UNIVERSITY OF NEW MEXICO HOSPITAL

Financial Statements with Supplementary Information

June 30, 2017 and 2016

(With Independent Auditors' Report Thereon)

UNIVERSITY OF NEW MEXICO HOSPITAL

Fiscal Year 2017 Official Roster

Board of Trustees

Debbie Johnson Albuquerque, NM	Chairperson (Term expires 6/30/18, Regent appointed)
Jerry McDowell Albuquerque, NM	Vice-Chair (Term expires 7/31/19, Regent appointed)
Christine Glidden Albuquerque, NM	Secretary (Term expires 4/25/20, County appointed)
Aimee Smidt, MD Albuquerque, NM	Member (Term expires 3/28/20, Regent appointed)
Nick Estes Albuquerque, NM	Member (Term expires 3/28/20, County appointed)
Raymond Loretto, DVM Jemez Pueblo	Member (Term expires 1/1/20, All Pueblo Council of Governors – Regent appointed)
A. Joseph Alarid Albuquerque, NM	Member (Term expires 6/30/18, Regent appointed)
Erik Lujan Albuquerque, NM	Member (Term expires 6/10/19, All Pueblo Council of Governors – Regent appointed)

UNIVERSITY OF NEW MEXICO HOSPITAL

Fiscal Year 2017 Official Roster

Administrative Officers

Chaouki T. Abdallah	President (Interim) – University of New Mexico
Paul Roth, M.D.	Chancellor – UNM Health Sciences Center Dean, School of Medicine – UNM Health Sciences Center
Steve McKernan	Chief Executive Officer – UNM Hospitals Chief Operating Officer – UNM Health System
Ella Watt	Chief Financial Officer – UNM Hospitals

UNIVERSITY OF NEW MEXICO HOSPITAL

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KPMG LLP
Two Park Square, Suite 700
6565 Americas Parkway, N.E.
Albuquerque, NM 87110-8179

Independent Auditors' Report

The University of New Mexico Health Sciences Center
Board of Trustees and
Mr. Timothy Keller, New Mexico State Auditor:

Report on the Financial Statements

We have audited the accompanying financial statements of the University of New Mexico Hospital (the Hospital), a division of the University of New Mexico, State of New Mexico, operated by the University of New Mexico Health Sciences Center Clinical Operations, organized as the University of New Mexico Hospital, which comprise the statement of net position as of June 30, 2017, and the related statements of revenues, expenses, and changes in net position and cash flows for the year then ended, and the related notes to the financial statements, which collectively comprise the Hospital's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of June 30, 2017, and the changes in its financial position and its cash flows for the year then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 1, the financial statements present only the Hospital and do not purport to, and do not, present fairly the financial position of the University of New Mexico, as of June 30, 2017, the changes in its financial position or its cash flows for the year then ended in accordance with U.S. generally accepted accounting principles. Our opinion is not modified with respect to this matter.

Other Matters

2016 Financial Statements

The accompanying financial statements of the Hospital as of and for the year ended June 30, 2016 were audited by other auditors whose report thereon dated October 21, 2016, expressed an unmodified opinion on those financial statements.

Required Supplementary Information

U.S. generally accepted accounting principles require that the management's discussion and analysis on pages 4-19, the schedule of the Hospital's proportionate share of the net pension liability (schedule 6), and the schedule of Hospital contributions (schedule 7) be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary and Other Information

Our audit for the year ended June 30, 2017 was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Hospital's 2017 basic financial statements. The accompanying comparison of budgeted and actual revenues and expenses (schedule 1), schedule of pledged collateral by banks (schedule 2), schedule of individual deposit and investment accounts (schedule 3), indigent care cost and funding report (schedule 4), and calculations of cost of providing indigent care (schedule 5) are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The comparison of budgeted and actual revenues and expenses (schedule 1), schedule of pledged collateral by banks (schedule 2), schedule of individual deposit and investment accounts (schedule 3), indigent care cost and funding report (schedule 4), and calculations of cost of providing indigent care (schedule 5) for the year ended June 30, 2017 are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the 2017 basic financial statements, except for the information marked as unaudited. Such information, except for the information marked as unaudited, has been subjected to the auditing procedures applied in the audit of the 2017 basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the 2017 basic financial statements or to the 2017 basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the comparison of budgeted and actual revenues and expenses (schedule 1), schedule of pledged collateral by banks (schedule 2), schedule of individual deposit and investment accounts (schedule 3), indigent care cost and funding report (schedule 4), and calculations of cost of providing indigent care (schedule 5) are fairly stated, in all material respects, in relation to the 2017 basic financial statements as a whole, except for the information marked as unaudited in the accompanying

indigent care cost and funding report (schedule 4), and calculations of cost of providing indigent care (schedule 5).

The information that is marked as unaudited in the accompanying indigent care cost and funding report (schedule 4) and calculations of cost of providing indigent care (schedule 5) has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 27, 2017 on our consideration of the Hospital's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospital's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Hospital's internal control over financial reporting and compliance.

KPMG LLP

Albuquerque, New Mexico
November 27, 2017

This section of the University of New Mexico Hospital's (the Hospital) annual financial report presents management's discussion and analysis of the financial performance of the Hospital during the fiscal years ended June 30, 2017 and 2016. This discussion should be read in conjunction with the accompanying financial statements and notes. Management has prepared the financial statements and the related note disclosures along with this discussion and analysis. As such, the financial statements, notes, and this discussion are the responsibility of Hospital's management.

Using the Annual Financial Report

This annual report consists of financial statements prepared in accordance with Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments*, as amended.

The financial statements prescribed by GASB 34 (the statements of net position, statements of revenues, expenses, and changes in net position, and the statements of cash flows) present financial information in a form similar to that used by commercial corporations. They are prepared under the accrual basis of accounting, whereby revenues and assets are recognized when the service is provided, and expenses and liabilities are recognized when others provide the service or goods are received, regardless of when cash is exchanged.

The statements of net position include all assets, deferred outflows, liabilities, and deferred inflows. Overtime, increases or decreases in net position (the difference between assets, deferred outflows, liabilities, and deferred inflows) is one indicator of the improvement or erosion of the Hospital's financial health when considered with nonfinancial facts such as patient statistics and the condition of facilities. This statement includes all assets and liabilities using the accrual basis of accounting, which is consistent with the accounting method used by nongovernmental hospitals and healthcare organizations.

The statements of revenues, expenses, and changes in net position present the revenues earned and expenses incurred during the year. Activities are reported as either operating or nonoperating. A public hospital's dependency on state or county aid can result in an operating deficit since the financial reporting model classifies such aid as nonoperating revenues, which is the case with the state appropriation and the Bernalillo County Mill Levy received by the Hospital. The utilization of capital assets is reflected in the financial statements as depreciation, which amortizes the cost of an asset over its expected useful life.

The statements of cash flows present information related to cash inflows and outflows summarized by operating, capital, and noncapital financing, and investing activities.

Three-Year Comparison of Financial Results

Condensed summary of net position

	June 30		
	2017	**2016**	**2015**
Assets:			
Current assets	$ 385,431,463	392,756,160	366,830,094
Capital assets	215,451,487	223,548,010	231,035,321
Noncurrent assets	40,440,198	37,093,211	35,594,782
Total assets	$ 641,323,148	653,397,381	633,460,197
Deferred outflows:			
Total deferred outflows of resources	$ 214,591	269,677	178,603
Liabilities:			
Current liabilities	$ 187,306,237	209,052,406	195,831,266
Noncurrent liabilities	109,573,774	116,814,441	129,440,283
Total liabilities	$ 296,880,011	325,866,847	325,271,549
Deferred inflows:			
Total deferred inflows of resources	$ 316,614	906,541	655,095
Net position:			
Net investment in capital assets	$ 112,026,487	114,583,010	116,035,266
Restricted net position, expendable	34,496,935	31,296,238	29,151,022
Unrestricted net position	197,817,692	181,014,422	162,525,868
Total net position	$ 344,341,114	326,893,670	307,712,156

Current assets include cash and other assets that are deemed to be consumed or convertible to cash within one year, and include cash, marketable securities, and accounts receivable. The Hospital's most significant current asset was cash and cash equivalents. The cash balance was $178.3 million, $143.3 million, and $146.5 million as of June 30, 2017, 2016, and 2015, respectively. A standard metric used to calculate the number of days that it would take to deplete existing cash balances is called "days cash on hand" (DCOH). This measure is used to assess how long the Hospital could cover operating expenses or outflows using existing cash balances. It is calculated by taking the cash balance divided by annual operating expenses excluding noncash items divided by the number of days in a calendar year. The DCOH for the Hospital was 68, 58, and 66 as of June 30, 2017, 2016, and 2015, respectively. As part of the FHA Insured Hospital Mortgage Revenue Bonds Series 2015 discussed further in note 9, the Hospital must meet a minimum DCOH of 21 days. As part of the cash management practice, the Hospital centrally manages all cash receipts and disbursements for all its affiliates, including the UNM Psychiatric Center (UNMPC) and the UNM Children's Psychiatric Center (UNMCPC), which are collectively referred to as the "Center." The corresponding liability, due to affiliates, reflects the cash balances held by the Hospital on behalf of its affiliates.

The second most significant current asset is patient receivables. The patient receivables balance was $116.1 million, $127.8 million, and $129.7 million as of June 30, 2017, 2016, and 2015, respectively.

The decrease in net patient receivables of $11.7 million as of June 30, 2017 compared to June 30, 2016 is primarily due to the implementation of Soarian, a new billing system, which went live on August 29, 2015. During the fiscal year 2017, collections in the first 60 days improved over FY16, which is attributed to operationalizing the conversion to the new system. Management was able to put forth considerable effort on revenue cycle initiatives due to the improved reporting capabilities of Soarian as well as the improved reporting to the front line to reduce registration errors, ensure coordination of benefits, validate eligibility, and reduce prior authorization denials. These efforts during fiscal year 2017 resulted in an increase in cash collections of $28.7 million as compared to fiscal year 2016.

At June 30, 2017, 2016, and 2015, the Hospital's current assets of $385.4 million, $392.8 million, and $366.8 million, respectively, were sufficient to cover current liabilities of $187.3 million (current ratio of 2.05), $209.1 million (current ratio of 1.87), and $195.8 million (current ratio of 1.87), respectively.

The Hospital's deferred outflows related to pensions decreased $55,086 at June 30, 2017 compared to June 30, 2016. During the year ended June 30, 2015, the Hospital implemented GASB Statement No. 68, *Accounting and Financial Reporting for Pensions – an amendment of GASB Statement No. 27* (GASB No. 68), which is effective for financial statements for periods beginning after June 15, 2014. GASB No. 68 replaces the requirements of Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers*, as well as the requirements of Statement No. 50, *Pension Disclosures*, as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements (hereafter jointly referred to as trusts) that meet certain criteria. It establishes standards for measuring and recognizing liabilities, deferred outflows of resources, and deferred inflows of resources, and expense/expenditures. The amounts recognized as deferred outflows of resources represent cash contributions made by the Hospital to the defined-benefit plan during the year ended June 30, 2017, net of changes in actuarial assumptions impacting the net pension liability. The number of employees at the Hospital covered by the defined-benefit plan was approximately 18 with the remaining 99.9% of employees covered under a defined-contribution plan.

Current liabilities are generally defined as amounts due within one year, and include accounts payable, accrued payroll, accrued compensated absences, amounts due to UNM, and estimated third-party payor settlements. The most significant liability is the accounts payable balance of $76.2 million, $60.9 million, and $54.2 million as of June 30, 2017, 2016, and 2015, respectively. The increases in accounts payable were primarily due to medical supplies, including pharmaceuticals, purchased services, and minor equipment purchases outstanding at June 30, 2017 and 2016. The next most significant liability balance is the estimated third-party payor settlements of $34.7 million, $49.3 million, and $33.2 million as of June 30, 2017, 2016, and 2015, respectively. The 2017 decrease in the estimated settlement account is primarily due to the payment of intergovernmental transfers due to the State of New Mexico from prior year. The Due to UNM balance was $19.3 million, $47.4 million, and $64.6 million as of June 30, 2017, 2016, and 2015, respectively. The decrease in this balance at June 30, 2017 is primarily due to the payment of medical services (physician providers and resident programs) accrued at fiscal year 2016 year-end. The decrease in this balance at June 30, 2016 was the result of paying the 2015 capital initiatives amount of $50.5 million in 2016 while not funding capital initiatives for 2016. Capital initiatives are to provide the capital funding for the purchase and construction of additional clinical facilities. Capital initiatives are more fully discussed in note 18. The capital initiatives payment was offset by increased amounts for physician providers and resident programs not paid as of June 30, 2016.

Deferred inflows of resources decreased $589,927 as of June 30, 2017 compared to June 30, 2016. The amounts recognized as deferred inflows of resources represent changes in the Hospital's net pension liability related to the defined-benefit plan for the year ended June 30, 2017. The Hospital's net pension liability and related deferred inflows and outflows are discussed in note 15.

Total net position as of June 30, 2017 increased by $17.4 million to $344.3 million. The increase was due to an operating loss of $59.0 million offset by net nonoperating revenue of $76.5 million.

Total net position as of June 30, 2016 increased by $19.2 million to $326.9 million. The increase was due to an operating loss of $64.9 million offset by net nonoperating and special item revenue of $84.1 million.

Condensed summary of revenues, expenses, and changes in net position

	Year ended June 30		
	2017	**2016**	**2015**
Total operating revenues	$ 927,644,546	871,638,746	904,873,810
Total operating expenses	(986,677,050)	(936,575,215)	(852,913,273)
Operating loss	(59,032,504)	(64,936,469)	51,960,537
Nonoperating revenues, expenses, other revenues, and special items	76,479,948	84,117,983	(33,920,372)
Total increase in net position	17,447,444	19,181,514	18,040,165
Net position, beginning of year	326,893,670	307,712,156	293,292,800
Change in accounting pronouncement	—	—	(3,620,809)
Net position, beginning of year as restated	326,893,670	307,712,156	289,671,991
Net position, end of year	$ 344,341,114	326,893,670	307,712,156

Operating Revenues

The sources of operating revenues for the Hospital are net patient services, state and local contracts and grants, and other operating revenues, with the most significant source being net patient services revenues. Operating revenues were $927.6 million, $871.6 million, and $904.9 million for the years ended 2017, 2016, and 2015, respectively.

Net patient service revenue comprises gross patient revenue, net of contractual allowances, charity care, provision for doubtful accounts, and any third-party cost report settlements. Net patient service revenues were $902 million, $848 million, and $880 million for the years ended 2017, 2016, and 2015, respectively.

(Continued)

Net patient service revenues for 2017 of $902 million increased $54 million from $848 million in 2016, which represents a 6% increase. The primary factors that caused the increase in net patient service revenue are an increase in discharges and in the acuity of inpatients. The Hospital's case mix index (CMI), an indicator of the severity of illness of inpatients, increased from 1.8637 in 2016 to 1.9872 in 2017, a 6.6% increase resulting in an increase in revenue of $44 million. Discharges also increased by 2%. The majority of the Hospital's third-party payer contracts are based on DRG reimbursement. This reimbursement methodology uses a per discharge amount which is multiplied by CMI. The combination of additional discharges and a higher CMI results in increased reimbursement on the Hospital's inpatient population. The increase is also the result of not having a recurring Medicaid Disproportionate Share refund to the State of New Mexico that is reflected in 2016's net patient service revenue. During fiscal year 2017, the State of New Mexico enacted a 5% inpatient and a 3% outpatient reimbursement reduction. The Hospital was able to mitigate the impact for these reimbursement reductions with improvements in revenue cycle initiatives, which reduced registration errors, ensured coordination of benefits, validated eligibility, and reduced prior authorization denials.

Net patient service revenues for 2016 of $848 million decreased $32 million from $880 million in 2015, which represents a 4% decrease. The primary factor that caused the decrease was a change in estimate for fiscal 2015's Disproportionate Share Medicaid reimbursement (DSH). DSH hospital reimbursement was enacted and put into regulation to assist hospitals with the burden of uncompensated care costs incurred for rendering services to both Medicaid and uninsured patients. The Affordable Care Act (ACA) through the Health Insurance Exchange and expansion of Medicaid in New Mexico has significantly reduced the uninsured patient population for UNM Hospitals. It has been estimated that this reduction in the uninsured patient population combined with the Medicaid rate increase effective January 1, 2014 for Safety Net Care Pool (SNCP) Hospitals will reduce the net uncompensated care costs for fiscal years 2015 through 2017. Given the estimated reduction of net uncompensated care costs for uninsured and Medicaid patients during fiscal 2015 upon which DSH payments would be based, the amount of $19 million recognized for DSH during fiscal 2015 was refunded to the State of New Mexico in fiscal 2016 as a change in estimate. Furthermore, no further DSH was expected nor accrued during fiscal 2016. If the Hospital had not recognized DSH in fiscal 2015, net patient service revenue would have been $860 million compared to $867 million in fiscal 2016.

As of March 2017, the New Mexico Human Services Department (HSD) reported that there were 920,000 members enrolled in Centennial Care, including 269,000 in the expansion population. HSD is estimating enrollment in Centennial Care will be approximately 956,000 as of June 2018.

The New Mexico Health Insurance Exchange, (HIX), is available to individuals/families with incomes above 138% of the Federal Poverty Line (FPL) and provides subsidized health insurance up to 400% FPL. The HIX estimated approximately 187,000 adults would qualify for exchange coverage, however, actual enrollment has stabilized around 50,000. Premiums have continued to increase based on the population having higher utilization than originally anticipated. The Hospital is designated as a site for enrollment with a direct connection to HIX.

