Schedule of Exhibits

Proposal	RFP # 2019-1001 – TPA Services HealthFirst Questionnaire
	Fee Schedule
	Executive Summary
Exhibit A	Audited Financial Statement
Exhibit B	Account Team Biographies
Exhibit C	HealthFirst Sample EOB
Exhibit D	Submission Form Performance Commitments and Penalties + HealthFirst Performance Guarantees
Exhibit E	Deviations From Specifications Form
Exhibit F	Summary Conditions & Specifications Form
Exhibit G	Conflict of Interest Questionnaire
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Exhibit I	House Bill 89 Verification Form
Exhibit J	HealthFirst E&O Coverage Certificate

HealthFIRST

RFP SUPPLIER RESPONSE TEMPLATE	
TRUCTIONS AND ASSUMPTIONS	
Complete the blue-shaded cells and submit responses as the TPA Questionnaire	
RFP #:	2019-1001
RFP Title:	ADMINISTRATIVE SERVICES ONLY (ASO) FOR MEDICAL, DENTAL, PPO NETWORK and COBRA/HIPPA SERVICES
SECTION 1: GENERAL QUESTIONNAIRE (To be answered by all Proposers)	
Describe your Organization	
Business Name:	HealthFirst TPA
Contact Address:	821 ESE Loop 323, Suite 200 Tyler, TX 75701
Contact Person:	Rachel Robertson
Contact Phone # :	903-509-5789
Contact Email:	rsrobertson@hfbenefits.com
Year Founded:	1983
Further Organization Description	
Where is your company headquarters located?	HealthFirst is headquartered in Tyler, Texas. The County of Upshur has been a HealthFirst client for 5+ years, and our staff members have developed a deep working relationship with County employees. Our team has an extensive knowledge of the Plan and special needs of the multiple departments and individual members. Because HealthFirst works with many public sector and nonprofit clients including municipalities, county governments, school districts and nonprofit agencies, we have developed a deep understanding of the specialized needs and requirements of governmental entities. We are sensitive to the needs of clients and strive to balance expectations of excellent benefits and customer service while also helping plans be good stewards of taxpayer dollars.
ase provide your most recent published financial statement and/or Best Insurance luring. (Please provide financial size category.)	Audited financial statement is supplied in Exhibit A. The 2018 audited financial statement will be available mid-summer, 2019, and can be furnished upon request.
Will there be an individual account manager dedicated to Upshur County, and if so, where will he/she be located? Please provide biographies of each individual.	The County of Upshur team will be led by account executive Rachel Robertson and account coordinator Frances Brown, and will include a staff of experts in medical management, claims, customer service, reporting, marketing and other essential services. Key members of the team include: Rachel Robertson, Frances Brown, Trish Terrell, Jolene Jackson, Monica Bauman and Janis High. Please see Exhibit B for Account Management Team bios. The team for the County of Upshur is located in Tyler, Texas and will be available to meet with the client and consultant to discuss plan performance and ensure we are meeting or exceeding client satisfaction. In addition, because our office is centrally located and plan members are so comfortable with our team they frequent our office to discuss claims and receive guidance.
Upshur County requires the right to approve any correspondence sent to our employees. Do you agree to the prior approval agreement?	Yes. Our client and member communication initiatives are uniquely developed for the County of Upshur, based on their needs. This includes but is not limited to: enrollment, provider updates, how to access information to better manage member benefits, and any customized pieces requested to help plan members further understand and utilize their benefits. HealthFirst will work in tandem with EBC and the County of Upshur to create a customized communication plan and ensure the County of Upshur approves any and all correspondence which is shared with their employees.

Will any of your services be sub-contracted with outside vendors? (If yes, please describe the services and with whom you sub-contract - i.e. ABC Company for ID card printing.)	HealthFirst has longstanding working relationships with many vendor partners. We work with these partners to determine the best match for each client based on levels of service, connectivity and value. Services proposed to be sub-contracted to our outside partners for the County of Upshur include: ID cards (printed by RedCard); EOBs (printed by RedCard); electronic claims payments (administered by Payplus); checks (processed and printed by RedCard); COBRA/HIPAA (administered by WageWorks); Sec. 125 (administered by WageWorks); Subrogation (processed through The Phia Group); GBAS Web (backend HR & Member portal); Case Management, Disease Management and Utilization Review (administered my MM Solutions, Outside Medical Claim Peer Review (several partners) and data aggregation (performed by Advanced Plan for Health). All of these vendors have worked with the County previously and/or currently and have direct integration with HealthFirst processes. HealthFirst will not sub-contract claims payment to another vendor with the exception of run out claims processing (UMR will process run out claims and HealthFirst will pay for run out claims processing administrative fees if selected as Contractor).
Will you be willing to have representatives available at initial employee educational and enrollment meetings as well as future open enrollments, health fairs, and other special requirements?	HealthFirst is happy to provide representation and support throughout and after the enrollment process including but not limited to hosting open enrollment sessions, educational meetings for members on employee benefits and wellness classes, and other activities which support the County's initiatives. HealthFirst has a tradition of participation and organization of annual health fairs and arranging for services from UT Health East Texas at health fairs for our clients. Some of these services include mobile mammography services, carotid artery screenings, BMI calculations, HgbA1C and cholesterol screenings. Often we can arrange for UT Health physician appointment schedulers to be onsite to connect members to primary care physicians, or even have physicians attend the fair to have one on one conversations regarding medical questions or concerns. Additionally, attendees can seek information from representatives on diabetes management, exercise programs, maternity and delivery excellence services, mental health and stroke awareness.
How long has your organization been doing business in the state of Texas?	HealthFirst was established in Tyler, Texas in 1983. The company was started by insurance industry veterans who saw the need for a technology savvy TPA to manage self-funded plans for employer groups of all sizes. As a pioneer in self-funded plan administration, HealthFirst has grown with the industry, but we retain our roots as a service-focused TPA. In fact, one of our very first clients is still with us today. After a period of expansion, HealthFirst was acquired in 1996 by East Texas Medical Center Regional Healthcare System, a leading hospital and clinic system in East Texas. In March 2018, ETMC joined Ardent Health Services and The University of Texas System to form a new health system, UT Health East Texas, to benefit East Texas. Ardent committed to investing $150 million over the next five years to further advance and expand the areas of care available to East Texans.
Will your phone unit provide support to the initial and on-going future enrollments by answering members' phone calls about benefits and networks, etc.	HealthFirst assigns a custom toll-free 800 number to each client. The HealthFirst customer service team is eager to provide exceptional member support as it relates to all questions regarding their benefits. In addition to having a live representative available during business hours County employees can also access their member information 24/7 through our member portal. Several portal features include verifying eligibility and enrollment, viewing claims and payment history, retrieving important forms and EOBS, and viewing SBCs and PDs.

Provide three Texas client references (preferably public sector clients).	Contact Name	Contact Title	Contact Phone	Contact E-mail
	Kathy Lutonsky, Wood County	Director of Human Resources	(903) 763-4639	klutonsky@co.wood.tx.us
	Jenny McFadden, Andrews Center	Director of Human Resources	(903) 597-1351	jmmcfadden@andrewscenter.com
	ReNissa Wade, City of Tyler	Director of Human Resources	(903) 531-1100	rwade@tylertexas.com

SECTION 1: SELF-FUNDED MEDICAL QUESTIONNAIRE (To be answered by TPA's and arriers) .	
Plan Administration	
Are customer service functions and claim payment performed in the same location?	Yes; the entire customer service, claims, account management and medical management teams for the County of Upshur are located at our corporate HealthFirst office in Tyler, Texas. Since all teams are local and housed on the same floor in our building, we are able to work closely together to provide real time responses to all inquiries and mitigate concerns while ensuring each member receives exemplary service.
Contractor will provide COBRA administration and the fee will be included in the submitted rate. The County will provide notification of termination to the Contractor who will then be responsible for all other aspects of the process, including but not limited to the following: employee notification for medical, drug, dental, and vision benefits; certificate of coverage for HIPAA compliance; billing and premium collection for medical, drug and dental benefits; mail identification cards and informational materials to the subscriber home.	Agree; this is the current process for the County's COBRA administration, though certain services are outsourced to a vendor partner.
Contractor agrees to provide the County with the Summary of Benefits and Coverage Notices prior to open enrollment for the County to distribute to employees.	Agree
Customer Service	
Contractor will develop, print, and distribute a customized, lay language, Summary Plan Document (SPD) booklets to be made available in electronic format or be mailed to the bscriber's home address at the time of initial enrollment and thereafter for new hires or er new subscribers? SPD shall be reviewed and approved by the County. The SPD will be developed and submitted to each subscriber not later than April of each year unless another date has been agreed upon by the County.	Agree
Eligibility	
Can you accept enrollment, maintenance, and termination data from the County online?	Yes; HealthFirst utilizes an online platform which allows the County to enroll, make changes, and terminate members.
Is enrollment available with electronic data feed capabilities?	Yes; HealthFirst has the ability to accept enrollment via electronic data feeds. Our preference is to receive eligibility data in the HIPAA approved ANSI 834 EDI Enrollment Implementation Format; however, we can also accept Excel file formats.

