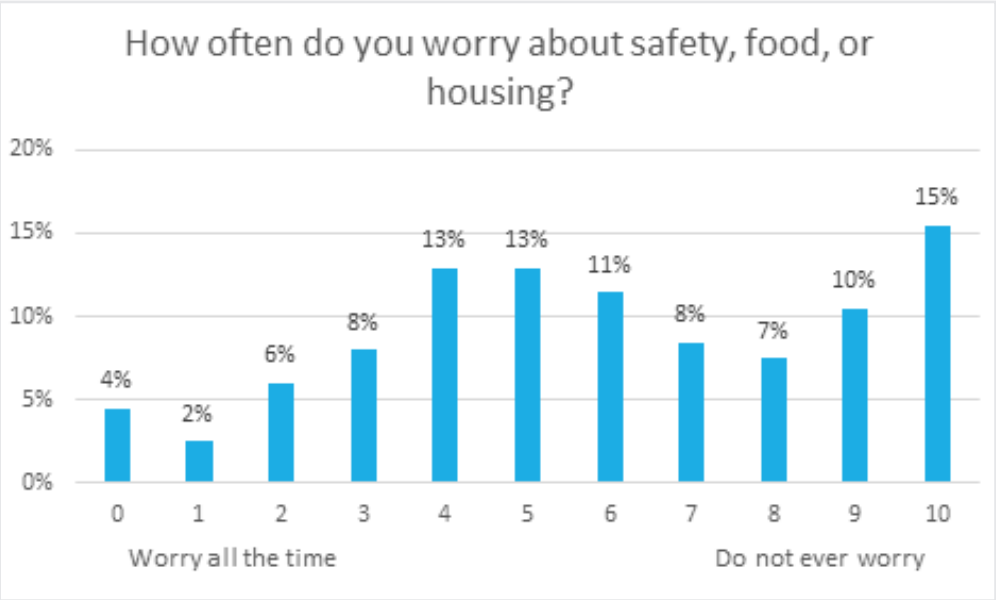
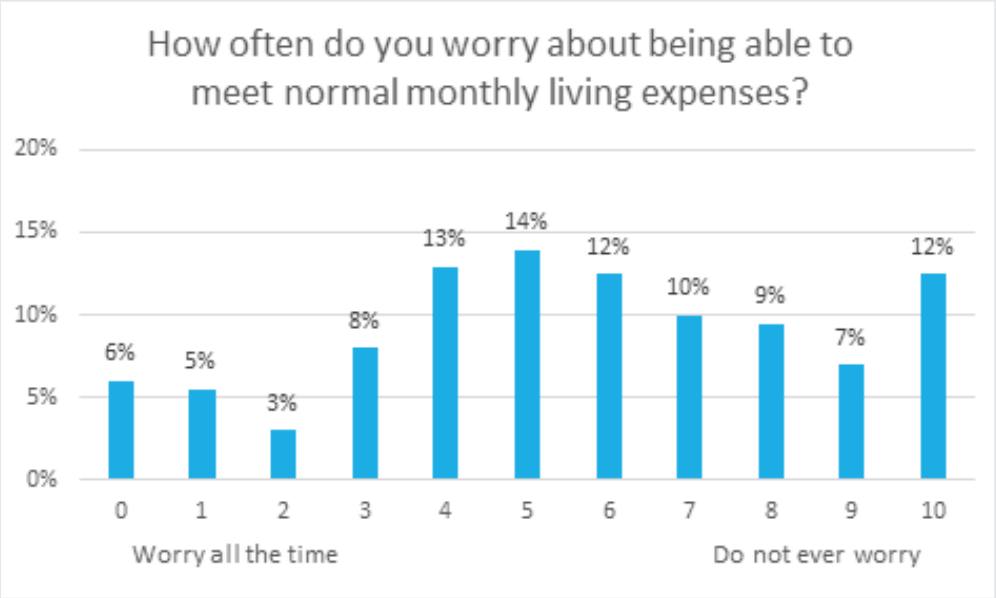


Figure 11. Many Manchester Residents Worry Sometimes about Meeting Normal Monthly Living Expenses



Appendix E-4

Huggins Trustee Certification re NH RSA 7:19-b(II) Standards

Appendix E-5

MCH Trustee Certification re NH RSA 7:19-b(II) Standards