Patient days and visits are important statistics for the Hospital and are presented below:

	Year ended June 30		
	2017	**2016**	**2015**
Licensed beds adult	308	308	308
Licensed beds OB	39	39	39
Licensed beds peds	154	154	154
Licensed beds newborn	36	36	36
Total licensed beds	537	537	537
Inpatient% of occupancy – adult	92.4 %	86.6 %	93.9 %
Inpatient% of occupancy – OB	58.1	61.4	58.6
Inpatient% of occupancy – peds	71.6	73.8	74.1
Inpatient% of occupancy – newborn	38.3	33.0	37.3
Percent of occupancy (staffed beds)	80.3 %	81.2 %	81.9 %
Discharges	25,248	24,827	25,328
Patient days	157,424	158,610	160,512
Observation days	14,573	13,411	9,680
Average length of stay	6.2	6.4	6.3
Outpatient visits	521,869	520,038	488,423
Emergency visits	78,467	84,523	80,020
Urgent care visits	17,613	17,665	23,704
Surgeries	20,887	19,947	19,460
Break down of days and discharges:			
Adults	15,389	14,740	14,815
Obstetrics	3,183	3,331	3,364
Pediatrics	4,446	4,457	5,009
Newborns	2,230	2,299	2,140
Total discharges	25,248	24,827	25,328
Adults	103,859	104,168	105,601
Obstetrics	8,266	8,768	8,347
Pediatrics	40,272	40,353	41,665
Newborns	5,027	5,321	4,899
Total patient days	157,424	158,610	160,512

Overall patient days for 2017 decreased 1,186 from 2016, which represents a 1.0% decrease. Adult and pediatric days were relatively flat to 2016 with a decrease of less than 0.5%, obstetric and newborn days both decreased 6%. The decrease in newborn and obstetric days correlates with the decrease in births. The Hospital was operating at full or near full capacity after taking into account both the inpatient days and the observation volumes during fiscal years 2017 and 2016. Although patient days were flat, 2017 adult and

(Continued)

pediatric discharges increased 638 from 2016, or by 3.3%. These increases were observed in the adult SAC/MedSurg units and in the Pediatric ICU. The Hospital was able to achieve decreases in lengths of stay of patients allowing more patients into the system to receive care.

Overall patient days for 2016 decreased 1,902 from 2015, which represents a 1% decrease. Adult days decreased 1% and pediatric days decreased 3%; however, there was a 9% increase in newborn days and 5% increase in obstetric days. The decrease in total adult patient days was primarily due to a shift from inpatient admissions to observation days, which is considered outpatient. Observation days for 2016 increased by 3,731 from 2015.

Patients Originating in the Designated Service Area

	2015		2016, Projected based upon 9 months of data		2017		Changes between 2015 to 2017	
Hospital	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
UNM Hospital	16,091	27.4 %	16,775	28.1 %	17,446	28.1 %	1,355	0.7 %
Lovelace Health System:								
Lovelace Medical Center	6,729	11.4	6,799	11.4	7,332	11.8	603	0.4
Lovelace Rehabilitation Center	564	1.0	640	1.1	621	1.0	57	—
Lovelace Westds ide Hospital	1,958	3.3	1,803	3.0	2,077	3.3	119	—
Lovelace Women's Hospital	7,386	12.6	7,067	11.8	6,589	10.6	(797)	(2.0)
Presbyterian Health Services:								
Presbyterian Hospital	18,487	31.4	18,305	30.6	18,472	29.7	(15)	(1.7)
Presbyterian Kaseman Hospital	3,082	5.2	3,272	5.5	3,978	6.4	896	1.2
Presbyterian Rus t Medical Center	4,186	7.1	4,716	7.9	5,340	8.6	1,154	1.5
Subtotal	58,483	99.4	59,377	99.4	61,855	99.5	3,372	0.1
Other New Mexico Hospitals	333	0.6	369	0.6	332	0.5	(1)	(0.1)
Total All Patients Originating in DSA	58,816	100.0 %	59,746	100.0 %	62,187	100.0 %	3,371	— %

DSA = Designated Service Area

Source: Truven Health Analytics

The increase in discharges of Hospital patients originating in the designated service area from 2015 to 2017 is largely due to the post-acute care efforts engaged in to reduce the length of stay in adult hospital beds, mainly due to agreements with community post-acute care providers to accept patients awaiting Medicaid coverage. The Hospital continues efforts to reduce length of stay in order to improve bed availability for the specialized care provided at the Hospital that is not available elsewhere within the community.

The Hospital offers a financial assistance program called UNM Care to which all eligible patients are encouraged to apply. This program assigns patients primary care providers and enables them to receive care throughout the Hospital and at all clinic locations. This program is available to Bernalillo County residents who also meet certain income and asset thresholds. Patients applying for coverage under UNM Care must apply for coverage under Medicaid or the HIX, if eligible. Patients may continue to receive UNM Care until they receive Medicaid eligibility or notification of coverage under the HIX. Patients certified under Medicaid or the HIX may continue to qualify for UNM Care as a secondary coverage for copays and deductibles if they meet the income guidelines. The Hospital uses the same sliding income scale as the ACA to determine if insurance coverage is

considered affordable. If coverage is determined not to be affordable, patients may be granted a hardship waiver to qualify for UNM Care and would not be required to pursue coverage under the HIX.

As of June 30, 2017, 2016, and 2015, there were approximately 6,700, 6,800, and 7,002 active enrollees in UNM Care, respectively. The income threshold for UNM Care is 300% of the FPL, and patients may apply for this program at various locations throughout the Hospital and various community locations. The Hospital does not pursue collection of amounts determined to qualify as charity care, with the exception of copayments. The cost of charity care provided under this program for fiscal years ended June 30, 2017, 2016, and 2015 was $30 million, $37 million, and $45 million, respectively. The implementation of the ACA resulted in a decrease in the cost of charity care of $6 million in 2017 from 2016 and $7 million in 2016 from 2015.

The Hospital provides care to patients who are either uninsured or underinsured and who do not meet the criteria for financial assistance. The Hospital encourages patients to meet with a financial counselor to develop payment arrangements. Although the Hospital pursues collection of these accounts usually through an extended payment plan or a discounted rate, interest is not charged on these accounts, liens are not placed on property or assets, and judgments are not filed against the patients. These accounts are fully reserved and recorded as provision for uncollectible accounts. Provision expense recorded for fiscal years 2017, 2016, and 2015 was $90 million, $52 million, and $63 million, respectively. The cost of care provided to patients who are either uninsured or underinsured and who do not meet the criteria for financial assistance for years ended June 30, 2017, 2016, and 2015 was $49.0 million, $29.2 million, and $33.1 million, respectively. The increase in the cost is associated with an increase in patients who have insurance due to the implementation of the HIX. Medicaid expansion was only for 0–138% of the FPL, which would have been charity patients only.

The Medicaid Supplemental Upper Payment Limit (UPL) funding was replaced with the Safety Net Care Pool (SNCP) Program effective January 1, 2014 as part of the implementation of Centennial Care. Under the SNCP program, the State is providing enhanced Fee for Service (FFS) rates for hospitals classified as SNCP hospitals and increasing the capitation paid to the Managed Care Organizations (MCO). The Hospital is classified as a SNCP provider and has recorded approximately $41.9 million, $36.3 million, and $48 million in revenue for fiscal years 2017, 2016, and 2015, respectively, net of the Intergovernmental Transfer (IGT) that is associated with enhanced FFS rates. The rates are effective for Medicaid discharges beginning January 1, 2014.

For the years ended June 30, 2017, 2016, and 2015, the Hospital provided IGTs to the State of New Mexico in the amounts of $40.6 million, $23.1 million, and $20.4 million, respectively. Due to the economic conditions in the State of New Mexico and nationally, the State has been unable in prior fiscal years to fund a portion of the nonfederal share to obtain federal matching funds (the State's Portion) for certain aspects of Indirect Medical Education (IME), Graduate Medical Education (GME), and enhanced capitation payments, thereby jeopardizing the viability of the Enhanced Payments and IME and GME programs. The State of New Mexico continues to have a negative outlook on State revenues and is unlikely in the future to be able to provide the State's Portion for certain aspects of Medicaid funding. The loss of the Enhanced MCO rates, IME and GME funding would have a large detrimental financial impact on the Hospital, which provides services to the enrollees in the Managed Medicaid and Medicaid Fee-for-Service Programs. This loss would also threaten the health, welfare and well-being of the enrollees in the Medicaid Fee-for-Service and Managed Medicaid Programs. As a result, the Hospital may, in the next fiscal year, enter into Memorandums of Understanding with the State of New Mexico under which the Hospital would agree to make IGTs to fund the nonfederal share of the Medicaid payment pursuant to federal Medicaid regulations at 42 CFR 433.51 (Eligible Operating Funds). The IGTs are recorded as a reduction of net patient service revenues in the accompanying statements of revenues and expenses.

The Medicare Recovery Audit Contract (RAC) program was created through the Medicare Modernization Act of 2003 (MMA). This is a program to review healthcare claims in order to identify and recover inappropriate payments made to providers for fee-for-service Medicare. The RAC program encompassing New Mexico became effective in March 2009, with Cotiviti Healthcare (formerly known as Connolly Consulting) as the current contractor. Currently, the RAC contractor can request up to 86 records every 45 days from the Hospital. Claims can be requested for up to three (3) years after the payment date. During 2017, the Hospital received requests for 5 record totaling $144,000 in payments. One record was declined for overpayment (currently under appeal), two were adjusted for underpayment, and two are pending final determination. Since inception of the RAC program, the Hospital has received requests for 3,113 records, representing approximately $41.6 million in Medicare payments. A total of $36 million has been approved and $5.2 was denied.

Other Operating Revenue

The Hospital expanded its outpatient pharmacy capacity by entering into contract pharmacy service arrangements. These contracted pharmacies are located throughout Albuquerque and the State and are able to fill and refill prescriptions written by physicians credentialed at the Hospital for patients of the Hospital. The contracted pharmacy bills the patient's underlying insurance and remits the payments to the Hospital on a monthly basis, net of a dispensing fee. The Hospital has recorded $17.4 million, $15.2 million, and $18.3 million for pharmacy services in other operating revenue for the years ended June 30, 2017, 2016, and 2015, respectively.

Operating Expenses

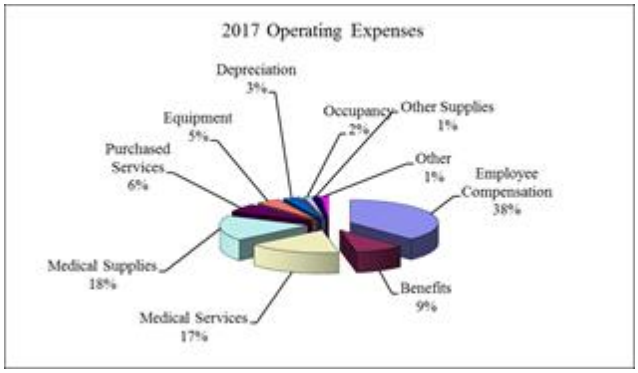
Operating expenses for the Hospital include items such as employee compensation and benefits, medical services, medical supplies, and equipment. For the year ended June 30, 2017, operating expenses, including depreciation of $32 million, totaled $987 million, an increase from 2016 of $50 million or 5%. The most significant expenditures were for employee compensation and benefits.

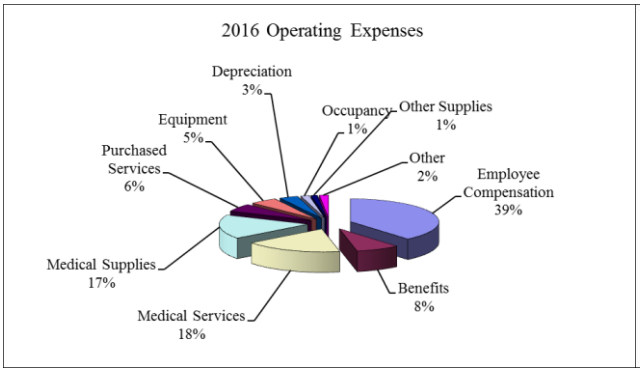
Compensation and benefits combined were $463.0 million, $438.1 million, and $396.3 million for the years ended June 30, 2017, 2016, and 2015, respectively. For fiscal years ended June 30, 2017, 2016, and 2015, the percentage of compensation and benefits combined to total operating expenses was 46.9%, 46.4%, and 46.5%, respectively. The $24.9 million increase from fiscal year 2016 to 2017 is attributable to merit-based increases awarded throughout fiscal year 2016 on employees' anniversary dates. These averaged between 2–3.2% for employees whose performance was determined to be satisfactory or higher. The full impact of these increases is reflected in the fiscal year 2017 compensation and benefits. The increase in compensation and benefits is also partially attributed to an increase in full time equivalents (FTEs). The need for additional resources was driven by the need to support expanded clinical services including lifeguard rotary, care management services, surgical services, radiology, pharmacy, centralized scheduling, and IT security, as well as the need to support coding and billing due to increased volumes.

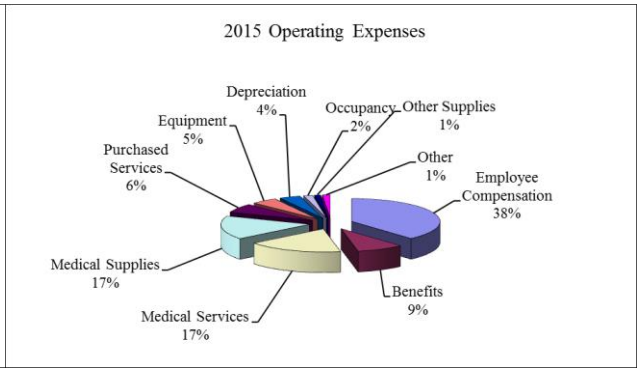
The remaining increase in operating expense in 2017 compared to 2016 was primarily attributed to an increase in medical supplies of $17.8 million (11%), purchased services of $9.3 million (18%), and medical services of $1.8 million (1%). Medical supplies increased as a result of increased pharmaceutical and biologics costs. The sharp increase in the cost of pharmaceuticals was the result of rampant inflation across the nation in that industry. Purchased services increased due to services related to recovery of denials and underpayments from third-party payers. Medical services increased as a result of increased support of physician providers for wage increases, coverage of locum tenens for services with specialty provider vacancies (dermatology, obstetrics, and gynecology), additional emergency services and pediatric physician coverage, and increases in resident positions.

For the year ended June 30, 2016, operating expenses, including depreciation of $32 million, totaled $936.6 million, an increase from 2015 of $84.0 million, or 9.8%. The most significant expenditures were for employee compensation and benefits. The overall increase was primarily attributed to increased compensation and benefits of $41.8 million (10.6%), medical supplies of $19.4 million (13.9%), medical services of $11.6 million (7.4%), and equipment of $6.7 million (16.7%). The $41.8 million increase from fiscal year 2015 to 2016 is attributed to the 2.0% employee wage increase that was awarded in May and June of 2015 and merit-based increases awarded throughout fiscal year 2016 at employees' anniversary dates. These averaged between 2–3.2% for employees whose performance was determined to be satisfactory or higher. The increase is also partially attributed to an increase in FTEs. The need for additional resources was driven by need to support expanded clinical services including the opening of the 4th street clinic, specialty clinics, digestive disease, cystic fibrosis, women's ultrasound, lifeguard, care management services, rehabilitation, radiology, neuropsychology, neurodiagnostics, as well as the need to support coding during the ICD-10 conversion and implementation of the new billing system. Medical supplies increased as a result of increased pharmaceutical and biologics costs, as well as increased costs related to implantable devices. The sharp increase in the cost of pharmaceuticals was the result of rampant inflation across the nation in that industry. Medical services increased as a result of increased support of physician providers for wage increases, coverage of locum tenens for service with specialty provider vacancies (dermatology and neurology), additional Cancer Center physician coverage, provider coverage for the newly opened 4th Street clinic, and increases in resident positions. Equipment expenses increased due to software maintenance and subscriptions as well as increased minor equipment purchases.

The following pie charts depict the operating expense mix for the years ended June 30, 2017, 2016, and 2015:







Nonoperating Revenues and Expenses

The sources of nonoperating revenues for the Hospital are Bernalillo County mill levy, State appropriation, bequest and contributions, State of New Mexico Land and Permanent fund, investment revenues and other nonoperating revenue with the most significant source being Bernalillo County mill levy revenues. The sources of nonoperating expenses for the Hospital are Mission support, interest on capital asset related debt and other nonoperating expenses. Net nonoperating revenues were $76.5 million and $77.9 million for the years ended 2017 and 2016, respectively.

For the years ending June 30, 2017 and 2016, the Bernalillo County Mill Levy tax subsidy was the most significant nonoperating revenue, totaling $82.1 million in 2017 and $81.5 million in 2016. This tax subsidy is provided for the operations and maintenance of the Hospital. The proceeds of the mill levy may not be repurposed for any purpose other than that which the voters approved.

The next largest source of nonoperating revenue in 2017 was State appropriation funding of $5.4 and $5.8 million in 2017 and 2016, respectively. Included in this amount was $4.9 and $5.3 million for the Carrie Tingley Hospital (CTH) in 2017 and 2016, respectively and $460,100 and $493,400 for the Young Children's Health Center (YCHC) in 2017 and 2016, respectively. During the 2016 Legislative Session, the State reduced the state appropriation for fiscal year 2017 by 2.43% and the state appropriation for fiscal year 2016 by 0.60%. During the 2016 Special Session, the State enacted an additional reduction of 5% for fiscal year 2017 state appropriation. The fiscal year 2017 total impact for both of these cuts was a reduction of $(390,000). State land revenue and oil and gas royalties for CTH for 2017 and 2016 were $890,000 and $850,000, respectively.