Network	
Do you currently offer any hospital tiered benefit arrangements (Accountable Care Organizations or EPO) in the East Texas area?	HealthFirst administers multi-tier network arrangements for almost of our clients. Currently, the County is accessing a two-tier benefit arrangement which includes our proprietary network, AccessDirect Platinum (ADP). The County utilizes ADP like an EPO since they do not have out-of-network benefits. The ADP network is currently wrapped with UnitedHealthcare ChoicePlus. Our recommendation is to move the wrap to another solution this year. We have included two options for the group: PHCS, which has a broad national network and low monthly access fees, or CIGNA, a broad national network with higher monthly access fees. Additionally, UTHET is building a Clinically Integrated Network, or CIN. The CIN is a system of coordinated care that is designed to reduce medical spend for both plan and members while delivering optimal results. By focusing on patient engagement, preventive care and collaborative care between all of a patient's providers, the CIN is designed to produce the best outcomes at the lowest overall cost. The CIN will take advantage of UTHET's vast provider network while positively impacting the patient experience and the financial impact on the plan.
Are you anticipating any material changes in network size (for either hospitals or providers) in the network area serving the County during the next 24 months?	Yes, Access Direct Platinum is expanding its reach in other counties that will help the County of Upshur save money at the facility that is their top provider. In Gregg County, HealthFirst is currently negotiating with several key providers including Longview Regional Medical Center, Diagnostic Clinic of Longview, and Texas Spine & Joint, in order to have these providers join the ADP network. HealthFirst is also excited about the new Ardent/UT partnership and the positive impact it will have on healthcare in East Texas. Over the next four years, Ardent will have invested $150 million into the system to further expand care, increase convenience and provide access. Immediate initiatives on the horizon for UT Health East Texas are: 1) a fully accredited NICU opening Q2 of 2020, 2) extension of the MD Anderson partnership, providing access to its nationally recognized cancer treatment across the service area, including in the downtown Tyler facility, at the competitive discounts offered by the AccessDirect Platinum (ADP) network. In this partnership, already in place at UT Health's North Campus, UTHET oncologists, surgeons and physicians serve as adjunct faculty at MD Anderson and follow the same protocols, guidelines and treatment plans as the cancer center. This gives East Texas patients access to MD Anderson's quality care right at home. UTHET physicians consult with providers in Houston, and for difficult or rare cases, can expedite appointments with specialists at the Houston campus. Additionally, MD Anderson clinical trials will be extended to patients at the UTHET facilities as early as 2021. 3) expansion of several critical departments, including cardiology, providing technology available nowhere else in East Texas, pulmonology, creating the largest lung care program in East Texas, and urology 4) the launch of a local telemedicine program through American Well in Q1 of 2020 which will increase access to ADP providers via convenient phone and video consults. This also will introduce an additional layer of psychiatric care, with access to psychiatrists and behavioral health therapists 5) the expansion of network urgent care and extended hour clinics, launching up to five urgent care clinics to create more after-hours access to care 6) extended evening and weekend hours at clinics, 7) through the North Campus, formerly the University of Tyler Health Science Center at Tyler, the system has a strong emphasis on education, research and physician development. The system is expanding its residency program, and is on target to bring 150 residents to East Texas over the next five years, in much-needed specialties including family medicine, internal medicine, psychiatry, rural family medicine and occupational medicine. In addition to providing an immediate economic and clinical impact, and providing immediate local relief to the nationwide physician shortage, these physicians will strengthen East Texas medical community long-term. Research shows that 60 percent of residents choose to remain in the area after their residency is completed, so the residency program has the long-term result of improving access to care. HealthFirst is also working on direct contracts with other UT partners, like UT Southwestern, to secure a preferred rate structure which can be passed on to clients.
What is the Contractor's standard process and advance notification timeframe to notify the County and its subscribers of network changes?	HealthFirst's standard process for notification is to send a monthly email, notifying all groups of material changes to the network. Additionally, our online provider directory is updated monthly. All changes are made after the monthly network board advisory committee meeting, when changes are formally accepted.
Describe the Contractor's transition process for handling patients that are currently receiving care in a non-network hospital as well as those currently receiving outpatient services at time of contract implementations.	HealthFirst recognizes the importance of care continuity. We work closely with our clients and their consultants to identify and connect with those members with ongoing conditions currently seeking treatment and work to transition care to in-network providers once conditions are stable and adequate care is available.

any parts of the Contactor's networks leased?	No. The ADP network is not leased as it was built by UT Health East Texas and HealthFirst to serve as a proprietary and exclusive regional narrow network. The exclusivity allows HealthFirst to offer competitive pricing and the ability to maintain tight relationships with network providers ensuring excellent service, exceptional care, and savings are benefits to the client and their members.
If yes, identify owner of the network and the geographic service area.	n/a
Is your designated network separate or a subset of your large network?	The proprietary ADP network is exclusive to HealthFirst and is not part of a large network.
Claims Payment Processing	
Contractor will furnish Explanation of Benefit (EOB) payment statements to subscribers after a claim has been received and payment issued or rejected. A sample copy of EOB is included.	A sample EOB can be found in Exhibit C. EOBs include a comprehensive set of data which is necessary for the member and provider to understand how a claim processed. HealthFirst can add a custom logo to EOBs and can customize portions of EOBs based on client request/need.
For those claims that require additional information before processing can continue, is a notice sent to the provider and/or subscriber advising them of this fact?	Yes. HealthFirst sends notices to providers and members alike advising them when and what additional information is needed prior to the claim being adjudicated. Members are notified via EOB. If we are requesting accident details or COB, we attach the forms to the EOB for member convenience. Providers are notified via EOB, and if medical records are being requested a separate letter is sent in conjunction with the EOB requesting the provider submit the requested information.
How much of a delay generates such notice?	Notices are sent at the time of adjudication. If necessary, up to two follow-up letters go out, at 3-week intervals.
Describe the process for obtaining medical consultation needed for claims payment determination.	If it is determined a claim must be reviewed for medical necessity, the claim and any supporting information is forwarded to our Medical Director for review of medical necessity. If a second review is required, the request is sent for an outside peer review.
at qualifications do the Contractor's medical consultant(s) possess?	Our in-house Medical Director is a board certified M. D. and we employ seven certified case manager R.N.s. Our staff follows nationally recognized Milliman criteria. All outside review companies are comprised of board certified specialists in their designated field. Our independent peer review companies include: MCMC, MRI, ProPeer, AMR and MES, all who are URAC or NCQA accredited.
How often do the Contractor's medical consultant(s) meet to review claims?	Our internal Medical Director reviews cases daily, if needed. Additionally, we utilize independent peer review companies as our physician panel for second level review, on an as-needed basis. All companies are comprised of board certified specialists in their designated field. Our independent peer review companies include: MCMC, MRI, ProPeer, AMR and MES, all who are URAC or NCQA accredited.
Please indicate your process for handling subrogation claims	HealthFirst partners with the well respected Phia Group, a law firm who specializes in subrogation and cost containment to negotiate subrogation claims. Certain diagnostic codes trigger the process, for instance, certain codes associated with emergency room visits will warrant examination. All information is sent to the vendor partner, and their specialists contact the member, attorneys, other insurance and any other parties needed to obtain recoveries due to the Plan.
Explain the current procedure for identifying and processing claims for Coordination of Benefits.	Each member with a covered dependent is required to complete an updated COB form annually during open enrollment to maintain records regarding primary and secondary insurance. Additionally, COB is also requested if a dependent is added during the plan year. The information provided on these forms is then used to coordinate payments by the responsible insurance plan(s). The process can be customized by client.
Describe the appeal process of a contested claim.	Appeals are reviewed and responded to within 60 days of receipt. If HealthFirst needs additional information from the plan or member, or the appeal is sent out for a peer review, there is potential for an extension beyond the 60 days. Claims appeals are outsourced to outside reviewers.