Contribution revenue was $2.3 million for 2017 compared to $2.1 million in 2016. The primary source for contributions is the annual Children's Miracle Network fund-raising drive, which raised approximately $1.0 million in 2017. In addition, there were donations that were used for child life, Carrie Tingley Hospital, and pediatric hospice. All donation monies are received by the UNM Foundation and are drawn upon by the Hospital.

For the years ended June 30, 2017 and 2016, Mission support was the most significant nonoperating expense, totaling $11.8 million in 2017 and $8.3 million in 2016. Mission support is provided to the University of New Mexico Health Sciences Center to further clinical activities and support the overall mission for the Health System. Included in nonoperating expense was $3.2 million of interest expense on capital asset related debt for each of the years ended June 30, 2017 and 2016.

Special Item

For the year ended June 30, 2016, the Hospital recognized a $6.2 million special item gain. Special items are defined by GASB as "significant transactions or other events within the control of management that are either unusual in nature or infrequent in occurrence." The special item gain of $6.2 million is related to the reversal of the OPEB liability as this post employment medical and dental defined-benefit plan was terminated December 31, 2015. This liability was originally recorded by the Hospital based on the actuarially determined net OPEB obligation as of June 30, 2014.

Capital Assets

At June 30, 2017, the Hospital had $215.5 million invested in capital assets, net of accumulated depreciation of $378.4 million. Depreciation charges for fiscal year 2017 totaled $32.1 compared to $32.0 million and $32.7 million in 2016 and 2015, respectively.

	June 30		
	2017	**2016**	**2015**
Land, building, and improvements	$ 191,757,431	188,642,900	184,129,590
Building service equipment	165,151,782	163,535,895	161,399,372
Fixed equipment	16,740,924	16,613,021	16,385,935
Major moveable equipment	215,896,198	237,144,047	224,610,736
Construction in progress	4,285,665	4,827,786	7,620,835
	593,832,000	610,763,649	594,146,468
Less accumulated depreciation	(378,380,513)	(387,215,639)	(363,111,147)
Net property and equipment	$ 215,451,487	223,548,010	231,035,321

During 2017, total capital assets decreased $8.1 million primarily as a result of a change in policy related to the capitalization of operating instruments and other small operating room equipment. The Hospital did a review of these items and noted that the actual useful lives were less than 3 years as a result of high volumes in the operating room and, as a result, increased wear and tear on these items. These items are now being expensed when purchased. During 2017, the largest capital additions were within major moveable equipment ($17.7 million) and land, building, and improvements ($6.7 million). IT systems are included within the major moveable equipment category. The larger major moveable equipment purchases included a Skyra Magnetom MRI scanner, a nurse call system, and a Da Vinci surgical robot. The Skyra MRI is designed to improve productivity and improve patient centered care by offering a full range of applications for clinical and research uses. The Da Vinci surgical robot offers patients a minimally invasive surgical option by using a 3D high-definition vision system and small instruments that bend and rotate better than the human hand. The larger building improvement projects that were capitalized included renovation of the orthopedic rehabilitation clinic, renovations in the main hospital for installation of the Skyra MRI equipment, and plumbing replacements for the older sections of the Hospital needed due to aging of the facility. Several new projects were initiated during fiscal year 2017 including roofing replacements at the main hospital and renovations to multiple offsite clinics. These projects were part of the construction in progress balance at June 30, 2017.

Debt Activity

The Hospital's bonds payable totaled $103.4 million and $109.0 million at June 30, 2017 and 2016, respectively. On May 14, 2015, the Hospital issued $115 million in new bonds (2015 Series bonds) to refinance the Federal Housing Administration (FHA) insured Hospital Mortgage Revenue Bonds, 2004 Series, issued by the UNM Board of Regents for the purpose of financing the construction, equipping, and furnishing of the 478,000-square-foot Women's and Children's Pavilion. The project was placed into service June 2007. The 2015 Series bonds were issued pursuant to a trust indenture, dated as of May 1, 2015, by and between the Hospital and Wells Fargo Bank, National Association, as trustee for the purpose of refinancing the 2004 Series bonds. The 2015 Series bonds carry interest rates that range from 0.484% to 3.532%. The Hospital

(Continued)

refunded the 2004 Series bonds to reduce its total debt service payments through 2032 by approximately $56.7 million and to obtain an economic gain (difference between the present values of the debt service payments on the old and new debt) of $15.9 million. The reduction in total debt service was accomplished through a combination of lower interest rates compared to the Series 2004 Bonds and using the balances in the no longer required 2004 Series Mortgage reserve, debt service reserve, collateral, surplus, and redemption accounts which resulted in a reduction of $42.9 million of the principal balance.

The current portion of this debt was $5.6 million and $5.5 million at June 30, 2017 and 2016, respectively.

The loan guarantee is considered federal assistance subject to the requirements of Office of Management and Budget (OMB) Uniform Guidance. Accordingly, the loan guarantee is considered a federal award for purposes of UNM's June 30, 2017 and 2016 Single Audit.

Change in Net Position

The Hospital's total change in net position showed a net increase for 2017 and 2016. Total net position (assets plus deferred outflows minus liabilities minus deferred inflows) is classified by the Hospital's ability to use these assets to meet operating needs. Unrestricted net position may be used to meet all operating needs of the Hospital. A portion of the Hospital's net position may be restricted as to use by sponsoring agencies, donors, or other nonhospital entities. The restricted net position is further classified as to the purpose for which the funds must be used. Restricted net position represents funds generated by contributions, gifts, and grants as well as funds restricted for use in accordance with the trust indenture and debt agreements. Net position increased approximately $17.4 million in fiscal year 2017. The increase in net position is due to net nonoperating revenue of $76.5 million, offset by $59.0 million in net operating loss.

Factors Impacting Future Periods

The Bernalillo County mill levy that the Hospital receives is based on property values. It is possible that the amount of the mill levy may remain flat or potentially decrease as a result of reduced property values and slowdowns in the building construction industry. The voters approved the renewal of the mill levy in the November 2016 election. The mill levy is subject to approval by the Bernalillo County voters every eight years, and it will be up for renewal in the November 2024 election.

The Hospital's facilities are leased from Bernalillo County (the County) by UNM under the 1999 lease agreement, as described under note 1 to the financial statements. Section IV. Term of this agreement provides for either party to the lease to reopen the terms and conditions by giving notices in the first three months of 2006, 2014, 2022, 2030, and 2038. On March 25, 2014, the County Commission approved Administrative Resolution AR 2014-21 to open negotiations with UNM on the lease agreement and to establish a taskforce to provide healthcare expertise to the County in support of the negotiations. The Hospital continues to work with the County and Indian Health Services (IHS) to finalize negotiations on the lease agreement. Agreement has not been finalized; however, the primary requests the Hospital will likely implement are: 1) continue to allocate at least 15% of the proceeds of the Mil Levy for the operation and maintenance of the Adult Psychiatric Center, 2) continue to fund from its operational funds one or more navigational service programs and a transitional planning and case management services program in the combined amount of no more than $2,060,000 annually to focus on patient navigation services and staffing of a reentry center for inmates released from the Metropolitan Detention Center (MDC), and program expansion of the Adult Psychiatric Center's case management service for patients released from the MDC to connect them to Pathways program navigators, preparation of an annual report of the number of Native Americans served by these programs will be included

as part of the "Annual UNMH report" to the Pueblos and Tribes, 3) the University will continue existing efforts and will collaborate with the County and IHS regarding the initiation of any new efforts addressing the services provided by the Hospital pursuant to the Lease Agreement, the Federal Contract, the 1999 Consent, and the 2004 Consent with focus on addressing (a) reporting and interaction, (b) accountability and transparency, (c) primary care/low-income care, (d) financial assistance, (e) Native American Care, (f) behavioral mental health and substance abuse care. The Draft MOU was posted on September 8, 2017 for a 30-day public comment period.

On August 2, 2017, CMS released the fiscal year 2018 Inpatient Prospective Payment (IPPS) Final Rule. The IPPS rates will increase by a market basket increase of 2.7%, less a 1.35% productivity reduction mandated under the Affordable Care Act (ACA), less a 0.6% reduction for two-midnight policy adjustments, plus a 0.4588% documentation and coding increase mandated by the American Taxpayer Relief Act of 2012 (ATRA). CMS imposed a 1.61% increase to the Federal Capital Rate. The net impact of the market basket increase and adjustments on the Hospital's reimbursement is estimated at $1 million increase.

The 2018 IPPS Final Rule implements the ACA that hospitals scoring in the top quartile of the nation for Hospital-acquired Conditions (HACs) are subject to a 1% penalty reduction in payments. The Hospital's HAC score is in the highest quartile; therefore, the Hospital continues to be subject to the 1% decrease. The Hospital's payment rates are expected to have a 0.05% negative impact under the Hospital Readmission Reduction Program required by ACA. The impact of these quality pay-for-performance programs is estimated at $1.1 million for federal fiscal year 2018, which is consistent with the payment reductions experienced in 2017.

Hospitals not submitting quality data and not meaningful use users of electronic health records (EHRs) in fiscal year 2018 are subject to a full reduction in the initial market basket increase of 2.7%. If a hospital is subject to both reductions, they will start with a market basket rate of 0.0%, and will receive an update of negative 1.5%. The Hospital has submitted quality measures and is considered a meaningful use user for fiscal year 2016; therefore, there will be no negative impact on the Hospital's reimbursement for these two factors.

Beginning in fiscal year 2014, ACA required changes to Medicare Disproportionate Share Hospital (DSH) payments. The Hospital receives 25% of the DSH payment previously received using the traditional formula as part of the "base" DRG payments for each Medicare inpatient discharge. The remaining 75% flows into a separate funding pool and is distributed based on each DSH-eligible hospital's ratio of uncompensated care relative to the total for all DSH-eligible hospitals. Beginning in federal fiscal year 2018, CMS, in its Final IPPS Rule, has incorporated Cost Report Worksheet S-10 uncompensated care cost as one of three factors averaged to determine a hospital's allocation of DSH Uncompensated Care payments. The other two factors, Medicaid days and Supplemental Security Income (SSI) Ratios, will be phased out over the next two years as CMS moves to using Worksheet S-10 data solely. The uncompensated care portion of the Medicare DSH funding is paid as a flat amount on each Medicare inpatient discharge. This pool is reduced or increased as uninsured populations change. The national uninsured rate is estimated to be 8.15% for fiscal year 2018 and Medicare has calculated an increase in the Medicare DSH payments for fiscal year 2018. The Hospital's estimated impact associated with the federal fiscal year 2018 Medicare Disproportionate share will be an increase of $2.7 million. The Hospital is projected to receive a 62% increase in uncompensated care DSH in federal fiscal year 2019 and a 26% increase in uncompensated care DSH for federal fiscal year 2020 based on the transition to Cost Report Worksheet S-10.

On July 13, 2017, CMS issued the proposed calendar year 2018 Outpatient Prospective Payment (OPPS) rule. CMS proposed to raise the base OPPS Payment rate by a market basket increase of 2.9%, less a productivity adjustment of 0.4% and 0.75% for reductions required under ACA. For hospitals that do not report the required quality measures identified by CMS, the update will be decreased by 2.0% age points, to -0.25%. The Hospital does report quality measures so no reduction is anticipated. This proposed rule is expected to increase the Hospital's OPPS reimbursement by $848,000. The proposed OPPS rule has also proposed to decrease the reimbursement for drugs acquired through the Office of Pharmacy Affairs section 340B drug program. For separately payable 340B Drugs CMS is proposing to decrease reimbursement from Average Wholesale Price (AWP) plus 6% to AWP less 22.5%, a 27% reduction. The rule proposes to implement this provision in a budget-neutral manner by redistribution of the savings to all hospitals through an increase in the national OPPS conversion factor. The provision also contemplates implementation in a nonbudget-neutral manner by retaining the savings rather than increasing payments for other OPPS services. Implementation of this provision of the proposed OPPS rule would have significant negative effects on the nation's safety net hospitals that are eligible for 340B drug purchases. The estimated impact of this proposed reduction on the Hospital is a decrease in reimbursement of $8.2 million. The bulk of this reduction will be related to infusion and chemotherapy drugs provided in the Hospital's Cancer Center. The Hospital relies on savings achieved by programs such as 340B drugs to provide state-of-the art, patient-centered care to the State's low-income and uninsured populations. Loss of margins on this program could negatively affect the Hospital's ability to provide coordinated care to disadvantaged populations. On August 21, 2017, the CMS Advisory Panel on Hospital Outpatient Payment (HOP Panel) issued a recommendation that CMS not finalize the proposal to decrease the payment rate on 340B purchased drugs and to collect data from public comment and other sources about the impact of the proposal and how CMS intends to shift the savings if the cut were implemented.

The proposed OPPS rule also includes a provision to remove total knee arthroplasty (TKA), aka total knee replacement, surgeries from the inpatient only list of procedures. The HOP Panel recommended removal of TKA from the inpatient only list in 2016. If approved, these surgeries could be performed on an outpatient basis at hospital facilities and ambulatory surgical centers, rather than require an admission to an inpatient hospital facility. CMS notes that it would expect providers to develop "evidence-based" criteria to determine if an outpatient setting is appropriate for any particular patient to receive a knee replacement procedure.

Section 603 of the Bipartisan Budget Act of 2015 required that services furnished in off-campus provider-based departments that began billing under OPPS on or after November 2, 2015 will no longer be paid under OPPS. Under this site-neutral payment policy, those services will be paid under another applicable Part B payment system. For calendar year 2017, CMS established the physician fee schedule as the applicable Part B payment system and set payment for most non excepted services at 50% of the OPPS rate. Services provided in a dedicated emergency department, services provided in an existing provider-based department prior to November 2, 2015, and services furnished in a hospital department located within 250 yards of a remote location of the Hospital are excepted from this rule. In the calendar year 2018 proposed Physician Fee Schedule rule (issued on July 13, 2017), CMS proposes significant reductions to the site-neutral payment rates. CMS proposes to decrease reimbursement to 25% of the OPPS rates. In May 2017, the Hospital opened its off-campus Women's Primary Care Clinic. Services provided at this clinic are subject to the site-neutral payment policy as described above.

In May 2017, BlueCross BlueShield of New Mexico (BCBS NM) provided notice to the Hospital that it would be terminating its Medicare Advantage Amendment effective September 1, 2017. The letter identified the Hospital as a provider with rates higher than the BCBSNM Medicare Plan fee schedule. The termination was provided without cause. The Hospital would be allowed to continue to furnish covered services to BCBS NM Medicare Advantage PPO members as a Nonparticipating provider. The Hospital has continued to negotiate with BCBS NM to ensure an adequate network for the Medicare Advantage PPO members. BCBS NM has issued an extension to the termination to November 1, 2017, to allow BCBS M and the Hospital additional time to agree upon and contractualize new terms under which the Medicare Advantage amendment may continue. Payments to the Hospital under the BCBS NM Medicare Advantage amendment are estimated at $24.6 million annually.

CMS has limited review of claims by Quality Improvement Organizations to a six-month look back period. Payments for admissions that have been reviewed but are waiting for a second review will be paid if they are older than six months. All claims outside of the six-month look back period will be removed from the sample for review and will be paid under Medicare Part A.

The Hospital is the only Level I Trauma Center in the State and is at physical capacity to treat adult patients. As such, the Hospital engaged the services of a national architectural and engineering firm with experience in designing teaching hospitals to identify location, size, phasing, and staging for a replacement hospital. The initial plan for the UNM Hospitals Modern Medical Facility has been received and is being evaluated. In August 2017, the Hospital received approval from the UNM Regents to move forward with Phase II planning for the Modern Medical Facility, development of design and architectural plans.

Contacting the Hospital's Financial Management

This financial report is designed to provide the Hospital's patients, suppliers, taxpayers, and creditors with a general overview of the Hospital's finances and to show the Hospital's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the Hospital's Finance and Accounting Department, Attn: Controller, PO Box 80600, Albuquerque, NM 87198-0600.

UNIVERSITY OF NEW MEXICO HOSPITAL

Statements of Net Position

June 30, 2017 and 2016

Assets	2017	2016
Current assets:		
Cash and cash equivalents	$ 178,328,724	143,264,472
Marketable securities	34,741,526	34,864,096
Restricted assets by trustee for debt service	80,107	74,683
Receivables:		
Patient (net of allowance for doubtful accounts and contractual adjustments of approximately $308,559,000 in 2017 and $296,217,000 in 2016)	116,099,713	127,752,057
Due from University of New Mexico	960,366	1,472,059
Due from University of New Mexico Health System	1,625,884	1,278,331
Due from University of New Mexico Medical Group	1,815,070	1,876,195
Estimated third-party payor settlements	24,276,335	52,316,989
Bernalillo County Treasurer	1,326,877	1,478,737
Other	2,896,040	2,886,450
Total net receivables	149,000,285	189,060,818
Prepaid expenses	6,991,653	10,802,220
Inventories	16,289,168	14,689,871
Total current assets	385,431,463	392,756,160
Noncurrent assets:		
Assets held by trustee:		
Restricted for mortgage reserve fund	17,978,206	16,052,772
Assets designated by UNM Hospital Board of Trustees	22,461,992	21,040,439
Total restricted and designated assets	40,440,198	37,093,211
Capital assets, net	215,451,487	223,548,010
Total noncurrent assets	255,891,685	260,641,221
Total assets	$ 641,323,148	653,397,381
Deferred Outflows		
Total deferred outflows related to pensions	$ 214,591	269,677
Liabilities		
Current liabilities:		
Accounts payable	$ 76,169,522	60,900,119
Accrued payroll	26,232,793	19,569,868
Due to University of New Mexico	19,301,559	47,438,440
Due to University of New Mexico Medical Group	2,114,744	3,177,580
Bonds payable – current	5,605,000	5,540,000
Interest payable bonds	86,684	88,110
Accrued compensated absences	22,899,423	22,883,491
Estimated third-party payor settlements	34,646,449	49,271,287
Other accrued liabilities	250,063	183,511
Total current liabilities	$ 187,306,237	209,052,406
Noncurrent liabilities:		
Bonds payable	97,820,000	103,425,000
Due to affiliates	8,948,907	10,464,632
Net pension liability	2,804,867	2,924,809
Total noncurrent liabilities	109,573,774	116,814,441
Total liabilities	$ 296,880,011	325,866,847
Deferred Inflows		
Total deferred inflows related to pensions	$ 316,614	906,541
Net Position		
Net investment in capital assets	$ 112,026,487	114,583,010
Restricted, expendable:		
For grants, bequests, and contributions	16,438,622	15,168,783
In accordance with the trust indenture and debt agreement	18,058,313	16,127,455
Unrestricted	197,817,692	181,014,422
Total net position	$ 344,341,114	326,893,670

See accompanying notes to financial statements.