Does your claim system check for duplicate charges? What are the criteria used?	HealthFirst utilizes Ingenix/Fair Health claims editing software. This software scans for duplicates and will flag all claims with at least three common characteristics. Fields checked include: Provider TIN, Procedure Codes (CPT/HCPCS), Amount of Charges, Date of Service, Claimant Name, Claimant SSN or System ID number.
Does your system check for bundling/ unbundling of claims? What are the criteria used?	HealthFirst utilizes the Ingenix/Fair Health claim editing system to check for bundling/unbundling of claims. This software reads the codes billed on a claim and edits what should be part of another code.
Please provide a copy of your Standard Performance Guarantees.	These are attached as Exhibit D.
Medical Management	
	Hospital Pre-Certification and Large Case Management
Briefly describe your case management and utilization review functions. Provide an estimate of savings associated with these programs.	Case management is designed to assist members with catastrophic illnesses and conditions and ensures they receive the appropriate care with network providers and facilities. This ultimately helps the plan control the high costs of catastrophic illnesses. Utilization review is used to determine medical necessity to protect the plan from unnecessary medical expenses. While it is difficult to estimate savings due to each member case being extremely unique, the mission of case management is to assist in keeping available services within the network, assisting with negotiations for services that may not be easily available in network, providing medical necessity review to make sure services are appropriate and necessary for care, and supporting members and families as needed. Ensuring services are performed within the network, when available, is vital to cost containment and plan performance as the discounts rendered through the ADP network are much greater than non-network facilities and providers.
Describe the process and criteria for identifying subscribers in need of large case management, including those with large outpatient expenses without having an inpatient stay.	The process for identifying and opening large case management on members involves daily review of precerts, predeterminations (medically necessary and review of benefits), high dollar claims reports, potential stop loss notices, or notification by the employer or member of a new, long term illness. Members with high outpatient expenses without an inpatient stay are flagged by this process.
	Centers of Excellence
Does the Contractor have a network of "Centers of Excellence"? If so, Describe how facilities are selected.	Our ADP network does not have designated Centers of Excellence. Many of our wrap network carriers do have designated Centers of Excellence, and use their internal guidelines for selection.
Define experimental treatment and the process for evaluating new treatments.	HealthFirst uses Milliman Care Guidelines to support the determination of an experimental or investigational drug, device, treatment or procedure.
What is the policy on experimental and catastrophic procedures such as organ or tissue transplants and new technologies?	HealthFirst uses Milliman Care Guidelines to support the determination of an experimental or investigational drug, device, treatment or procedure.
Describe the selection criteria or prior authorization process to gain access to the centers.	If the health service that is sought requires prior authorization, our Medical Management team will work with the provider and member to authorize the service.
Describe how case management is provided for subscribers who access Centers of Excellence (i.e., are they handled in a unit separate from other catastrophic cases)?	Case management is handled within the same unit.
Banking Arrangements	
Are checks issued on the employer's or carrier's stock?	Checks are issued on employer branded stock that are printed at Red Card. The cost for this is included in administration.
Do you require a minimum balance to be maintained or can the County use a zero balance account?	The County may use a zero balance account.
ID Cards	
Are ID cards customizable?	Yes, ID cards can be customized to the County's specifications.
Please describe ID card distribution.	ID card distribution is client specific. Methodologies currently in place include mailing to employee home, mailing to the Client for distribution, or mailing to multiple client locations for distribution.

Nurse Line & Patient Engagement	
nurse advisory toll free number available? Is there any associated cost?	We do not have a 24-hour nurseline at this time; however, our team of certified RN case managers is available during business hours for questions and consultation. Additionally, the UTHET system will be introducing its own proprietary telemedicine platform in 2020.
Provide your definition of patient engagement? Explain how your levels of engagement are changing behavior. What percent of your engagement activity is telephonic versus mail based?	Patient engagement is voluntary in case management. Members are identified as candidates for case management by diagnosis codes and claims, with two main benefit areas: First, case management can benefit the plan, as it allows us to provide information to the carriers for review as requested, so that carriers may more accurately assess risk and provide reinsurance quotes. Second, it can benefit the individual patient, as the nurses and certified case managers on the medical management staff personally assist members in navigating claims, network providers, procedures, etc., to make sure they are receiving the right care at the right facility/provider. A member identified for engagement receives a packet about case management and a form to return giving consent to participate. Case managers do a telephonic assessment and answer any questions. The level of engagement is dependent on the member/family if applicable, whether email or telephone is the primary contact depends on the wishes of the patient. We do not currently measure engagement rates as this is a voluntary process. However, engagement rates are normally measured in our disease management program, which requires an additional PEPM cost. Candidates are identified through predictive modeling, focusing on those with multiple chronic conditions who are not receiving nationally recognized standard of care treatments. After an initial assessment, members receive a treatment plan to close their care gaps and receive education on their individual conditions, usually lasting 6-9 months. For mandatory programs, the coach will report to the employer those who are not participating as required. Letters are utilized but the majority of this program is done by phone. Reviews of groups with this program in place for more than three years have shown a decrease in claims spend and hospital utilization and improved compliance with recommended standards of care, which is reflective of behavior change. HealthFirst has not recommended this program for the County at this time.
Stop Loss Integration	
Is your system set up to automatically pend stop loss claims, so an audit can be performed prior to issuing the check? What is the turnaround time for this to happen?	While our system is not set up to automatically pend stop loss claims, in order to ensure secured network discounts are not forfeited, all claims over $50K are pended for outside audit prior to adjudication. The turn around time on this process is three to seven days.
Please describe the stop loss filing process that will be used for the County.	Multiple processes are in place to ensure potential high cost claimants are identified. First, if the dedicated processor sees indications the member will hit stop loss, a notice is set on the members account and an email is sent to our internal stop loss department advising of the potential hit. Additionally, our system is set to notify us when a member has met half of the spec. At that time, the members account is flagged and the stop loss department is notified. The same process is in place when a member goes over spec. Once a claimant goes over spec, HealthFirst's stop lost department is notified by the claim department, typically via email with claim information included. A stop loss specialist then compiles all documentation needed to send to the reinsurance carrier to obtain reimbursement.
If pharmacy benefits are provided through a third-party, are you able to integrate medical and pharmacy cost data into one combined summary to provide to the stop loss carrier?	HealthFirst is able to integrate medical and pharmacy cost data into one combined summary, so long as HealthFirst is receiving the pharmacy data.
Audits	
What is the frequency of your internal audits?	Within our claims team is our Quality Assurance department that conducts weekly audits across each processor and each client. This team is also responsible for ensuring that new clients, new benefit plans, and changes to benefit plans are correctly implemented. Once the plan is built in our claims processing system the Quality Assurance team processes claims in the test environment until claims process according to the signed Plan Document of the client. Claims are not processed in the live system until claims process correctly in the test environment for at least one month.
What is the frequency of your external audits?	HealthFirst submits a random sample of claims every month for outside audit. Additionally, we engage in an annual SSAE18 SOC1 Type II audit.

Who performs external audits?	Partner Plus Consulting, Inc. performs our monthly and annual audits.
Would you be willing to pay for an outside audit?	HealthFirst submits to and pays for monthly and annual audits and maintains financial and payment accuracy levels at and above Industry Excellence levels: Financial Accuracy 99.57% Payment Accuracy 98.49%
At what trigger point do you conduct/require hospital claims audit?	Any claim over $15,000 is reviewed by senior staff. Claims for network providers are often excluded from audit as their contracts often stipulate "without audit", however, we do still conduct internal reviews to ensure all the proper plan administration guidelines are followed (COB has been reviewed, precert obtained, accident details obtained, no subro applies, claims paid in accordance with plan benefits). All out of network claims that exceed $15,000 and, more specifically, providers who are unwilling to negotiate discounts are also sent for review. External review occurs once a claim hits the $50K threshold. These amounts are standard, but can be customized based on client need.
Reporting / Access to Claims Data	
When are your monthly aggregate reports released?	Aggregate reports are released as soon as all of the necessary data has been received, but no later than the 15th of the month. Medical data is generally available for reporting by the first Monday following the end of the month. A delay in receiving other necessary data coming from vendor partners such as Rx or dental can cause delay in the release.
Will the County have access to a reporting site with raw Medical and RX claims data?	Yes, we can send claims data for analysis and allow access to our reporting system 'Advanced Plan for Health.
Do you have a dedicated reporting department? If so, please provide names and titles.	Yes, we have a dedicated reporting team. Team members include Susan Kohler, reporting analyst; Alex Texcucano, reporting analyst; and Jessica Clark, financial model analyst.

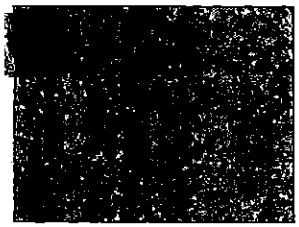
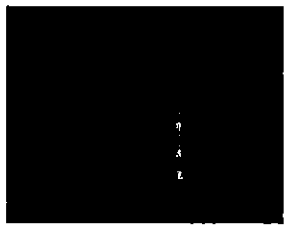
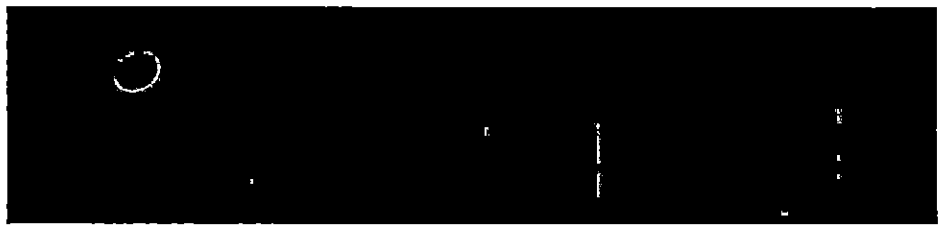
Medical & Dental Administration - Proposed TPA Fees	
Administrative Services	**PEPM**
Medical Administration	$ 18.00
Pre-Certification / UR	$ 2.70
Dental Administration	$ 3.00
COBRA & HIPAA Administration	$ 2.00
Total Administrative Costs (dependent upon wrap network selection)	**$31.70 - $37.70**
Rate Guarantee	**3 years**
TPA Fee Abatement Available First Year	**N/A, but HealthFirst will pay for UMR run-out claims processing if selected as Contractor.**
Additional Costs	
Case Management	$150 per hour
Plan Management Fee	$1,000 per year
Cost Reduction and Savings Program	30% of savings
Subrogation Recovery	30% of recoveries
Initial or Renewal Set up fees	Included
Miscellaneaous Printing Costs	Included
Miscellaneous or any other fees not mentioned	$5/PEPM for non-preferred stop loss carriers
Rx Consultant/Auditing	Included
Population Health & Plan Performance Analytics	Included
Open Enrollment Support (Onsite)	Included
Health Events	Included
Custom ID Cards	Included
Ad Hoc Reporting	Included
Dedicated Customer Service Phone Number	Included

Wrap Network Options	PEPM
CHOOSE ONE OPTION	
ADP wrapped with PHCS	$ 6.00
ADP wrapped with Cigna	$ 12.00

RFP Response

County of Upshur

Executive Summary

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Executive Summary

HealthFirst appreciates the opportunity to respond to the Request for Proposal by the County of Upshur to provide healthcare benefits administration services for its employee benefits program.