UNIVERSITY OF NEW MEXICO HOSPITAL

Statements of Revenues, Expenses and Changes in Net Position

Years ended June 30, 2017 and 2016

	2017	2016
Operating revenues:		
Net patient service	$ 902,433,423	847,756,932
State and local contracts and grants	2,041,138	1,651,109
Other operating	23,169,985	22,230,705
Total operating revenues	927,644,546	871,638,746
Operating expenses:		
Employee compensation	374,337,765	363,273,536
Benefits	88,703,359	74,832,473
Medical services	168,813,185	167,019,185
Medical supplies	176,912,380	159,166,315
Purchased services	61,832,847	52,521,471
Equipment	44,588,459	46,879,551
Depreciation	32,089,633	32,030,307
Occupancy	14,617,764	14,406,716
Other	14,398,206	15,548,781
Other supplies	10,383,452	10,896,880
Total operating expenses	986,677,050	936,575,215
Operating loss	(59,032,504)	(64,936,469)
Nonoperating revenues (expenses):		
Bernalillo County mill levy	82,139,803	81,471,947
State appropriation	5,398,300	5,789,100
State of New Mexico Land and Permanent Fund proceeds	890,198	850,430
Investment income (interest, dividends, gains, and losses)	111,248	479,924
Equity (loss) in income of TriCore and TriCore Lab Svc Corp.	1,421,552	(413,021)
Health System Mission support	(11,814,704)	(8,306,465)
Interest on capital asset-related debt	(3,170,552)	(3,182,592)
Bequests and contributions	2,310,639	2,095,358
Other nonoperating revenue	67,563	2,919
Other nonoperating expense	(874,099)	(864,581)
Net nonoperating revenue	76,479,948	77,923,019
Increase in net position, before special items	17,447,444	12,986,550
Special item:		
Gain on reversal of OPEB liability	—	6,194,964
Increase in net position	17,447,444	19,181,514
Net position, beginning of year	326,893,670	307,712,156
Net position, end of year	$ 344,341,114	326,893,670

See accompanying notes to financial statements.

UNIVERSITY OF NEW MEXICO HOSPITAL

Statements of Cash Flows

Years ended June 30, 2017 and 2016

	2017	2016
Cash flows from operating activities:		
Cash received from Medicaid and Medicare	$ 587,663,156	484,443,405
Cash received from insurance and patients	413,862,344	372,855,338
Cash received from contracts and grants	818,510	2,666,658
Cash payments to employees	(363,350,103)	(353,777,918)
Cash payments to suppliers	(396,600,600)	(439,906,470)
Cash payments to University of New Mexico	(197,406,178)	(71,807,594)
Cash payments to University of New Mexico Health System	(347,553)	(1,077,284)
Cash payments to University of New Mexico Medical Group	(2,286,135)	(663,344)
Cash payments to State of New Mexico for intergovernmental transfer	(74,023,917)	(12,220,335)
Cash payments to affiliates	(1,515,725)	(752,855)
Other receipts	24,334,078	21,549,408
Net cash (used in) provided by operating activities	(8,852,123)	1,309,009
Cash flows from noncapital financing activities:		
Cash received from Bernalillo County mill levy	82,291,663	81,410,808
Cash received from state general fund and other state fund appropriations	5,398,300	5,789,100
Cash received from State of New Mexico Land and Permanent Fund	957,935	844,779
Cash receipts for other than capital or operating purposes	67,563	2,919
Cash received from contributions for other-than-capital purposes	2,310,639	2,095,358
Cash paid for mission support	(11,814,705)	(8,306,465)
Net cash provided by noncapital financing activities	79,211,395	81,836,499
Cash flows from capital financing activities:		
Principal payments of bonds	(5,540,000)	(6,035,000)
Interest payments on capital assets-related to debt	(3,171,978)	(3,521,307)
Purchases of capital assets	(24,038,112)	(24,542,996)
Cash payments to University of New Mexico	—	(50,500,000)
Cash payments for debt-related activities	(829,097)	(864,581)
Net cash used in capital financing activities	(33,579,187)	(85,463,884)
Cash flows from investing activities:		
Cash payments for 2015 bond reserve fund	(1,908,474)	(1,909,877)
Proceeds from sales and maturities of investments	36,189,233	33,091,589
Purchase of investments	(36,437,983)	(32,432,762)
Interest and dividends on investments	441,391	346,121
Net cash used in investing activities	(1,715,833)	(904,929)
Net increase (decrease) in cash and cash equivalents	35,064,252	(3,223,305)
Cash and cash equivalents, beginning of year	143,264,472	146,487,777
Cash and cash equivalents, end of year	$ 178,328,724	143,264,472

See accompanying notes to financial statements.

(Continued)

UNIVERSITY OF NEW MEXICO HOSPITAL

Statements of Cash Flows

Years ended June 30, 2017 and 2016

		2017	2016
Reconciliation of operating loss to net cash (used in) provided by operating activities:			
Operating loss	$	(59,032,504)	(64,936,469)
Adjustments to reconcile operating loss to net cash used in operating activities:			
Depreciation expense		32,089,633	32,030,307
Provision for doubtful accounts		90,272,433	52,093,114
Changes in assets, deferred outflows, liabilities, and deferred inflows:			
Patient receivables		(78,620,089)	(50,108,227)
Due from University of New Mexico		511,693	(691,935)
Due from University of New Mexico Health System		(347,553)	(1,077,284)
Due from University of New Mexico Medical Group		61,125	(663,344)
Estimated third-party payor settlements receivables		28,040,654	(20,717,571)
Other receivables and prepaid expenses		3,752,032	(7,371,588)
Inventories		(1,599,297)	(1,072,343)
Deferred outflow of resources related to pensions		55,086	(253,753)
Accounts payable		15,269,403	9,907,524
Accrued expenses		6,745,409	5,283,288
Due to University of New Mexico		(28,136,881)	31,904,771
Due to University of New Mexico Medical Group		(1,062,835)	1,405,112
Estimated third-party payor settlements liabilities		(14,624,838)	16,054,160
Due to affiliates		(1,515,725)	(752,855)
Net pension liability		(119,942)	(138,023)
Deferred inflow of resources related to pensions		(589,927)	414,125
Net cash (used in) provided by operating activities	$	(8,852,123)	1,309,009

See accompanying notes to financial statements.

(1) Description of Business

University of New Mexico Hospital (the Hospital), operated by the University of New Mexico (UNM) Health Sciences Center (HSC), is certified as a short-term acute care provider with a full range of medical services provided primarily to the New Mexico community. UNM is a state institution of higher education created by the New Mexico Constitution. The accompanying financial statements of the Hospital are intended to present the financial position and changes in financial position and cash flows of only that portion of the business-type activities of UNM that is attributable to the transactions of the Hospital. The Hospital is not a legally separate entity and is, therefore, reported as a division of UNM and included in the basic financial statements of UNM. The Hospital, as a division of UNM, has no component units.

The Hospital's facilities are leased from Bernalillo County (the County) by UNM. The lease provides for a $1 annual rental payment, an allocation of the County mill levy, and medical treatment for American Indians as required by a 1952 agreement with the federal government, and is contingent on approval of the mill levy by the electorate every eight years with the last voter approval in November 2016. Effective as of November 18, 2004, the UNM Board of Regents and the Board of County Commissioners entered into a First Amendment to the Original Lease, as amended, (the Lease), under which, among other things, (i) the term of the Original Lease was extended until June 30, 2055, which is after the maturity of the Department of Housing and Urban Development (HUD)-insured loan (refer to note 9, Bonds Payable); (ii) the Hospital was authorized to obtain the HUD-insured loan; (iii) the Hospital was authorized to encumber the Lease with a leasehold mortgage; and (iv) the actions that are to be taken concerning the operations of the Hospital in the event of a default under the HUD-insured loan were described.

The UNM Board of Regents is the ultimate governing authority of the Hospital, but it has delegated certain oversight responsibilities to the UNM HSC Board of Trustees. The Hospital is governed by the UNM HSC Board of Trustees, which consists of nine members, including seven members appointed by the UNM Board of Regents, two of which are nominated by the All Pueblo Council of Governors (APCG). The two remaining members are appointed by the County Commission.

In 2007, UNM Carrie Tingley Hospital (CTH) inpatient unit relocated to the Women's and Children's Pavilion, a new addition to the Hospital known as Children's Hospital and Critical Care Pavilion (CHCCP). As a result, CTH's healthcare provider number was terminated, and CTH became a pediatric unit of the Hospital.

(Continued)

CTH was created in 1989 by the legislature of the State of New Mexico to provide care and treatment for the physically challenged children of the State of New Mexico in need of long-term inpatient or outpatient care. A brief summary of CTH's financial results for the years ended June 30 is as follows:

		2017	2016
Total operating revenues	$	12,257,233	12,433,216
Total operating expenses		(18,439,663)	(18,957,161)
Operating loss		(6,182,430)	(6,523,945)
Nonoperating revenue		6,086,761	6,180,267
Total decrease in net position		(95,669)	(343,678)
Net position, beginning of year		2,613,691	2,957,369
Net position, end of year	$	2,518,022	2,613,691

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying financial statements have been prepared using the economic resource measurement focus and the accrual basis of accounting, in accordance with U.S. generally accepted accounting principles for healthcare organizations, and are presented in accordance with the reporting model as prescribed in Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments,* as amended by GASB Statement No. 37, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments: Omnibus*; GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*; and GASB Statement No. 38, *Certain Financial Statement Note Disclosures; and GASB Statement No. 63, Financial Reporting of Deferred Outflows of Resources, Deferred Inflow of Resource, and Net Position*. The Hospital follows the business-type activities' requirements of GASB Statement No. 34 and No. 63. This approach requires the following components of the Hospital's financial statements:

- Management's discussion and analysis
- Basic financial statements, including a statement of net position, statement of revenues, expenses, and changes in net position, and statement of cash flows using the direct method for the Hospital as a whole
- Notes to financial statements

(Continued)

GASB Statement No. 34 and subsequent amendments including GASB Statement No. 63 as discussed below, established standards for external financial reporting and requires that resources be classified for accounting and reporting purposes into the following three net position categories:

- *Net Investment in Capital Assets* – Capital assets, net of accumulated depreciation and outstanding principal balances of debt attributable to the acquisition, construction, or improvement of those assets.
- *Restricted Net Position – Expendable* – Assets whose use by the Hospital is subject to externally imposed constraints that can be fulfilled by actions of the Hospital pursuant to those constraints or that expire by the passage of time.
- *Unrestricted Net Position* – Assets that are not subject to externally imposed constraints. Unrestricted net position may be designated for specific purposes by action of the Board of Trustees or the UNM Board of Regents or may otherwise be limited by contractual agreements with outside parties.

(b) Recent Accounting Pronouncements

In November 2016, GASB issued Statement No. 83, *Certain Asset Retirement Obligations*. Statement No. 83 addresses accounting and financial reporting for certain asset retirement obligations with the establishment of criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources for asset retirement obligations. Statement No. 83 is effective for reporting periods beginning after June 15, 2018; early adoption is encouraged. The Hospital is evaluating the impact the standard will have on its financial statements.

In March 2016, GASB issued Statement No. 82, *Pension Issues – an Amendment of GASB Statements No. 67, No. 68, and No. 73*. Statement No. 82 addresses issues regarding (1) the presentation of payroll-related measures in required supplementary information, (2) the selection of assumptions and the treatment of deviations from the guidance in an Actuarial Standard of Practice for financial reporting purposes, and (3) the classification of payments made by employers to satisfy employee contribution requirements. The effective date for Statement No. 82 is for reporting periods beginning after June 15, 2016, except for the requirements of paragraph 7 in a circumstance in which an employer's pension liability is measured as of a date other than the employer's most recent fiscal year-end. In that circumstance, the requirements of paragraph 7 are effective for that employer in the first reporting period in which the measurement date of the pension liability is on or after June 15, 2017. The Hospital will adopt this Statement in fiscal year 2018; adoption is not anticipated to have a significant impact.

In August 2015, GASB issued Statement No. 77, *Tax Abatement Disclosures*. Statement No. 77 established financial reporting standards for tax abatement agreements entered into by state and local governments. The effective date for Statement No. 77 is for reporting periods beginning after December 15, 2015. The adoption of Statement No. 77 did not significantly impact the Hospital. See note 2(p).

(c) Use of Estimates

The preparation of financial statements in accordance with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the financial statement

dates, and the reported amount of revenues and expenses during the reporting periods. Due to uncertainties inherent in the estimation process, actual results could differ from those estimates.

(d) Operating Revenues and Expenses

The Hospital's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues, such as patient service revenue, result from exchange transactions associated with providing healthcare services, the Hospital's principal activity. Exchange transactions are those in which each party to the transaction receives and gives up essentially equal values. Operating expenses are all expenses incurred to provide healthcare services.

(e) Grants and Contracts

Revenue from grants and contracts is recognized to the extent of direct costs and allowable indirect expenses incurred under the terms of each agreement. Funds restricted by grantors for operating purposes are recognized as revenue when the grant eligibility requirements have been met.

(f) Nonoperating Revenue and Expenses

Nonoperating revenue includes activities that have the characteristics of nonexchange transactions, such as appropriations, gifts, and government levies. Nonoperating revenues also include revenues earned outside the clinical operations of the Hospital. These revenue streams are recognized under GASB Statement No. 33, *Accounting and Financial Reporting for Nonexchange Transactions*. Appropriations are recognized in the year they are appropriated, regardless of when actually received. Bequests and contributions are recognized when all applicable eligibility requirements have been met. Investment income is recognized in the period in which it is earned. The mill levy is recognized in the period in which it is collected by the County.

(g) Cash and Cash Equivalents

The Hospital considers all highly liquid investments (excluding amounts whose use is limited) purchased with an original maturity of three months or less to be cash equivalents.

(h) Investments and Investment Return

Investments are recorded at fair value. At June 30, 2017 and 2016, investments consist of obligations of the U.S. government and U.S. government agencies. Investment income includes interest and realized and unrealized gains and losses on investments. Investment income is reported as nonoperating revenue when earned.

(i) Inventories

Inventories are recorded at the lower of cost or market. Cost is determined using the first-in, first-out method, except the replacement cost method is used for pharmacy and operating room inventories. Inventory consists principally of medical, surgical, and maintenance supplies, and pharmaceuticals are stated at the lower of cost or market.

(j) Assets Designated by UNM Hospital Board of Trustees

The investment in TriWest Healthcare Alliance Corporation (TriWest) is accounted for at fair value. The investments in TriCore Reference Laboratories (TRL or TriCore) and TriCore Laboratory Services Corporation (TLSC) are accounted for using the equity method.

(k) Capital Assets

Capital assets are stated at cost or at estimated fair value on date of acquisition. Donated property and equipment are stated at fair market value when received. The Hospital's capitalization policy for assets includes all items with a unit cost of more than $5,000 with the exception of small operating room instruments that have historically needed replacement prior to the end of their recommended useful lives. These instruments are expensed when purchased. Depreciation on capital assets is calculated using the straight-line method over the estimated useful lives of the assets as indicated in the "Estimated Useful Lives of Depreciable Hospital Assets," Revised 2013 Edition published by the American Hospital Association. Repair and maintenance costs are charged to expense as incurred. On a quarterly basis, the Hospital assesses long-lived assets in order to determine whether or not it is necessary to retire, replace, or impair based on condition of the assets and their intended use. There was no impairment of capital assets for the year ended June 30, 2017.

(l) Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the NM Education Retirement Board (ERB) plan and additions to/deductions from ERB's fiduciary net position have been determined to be the same basis as they are reported by ERB. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms.

(m) Due to Affiliates

The Hospital receives all cash on behalf of the Center and pays all obligations. Amounts due to affiliates consist mainly of cash collected in excess of expenses paid and do not bear interest.

(n) Net Patient Service Revenues

Net patient service revenues are recorded at the estimated net realizable amount due from patients, third-party payors, and others, for services rendered. Retroactive adjustments under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Contractual adjustments resulting from agreements with various organizations to provide services for amounts that differ from billed charges, including services under Medicare, Medicaid, and certain managed care programs, are recorded as deductions from patient revenues.

As part of the New Mexico Medicaid managed care program, Centennial Care. The Human Services Department (HSD) established a Safety Net Care Pool (SNCP) to support uncompensated care (UC) and delivery system reform. Eligible SNCP hospitals are sole community hospitals and UNM Hospital, the state-operated teaching hospital in New Mexico. Through the SNCP, Medicaid Fee-For-Service (FFS) and managed care reimbursement rates were enhanced to compensate eligible hospitals for

uncompensated care costs incurred effective April 1, 2014. The Centennial Care waiver requires annual initial and final reconciliation UC applications to determine uncompensated care costs (UCC) and offsetting revenues. Any UCC disbursements that exceed the calculated UCC costs will be recouped by the HSD. The Centennial Care program also provides for a Hospital Quality Improvement Incentive (HQII) Pool to compensate hospital providers that report quality measures. The Hospital received SNCP HQII payments of $1.0 million and $947,889 in fiscal years 2017 and 2016, respectively.

The Hospital receives Medicaid Indirect Medical Education (IME) payments as outlined in the New Mexico Administrative Code §8.311.3.12F(8). IME funding is provided to hospitals that have residents in an approved graduate medical education (GME) program to subsidize the higher patient care costs of teaching hospitals relative to nonteaching hospitals. GME funding is provided to the Hospital to subsidize the cost of direct and indirect medical education expenses for training residents in community-based primary care residency programs.

(o) Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without expectation of payment or at amounts less than established rates. The Hospital does not pursue collection of amounts determined to qualify as charity care with the exception of copayments. Charity care is treated as a deduction from gross revenue.

(p) Bernalillo County Taxes

The amount of the property tax levy is assessed annually on November 1 on the valuation of property as determined by the County Assessor and is due in equal semi-annual installments on November 10 and April 10 of the next year. Taxes become delinquent 30 days after the due date unless the original levy date has been formally extended. Taxes are collected on behalf of the Hospital by the County Treasurer and are remitted to the Hospital in the month following collection. Revenue is recognized in the fiscal year the levy is collected by the County. This tax subsidy is provided for the operation and maintenance of the Hospital. The proceeds of the levy may not be used for any purpose other than that which the voters approved.

Bernalillo County may utilize property tax exemptions and abatements to stimulate economic development and investment in the community. The proceeds of the levy were reduced by $626,000 during the year ended June 30, 2017 as a result of the exemptions and abatements granted.

(q) State Appropriation

The funding for the state appropriation is included in the General Appropriation Act, which is approved by the House and Senate of the State Legislature and signed by the governor before going into effect. Total funds appropriated for 2017 and 2016 include $5,398,300 and $5,789,100, respectively, in the General Fund. The General Fund is designated as a nonreverting fund, per House Bill 2, Section 4, Sub-Section J, Higher Education.

(r) Income Taxes

As part of a state institution of higher education, the income of the Hospital is generally excluded from federal and state income taxes under Section 115(1) of the Internal Revenue Code. However, income

generated from activities unrelated to the Hospital's exempt purpose is subject to income taxes under Internal Revenue Code, Section 511(a)(2)(B). During the years ended June 30, 2017 and 2016, there was no income generated from unrelated activities.

(s) Intergovernmental Transfers

Intergovernmental transfers (IGTs) are recognized in the period in which the Hospital incurs an obligation to make payments to other governmental entities as evidenced by executed MOUs between the State of New Mexico and the Hospital. Of the total $45.4 million recorded IGT obligations, approximately $38.6 million were paid as of the end of fiscal year 2017. Approximately, $22.8 million of the $23.1 million due as of June 30, 2016 was paid in the subsequent fiscal year. All amounts not paid as of the end of fiscal year 2015 were subsequently paid in fiscal year ended June 30, 2016. Due to the nature of the MOU to fund a portion of the nonfederal share to obtain federal matching funds for the Medicaid "Centennial Care," and since the Medicaid "Centennial Care" program is for the provision of patient care. IGTs were recorded as a reduction of net patient service and premium revenues.

(t) Capital Appropriation

There were no capital appropriations made by the State Legislature for the Hospital during the fiscal years ended June 30, 2017 and 2016.

(u) Special Item

Significant transactions or other events within the control of management that are either unusual in nature or infrequent in occurrence are reported as special items in the Statements of Revenues, Expenses, and Changes in Net Position. In fiscal year 2016, the Hospital recognized a special item gain of $6,194,964 related to the release of the OPEB liability as this post employment medical and dental defined-benefit plan was terminated December 31, 2015 (note 16). This liability was originally recorded by the Hospital based on the actuarially determined net OPEB obligation as of June 30, 2014.

(v) Risk Management

The Hospital sponsors a self-insured health plan in which UNM Psychiatric Center and UNM Children's Psychiatric Center (collectively, the Center) also participate, as all employees are under the centralized umbrella of the Hospital. Blue Cross and Blue Shield of New Mexico and HMO New Mexico (BCBSNM and HMONM) provide administrative claim payment services for the Hospital's plan. Liabilities are based on an estimate of claims that have been incurred but not reported (IBNR) and claims received but not yet paid. At June 30, 2017 and 2016, the estimated amount of the Hospital's IBNR and accrued claims was approximately $7.9 million and $3.3 million, respectively, which is included in accrued payroll. As the Hospital receives all cash and pays all obligations of the Center, the estimated amount of the Center's IBNR and accrued invoices recorded in the Hospital's accrued payroll was approximately $673,000 and $284,000 at June 30, 2017 and 2016, respectively. The liability for IBNR was based on actuarial analysis calculated using information provided by BCBSNM.

Changes in the reported Hospital liability during fiscal years 2017 and 2016 resulted from the following:

	Beginning of fiscal year	Current year claims and changes in estimates	Claim payments	Balance at fiscal year-end
2016–2017	$ 3,320,117	39,373,456	(34,813,136)	7,880,437
2015–2016	3,606,899	36,997,102	(37,283,884)	3,320,117

(w) Financial Reporting by Employers for Postemployment Benefits Other than Pensions

Prior to fiscal year 2016, the Hospital and the Center provided other postemployment benefits (OPEB) as part of the total compensation offered to attract and retain the services of qualified employees. OPEB included postemployment medical and dental healthcare provided separately from a benefit or pension plan. GASB Statement No. 45, *Accounting and Financial Reporting by Employees for Postemployment Benefits Other Than Pensions*, establishes standards for the measurement, recognition, and display of OPEB expense/expenditures and related liabilities (assets), note disclosures, and required supplementary information (RSI) in the financial reports of state and local governmental employers. As of December 31, 2015, the OPEB plan was dissolved and ceased to be offered to employees.

In fiscal year 2016, the Hospital recognized a special item gain of $6,194,964 related to the release of the OPEB liability as this post employment medical and dental defined-benefit plan was terminated as of December 31, 2015 (note 16). This liability was originally recorded by the Hospital based on the actuarially determined net OPEB obligation as of June 30, 2014.

(x) Classification

Certain 2016 amounts have been reclassified to conform to the 2017 presentation.

(3) Cash, Cash Equivalents And Investments

(a) Cash and Cash Equivalents

(i) Deposits

The Hospital's deposits are held in demand accounts and repurchase agreements with a financial institution. State statutes require financial institutions to pledge qualifying collateral to the Hospital to cover at least 50% of the uninsured deposits; however, the Hospital requires more collateral as it considers prudent. All collateral is held in third-party safekeeping.

The carrying amounts of the Hospital's deposits with financial institutions at June 30, 2017 and 2016 are $178,328,724 and $143,264,472, respectively.

Bank balances are collateralized as follows:

	June 30	
	2017	**2016**
Amount insured by the Federal Deposit Insurance Corporation (FDIC)	$ 1,000,000	1,000,000
Amount collateralized with securities held in the Hospital's name	183,274,521	175,777,389
	$ 184,274,521	176,777,389

Interest-bearing deposit accounts are subject to FDIC's standard deposit insurance amount of $250,000 per type of account.

(ii) Custodial Credit Risk – Deposits

Custodial credit risk is the risk that, in the event of a bank failure, the Hospital's deposits may not be returned to it. The Hospital has a custodial risk policy for deposits that requires collateral in an amount greater than or equal to 50% of the deposit not insured by the FDIC. A greater amount of collateral is required when the Hospital determines it is prudent. As of June 30, 2017 and 2016, the Hospital's bank deposits were not exposed to custodial credit risk.

(b) Marketable Securities

(i) Interest Rate Risk – Debt Investments

Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Currently, the Hospital does not have a specific policy to limit its exposure to interest rate risk.

A summary of the marketable securities and their respective maturities and their exposure to interest rate risk is as follows:

	June 30, 2017		
	Fair value	**Less than 1 year**	**1–5 years**
Items subject to interest rate risk:			
Money market funds	$ 138,761	138,761	—
U.S. Treasury notes	17,837,709	4,289,033	13,548,676
U.S. government agency or government-sponsored entity obligations:			
FHLB	3,955,137	—	3,955,137
FHLMC	5,842,866	—	5,842,866
FNMA	6,967,053	—	6,967,053
Total items subject to interest rate risk	34,741,526	4,427,794	30,313,732
Total marketable securities	$ 34,741,526	4,427,794	30,313,732

	June 30, 2016		
	Fair value	**Less than 1 year**	**1–5 years**
Items subject to interest rate risk:			
Money market funds	$ 21,531	21,531	—
U.S. Treasury notes	23,556,740	5,964,216	17,592,524
U.S. government agency or government-sponsored entity obligations:			
FHLMC	3,107,984	—	3,107,984
FNMA	8,177,841	2,485,131	5,692,710
Total items subject to interest rate risk	34,864,096	8,470,878	26,393,218
Total marketable securities	$ 34,864,096	8,470,878	26,393,218

(ii) Custodial Credit Risk – Debt Investments

For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Hospital will not be able to recover the value of its investments or collateral that is in the possession of an outside party. Marketable securities of $34,602,765 and $34,842,565 at 2017 and

2016, respectively, are insured, registered, and held by the counterparty's agent in the Hospital's name.

The Hospital's custodial risk policy for investments in U.S. Treasury securities and U.S. government agency obligations is in accordance with Chapter 6, Article 10, Section 10 of the NMSA, 1978. An outside consulting firm makes investment decisions, and the investments are held in safekeeping by a financial institution.

(iii) Credit Risk – Debt Investments

Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill their obligations. The Hospital is required to disclose credit ratings of its debt investments in order to assess credit risk. U.S. obligations, investments explicitly guaranteed by the U.S. government, and nondebt investments are excluded from this requirement. Currently, the Hospital has a policy that restricts short-term investments to specific investment ratings issued by nationally recognized statistical rating organizations. The policy states that cash equivalent reserves shall consist of interest-bearing or discount instruments of the U.S. government or agencies thereof.

A summary of the marketable securities at June 30, 2017 and 2016 and their exposure to credit risk is as follows:

	2017		2016	
	Rating	**Fair value**	**Rating**	**Fair value**
Items not subject to credit risk:				
U.S. Treasury securities:				
Treasury notes	N/A	$ 17,837,709	N/A	$ 23,556,740
Items subject to credit risk:				
Money market funds	Not rated	138,761	Not rated	21,531
U.S. government agency obligations:				
FHLB	Moody's-Aaa	3,955,137	N/A	—
FHLMC	Moody's-Aaa	5,842,866	Moody's-Aaa	3,107,984
FNMA	Moody's-Aaa	6,967,053	Moody's-Aaa	8,177,841
Total items subject to credit risk		16,903,817		11,307,356
Total marketable securities		$ 34,741,526		$ 34,864,096

(iv) Concentration of Credit Risk – Investments

Concentration of credit risk is the risk of loss attributed to investments in a single issuer. Investments in any one issuer that represent 5% or more of all total investments are considered to be exposed to concentrated credit risk and are required to be disclosed. Investments issued or

explicitly guaranteed by the U.S. government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement.

For long-term investments, the Hospital has a policy to limit its exposure to concentrated risk. It states the portfolio will be constructed and maintained to provide prudent diversification with regard to concentration of holdings in individual issues, corporations, or industries.

The Hospital's exposure to concentrated credit risk is as follows: $3,955,137, which is invested in Federal Home Loan Bank (FHLB) securities and equates to 11.4% of marketable securities held at June 30, 2017. An additional $6,967,053 is invested in Federal National Mortgage Association (FNMA) securities, which equates to 20.1% of marketable securities held as of June 30, 2017. An additional $5,842,866 is invested in Federal Home Loan Mortgage Corporation (FHLMC) securities, which equates to 16.8% of marketable securities held as of June 30, 2017.

(c) Short-Term Investments

(i) Interest Rate Risk – Debt Investments

Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Currently, the Hospital does not have a specific policy to limit its exposure to interest rate risk.

A summary of the short-term investments and their respective maturities and their exposure to interest rate risk is as follows:

	June 30, 2017	
	Fair value	Less than 1 year
Items subject to interest rate risk:		
Money market funds	$ 80,107	80,107
Total items subject to interest rate risk	80,107	80,107
Total short-term investments	$ 80,107	80,107

	June 30, 2016	
	Fair value	Less than 1 year
Items subject to interest rate risk:		
Money market funds	$ 74,683	74,683
Total items subject to interest rate risk	74,683	74,683
Total short-term investments	$ 74,683	74,683

(Continued)

The fair values of short-term U.S. Treasury and U.S. government agency obligations are based on acquisition cost, provided there is no significant impairment due to changes in the credit standing of the issuer.

(ii) Custodial Credit Risk – Debt Investments

For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Hospital will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. At June 30, 2017 and 2016, there were no short-term investments subject to custodial credit risk.

The Hospital's custodial risk policy for the bond proceeds conforms to the trust indenture, and the trustee holds the investments in safekeeping.

(iii) Credit Risk – Debt Investments

Credit risk is the risk that an issuer or other counterparty to an investment will not fulfill their obligations. The Hospital is required to disclose credit ratings of its debt investments in order to assess credit risk. U.S. obligations, investments explicitly guaranteed by the U.S. government, and nondebt investments are excluded from this requirement. Currently, the Hospital has a policy that restricts short-term investments to specific investment ratings issued by nationally recognized statistical rating organizations. The policy states that cash equivalent reserves shall consist of interest-bearing or discount instruments of the U.S. government or agencies thereof.

A summary of the short-term investments at June 30, 2017 and 2016 and their exposure to credit risk is as follows:

	2017		2016	
	Rating	**Fair value**	**Rating**	**Fair value**
Items subject to credit risk:				
Money market funds	Not rated	$ 80,107	Not rated	$ 74,683
Total items subject to credit risk		80,107		74,683
Total short-term investments		$ 80,107		$ 74,683

The fair values of short-term U.S. Treasury and U.S. government agency obligations are based on acquisition cost, provided there is no significant impairment due to credit standing of the issuer.

(d) Long-Term Investments

(i) Interest Rate Risk – Debt Investments

Currently, the Hospital does not have a specific policy to limit its exposure to interest rate risk.

A summary of the long-term investments and their respective maturities and their exposure to interest rate risk is as follows:

	June 30, 2017	
	Fair value	Less than 1 year
Items not subject to interest rate risk:		
Investments in nonpublic entities*	$ 22,461,992	—
Items subject to interest rate risk:		
Money market fund	17,978,206	17,978,206
Items subject to interest rate risk	17,978,206	17,978,206
Total long-term investments	$ 40,440,198	17,978,206

* Investments in nonpublic entities include TriWest (recorded at fair value) and TRL and TLSC (recorded using the equity method of accounting)

	June 30, 2016	
	Fair value	Less than 1 year
Items not subject to interest rate risk:		
Investments in nonpublic entities*	$ 21,040,439	—
Items subject to interest rate risk:		
Money market fund	16,052,772	16,052,772
Items subject to interest rate risk	16,052,772	16,052,772
Total long-term investments	$ 37,093,211	16,052,772

* Investments in nonpublic entities include TriWest (recorded at fair value) and TRL and TLSC (recorded using the equity method of accounting)

(ii) Custodial Credit Risk – Debt Investments

As of June 30, 2017 and 2016, the Hospital held no U.S. government obligations for long-term investment purposes.

The Hospital's custodial risk policy for the bond proceeds conforms to the trust indenture, and the trustee holds the investments in safekeeping.

(iii) Credit Risk – Debt Investments

The Hospital is required to disclose credit ratings of its debt investments in order to assess credit risk. U.S. obligations, investments explicitly guaranteed by the U.S. government, and nondebt

investments are excluded from this requirement. Currently, the Hospital has a policy that restricts long-term investments to specific investment ratings issued by nationally recognized statistical rating organizations. The policy states that cash equivalent reserves shall consist of interest-bearing or discount instruments of the U.S. government or agencies thereof.

A summary of the investments at June 30, 2017 and 2016 and their exposure to credit risk is as follows:

	2017		2016	
	Rating	Fair value	Rating	Fair value
Items not subject to credit risk:				
Investments in nonpublic entities*	N/A	$ 22,461,992	N/A	$ 21,040,439
Items subject to credit risk:				
Money market funds	Not rated	17,978,206	Not rated	16,052,772
Total items subject to credit risk		17,978,206		16,052,772
Total long-term investments		$ 40,440,198		$ 37,093,211

* Investments in nonpublic entities include TriWest (recorded at fair value) and TRL and TLSC (recorded using the equity method of accounting).

(4) Fair Value Measurement

The Hospital has implemented GASB Statement No. 72, *Fair Value Measurement and Application*. GASB 72 requires the use of valuation techniques for measuring fair value and establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described as follows:

Level 1 inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.

Level 2 inputs to the valuation methodology include the following:

- Quoted prices for similar assets or liabilities in active markets
- Quoted prices for identical or similar assets or liabilities in inactive markets
- Inputs other than quoted prices that are observable for the asset or liability
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means

(Continued)

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 inputs to the valuation methodology are unobserved and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value:

U.S. Treasury Securities: U.S. Treasury securities are recorded at fair value using quoted market prices (Level 1).

U.S. Agency and Government-Sponsored Entity Securities: Mortgage pass-through securities are model-driven based on spreads of the comparable to-be-announced security (Level 2).

Investments in nonpublic entities: The Hospital holds a noncontrolling equity interest in TriWest, which is recorded at fair value based on the results of operations of the investee (Level 3).