HealthFirst is a third-party administrator (TPA) that provides a complete, seamless benefits experience for plan sponsors, network providers, and plan participants. Designed to contain the rapidly rising costs of healthcare, our solution also provides excellent coverage and service. Highlights of our capabilities include:

- Complete TPA services (Eligibility, Enrollment, Claims, Billing, Cobra/HIPAA, Rx, Plan Documents and SBCs, Subrogation).
- The ability to work with proprietary networks.
- In-house health management services (pre-certification, case management).
- Complete data reporting.
- Stellar customer service, including an 800-number customized for your group; an online portal serving members, sponsor and providers.

Proposed Services

As the incumbent administrator, HealthFirst proposes a continuation of its customized solution. The enclosed RFP response outlines our services, including but not limited to these:

- Customer Service (phone and online access).
- Claims processing, payment and adjudication.
- Provider relations (build network, maintain fee schedule, reprice claims, manage provider questions/customer service, out-of-network negotiations).
- Precertification and utilization management.
- Web portal for providers, members and group administrators.
- Reports (utilization, diagnosis, financial and others).

About HealthFirst

HealthFirst is a full-service third-party administrator based in Tyler, Texas. Since 1983, we have created customized plans tailored to the needs of each employer. In 2018, we became a part of the UT Health East Texas system, an alliance of Ardent Health Services and the University of Texas Health Science Center. This unique partnership provides access to high-quality medical care by hospitals and affiliated clinics, along with our partnership with other narrow networks throughout the United States.

Our mission is to bring unmatched innovation and excellence to our health plan management services. HealthFirst clients include hospitals and indigent care districts, city and county governments, public school districts and private employers.

Additional Services

❖ ADP Network Expansion

HealthFirst is in final negotiations to add several key providers to its proprietary AccessDirect Platinum network. Expected to be available in the fourth quarter of 2019, and to replace existing agreements with wrap networks in affected areas, the new agreements are being negotiated with several providers that are among those most utilized by County members, including:

- Longview Regional Medical Center
- Diagnostic Clinic of Longview
- Texas Spine & Joint Facility

❖ Rx Savings Opportunities

HealthFirst works with many Pharmacy Benefit Managers, and has retained the services of an outside Rx consultant to review contracts for its PBM partners and clients, at no charge to clients. The consultant has recently assisted in re-negotiating a new contract with one of our preferred PBM partners, MedTrak Rx, the current vendor for the County. The contract has reduced some of the key costs associated with Rx spend, including average wholesale price of drugs. Upon renewal, we will analyze the existing and the new contract using 2018-2019 data to determine the model that will produce the most cost savings for the County in the new plan year.

❖ Indigent Care Administration

As a HealthFirst client, Upshur County is eligible for preferred pricing for our Indigent Care administration program. Utilizing the IHS eligibility and claims paying system, and HealthFirst's experienced staff of claims processors and eligibility specialists, our services can cut costs and increase efficiencies for public entities, particularly when using our health management staff to perform pre-certification, potentially eliminating thousands of dollars in healthcare spend by denying medically unnecessary procedures.

"HealthFirst has handled our health insurance program for more than 30 years. We have been very pleased with the manner in which they . . . pay our claims, provide support to providers and members alike, and provide analytical reports that allow us to see exactly where our money is spent."

-- Jenny McFadden, Andrews Center, Texas.

We make health plans our business...so you can concentrate on yours.

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East Texas Medical Center Regional Healthcare System and Subsidiaries

Consolidated Financial Statements and Consolidating Supplemental Information
October 31, 2017, 2016 and 2015

East Texas Medical Center Regional Healthcare System and Subsidiaries
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October 31, 2017, 2016 and 2015

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Report of Independent Auditors

To the Board of Directors of
East Texas Medical Center
Regional Healthcare System

We have audited the accompanying consolidated financial statements of East Texas Medical Center Regional Healthcare System and its subsidiaries, which comprise the consolidated balance sheets as of October 31, 2017, 2016 and 2015, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of East Texas Medical Center Regional Healthcare System and its subsidiaries as of October 31, 2017, 2016 and 2015, and the results of their operations, their changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Notes 2 and 20 to the consolidated financial statements, on March 1, 2018, the Company completed the sale of a significant portion of its operations. The Company will settle its remaining obligations, contribute all remaining assets to the East Texas Medical Center Foundation, and the Company will be dissolved. Our opinion is not modified with respect to this matter.

PricewaterhouseCoopers LLP

Dallas, Texas
March 14, 2018

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidated Balance Sheets
October 31, 2017, 2016 and 2015

(in thousands)	2017	2016	2015
Assets			
Current assets			
Cash and cash equivalents	$ 29,876	$ 45,855	$ 103,118
Marketable securities	145,208	196,831	178,130
Current portion of assets limited as to use	61,285	12,442	10,304
Accounts receivable			
Patient, net	83,624	85,531	80,551
Supplemental Medicaid receivable	-	5,052	12,694
Other	8,781	11,899	7,743
Supplies	13,389	13,747	13,766
Estimated third party settlements	-	269	-
Prepaid expenses and other	24,732	11,786	11,770
Total current assets	366,895	383,412	418,076
Assets limited as to use, net of current portion	14,505	49,015	48,365
Long-term investments	8,029	7,916	7,558
Property and equipment, net	307,124	378,759	396,173
Other assets	6,979	7,735	6,954
Total assets	$ 703,532	$ 826,837	$ 877,126
Liabilities and Net Assets			
Current liabilities			
Accounts payable and accrued expenses	$ 101,908	$ 79,034	$ 77,461
Current portion of notes and bonds payable	304,437	7,619	11,707
Current portion of capital lease obligations	5,315	8,519	10,613
Supplemental Medicaid payable	7,499	-	-
Current portion of estimated malpractice costs	10,758	2,928	3,132
Deferred revenue	887	840	814
Estimated third party settlements	393	-	26
Total current liabilities	431,197	98,940	103,753
Estimated malpractice costs, net of current portion	11,736	6,487	6,215
Notes and bonds payable, net of current portion	-	304,791	329,003
Capital lease obligations, net of current portion	4,703	13,853	20,950
Accrued pension	33,103	44,272	34,523
Other liabilities	849	1,432	779
Total liabilities	481,588	469,775	495,223
Net assets			
Unrestricted	213,915	349,146	374,345
Temporarily restricted	5,005	4,892	4,534
Permanently restricted	3,024	3,024	3,024
Total net assets	221,944	357,062	381,903
Total liabilities and net assets	$ 703,532	$ 826,837	$ 877,126

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

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidated Statements of Operations
Years Ended October 31, 2017, 2016 and 2015

(in thousands)	2017	2016	2015
Unrestricted revenue and other support			
Patient service revenue (net of contractual allowances and discounts)	$ 948,563	$ 973,758	$ 932,223
Provisions for bad debt	(196,294)	(189,698)	(163,660)
Net patient service revenue less provisions for bad debt	752,269	784,060	768,563
Other revenue	109,170	130,695	100,947
Total revenue and other support	861,439	914,755	869,510
Expenses			
Salaries and wages	424,461	415,029	390,897
Employee benefits	98,789	92,554	87,414
Professional fees	63,447	57,536	45,750
Supplies and other expenses	237,877	229,450	211,026
Purchased services	67,773	70,035	67,560
Depreciation and amortization	39,693	51,787	52,344
Held-for-sale impairment charge	58,748	-	-
Interest	17,398	18,469	19,633
Total expenses	1,008,186	934,860	874,624
Loss from operations	(146,747)	(20,105)	(5,114)
Nonoperating losses:			
Other than temporary impairment on marketable securities	(1,820)	-	-
Total nonoperating losses	(1,820)	-	-
Revenue and other support in deficit of expenses	(148,567)	(20,105)	(5,114)
Defined benefit pension adjustment	13,035	(5,308)	(5,002)
Unrealized gains (losses) on investments	301	214	(417)
Discontinued operations	-	-	(5,800)
Decrease in unrestricted net assets	$ (135,231)	$ (25,199)	$ (16,333)

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

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidated Statements of Changes in Net Assets
Years Ended October 31, 2017, 2016 and 2015