	Assets at fair value as of June 30, 2017		
	Level 1	**Level 2**	**Level 3**
Fixed income	$ 17,837,709	16,765,056	—
Investment in TriWest	—	—	5,000,000
Total	$ 17,837,709	16,765,056	5,000,000

	Assets at fair value as of June 30, 2016		
	Level 1	**Level 2**	**Level 3**
Fixed income	$ 23,556,740	11,285,825	—
Investment in TriWest	—	—	5,000,000
Total	$ 23,556,740	11,285,825	5,000,000

(5) Concentration of Risk

The Hospital receives payment for services rendered to patients under payment arrangements with payors, which include: (i) Medicare and Medicaid, (ii) other third-party payors including commercial carriers and health maintenance organizations, and (iii) others. The other payor category includes U.S. Public Health Service, self-pay, counties and other government agencies. The following summarizes patient accounts receivable and the percentage of gross accounts receivable from all payors as of June 30:

	2017		2016	
Medicaid	$ 162,561,649	38%	$ 153,782,196	36%
Medicare	111,624,131	27	95,002,787	23
Other third-party payors	80,687,119	19	104,301,455	25
Others	69,786,192	16	70,883,104	17
Total patient accounts receivable	424,659,091	100%	423,969,542	101%
Less allowance for uncollectible accounts and contractual adjustments	(308,559,378)		(296,217,485)	
Patient accounts receivable, net	$ 116,099,713		$ 127,752,057	

(6) Restricted and Designated Assets

The following summarizes restricted and designated assets as of June 30:

	2017	2016
Current:		
Restricted for debt service	$ 80,107	74,683
Noncurrent:		
Restricted for mortgage reserve fund	17,978,206	16,052,772
Restricted for debt service reserve	—	—
Restricted for collateral	—	—
Designated by UNM Hospital Board of Trustees	22,461,992	21,040,439
	$ 40,520,305	37,167,894

Restricted assets are classified in the accompanying statements of net position as current and noncurrent assets. Current assets are restricted by the FHA for current debt service use. The noncurrent assets are designated by the FHA and the Hospital Board of Trustees for future use subject to approval by the respective parties.

(Continued)

As of June 30, 2017, $80,107 in the held by trustee for debt service account represents a portion of the bond interest payment due December 20, 2017. As of June 30, 2016, $74,683 in the held by trustee for debt service account represents a portion of the bond interest payment due December 20, 2016.

The Hospital has established a “Mortgage Reserve Fund” in accordance with the requirements and conditions of the FHA Regulatory Agreement. Notwithstanding any other provision in the Regulatory Agreement, the Mortgage Reserve Fund may be used by HUD if the Hospital is unable to make a mortgage note payment on the due date. The Hospital is required to make contributions to the fund based on the Mortgage Reserve Fund schedule.

Assets Designated by Board of Trustees – In 1997, the Hospital contributed $2,612,500 to TriWest, an organization formed to administer healthcare benefits to military retirees and dependents of active duty personnel in the CHAMPUS/TriCare Central Region, in exchange for 2,613 shares of common stock, which represented an approximate 10.8% ownership of TriWest as of June 30, 2013. On March 31, 2014, TriWest completed a recapitalization in which the Hospital’s shares were repurchased by TriWest in exchange for cash and tracking common stock shares. The Hospital received 289.7 shares of tracking stock with a cost basis of $5 million as well as $40,140,911, paid during fiscal years ended June 30, 2014 and 2015, as a result of the recapitalization. The Hospital recognized no return on investment during the years ended June 30, 2017 and 2016. The investment in TriWest is accounted for at fair value.

The Hospital has an affiliation agreement with Presbyterian Healthcare Services for the operation of a consolidated clinical laboratory (TriCore) to optimize the quality, performance, and delivery of routine and specialized clinical laboratory tests for patients throughout the State of New Mexico in a cost-effective and timely manner.

The Hospital contributed $3,999,965 in cash and equipment during 1998 related to the affiliation agreement, titled TriCore. During 2004, TriCore reorganized its business activities into two entities: TriCore whose business consists of laboratory testing services for nonmembers; and TLSC, which organized solely to perform laboratory services, on a centralized basis, for its members, the Hospital, and Presbyterian Healthcare Services. TLSC is a tax-exempt, cooperative hospital service organization under Section 501(e) of the Internal Revenue Code of 1986.

UNM, through the Hospital, has a 50% interest in TriCore totaling approximately $12,535,000 and $11,547,000 at June 30, 2017 and 2016, respectively, which is being accounted for using the equity method.

The Hospital has a 50% interest in TLSC totaling approximately $4,927,000 and $4,494,000 at June 30, 2017 and 2016, respectively, which is being accounted for using the equity method. The Hospital recorded laboratory expenses of approximately $32,327,000 in 2017 and $30,230,000 in 2016.

(7) Capital Assets

The major classes of capital assets at June 30 and related activity for the year then ended is as follows:

	Year ended June 30, 2017				
	Beginning balance	Additions	Transfers	Retirements	Ending balance
Center capital assets not being depreciated:					
Land	$ 1,747,245	—	—	—	1,747,245
Construction in progress	4,827,786	6,589,975	(7,132,096)	—	4,285,665
	$ 6,575,031	6,589,975	(7,132,096)	—	6,032,910
Center depreciable capital assets:					
Land and land improvements	$ 11,834,179	—	87,358	—	11,921,537
Building and building improvements	175,061,476	79,721	2,956,957	(9,505)	178,088,649
Building service equipment	163,535,895	59,758	3,488,264	(1,932,135)	165,151,782
Major moveable equipment	237,144,047	17,569,699	118,198	(38,935,746)	215,896,198
Fixed equipment	16,613,021	47,774	171,726	(91,597)	16,740,924
Total depreciable capital assets	604,188,618	17,756,952	6,822,503	(40,968,983)	587,799,090
Less accumulated depreciation for:					
Land improvements	(8,534,541)	(473,986)	—	—	(9,008,527)
Building and building improvements	(89,435,001)	(5,025,297)	—	9,504	(94,450,794)
Building service equipment	(92,058,506)	(9,137,458)	—	1,907,718	(99,288,246)
Major moveable equipment	(184,709,145)	(16,805,466)	778	38,915,162	(162,598,671)
Fixed equipment	(12,478,446)	(647,426)	—	91,597	(13,034,275)
Total accumulated depreciation	(387,215,639)	(32,089,633)	778	40,923,981	(378,380,513)
Center depreciable capital assets, net	$ 216,972,979	(14,332,681)	6,823,281	(45,002)	209,418,577
Capital asset summary:					
Center capital assets not being depreciated	$ 6,575,031	6,589,975	(7,132,096)	—	6,032,910
Center depreciable capital assets, at cost	604,188,618	17,756,952	6,822,503	(40,968,983)	587,799,090
Center total cost of capital assets	610,763,649	24,346,927	(309,593)	(40,968,983)	593,832,000
Less accumulated depreciation	(387,215,639)	(32,089,633)	778	40,923,981	(378,380,513)
Center capital assets, net	$ 223,548,010	(7,742,706)	(308,815)	(45,002)	215,451,487

Transfers represent the movement of capital between the University Health System family of companies.

(Continued)

The major classes of capital assets at June 30 and related activity for the year then ended is as follows:

	Year ended June 30, 2016				
	Beginning balance	Additions	Transfers	Retirements	Ending balance
Center capital assets not being depreciated:					
Land	$ 1,747,245	—	—	—	1,747,245
Construction in progress	7,620,835	7,475,690	(10,268,739)	—	4,827,786
	$ 9,368,080	7,475,690	(10,268,739)	—	6,575,031
Center depreciable capital assets:					
Land and land improvements	$ 11,677,704	—	156,475	—	11,834,179
Building and building improvements	170,704,641	89,630	4,267,205	—	175,061,476
Building service equipment	161,399,372	14,740	2,121,783	—	163,535,895
Major moveable equipment	224,610,736	16,813,820	3,645,306	(7,925,815)	237,144,047
Fixed equipment	16,385,935	149,116	77,970	—	16,613,021
Total depreciable capital assets	584,778,388	17,067,306	10,268,739	(7,925,815)	604,188,618
Less accumulated depreciation for:					
Land improvements	(7,792,716)	(741,825)	—	—	(8,534,541)
Building and building improvements	(84,492,830)	(4,942,171)	—	—	(89,435,001)
Building service equipment	(82,858,060)	(9,200,446)	—	—	(92,058,506)
Major moveable equipment	(176,137,794)	(16,497,166)	—	7,925,815	(184,709,145)
Fixed equipment	(11,829,747)	(648,699)	—	—	(12,478,446)
Total accumulated depreciation	(363,111,147)	(32,030,307)	—	7,925,815	(387,215,639)
Center depreciable capital assets, net	$ 221,667,241	(14,963,001)	10,268,739	—	216,972,979
Capital asset summary:					
Center capital assets not being depreciated	$ 9,368,080	7,475,690	(10,268,739)	—	6,575,031
Center depreciable capital assets, at cost	584,778,388	17,067,306	10,268,739	(7,925,815)	604,188,618
Center total cost of capital assets	594,146,468	24,542,996	—	(7,925,815)	610,763,649
Less accumulated depreciation	(363,111,147)	(32,030,307)	—	7,925,815	(387,215,639)
Center capital assets, net	$ 231,035,321	(7,487,311)	—	—	223,548,010

Transfers represent the movement of capital between the University Health System family of companies.

(Continued)

(8) Compensated Absences

Qualified hospital employees are entitled to accrue sick leave and annual leave based on their FTE status.

(a) Sick Leave

Full-time employees accrue four hours of sick leave each two-week pay period (13 days per annum) up to a maximum of 1,040 hours to be used for major and minor sick leave. Seven of these days are accumulated into a minor sick leave bank. Part-time employees who are at least 0.5 FTE earn sick leave on a prorated basis each pay period. At June 30 of each year, employees have the opportunity to exchange for annual leave, major sick leave or cash all hours accumulated in excess of 24 hours on an hour-for-hour basis. At termination, only employees who retire from the Hospital and qualify under the Hospital's policy or estates of employees who die as the result of a compensable occupational illness or injury are eligible for payment of unused accumulated hours. Accrued sick leave as of June 30, 2017 and 2016 of approximately $3,638,000 and $3,654,000, respectively, is computed by multiplying each employee's current hourly rate by the number of hours accrued.

Major and minor sick leave balances earned by employees previously employed by UNM under the UNM plan were transferred to the Hospital. Under the UNM plan, only employees hired prior to July 1, 1984 were eligible to accrue major sick leave. Eligible employees accrued sick leave each pay period at an hourly rate, which was based on their date of hire and employment status.

The excess minor sick leave hours carried over from UNM were converted to cash in December 2000, at a rate equal to 50% of the employee's hourly wage, multiplied by the number of hours converted. Upon retirement, all minor hours in excess of 600 are paid at a rate equal to 50% of the employee's hourly wage multiplied by the number of hours in excess of 600 unused sick leave hours based on FTE status, not to exceed 440 hours of such sick leave.

Immediately upon retirement or death, a consolidated employee is entitled to receive cash payment for unused major sick leave hours in excess of 1,040 at a rate equal to 28.5% of the employee's hourly wage multiplied by the number of hours in excess of 1,040 major sick leave hours based on FTE status. Partial hours are rounded to the nearest full hour.

(b) Annual Leave

Full-time employees accrue annual leave based on their length of employment up to a maximum of 480 hours. Part-time employees who are at least 0.5 FTE earn annual leave on a prorated basis each pay period. At June 30 of each year, employees have the opportunity to exchange for cash up to 80 annual leave hours accumulated in excess of 240 hours. At termination, employees are eligible for payment of unused accumulated hours, not to exceed 480 hours. Accrued annual leave as of June 30, 2017 and 2016 of approximately $18,783,000 and $18,705,000, respectively, is computed by multiplying each employee's current hourly rate by the number of hours accrued.

Upon retirement, death, or involuntary termination, a consolidated employee is entitled to receive cash payment for annual leave earned prior to consolidation up to a maximum of 252 hours at a rate equal to 50% of the employee's hourly wage. Upon voluntary termination, a maximum of 168 hours is paid out at a rate equal to 50% of the employee's hourly wage.

During the years ended June 30, 2016 and 2015, the following changes occurred in accrued compensated absences:

	Balance July 1, 2016	Increase	Decrease	Balance June 30, 2017
$	22,883,491	28,151,835	(28,135,903)	22,899,423

	Balance July 1, 2015	Increase	Decrease	Balance June 30, 2016
$	20,962,986	27,876,903	(25,956,398)	22,883,491

The balances above include annual leave and sick leave, disclosed above, in addition to compensatory time and holiday, totaling approximately $478,000 and $525,000 in fiscal years 2017 and 2016, respectively. The portion of accrued compensated absences due after one year is not material and, therefore, is not presented separately.

(9) Bonds Payable

On June 9, 2004, the Regents adopted a Parameters Resolution authorizing the construction of the CHCCP and issuing bonds insured by HUD. On October 14, 2004, the Regents adopted Resolutions authorizing the amendment of the Lease to accommodate the requirements of HUD and to authorize execution of the HUD documents. On October 14, 2004, UNM Board of Regents issued FHA insured Hospital Mortgage Revenue Bonds (University of New Mexico Hospital Project), Series 2004 in the aggregate principal amount of $192,250,000. Interest on the bonds ranged from 2% to 5% and was paid semi-annually on each January 1 and July 1, commencing January 1, 2005. The Series 2004 bonds were issued for the purpose of financing the construction, equipping, and furnishing of the CHCCP, which provides care to patients requiring trauma, children's and women's services, funding the Debt Service Reserve Fund, and paying costs of issuance associated with the bonds.

In conjunction with this construction project, the U.S. HUD, under Section 242 CFDA No. 14.128, issued a loan guaranty for the mortgage amount of $183,399,000, and the UNM Regents adopted Resolutions authorizing the Final Endorsement of the HUD Insurance.

On December 12, 2014, the Regents adopted a Parameters Resolution authorizing the issuance of the GNMA-Backed, HUD-Insured Mortgage Bonds to redeem and refinance the remaining 2004 bonds. On May 7, 2015, the Regents adopted Resolutions authorizing the execution of amended FHA Documents and Loan Modification Documents in connection with the redemption and refinancing of the remaining 2004 bonds.

On May 14, 2015, the Hospital issued $115,000,000 in new bonds (2015 Series bonds) to refinance the remaining 2004 bonds. The Bonds were issued pursuant to a trust indenture, dated as of May 1, 2015, by and between the Hospital and Wells Fargo Bank, National Association, as trustee for the purpose of refinancing the CHCCP. The 2015 Series bonds carry interest rates that range from 0.484% to 3.532%.

(Continued)

The Regents granted the GNMA Issuer in respect of the UNMH HUD-Insured Bonds a security interest in all of UNM Hospital's revenues, cash (with the exception of the proceeds of the UNM Hospital mill levy and state appropriations), accounts receivable, contract rights, and the proceeds of the same. In addition, in that certain Regulatory Agreement signed by the Regents, that is still in effect today, the University agreed and committed to HUD that it would not "assign, transfer, dispose of, or encumber any personal property of the project including revenues from any source…" Lastly, in accordance with the terms of the Lease under which the University leases a portion of the UNM Hospital facility from Bernalillo County, all reserves of the UNM Hospital covered by the Lease are restricted to use for operation and maintenance of the UNM Hospital.

The refinancing of the 2004 Series bonds during fiscal year 2015 reduced the Hospital's total debt service payments by approximately $56.7 million through 2032 and resulted in an economic gain (difference between the present values of the debt service payments on the old and new debt) of $15.9 million.

The 2015 Series bonds were issued as special limited obligations of the Hospital and are secured primarily by fully modified mortgage backed securities in the aggregate principal amount of $109,585,926 (the GNMA Securities), issued by Prudential Huntoon Paige Associates, Ltd. (the Lender), guaranteed as to principal and interest by the Government National Mortgage Association (GNMA), with respect to the Mortgage Note.

Under the GNMA Mortgage Backed Securities Program, the GNMA Securities are a "fully modified pass-through" mortgage-backed security issued and serviced by the Lender. The face amount of the GNMA Securities is to be the same amount as the outstanding principal balance of the Mortgage Note. The Lender is required to pass through to the trustee, as the holder of the GNMA Securities, by the 15th day of each month, the monthly scheduled installments of principal and interest on the Mortgage Note (less the GNMA guaranty fee and the Lender's servicing fee), whether or not the Lender receives such payment from the Hospital under the Mortgage Note, plus any unscheduled prepayments of principal of the Mortgage Note received by the Lender. The GNMA Securities are issued solely for the benefit of the trustee on behalf of the Bondholders, and any and all payments received with respect to the GNMA Securities are solely for the benefit of the Bondholders.

Interest expense associated with the bonds payable was approximately $3,171,000 and $3,183,000. Interest income earned from the investment of the bond proceeds was approximately $21,667 and $1,946 for the years ended June 30, 2017 and 2016, respectively.

Bonds payable activity consists of the following:

	Year ended June 30, 2017				
	Beginning balance	Additions	Deductions	Ending balance	Amounts due within one year
FHA Insured Hospital Mortgage: Revenue:					
Bond Series 2015	108,965,000	—	(5,540,000)	103,425,000	5,605,000
	108,965,000	—	(5,540,000)	103,425,000	5,605,000

(Continued)

	Year ended June 30, 2016				
	Beginning balance	Additions	Deductions	Ending balance	Amounts due within one year
FHA Insured Hospital Mortgage:					
Revenue:					
Bond Series 2015	115,000,000	—	(6,035,000)	108,965,000	5,540,000
	115,000,000	—	(6,035,000)	108,965,000	5,540,000

Future debt service (including mandatory redemptions) as of June 30, 2017 for the bonds is as follows:

	Principal	Interest	Total
Years ending June 30:			
2018	$ 5,605,000	3,120,623	8,725,623
2019	5,700,000	3,040,023	8,740,023
2020	5,815,000	2,937,537	8,752,537
2021	5,950,000	2,818,446	8,768,446
2022	6,105,000	2,676,657	8,781,657
2023–2027	33,670,000	10,492,272	44,162,272
2028–2032	40,580,000	4,052,264	44,632,264
	$ 103,425,000	29,137,822	132,562,822

On November 15, 2004, the Hospital established a Mortgage Reserve Fund in accordance with the requirements and conditions of the 2004 FHA Regulatory Agreement. On May 14, 2015, a new Mortgage Reserve Fund was established for the 2015 series bonds.