(in thousands)	2017	2016	2015
Unrestricted net assets			
Revenue and other support in deficit of expenses	$ (148,567)	$ (20,105)	$ (5,114)
Defined benefit pension adjustment	13,035	(5,308)	(5,002)
Unrealized gains (losses) on investments	301	214	(417)
Discontinued operations	-	-	(5,800)
Decrease in unrestricted net assets	(135,231)	(25,199)	(16,333)
Temporarily restricted net assets			
Contributions	491	339	336
Investment income	939	236	169
Net assets released from restriction	(1,317)	(217)	(212)
Increase in temporarily restricted net assets	113	358	293
Changes in net assets	(135,118)	(24,841)	(16,040)
Net assets			
Beginning of year	357,062	381,903	397,943
End of year	$ 221,944	$ 357,062	$ 381,903

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

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended October 31, 2017, 2016 and 2015

(in thousands)	2017	2016	2015
Cash flows from operating activities			
Change in net assets	$ (135,118)	$ (24,841)	$ (16,040)
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities			
Depreciation and amortization	39,693	51,787	52,344
Held-for-sale impairment charge	58,748	-	-
Settlement expense	20,649	-	-
Net realized and unrealized (gains) losses on investments	(436)	(330)	355
Other than temporary impairment on marketable securities	1,820	-	-
Loss (gain) on disposal of assets	1,939	-	(1,560)
Defined benefit pension adjustment	(13,035)	5,308	5,002
Restricted contributions	(491)	(339)	(336)
Restricted investment income	(939)	(236)	(169)
Changes in operating assets and liabilities			
Patient accounts receivable	1,907	(3,836)	(1,200)
Other account receivable	12,551	7,642	39,831
Supplies	358	19	409
Prepaid expenses and other	(9,828)	(5,316)	1,977
Accounts payable and accrued expenses	2,896	84	(4,033)
Deferred revenue	47	26	(276)
Estimated malpractice costs	13,079	68	880
Estimated third party settlements	662	(295)	(2,674)
Other assets and liabilities	3,007	5,801	1,491
Net cash (used in) provided by operating activities	(2,491)	35,542	76,001
Cash flows from investing activities			
Capital expenditures	(30,005)	(32,048)	(24,280)
Proceeds from sale of fixed assets	-	-	2,000
Purchases of marketable securities	(5,096)	(179,010)	(225,501)
Proceeds from sale of marketable securities	55,143	160,548	46,956
Purchases of investments and assets whose use is limited	(15,929)	(6,234)	(7,542)
Proceeds from sale of investments and assets whose use is limited	1,483	3,088	6,549
Net cash provided by (used in) investing activities	5,596	(53,656)	(201,818)
Cash flows from financing activities			
Proceeds from issuance of notes and bonds payable	-	1,025	4,136
Principal payments on notes and bonds payable	(8,160)	(29,513)	(20,764)
Principal payments on capital lease obligations	(12,354)	(11,236)	(12,348)
Restricted contributions	491	339	336
Restricted investment income	939	236	169
Net cash used in financing activities	(19,084)	(39,149)	(28,471)
Net decrease in cash and cash equivalents	(15,979)	(57,263)	(154,288)
Cash and cash equivalents			
Beginning of year	45,855	103,118	257,406
End of year	$ 29,876	$ 45,855	$ 103,118
Supplemental disclosure of cash flow information			
Interest paid, net of amounts capitalized	$ 17,468	$ 18,340	$ 19,692
Assets acquired through obligations under capital leases	-	2,045	10,023
Property and equipment purchases included in accounts payable	818	1,489	305

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

1. Organization

East Texas Medical Center Regional Healthcare System (the "System" or the "Company") is a corporation organized pursuant to the provisions of the Texas Nonprofit Corporation Act, and is exempt from federal income tax under the provisions of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. The System operates as a central location for top management to support and guide the activities of the System's subsidiaries. The System's subsidiaries are as follows:

- East Texas Medical Center ("ETMC")
- East Texas Medical Center Athens ("Athens")
- East Texas Medical Center Carthage ("Carthage")
- East Texas Medical Center Fairfield ("Fairfield")
- East Texas Medical Center Foundation ("Foundation")
- East Texas Medical Center Healthcare Associates ("501A")
- East Texas Medical Center Henderson ("Henderson")
- East Texas Medical Center Home Services ("Home Services")
- East Texas Medical Center Jacksonville ("Jacksonville")
- East Texas Medical Center Pittsburg ("Pittsburg")
- East Texas Medical Center Quitman ("Quitman")
- East Texas Medical Center Regional Health Services, Inc. ("Services") and Subsidiaries:
  - Access Direct — A Preferred Provider Network, Inc. ("Access Direct")
  - Centralized Credentialing Services, Inc. ("Centralized Credentialing")
  - Healthfirst TPA, Inc. ("TPA")
  - MM Solutions, Inc. ("MM Solutions")
  - Paramedics Plus LLC ("Paramedics Plus")
- East Texas Medical Center Rehabilitation Hospital ("Rehab")
- East Texas Medical Center Specialty Hospital ("Specialty")
- East Texas Medical Center Trinity ("Trinity")
- East Texas Flight Ambulance ("Air One")
- ETMC EMS ("EMS")

Each of the above entities is exempt from federal income tax under the provisions of section 501(c)(3) of the Internal Revenue Code of 1986, as amended with the exception of Services and its subsidiaries.

The System has locations throughout 9 East Texas counties. The System's purpose is to provide high quality healthcare services to the residents of the region.

During 2015, the System resolved to cease hospital operations at its Fairfield and Trinity locations upon expiration of the leases for those facilities. The Fairfield lease terminated effective December 31, 2016. The Trinity lease terminated effective August 1, 2017.

During 2014, the System began evaluating the economic feasibility of operations at various locations. Based on the assessment, the System resolved to cease hospital operations at its Clarksville, Gilmer, Crockett, and Mount Vernon locations. ETMC Clarksville, ETMC Crockett, ETMC Gilmer, and ETMC Mt. Vernon were subsidiaries, which operated these facilities. Each of these subsidiaries ceased hospital operations and were dissolved as separate legal entities in 2015.

2. Summary of Significant Accounting Policies

Going Concern Assessment
Under the going concern assumption, an entity is ordinarily viewed as continuing in business for the foreseeable future. Accordingly, assets and liabilities are recorded on the basis that the entity will be able to realize its assets and discharge its liabilities in the normal course of business.

Due to noncompliance with our debt covenants existing as of the October 31, 2017 measurement date as further described in Note 11 - *Notes, Bonds Payable and Obligations Under Capital Leases*, on March 1, 2018, our creditors had the ability to declare the principal amount then outstanding under all existing bond issuances to be due and payable immediately. Amounts outstanding under our existing bond issuances as of October 31, 2017 are therefore classified as current liabilities. We do not have access to sufficient cash from our operating sources to retire the resulting debt obligations.

As of October 31, 2017, the System had reached an agreement in principle with AHS East Texas Health System, LLC to sell EMS, Access Direct, Centralized Credentialing, TPA, MM Solutions and the assets and operations of each of the System's other subsidiaries as described within Note 1 - *Organization*, with the exception of Paramedics Plus and Foundation. The entities subject to the sale represent a significant portion of our operations. Our ability to continue as a going concern is dependent on our ability to complete the sale and to use the proceeds to settle our outstanding obligations then due under our existing bond issuances before they became due and payable on March 1, 2018.

We completed the sale to AHS East Texas Health System, LLC on March 1, 2018. Concurrent with the closure of the sale, the System defeased the remaining principal then outstanding of the Series 2007A and Quitman bonds in the amount of $254.6 million. Additionally, in February 2018, the System called and paid $33.0 million, representing all amounts outstanding under the Pittsburg and Henderson revenue bonds.

Upon the execution of the sale on March 1, 2018, the System has been renamed ETX Successor System ("ETX" or the "System" or the "Company") and consists of the following remaining subsidiaries, as renamed:

- ETX Successor Tyler ("ETMC")
- ETX Successor Athens ("Athens")
- ETX Successor Carthage ("Carthage")
- System Foundation ("Foundation")
- ETX Successor Healthcare Associates ("501A")
- ETX Successor Henderson ("Henderson")
- ETX Successor Home Services ("Home Services")
- ETX Successor Jacksonville ("Jacksonville")

- ETX Successor Pittsburg ("Pittsburg")
- ETX Successor Quitman ("Quitman")
- ETX Successor Regional Health Services, Inc. ("Services") and Subsidiary:
  - Paramedics Plus LLC ("Paramedics Plus")
- ETX Successor Rehabilitation Hospital ("Rehab")
- ETX Successor Specialty Hospital ("Specialty")
- ETX Flight Ambulance ("Air One")

Subsequent to the execution of the sale to AHS East Texas Health System, LLC and the settlement of all outstanding bond obligations, the System had available cash and cash equivalents of $185.0 million on March 1, 2018.

On February 22, 2018, the System entered into an asset purchase agreement with Paramedics Logistics Operating Company, LLC to sell the assets and operations of Paramedics Plus. The agreement contains a March 31, 2018 closing date for the completion of the sale and transfer of ownership.

Upon the completion of the sale of Paramedics Plus, the System will have no remaining revenue-generating operations. The remaining assets of the System will consist primarily of cash, marketable securities, assets limited as to use, and long-term investments. The remaining liabilities and obligations of the System will consist primarily of balances related to supplemental Medicaid payables, estimated medical malpractice, professional and general liability costs, liabilities related to settled litigation, accrued pension, and general operating expenses. These events and conditions are significant in relation to the System's ability to meet its obligations. Our ability to continue as a going concern is dependent on our ability to use the remaining assets to settle our remaining liabilities and obligations as well as to fund our future operating expenses.

The System purchased a loss portfolio transfer insurance policy on February 28, 2018 for $18.0 million, which provides insurance coverage for any medical malpractice, professional or general liability claims incurred on or prior to February 28, 2018. Additionally, the System purchased extended tail coverage insurance policies on February 28, 2018 for $3.3 million, extending its coverage for other various insurable exposures. The combination of loss portfolio transfer insurance and extended tail coverage insurance covers all existing or new claims which may be brought against the System or its subsidiaries for events occurring prior to March 1, 2018. In addition to the management plans already executed as of March 14, 2018, the date the financial statements were issued, we have plans to pay any amounts determined to be owed to the Medicaid program related to fiscal years 2012 through 2016 upon completion of the customary Medicaid audit and review procedures and to terminate the System's three frozen pension plans after purchasing annuities to provide monthly benefit payments to beneficiaries and pay any other termination costs. As of October 31, 2017, the System has accrued balances for estimated supplemental Medicaid payable and pension of $19,874,000 and $33,103,000, respectively. Actual costs to resolve these remaining liabilities and obligations could differ from these estimates. All remaining assets will be contributed to the Foundation which will transfer all funds to a charitable trust with the objective of supporting the healthcare needs in the East Texas community. It is anticipated that this process will take at least two years to complete. Upon the completion of this plan, the System will be legally dissolved.

ASU 2014-15 *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern* requires that we evaluate whether there is substantial doubt about our ability to meet our financial

obligations when they become due during the twelve month period from the date these financial statements are issued. Given that we do not have access to sufficient cash from our operating sources to retire the resulting debt obligations and that after the completion of the sale of Paramedics Plus the System will have no remaining revenue-generating operations, we must then evaluate whether our plans are probable of being executed in a manner sufficient to settle our liabilities and obligations prior to those obligations becoming due and payable, and if executed, that such plans are probable of mitigating the substantial doubt. We have performed such an evaluation and, based on the successful execution of the sale on March 1, 2018 and settlement of the System's outstanding debt obligations in addition to the results of our assessment of our ability to meet our obligations that remain after the settlement of our debt as they come due, we believe it is probable that our remaining plans will be effectively executed and that such execution mitigates the relevant events and conditions that raise substantial doubt regarding our ability to continue as a going concern within the twelve-month period from the date these financial statements are issued.

Principles of Consolidation
The accompanying consolidated financial statements include the accounts of the System and its wholly owned subsidiaries. All significant intercompany transactions have been eliminated.

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

Cash and Cash Equivalents
Cash and cash equivalents include investments in money market accounts with original maturities of three months or less when purchased, excluding amounts whose use is limited by board designation or restricted under bond agreements.

Marketable Securities
Marketable securities, which consist primarily of cash and cash equivalents, fixed income securities, US government bonds, and money market funds, have been categorized as other-than-trading and are stated at fair value. Marketable securities available for current operations are classified as current assets. For the purpose of determining gross realized gains and losses, which are included in the consolidated statements of operations, the cost of marketable securities sold is based upon specific identification. Unrealized gains and losses are included as a component of other changes in unrestricted net assets until realized from a sale or other-than-temporary impairment. Other-than-temporary impairment losses are recorded as non-operating losses in the consolidated statements of operations.

Assets Limited as to Use
Investments classified as assets limited as to use are presented in the financial statements at their fair value. Fair values are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

Realized and unrealized gains and losses on investments are determined by comparison of the actual cost to the proceeds at the time of disposition, or market values as of the end of the financial statement period.

Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the determination of revenue and other support in deficit of expenses

unless the income or loss is restricted by donor. Investment income restricted for specified purposes by donor is recorded as temporarily restricted in the consolidated statements of changes in net assets. Unrealized gains and losses on investments are excluded from the determination of revenue and other support in deficit of expenses unless the investments are trading securities.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, which includes third-party insurers, Medicare and Medicaid, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined. We believe the amounts recorded are adequate to provide for any final adjustments.

The System participates in the Medicare and Medicaid programs. Laws and regulations governing these programs are 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 future. We believe that the System is in compliance with all applicable laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Refer to Note 16 - *Commitments and Contingencies* for discussion of ongoing litigation relating to alleged noncompliance.

Other Revenue

Other revenue is recognized from services rendered for other than providing health care services to patients. It consists primarily of revenue recognized by the for-profit subsidiaries. Also included in other revenue are proceeds from cafeteria and gift shop sales.

Charity Care

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

Supplies

Supplies inventory is valued at the lower of cost or market on a first-in, first-out basis.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Maintenance and repairs are charged to operations as incurred; major renewals and betterments are capitalized. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital leases and leasehold improvements are amortized over the lease term or the estimated useful life of the equipment, whichever is shorter. Charges for depreciation and amortization are included in the accompanying consolidated statements of operations. The estimated useful lives of the property and equipment held by the System are as follows:

Land improvements	10–20 Years
Buildings	25–40 Years
Leasehold improvements	5–15 Years
Major movable equipment	5–15 Years
Equipment under capital leases	5 Years
Automobiles and trucks	4 Years

During periods of construction, the System capitalizes interest costs, net of the related interest earnings, on certain assets constructed with the proceeds of the System's borrowings. The capitalized interest is recorded as part of the asset to which it relates and is depreciated over the asset's estimated useful life.

Upon sale or retirement of property and equipment, the cost and related accumulated depreciation are eliminated from the respective accounts and the gain or loss is included in the statement of operations.

We evaluate the carrying value of property and equipment to be held-and-used for impairment whenever events or changes in circumstance indicate that the carrying amount may not be recoverable. The carrying value of a long-lived asset group is not recoverable if it exceeds the sum of the undiscounted cash flows expected to result from the use and eventual disposition of the asset group. We measure impairment as the amount by which the carrying value exceeds the estimated fair value. Estimated fair value is determined primarily using the projected future cash flows discounted at a rate commensurate with the risk involved.

Property and equipment to be disposed of by sale are classified as held-for-sale when the applicable criteria are met, and recognized within the consolidated balance sheet at the lower of carrying value or fair value less costs to sell. Depreciation on such assets is ceased on the date the held-for-sale criteria are met.

Intangible Assets
Goodwill represents the excess purchase price over the estimated fair value of net identifiable assets acquired and liabilities assumed from purchased businesses. We assess goodwill for impairment annually at October 31, and between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. If the carrying amount of the reporting unit's goodwill exceeds its implied fair value, an impairment charge is recognized. Any impairment would be recognized by a charge to income from operations and a reduction in the carrying value of the goodwill.

Donor Restricted Gifts
Unconditional promises to give cash and other assets to the System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received or the condition has been substantially met. Gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of changes in net assets as net assets released from restriction. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated statements of operations.

Unrestricted Net Assets
Contributions and gifts which are received with no restrictions or specified uses identified by the grantors or donors are included as unrestricted revenue in the statement of operations of the System when received.

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the System has been limited by donors to a specific period or purpose. Temporarily restricted net assets are available for various

healthcare activities and were approximately $5,005,000, $4,892,000, and $4,534,000 at October 31, 2017, 2016, and 2015, respectively.

Permanently restricted net assets have been restricted by donors to be maintained by the System in perpetuity. Permanently restricted net assets are held for the following purposes at October 31, 2017, 2016 and 2015:

(in thousands)

Mobile mammography	$	1,596
Nursing education		1,230
Physical therapy		198
	$	3,024

Revenue and Other Support in Deficit of Expenses
The statement of operations includes revenue and other support in deficit of expenses. Changes in unrestricted net assets which are excluded from revenue and other support in deficit of expenses, consistent with industry practice, include unrealized gains and losses on investments, changes in the defined benefit plan minimum liability, results from discontinued operations and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Deferred Financing Costs
Financing costs associated with the issuance of the Hospital Revenue Bonds have been capitalized and are being amortized over the period during which the debt is outstanding using the effective interest rate method. During the current year, the System adopted the provisions within ASU 2015-03, "*Interest - Imputation of Interest: Simplifying the Presentation of Debt Issuance Costs.*" Deferred financing costs are included as a direct reduction to the carrying value of notes and bonds payable in the consolidated balance sheets.

Recognition of Professional Liability Expense
As described in Note 9 – *Self Insurance*, the System has established a self-insurance trust for payment of professional liability losses and related costs. Professional liability expense is recognized based on an estimated accrual for known incidents and claims and an estimated accrual for incurred but not reported incidents.

Recent Accounting Pronouncements
In May 2014, FASB issued ASU 2014-09, "*Revenue from Contracts with Customers (Topic 606).*" Under the new provisions, an entity will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. It also requires more detailed disclosures to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The System is currently evaluating the provisions of ASU 2014-09, which are effective for annual reporting periods beginning after December 15, 2017, as amended by ASU 2015-14.