The Mortgage Reserve Fund's final required contribution of $1,910,199 was made during fiscal year 2017, at which time the Mortgage Reserve Fund was fully funded.

The Mortgage Note bears interest at 3.29%. The Mortgage Note has a term of 205 months following the commencement of amortization and matures on June 1, 2032. Principal and interest are payable in equal monthly installments upon commencement of amortization. A mortgage servicing fee of 12 basis points and a GNMA guaranty fee of 13 basis points are also included in the monthly payment, for a total of 3.54%.

(10) Net Patient Service Revenues

The majority of the Hospital's revenue is generated through agreements with third-party payors that provide for reimbursement to the Hospital at amounts different from its established charges. Approximately 65% of the Hospital's gross patient revenue for both fiscal years ended June 30, 2017 and 2016 was derived from the Medicare and Medicaid programs, the continuation of which are dependent upon governmental policies. 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 revenue estimates could change as a result of regulatory review. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's billings at established charges for

services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement from major third-party payors follows:

Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These Medical Severity Diagnosis Related Group (MS-DRG) rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Most Medicare outpatient services are prospectively paid through Medicare's Outpatient Prospective Payment system (OPPS). Services excluded from the OPPS and paid under separate fee schedules include: clinical lab, certain rehabilitation services, durable medical equipment, renal dialysis treatments, ambulance services, and professional fees of physicians and nonphysician practitioners.

Medicaid – Inpatient acute care services rendered to Medicaid FFS program beneficiaries are paid at prospectively determined rates per discharge based upon the MS-DRG system. These rates vary according to clinical factors, patient diagnosis, and negotiated base rates for each Medicaid Managed Care Organization (MCO).

As a state-operated teaching hospital, the Hospital is eligible for enhanced reimbursement rates under the SNCP program effective April 1, 2014. These enhanced reimbursement rates have been recorded in the financial statements in net patient service revenue. For outpatients, payments are made based upon an OPPS.

In addition, the Hospital has reimbursement agreements with certain MCOs that have contracted with Centennial Care programs to administer services to enrolled Medicaid beneficiaries. The State of New Mexico began its Centennial Care program effective January 1, 2014. The basis for reimbursement under these agreements includes prospectively determined rates (MS-DRG) or per diem for inpatient services, and prospectively determined payments for outpatient services.

Other – The Hospital has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates-per-discharge, discounts from established charges, and prospectively determined per diem rates.

A summary of net patient revenues follows for the years ended June 30:

	2017	2016
Charges at established rates	$ 1,874,149,816	1,731,147,716
Charity care	(57,148,931)	(66,940,473)
Contractual adjustments	(824,295,029)	(764,357,197)
Provision for doubtful accounts	(90,272,433)	(52,093,114)
Net patient revenues	$ 902,433,423	847,756,932

The Hospital is reimbursed by the Medicare and Medicaid programs on a prospective payment basis for hospital services, with certain items reimbursed at an interim rate with final settlement determined after submission of annual cost reports by the Hospital. The annual cost reports are subject to audit by the Medicare Administrative Contractor and the Medicaid audit agent. Cost reports through 2015 have been

final settled for the Medicaid programs. Cost reports through 2012, except for 2005, have been final settled for the Medicare program. Retroactively calculated contractual adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Current year estimates, settlements of prior year cost reports, and changes in prior year estimates resulted in net increases to net patient service revenue of approximately $20.0 million and $7.9 million for the years ended June 30, 2017 and 2016, respectively. During the fiscal year ended June 30, 2017, a $3.6 million liability for Medicare and a $1.4 million liability for Medicaid were accrued as estimates for the fiscal year 2017 cost report. During the fiscal year ended June 30, 2016, $3.6 million liability for Medicare and $1.3 million liability for Medicaid were accrued as estimates for the fiscal year 2016 cost report. UNM Hospital's cost reports are typically filed by November 30. Management believes these estimates are appropriate. 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. Estimates are continually monitored and reviewed, and as settlements are made or more information is available to improve estimates, differences are reflected in current operations. During fiscal year 2017, the Hospital received a reimbursement from Tricare of $1,469,697, which is included in the totals above. During fiscal years 2017 and 2016, the Hospital received aggregate settlements of $780,670 and $571,420, respectively, from U.S. Public Health Services, which are included in the totals above.

(11) 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. The following information measures the level of charity care provided during the years ended June 30:

	2017	2016
Charges foregone, based on established rates	$ 57,148,931	66,940,473
Estimated costs and expenses incurred to provide charity care	30,129,000	37,285,843
Equivalent percentage of charity care charges foregone to total gross revenue	3%	4%

(12) Malpractice Insurance

As a part of UNM, the Hospital has immunity from tort liability except as waived by the New Mexico legislature. In this connection, under the New Mexico Tort Claims Act (NMTCA), the New Mexico Legislature waived the State's and the Hospital's immunity from liability for claims arising out of negligence out of the operation of the Hospital, the treatment of the Hospital's patients, and the healthcare services provided by Hospital employees. In addition, the NMTCA limits, as an integral part of this waiver of sovereign immunity, the amount of damages that can be assessed against the Hospital on any tort claim including medical malpractice, professional, or general liability claims.

The NMTCA provides that total liability for all claims that arise out of a single occurrence shall not exceed $750,000 set forth as follows: (a) $200,000 for real property; (b) up to $300,000 for past and future medical and medically related expenses; and (c) up to $400,000 for past and future noneconomic losses (such as

pain and suffering) incurred or to be incurred by the claimant. While the language of the NMTCA does not expressly provide for third-party claims such as loss of consortium, the New Mexico appellate court decisions have allowed claimants to seek loss of consortium. As a result, if loss of consortium claims are presented, those claims cannot exceed $350,000 in the aggregate. Thus, it appears that if a claim presents both direct claims and third-party claims, the maximum exposure of the Public Liability Fund, and therefore, UNM Hospitals, cannot exceed $1,050,000. The NMTCA prohibits the award of punitive or exemplary damages against the Hospital.

The NMTCA requires the State Risk Management Division (RMD) to provide coverage to the Hospital for those torts where the Legislature has waived the State's immunity from liability up to the damages limits of the NMTCA, as described above, plus the cost incurred in defending any claims and/or lawsuits (including attorney's fees and expenses), with no deductible and with no self-insured retention by the Hospital. As a result of the foregoing, the Hospital is fully covered for claims and/or lawsuits relating to medical malpractice or professional liability occurring at the Hospital.

(13) Related-Party Transactions

The Hospital provides professional services, referral services, and office space to UNM and other entities associated with UNM. The Hospital billed the following amounts, included as an expense reduction in the accompanying statements of revenues, expenses, and changes in net position, for services rendered during the years ended June 30:

		2017	2016
UNM Health Sciences Center	$	8,058,197	5,938,196
UNM		2,237,335	2,970,130
UNM Health Systems		524,304	500,433
	$	10,819,836	9,408,759

The Hospital reimburses UNM and other entities associated with UNM, for the cost of utilities and the salaries of various medical and administrative personnel incurred on behalf of the Hospital. The Hospital incurred expenses, included in total expenses in the accompanying statements of revenues, expenses, and changes in net position, related to the following entities during the years ended June 30:

		2017	2016
UNM Health Sciences Center	$	182,436,577	167,455,002
UNM		2,460,656	2,453,224
UNMMG		6,756,535	14,873,663
UNM Health Systems		10,474,797	13,905,611
	$	202,128,565	198,687,500

(Continued)

(14) Defined-Contribution Benefit Plans

The Hospital has a defined-contribution plan covering eligible employees, which provides retirement benefits. The name of the plan is UNM Hospital Tax Sheltered Annuity Plan, formerly known as the University of New Mexico Hospital/Bernalillo Medical Center Tax Sheltered Annuity Plan. The Hospital contributes either 5.5% or 7.5% of an employee's salary to the plan, depending on employment level. The plan was established by the UNM Hospital Board of Trustees and can be amended at its discretion. The plan is administered by the Hospital's Human Resources Department.

The expense for the defined-contribution plan was approximately $15,227,000 and $12,952,000 in fiscal years 2017 and 2016, respectively. Total employee contributions under this plan were approximately $16,565,000 and $15,462,000 in fiscal years 2017 and 2016, respectively. The Hospital also offers a Roth 403b defined-contribution plan option. Total employee contributions were approximately $1,372,000 and $1,192,000 in fiscal years 2017 and 2016, respectively.

The Hospital also has a deferred compensation plan, called the UNM Hospital 457(b) Deferred Compensation Plan, which provides employees with additional retirement savings plan. The Hospital does not contribute to this plan. Employees can make voluntary contributions to this plan. The plan was established by the UNM Hospital Board of Trustees and can be amended at its discretion. The plan is administered by the Hospital's Human Resources Department. There was no expense for the deferred compensation plan in 2017 or 2016 as the Hospital does not contribute to this plan. Total employee contributions under this plan were approximately $2,794,659 and $2,768,000 in 2017 and 2016, respectively.

In addition, the Hospital has a 401(a) defined-contribution plan, called the UNM Hospital 401(a) Plan, which was established for the purpose of providing retirement benefits for eligible participants and their beneficiaries. The 401(a) plan allows for tax-deferred employer contributions based on management's recommendation that is approved by the Board of Trustees on an annual basis. The plan was established by the UNM Hospital Board of Trustees and can be amended at its discretion. All assets of the plan are held in a trust fund, are not considered hospital assets, and are under the direction of a plan administrator. The expense for the 401(a) defined-contribution plan was $541,000 and $505,000 in fiscal years 2017 and 2016, respectively. Only the Hospital contributes to this plan.

(15) Defined-Benefit Pension Plan

A small portion (18 as of June 30, 2017 and 2016) of the Hospital's full-time employees participate in a public employee retirement system authorized under the Educational Retirement Act.

(a) Plan Description

ERB was created by the state's Educational Retirement Act, Section 22-11-1 through 22-11-52, NMSA 1978, as amended, to administer the New Mexico Educational Employees' Retirement Plan (Plan). The Plan is a cost-sharing, multiple employer plan established to provide retirement and disability benefits for certified teachers and other employees of the state's public schools, institutions of higher learning, and agencies providing educational programs. The Plan is a pension trust fund of the State of New Mexico. The New Mexico legislature has the authority to set or amend contribution rates.

ERB issues a publicly available financial report and a comprehensive annual financial report that can be obtained at www.nmerb.org.

(b) Benefits Provided

The Plan provides retirement and disability benefits. Retirement benefits are determined by taking 2.35% of the employee's final average annual salary multiplied by the employee's years of service. Employees employed before July, 1, 2010 are eligible to retire when one of the following events occur: the employee's age and earned service credit sum to 75 or more; the employee is at least sixty-five years of age and has five or more years of earned service credit; or the employee has service credit totaling 25 years or more. Employees hired on or after July 1, 2010 and before July 1, 2013 are eligible to retire when one of the following events occur: the employee's age and earned service credit sum to 80 or more; the employee is at least sixty-seven years of age and has five or more years of earned service credit; or the employee has service credit totaling 30 years or more. Employees hired on or after July 1, 2013 are eligible to retire when one of the following events occur: the employee is at least 55, and has earned 30 or more years of service credit; the employee's minimum age and earned service sum to 80 or more; or the employee is at least sixty-seven years of age and has five or more years of earned service credit. Employees are eligible for service-related disability benefits provided they have credit for at least 10 years of service and the disability is approved by the Plan.

(c) Contributions

For the fiscal year ended June 30, 2017 employers contributed 13.90% of employees' gross annual salary to the Plan, and employees who earned more than $20,000 contributed 10.70% of their gross annual salary. Employees who earned $20,000 or less contributed 7.90%. During the fiscal year ending June 30, 2017, employers will continue to contribute 13.90%, and employees earning more than $20,000 will contribute 10.70% of their gross annual salary. Employees earning $20,000 or less will continue to contribute 7.9%. The Hospital's cash contributions to the ERB for fiscal years ended June 30, 2017, 2016, and 2015 were approximately $146,000, $169,000 and $178,000, respectively.

At June 30, 2017 and 2016, the Hospital reported a liability of approximately $2,805,000 and $2,925,000, respectively, for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2016 and 2015, respectively, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of those dates. The Hospital's proportion of the net pension liability was based on a projection of the Hospital's long-term share of contributions to the pension plan relative to the projected contributions of all participating employers, actuarially determined. At June 30, 2016, the Hospital's proportion was 0.03898%, which was a decrease of 0.00618% from its proportion measured as of June 30, 2015. At June 30, 2015, the Hospital's proportion was 0.04516%, which was a decrease of 0.00852% from its proportion measured as of June 30, 2014.

For the year ended June 30, 2017, the Hospital recognized a pension benefit of approximately $511,000. For the year ended June 30, 2016, the Hospital recognized pension expense of $190,000. At June 30, the Hospital reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2017	
	Deferred outflows of resources	Deferred inflows of resources
Differences between expected and actual experience	$ 12,084	27,368
Net difference between projected and actual earning on pension plan investments	—	24,521
Changes in assumptions	56,698	—
Changes in proportion and differences between Hospital contributions and proportionate share of contributions	—	264,725
Reallocation of deferred amounts	—	—
Hospital contributions subsequent to the measurement date	145,809	—
	$ 214,591	316,614

The $145,809 reported at June 30, 2017 as deferred outflows of resources related to pensions resulting from Hospital contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2018:

	June 30, 2016	
	Deferred outflows of resources	Deferred inflows of resources
Differences between expected and actual experience	$ —	58,954
Net difference between projected and actual earning on pension plan investments	—	46,147
Changes in assumptions	100,600	—
Changes in proportion and differences between Hospital contributions and proportionate share of contributions	—	801,440
Hospital contributions subsequent to the measurement date	169,077	—
	$ 269,677	906,541

The $169,077 reported at June 30, 2016 as deferred outflows of resources related to pensions resulting from Hospital contributions subsequent to the measurement date was recognized as a reduction of the net pension liability in the year ended June 30, 2017.

(Continued)

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

Year ended June 30:	
2018	$ (223,800)
2019	(110,564)
2020	45,703
2021	40,829
2022	—
	$ (247,832)

(d) Actuarial Assumptions

The total pension liability in the June 30, 2015 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	3.00%
Salary increases	Composed of 3.00% inflation, plus 0.75% productivity increase rate, plus step rate promotional increases for members with less than 10 years of service
Investment rate of return	7.75%
Mortality – Healthy Males	RP-2000 Combined Mortality Table with White Collar Adjustment, generational mortality improvements with Scale BB setback for females
Mortality – Healthy Females	GRS Southwest Region Teacher Mortality Table, set back one year, generational mortality improvements in accordance with Scale BB from the table's base year of 2012

The total pension liability, net pension liability, and certain sensitivity information are based on an actuarial valuation performed as of June 30, 2015. The liabilities reflect the impact of Senate Bill 115, signed into law on March 29, 2013, with assumptions adopted by the ERB Board of Trustees on June 12, 2015 in conjunction with the six-year experience study period ended June 20, 2014.

The long-term expected rate of return on pension plan investments is determined annually using a building-block approach that includes the following: rate of return projections are the sum of current yield plus projected changes in price (valuation, defaults, etc.); application of key economic projections (inflation, real growth, Dividends, etc.); structural themes (supply and demand imbalances, capital flows, etc.) These items are developed for each major asset class.

The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized in the following table:

	Target allocation	Estimated rate of return
Asset class:		
Equities – Domestic	20 %	8.00 %
Equities – International	15	8.57
Fixed income	28	4.35
Alternatives	36	7.38
Cash	1	3.25
	100 %	

(e) Discount Rate

A single discount rate of 7.75% was used to measure the total pension liability as of June 30, 2016. This single discount rate was based on the expected rate of return on pension plan investments of 7.75%. Based on the stated assumptions and the projection of cash flows, the Plan's fiduciary net position and future contributions were sufficient to finance all projected future benefit payments of current Plan membership. Therefore, the long-term expected rate of return on Plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

(f) Sensitivity of the Center's Proportionate Share of the Net Pension Liability to Change in the Discount Rate

The following table provides the sensitivity of the net pension liability to changes in the discount rate. In particular, the table presents the Plan's net pension liability, if it were calculated using a single discount rate that is one-percentage-point lower (6.75%) or one-percentage-point higher (8.75%) than the single discount rate:

	June 30, 2017		
	1% Decrease (6.75%)	Discount rate (7.75%)	1% Increase (8.75%)
Hospital's proportionate share of the net pension liability	3,620,684	2,804,867	1,909,646

(g) Pension Plan Fiduciary Net Position

Detailed information about the pension plan's fiduciary net position is available in the separately issued Plan financial report available at www.nmerb.org.

(16) Other Postemployment Benefit Plan

Prior to fiscal year 2016, the Hospital and the Center participated in a post employment medical and dental defined-benefit plan that offered post employment healthcare coverage to eligible retirees and their

dependents. As of December 31, 2015, this defined-benefit plan was terminated and is no longer available to employees or employee dependents of either the Hospital or the Center. In fiscal year 2016, the Hospital recognized a special item gain of $6,194,964 related to the release of the OPEB liability. The liability was originally recorded by the Hospital based on the actuarially determined net OPEB obligation as of June 30, 2014.