In July 2015, FASB issued ASU 2015-11, "*Simplifying the Measurement of Inventory.*" This update requires an entity to measure inventory at the lower of cost or net realizable value. Net realizable value is the estimated selling price in the ordinary course of business, less reasonably predictable costs of completion, disposal, and transportation. This update applies to all inventory with the exception of inventory measured using last-in, first-out (LIFO) or the retail inventory method. The

System has evaluated all of the provisions, which are effective for fiscal years beginning after December 15, 2016 and determined it is not expected to have a material impact on the consolidated financial statements.

In February 2016, FASB issued ASU 2016-02, "*Leases.*" This update requires lessees to record a lease liability that represents the lessee's future lease obligation and a right-of-use asset that represents the lessee's right to use or control of a specified asset for the lease term. The System is currently evaluating the provisions of ASU 2016-02, which are effective for fiscal years beginning after December 15, 2018.

In May 2016, FASB issued ASU 2016-12, "*Revenue from Contracts with Customers: Narrow-Scope Improvements and Practical Expedients.*" This update adds clarification to the new revenue recognition standards issued in ASU 2014-09. The System is currently evaluating the provisions of ASU 2016-12, which are effective for fiscal years beginning after December 15, 2017.

In August 2016, FASB issued ASU 2016-14, "*Presentation of Financial Statements of Not- for-Profit Entities.*" This update requires not-for-profit entities to report two classes of net assets, as well as enhances disclosures on board designated funds, liquidity, and functional expenses. The System is currently evaluating the provisions of ASU 2016-14, which are effective for fiscal years beginning after December 15, 2017.

In August 2016, FASB issued ASU 2016-15, "*Classification of Certain Cash Receipts and Cash Payments.*" This update provides cash flow statement classification guidance. The System is currently evaluating the provisions of ASU 2016-15, which are effective for fiscal years beginning after December 15, 2018.

In December 2016, FASB issued ASU 2016-20, "*Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers.*" This update adds clarification to the new revenue recognition standards issued in ASU 2014-09. The System is currently evaluating the provisions of ASU 2016-20, which are effective for fiscal years beginning after December 15, 2017.

In March 2017, FASB issued ASU 2017-07, "*Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost.*" This ASU requires that an employer report the service cost component in the same line item as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost are required to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations, if one is presented. The System is currently evaluating the provisions of ASU 2017-07, which are effective for fiscal years beginning after December 15, 2018.

Reclassifications
Certain prior period amounts have been reclassified to conform to the current period presentation.

3. Endowments

The System's endowment consists of approximately five individual donor restricted endowment funds established for a variety of healthcare related purposes. The net assets associated with endowment funds are classified and reported based on the existence or absence of donor imposed restrictions.

The Board of Trustees of the Foundation has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the original gift as of the gift date of the donor restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the System classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Foundation in a manner consistent with the standard of prudence prescribed by UPMIFA.

In accordance with UPMIFA, the Foundation considers the following factors in making a determination to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.

(2) The purpose of the organization and the donor restricted endowment fund.

(3) General economic conditions.

(4) The possible effect of inflation and deflation.

(5) The expected total return from income and the appreciation of investments.

(6) Other resources of the organization, and

(7) The investment policies of the organization.

Endowment net asset composition by type of fund as of October 31, 2017 follows:

(in thousands)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 3,142	$ 3,024	$ 6,166

Changes in endowment net assets for the year ended October 31, 2017 follows:

(in thousands)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 2,255	$ 3,024	$ 5,279
Investment return				
Investment income	-	90	-	90
Net appreciation (realized and unrealized)	-	800	-	800
Total investment return	-	890	-	890
Appropriation of endowment assets for expenditure	-	(3)	-	(3)
Endowment net assets at end of year	$ -	$ 3,142	$ 3,024	$ 6,166

Endowment net asset composition by type of fund as of October 31, 2016 follows:

(in thousands)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 2,255	$ 3,024	$ 5,279

Changes in endowment net assets for the year ended October 31, 2016 follows:

(in thousands)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 2,061	$ 3,024	$ 5,085
Investment return				
Investment income	-	187	-	187
Net appreciation (realized and unrealized)	-	15	-	15
Total investment return	-	202	-	202
Appropriation of endowment assets for expenditure	-	(8)	-	(8)
Endowment net assets at end of year	$ -	$ 2,255	$ 3,024	$ 5,279

Endowment net asset composition by type of fund as of October 31, 2015 follows:

(in thousands)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 2,061	$ 3,024	$ 5,085

Changes in endowment net assets for the year ended October 31, 2015 follows:

(in thousands)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 1,940	$ 3,024	$ 4,964
Investment return				
Investment income	-	119	-	119
Net appreciation (realized and unrealized)	-	11	-	11
Total investment return	-	130	-	130
Appropriation of endowment assets for expenditure	-	(9)	-	(9)
Endowment net assets at end of year	$ -	$ 2,061	$ 3,024	$ 5,085

Description of amounts classified as permanently restricted net assets and temporarily restricted net assets (endowment only) follows:

(in thousands)	2017	2016	2015
Permanently restricted net assets			
The portion of endowment funds that is required to be retained permanently either by explicit donor stipulation or by UPMIFA	$ 3,024	$ 3,024	$ 3,024
Total endowment funds classified as permanently restricted net assets	$ 3,024	$ 3,024	$ 3,024
Temporarily restricted net assets			
Term endowment funds	$ 3,142	$ 2,255	$ 2,061
Total endowment funds classified as temporarily restricted net assets	$ 3,142	$ 2,255	$ 2,061

Endowment Funds with Deficits

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist, they are classified as a reduction of unrestricted net assets. There were no deficits of this nature reported in unrestricted net assets at October 31, 2017, 2016 or 2015.

Return Objectives and Risk Parameters

The Foundation has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of endowment assets. Under this policy, the return objectives for the endowment assets, measured over a full market cycle, shall be to maximize the return against a blended index, based on the endowment's target allocation applied to the appropriate individual benchmarks.

Strategies Employed for Achieving Investment Objectives

To achieve its long-term rate of return objectives, the Foundation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Foundation targets a diversified asset allocation that places greater emphasis on equity-based investments to achieve its long-term objectives within prudent risk constraints.

Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives

The Board of Trustees of the Foundation determines the method to be used to appropriate endowment funds for expenditure. The Foundation has a policy of preserving the original gift as an income producing investment only, with a long term goal of providing income from the invested funds for the purpose of funding one or more programs, as directed. In establishing this policy, the Board established investment allocation targets and ranges to achieve a rate of return that would maintain real purchasing power over long periods of time.

4. Charity Care

Of the System's $236 million, $229 million and $241 million of total charity expenses reported in 2017, 2016 and 2015, respectively, the estimated direct and indirect cost of providing these services was $32 million, $36 million, and $39 million, respectively. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on total expenses divided by gross patient service revenue.

5. Net Patient Service Revenue

Net patient service revenue for the years ended October 31, 2017, 2016 and 2015 is comprised of the following:

	2017		
(in thousands)	**Third-Party Payors**	**Self-Pay**	**Total All Payors**
Patient service revenue (net of contractual allowances and discounts)	$ 733,414	$ 215,149	$ 948,563

	2016		
(in thousands)	**Third-Party Payors**	**Self-Pay**	**Total All Payors**
Patient service revenue (net of contractual allowances and discounts)	$ 766,319	$ 207,439	$ 973,758

	2015		
(in thousands)	**Third-Party Payors**	**Self-Pay**	**Total All Payors**
Patient service revenue (net of contractual allowances and discounts)	$ 751,826	$ 180,397	$ 932,223

The System maintains allowances for uncollectible accounts for estimated losses resulting from a payor's inability to make payments on accounts. The System assesses the reasonableness of the allowance account based on historical write-offs, cash collections, the aging of the accounts and other economic factors. Accounts are written off when collection efforts have been exhausted. We continually monitor and adjust allowances associated with receivables. The allowance for doubtful accounts at October 31, 2017, 2016 and 2015 was approximately $194,544,000, $184,284,000, $178,329,000, respectively.

The System has agreements with third-party payors that provide for payments at amounts different from its established rates. The amounts by which the established rates exceed the amounts recoverable from these payors are accounted for as deductions from revenue. A summary of the System's payment arrangements with major third-party payors follows:

- Medicare - Inpatient care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge ("PPS"). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are reimbursed under a prospective payment methodology based on a system of ambulatory payment classifications ("APC"). The System is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicare fiscal intermediary. Any differences between final audited settlements and amounts accrued at the end of the prior reporting period are included in current operations. Net patient service revenue for the years ended October 31, 2017, 2016 and 2015 increased by approximately $2,686,000, decreased by $13,000, and increased by $1,625,000, respectively, related to changes in amounts previously estimated as a result of final settlements and revisions to cost report estimates. Medicare cost reports have been audited and settled by the fiscal intermediary through 2013 for Mt. Vernon, Henderson, and Jacksonville; through 2014 for Tyler, Gilmer, and Rehab; through 2015 for Athens, Carthage, Clarksville, Crockett, Pittsburg, Trinity, Quitman, and Fairfield; and through 2016 for Specialty.