(17) Commitments and Contingencies

(a) Lease Commitments

The Hospital is committed under various leases for building and office space and data processing equipment. Rental expenses on operating leases and other nonlease equipment amounted to $10,777,884 and $10,191,279 during fiscal years ended June 30, 2017 and 2016, respectively.

The Hospital has entered into an MOU with UNM to lease the medical facility referred to as the Ambulatory Care Center and usage of the related parking structure through fiscal year 2019. The Hospital pays semiannual installments of approximately $975,000 under this MOU.

Future minimum lease commitments for operating leases for the years subsequent to June 30, 2017, under noncancelable operating leases and memorandums of understanding, are as follows:

	Amount
Years ending June 30:	
2018	$ 4,337,924
2019	2,108,373
2020	1,801,594
2021	676,468
2022	755,168
2023–2027	4,330,770
2028–2032	4,476,564
2033–2037	3,195,014
2038–2042	9,930
	$ 21,691,805

(b) Contingencies

The Hospital is currently a party to various claims and legal proceedings. The Hospital makes provisions for a liability when it is both probable that a liability has been incurred and the amount of the loss can be reasonably estimated. The Hospital believes it has adequate provisions for potential liability in litigation matters. The Hospital reviews these provisions on a periodic basis and adjusts these provisions to reflect the impact of negotiations, settlements, rulings, advice of legal counsel, and other information and events pertaining to a particular case. Based on the information that is currently available to the Hospital, the Hospital believes that the ultimate outcome of litigation matters, individually and in aggregate, will not have a material adverse effect on its results of operations or financial position. However, litigation is inherently unpredictable.

(18) Capital Initiatives

In fiscal year 2015, the Hospital and the UNM HSC entered into an MOU for a ninth year, to collaborate on strategic capital projects. Per the agreement, the Hospital recorded a nonoperating expense of approximately $129 million in fiscal year 2015 to provide for the development of clinical facilities pursuant to the agreement. All capital facilities are owned by UNM HSC for use by the Hospital. Capital project disbursements from capital initiatives funds held by UNM HSC in fiscal years 2017 and 2016 and the ending balances for each fiscal year are reflected in the table below.

As of June 30, 2017, the ending balance of $203,605,605 comprises cash. As of June 30, 2016, the ending balance of $217,325,259 comprised cash with a due from the Hospital for the remainder.

The Regents granted the Bond Trustee in respect of the UNMH HUD-Insured Bonds a security interest in all of the Hospital's cash (with the exception of the proceeds of the Hospital's mill levy and state appropriations), accounts receivable, contract rights, and the proceeds of the same. In addition, in that certain Regulatory Agreement signed by the Regents, that is still in effect today, the University agreed and committed to HUD that it would not "assign, transfer, dispose of, or encumber any personal property of the project including revenues from any source…" Lastly, in accordance with the terms of the Lease under which the University leases a portion of the Hospital's facility from Bernalillo County, all reserves of the Hospital covered by the Lease are restricted to use for operation and maintenance of the Hospital.

	July 1 Beginning balance	UNMH contributions to fund	Capital project disbursements from fund	June 30 Ending balance
Fiscal year 2017	$ 217,325,259	—	(13,719,654)	203,605,605
Fiscal year 2016	221,925,844	—	(4,600,585)	217,325,259

Schedule 1

UNIVERSITY OF NEW MEXICO HOSPITAL

Comparison of Budgeted and Actual Revenues and Expenses

Year Ended June 30, 2017

	Budget (original)	Budget (final)	Actual	Budget variance
Operating revenues:				
Net patient service and premium	$ 869,522,100	869,522,091	902,433,423	32,911,332
Other operating revenue	21,853,774	21,853,778	25,211,123	3,357,345
Total operating revenues	891,375,874	891,375,869	927,644,546	36,268,677
Operating expenses	(965,916,661)	(973,705,922)	(986,677,050)	(12,971,128)
Operating (loss) gain	(74,540,787)	(82,330,053)	(59,032,504)	23,297,549
Nonoperating revenues and other revenues, net	77,217,139	85,006,407	76,479,948	(8,526,459)
Increase in net assets	$ 2,676,352	2,676,354	17,447,444	14,771,090

Note A:

The Hospital prepares a budget for each fiscal year, using the accrual basis of accounting, which is subject to approval by the Board of Trustees and the UNM Board of Regents. The amount budgeted for the Hospital's operations is included in the UNM budget and submitted to the New Mexico Commission on Higher Education for approval. All revisions to the approved budget must be approved by the parties included in the original budget process. The budget is controlled at the major administrative functional area, which is reported at the UNM level. There is no carryover of budgeted amounts from one year to the next.

See accompanying independent auditors' report.

Schedule 2

UNIVERSITY OF NEW MEXICO HOSPITALS
PLEDGED COLLATERAL BY BANKS

Year Ended June 30, 2017

	Pledged collateral			Bank Balance		
	Type of security	CUSIP	Maturity	Bank of America Albuquerque, New Mexico	Wells Fargo Bank Albuquerque, New Mexico	Total
Funds on deposit:						
Demand deposits				$ 49,557,211	$ 134,717,310	$ 184,274,521
FDIC insurance				(500,000)	(500,000)	(1,000,000)
Total uninsured public funds				$ 49,057,211	$ 134,217,310	$ 183,274,521
50% collateral requirement per Section 6-10-17 NMSA				$ 24,528,606	$ 67,108,655	$ 91,637,261
				Fair market value of securities in safekeeping		
Pledged collateral*						
	FNMA	31418B5E2	6/1/2031		53,976,076	53,976,076
	FNMA	31418BUN4	9/1/2035		30,120,651	30,120,651
	FNMA	3136A73U4	8/25/2027		21,386,524	21,386,524
	FNMA	3140F4KG0	5/1/2046		20,605,820	20,605,820
	FNMA	3136A7AF9	1/25/2030		18,130,765	18,130,765
	FMAC	3132GUBR4	6/1/2042	42,420,283		42,420,283
	FMAC	3128MAC72	11/1/2044	2,461,932		2,461,932
	FMAC	3128MJQ78	2/1/2042	1,997,928		1,997,928
	FMAC	3132GRHL8	2/1/2042	1,263,692		1,263,692
	FNMA	3138EHXR8	2/1/2042	566,561		566,561
	FNMA	31371J5B6	6/1/2031	337,194		337,194
	FNMA	31384VQF2	1/1/2030	47,074		47,074
	FNMA	31419AVF1	4/1/2039	725		725
	FMAC	31294KNX9	2/1/2018	364		364
	FNMA	31384WLN8	5/1/2031	4		4
Total pledged collateral				49,095,757	144,219,836	193,315,593
Excess of pledged collateral over the required amount				$ (24,567,151)	$ (77,111,181)	$ (101,678,332)

* Pledged collateral is held in safekeeping by the Bank of New York Mellon in the Hospital's name.

See accompanying independent auditors' report.

Schedule 3

UNIVERSITY OF NEW MEXICO HOSPITAL

Schedule of Individual Deposit and Investment Accounts

Year Ended June 30, 2017

Name of bank/broker	Account type	Balance per bank statement	Reconciled balance per financial statement
UNM Hospital cash:			
Bank of America:			
Operating	Checking	$ 49,557,211	49,558,202
Wells Fargo Bank			
Operating	Checking	83,113,060	77,127,526
Operating	Savings	51,604,250	51,604,250
Petty cash	Cash on hand	—	38,746
Total UNM Hospital cash		$ 184,274,521	178,328,724
UNM Hospital short-term investments:			
Morgan Stanley	Money market funds	$ 138,761	138,761
Wells Fargo	Money market funds	80,107	80,107
Morgan Stanley	U.S. Treasury notes	17,837,709	17,837,709
Morgan Stanley	FNMA	6,967,053	6,967,053
	FHLMC	5,842,866	5,842,866
Morgan Stanley	FHLB	3,955,137	3,955,137
Total UNM Hospital short-term investments		$ 34,821,633	34,821,633
UNM Hospital long-term investments:			
Wells Fargo	Money market funds	$ 17,978,206	17,978,206
Investment in TriWest	Equity securities	5,000,000	5,000,000
Investment in TriCore Reference Lab (TRL)	Equity securities	12,535,036	12,535,036
Investment in TLSC	Equity securities	4,926,956	4,926,956
Total UNM Hospital long-term investments		$ 40,440,198	40,440,198

See accompanying independent auditors' report.

Schedule 4

UNIVERSITY OF NEW MEXICO HOSPITAL

Indigent Care Cost and Funding Report

	Years ended June 30,		
	2017	**2016**	**2015**
		Unaudited	Unaudited
Funding for Indigent Care:			
State appropriations specified for indigent care – Out of County Indigent Fund	$ —	—	662,600
County indigent funds received	—	—	—
Out of county indigent funds received	13,868	9,242	178,286
Payments and copayments received from uninsured patients qualifying for indigent care	41,272	44,889	148,691
Reimbursement received for services provided to patients qualifying for coverage under EMSA	2,902,604	3,155,126	4,724,513
Charitable contributions received from donors that are designated for funding indigent care	338,834	350,081	333,659
Other sources:			
Other source	—	—	—
Total Funding for Charity Care	3,296,578	3,559,338	6,047,749
Cost of Providing Indigent Care:			
Total cost of care for providing services to:			
Uninsured patients qualifying for indigent care	12,175,294	13,956,651	48,239,122
Patients qualifying for coverage under EMSA	5,306,095	5,671,578	6,666,072
Cost of care related to patient portion of bill for insured patients qualifying for indigent care	12,732,564	25,829,688	14,963,900
Direct costs paid to other providers on behalf of patients qualifying for indigent care	5,221,142	2,016,562	751,209
Total Cost of Providing Indigent Care	35,435,095	47,474,479	70,620,303
Excess (Shortfall) of Funding for Charity Care to Cost of Providing Indigent Care	$ (32,138,517)	(43,915,141)	(64,572,554)
Patients Receiving Indigent Care Services (Unaudited):			
Total number of patients receiving indigent care	20,813	63,460	45,036
Total number of patient encounters receiving indigent care	91,525	124,626	105,771

See accompanying independent auditors' report.

Schedule 5

UNIVERSITY OF NEW MEXICO HOSPITAL

Calculations of Cost of Providing Indigent Care

	Years ended June 30,		
	2017	**2016**	**2015**
		Unaudited	Unaudited
Uninsured patients qualifying for indigent care:			
Charges for these patients	$ 23,124,965	24,069,684	91,042,491
Ratio of cost to charges	52.7%	58.0%	53.0%
Cost for uninsured patients qualifying for indigent care	$ 12,175,294	13,956,651	48,239,122
Patients qualifying for coverage under Emergency Medical Services for Aliens (EMSA):			
Charges for these patients	$ 10,078,053	10,201,372	12,656,871
Ratio of cost to charges	52.7%	55.6%	52.7%
Cost for Patients qualifying for coverage under Emergency Medical Services for Aliens (EMSA)	$ 5,306,095	5,671,578	6,666,072
Cost of care related to patient portion of bill for insured patients qualifying for indigent care:			
Indigent/charity care adjustments for these patients	$ 24,183,408	47,115,613	28,902,566
Ratio of cost to charges	52.7%	54.8%	51.8%
Cost of care related to patient portion of bill for insured patients qualifying for indigent care	$ 12,732,564	25,829,688	14,963,900
Direct costs paid to other providers on behalf of patients qualifying for indigent care	$ 5,221,142	2,016,562	751,209
Payments to other providers for care of these patients	$ 5,221,142	2,016,562	751,209

See accompanying independent auditors' report.

Schedule 6

UNIVERSITY OF NEW MEXICO HOSPITAL

Schedule of the Hospital's Proportionate Share of the Net Pension Liability

Last 10 Fiscal Years

The schedule of proportionate share of net pension liability and the schedule of employer contributions present multiyear trend information for the last 10 fiscal years. Fiscal year 2015 was the year of implementation, therefore, only three years are shown. Until a full 10-year trend is compiled, information for those years for which information is available will be presented.

	2017	2016	2015
Hospital's proportion of the net pension liability	0.03898%	0.04516%	0.05368%
Hospital's proportionate share of the net pension liability	$ 2,804,867	2,924,809	3,062,832
Hospital's covered-employee payroll	1,096,830	1,232,876	1,479,662
Hospital's proportionate share of the net pension liability as a percentage of its covered-employee payroll	256%	237%	207%
Plan fiduciary net position as a percentage of the total pension liability	61.58%	63.97%	66.54%

See accompanying independent auditors' report.

Schedule 7

UNIVERSITY OF NEW MEXICO HOSPITAL

Schedule of Hospital Contributions

The schedule of proportionate share of net pension liability and the schedule of employer contributions present multiyear trend information for the last 10 fiscal years. Fiscal year 2015 was the year of implementation, therefore, only three years are shown. Until a full 10-year trend is compiled, information for those is available will be presented.

	Years ended June 30,		
	2017	**2016**	**2015**
Contractually required contribution	$ 145,809	169,077	203,627
Contributions in relation to the contractually required contribution	145,809	169,077	178,415
Contribution deficiency (excess)	$ —	—	25,212
Hospital's covered-employee payroll	1,048,985	1,096,830	1,232,876
Contributions as a percentage of covered-employee payroll	13.90%	15.42%	14.47%

See accompanying independent auditors' report.

KPMG LLP
Two Park Square, Suite 700
6565 Americas Parkway, N.E.
Albuquerque, NM 87110-8179

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The University of New Mexico Health Sciences Hospital
Board of Trustees and
Mr. Timothy Keller, New Mexico State Auditor

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of the University of New Mexico Hospital (the Hospital), a division of the University of New Mexico, State of New Mexico, operated by the University of New Mexico Health Sciences Center Clinical Operations, organized as the University of New Mexico Hospital, which comprise the statement of net position as of June 30, 2017, and the related statements of revenues, expenses, and changes in net position and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 27, 2017.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Hospital's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of Hospital's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*. We note a certain matter that is required to be reported per Section 12-6-5

NMSA 1978, that we have described in the accompanying schedule of findings and responses as item 2017-001.

The Hospital's Response to the Finding

Hospital's response to the finding identified in our audit is described in the accompanying schedule of findings and responses. The Hospital's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospital's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

KPMG LLP

Albuquerque, New Mexico
November 27, 2017

UNIVERSITY OF NEW MEXICO HOSPITAL

Schedule of Findings and Responses

Year ended June 30, 2017

Other Findings as Required by Section 12-6-5 NMSA 1978

2017-001. Terminated Employee Documentation Process – Control Deficiency – UNM Hospital

Criteria

In accordance with current Hospital policy, it is the responsibility of the HR department or an employee's supervisor to complete required documentation to notify the IT department when an employee terminates Hospital employment. The status of terminated employees should be updated in the Hospital's IT systems on a timely basis. Based on industry standards, the appropriate disabling of access within IT systems would occur within a reasonable time, or five working days of termination.

Condition

Our testwork revealed that notification of employee terminations was not always provided in a timely manner to the IT department. We identified three employees from the population sampled for whom access to the Millennium system was not timely disabled after termination. We verified that none of these employees recorded any activity in Millennium subsequent to their termination.

For our testwork we compared all employee terminations during the year to determine if any of these employees still had access to the Millennium system as of June 30, 2017.

Effect

There is an increased risk that a terminated employee has continued access to IT systems and the data contained therein subsequent to termination.

Cause

Departments are not complying with existing Hospital policies to timely notify the IT department of final employment dates for terminating employees.

Recommendation

The Hospital should develop a procedure to enforce timely documentation of terminated employees. This documentation and disabling of user access within IT systems should take place within a reasonable time, or five working days of termination of employment.

Management's Response

UNMH Human Resources is modifying the termination process to trigger immediate notification from the HR system directly to the e-mail distribution list for IT account disabling. UNMH Human Resources is also going to communicate to UNMH Management the process and requirements for employee separation checklist. This process was implemented in August 2017 and is the responsibility of the UNMH Human Resources Administrator.

UNIVERSITY OF NEW MEXICO HOSPITAL

Summary Schedule of Prior Audit Findings

Year ended June 30, 2017

Finding 2016-001. Formalized Review of All Soarian Users – Other Matter

Current Status: Resolved

UNIVERSITY OF NEW MEXICO HOSPITAL

Exit Conference

Year ended June 30, 2017

The Hospital's management prepared the financial statements and is responsible for the contents.

An exit conference was conducted on September 27, 2017 with a member of the Finance and Audit Committee of the Board of Trustees and a member of the Hospital's management. During this meeting, the contents of this report were discussed.

University of New Mexico Hospital

Jerry McDowell, Chair, Finance/Audit Committee

Erik Lujan, Finance/Audit Committee Member

Nick Estes, Finance/Audit Committee Member

Steve McKernan, Chief Executive Officer, UNM Hospitals

Michael Chicarelli, Administrator, Professional and Support Services, UNM Hospitals

Ella Watt, Chief Financial Officer, UNM Hospitals

Julie Alliman, Controller, UNM Hospitals

Kimberly Clay, Finance Director, UNM Hospitals

Rodney McNease, Executive Director, UNM Hospitals Behavioral Health Operations

Sara Frasch, Human Resources Administrator, UNM Hospitals

Dr. Michael Gomez, Executive Physician, UNM Health Sciences Center

Dr. Jonathon Bolton, Department of Psychiatry

Purvi Mody, Chief Compliance Officer, UNM Health Systems

Manilal Patel, Director, Internal Audit, University of New Mexico

Michael Schwantes, Chief Financial Services Officer, UNM Health Sciences Center

Debra Owens, Administrative Assistant to CFO, UNM Hospitals

KPMG

John Kennedy, Partner, KPMG

Jaime Cavin, Senior Manager, KPMG

Ruth Senior, Manager, KPMG

UNMH is responsible for the contents of the financial statements. KPMG LLP assisted with the preparation of the financial statements.