  For the years ended October 31, 2017, 2016 and 2015, 34%, 32%, and 35%, respectively, of total net patient service revenue resulted from the Medicare program.

- Medicaid - Inpatient acute care services are reimbursed under the Medicaid PPS system and outpatient services are reimbursed under a cost reimbursement methodology. The System's outpatient services are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicaid fiscal intermediary. Any differences between final audited settlements and amounts accrued at the end of the prior reporting period are included in current operations. Net patient service revenue increased by $66,000 for the year ended October 31, 2017, remained the same for the year ended October 31, 2016, and decreased by $567,600 for the year ended October 31, 2015 related to changes in amounts previously estimated as a result of final settlements and revisions to cost report estimates. Medicaid cost reports have been audited and settled by the fiscal intermediary through 2012 for Jacksonville, Crockett, Pittsburg, Mt. Vernon, and Tyler; through 2013 for Athens, Gilmer, and Henderson; through 2014 for Rehab, Fairfield, Clarksville, and Trinity; and through 2015 for Carthage and Quitman.

  For the years ended October 31, 2017, 2016, and 2015, 10%, 13%, and 12%, respectively, of total net patient service revenue resulted from the Medicaid program.

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

  For the year ended October 31, 2017, 33% of total net patient service revenue resulted from commercial insurance carriers and preferred provider organizations. For both years ended October 31, 2016 and 2015, 34% of total net patient service revenue resulted from commercial insurance carriers and preferred provider organizations.

- Self Pay - The System has an uninsured patient policy covering all System hospitals. Under the terms of this policy, a discount from each hospital's established rates is made available to uninsured patients who do not qualify for charity care. Effective March 1, 2017, the uninsured patient discount rate was 75%. Prior to this effective date, the discount rate was 60%. The discounts given to self pay patients are accounted for as deductions from revenue.

The System participates in the Medicaid disproportionate share hospital (DSH) funding program, established by the State of Texas and administered by the Health and Human Services Commission (HHSC), which created additional federal matching funds to increase access to healthcare by Texas' indigent patients and defray the cost of treating indigent patients. Funds are distributed to hospitals providing a high volume of services to Medicaid and uninsured patients.

The System also participates in the Texas Medicaid Section 1115 Waiver program (Waiver). The Waiver program provides for two pools of funds, an uncompensated care pool (UC pool) and a delivery system reform incentive payment pool (DSRIP pool). To receive payments from the UC pool, a hospital must submit an application estimating its uncompensated costs for services provided to Medicaid and uninsured patients. The DSRIP pool provides payments to hospitals upon achieving certain goals and metrics that are intended to increase access to health care, improve the quality of care, and enhance the health of patients and families they serve.

For the years ended October 31, 2017, 2016 and 2015, the System recognized total DSH and Waiver revenues of $33,271,000, $70,060,000 and $52,450,000, respectively, which is included in net patient service revenue. Unsettled amounts are recorded as supplemental Medicaid receivables or payables in the accompanying consolidated balance sheets. We have recorded a Supplemental Medicaid payable of $7,499,000 at October 31, 2017 and a Supplemental Medicaid receivable of $4,993,000, and $12,622,000 at October 31, 2016 and 2015, respectively.

6. Investments

Assets Limited as to Use

Under Indenture Agreements
Assets limited as to use under indenture agreements are trust funds set up under the terms of bond indentures. The System is required to maintain a debt service reserve fund at a minimum amount specified in the indenture agreement.

Internally Designated for Capital Acquisition
Assets internally designated for capital acquisition represent funds set aside by the board of directors to fund future purchases of property and equipment.

Self-Insurance
Assets internally designated for self-insurance programs represent funds set aside by the board of directors to fund the System's self-insurance programs, including professional liability and health benefits.

The fair value and composition of assets limited as to use at October 31, 2017, 2016 and 2015 are set forth below:

(in thousands)	2017	2016	2015
Internally designated for capital acquisition			
Certificates of deposit	$ 2,883	$ 2,870	$ 2,758
Held by trustees under indenture agreements			
Cash and mutual funds	41,127	38,197	37,947
US government obligations	7,878	-	-
	49,005	38,197	37,947
Held by trustees for self-insurance			
Cash and mutual funds	14,267	11,875	11,371
Certificates of deposit	3,824	2,806	2,230
US government obligations	2,259	1,835	829
Municipal bonds and notes	2,822	3,137	3,019
Corporate bonds and notes	730	737	515
	23,902	20,390	17,964
Total assets limited as to use	75,790	61,457	58,669
Less: Assets limited as to use, required for current liabilities	61,285	12,442	10,304
Assets limited as to use, net of current portion	$ 14,505	$ 49,015	$ 48,365

Marketable Securities

The amortized cost and fair value of the System's marketable securities at October 31, 2017 are summarized as follows:

(in thousands)

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Certificates of deposit	$ 11,939	$ 9	$ (18)	$ 11,930
US government obligations	106,087		(1,672)	104,415
Municipal bonds and notes	3,540	21	(7)	3,554
Corporate bonds and notes	25,364	68	(123)	25,309
Total marketable securities	$ 146,930	$ 98	$ (1,820)	$ 145,208

The System's investment policy governing other-than-trading marketable securities precludes the investment portfolio managers from selling any security at a loss without prior authorization from the System. The investment managers also limit the exposure to any one issue, issuer or type of investment. The System performed an other-than-temporary impairment analysis for securities in an unrealized loss position as of October 31, 2017 and determined that it does not have the intent or ability to hold the other-than-trading marketable securities long enough to allow for the recovery of temporary declines in the market value of the marketable securities in an unrealized loss position. As a result, an other-than-temporary impairment loss in the amount of $1,820,000 was recorded in the consolidated statement of operations in 2017. No other-than-temporary impairment losses were recorded in 2016 or 2015.

Long-Term Investments

Investments that are not available for current operations are classified as long-term investments. The fair values of long-term investments at October 31, 2017, 2016 and 2015 are summarized as follows:

(in thousands)	2017	2016	2015
Mutual funds	$ 3,096	$ 3,566	$ 3,220
Marketable debt securities	631	622	656
Marketable equity securities	4,302	3,728	3,682
Total long-term investments	$ 8,029	$ 7,916	$ 7,558

Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and those changes could materially affect the amounts reported on the consolidated balance sheets and statements of operations.

Investment Income

Interest income and realized gains and losses on the sale of other-than-trading marketable securities, long-term investments, and assets limited as to use are included in other revenue in the statement of operations and are comprised of the following for the years ended October 31, 2017, 2016 and 2015:

(in thousands)	2017	2016	2015
Income			
Interest income	$ 3,378	$ 3,500	$ 2,107
Net realized (losses) gains on the sale of securities	(57)	25	2
Investment income	$ 3,321	$ 3,525	$ 2,109

7. Property and Equipment

Property and equipment at October 31, 2017, 2016 and 2015 are summarized as follows:

(in thousands)	2017	2016	2015
Land and land improvements	$ 34,728	$ 35,142	$ 35,107
Buildings	513,754	538,162	529,240
Leasehold improvements	30,561	35,920	34,179
Major moveable equipment	446,087	448,473	433,224
Equipment under capital leases	63,850	63,850	61,600
Automobiles and trucks	26,270	25,200	24,399
	1,115,250	1,146,747	1,117,749
Less: Accumulated depreciation and amortization	(758,464)	(774,264)	(733,189)
	356,786	372,483	384,560
Less: Held-for-sale impairment	(57,748)	-	-
Equipment deposits and construction in progress	8,086	6,276	11,613
Property and equipment, net	$ 307,124	$ 378,759	$ 396,173

No interest costs were capitalized during construction for the years ended October 31, 2017, 2016 and 2015.

Depreciation and amortization expense for the years ended October 31, 2017, 2016 and 2015 was $39,693,000, $51,787,000 and $52,344,000, respectively. Accumulated amortization for facilities and equipment under capital lease obligations was $51,876,000, $48,257,000 and $45,717,000 at October 31, 2017, 2016 and 2015 respectively.

As described within Note 19 - *Discontinued Operations*, in 2017, we committed to a plan to sell substantially all assets and operations of the System's hospital and Texas-based EMS operations, as well as the System's Paramedics Plus operations in two separate transactions and concluded that the disposal groups met the required criteria for classification as held-for-sale. The disposal groups were measured at the lower of their carrying value or fair value less costs to sell. In accordance with the order of impairment testing required by ASC 360-10, the carrying value of the disposal groups were adjusted based on the results of impairment tests performed over other assets and goodwill. Utilizing a market approach which primarily uses merger and acquisition activity, we evaluated the fair value less costs to sell the disposal groups. Based on the excess of carrying value compared to the fair value less costs to sell, we recorded impairments of property and equipment to be disposed of by sale totaling $57,748,000 for the year ended October 31, 2017 which is included in the consolidated statement of operations as an held-for-sale impairment charge. Depreciation on assets related to the hospital and Texas-based EMS operations and Paramedics Plus operations was discontinued upon meeting the held-for-sale criteria on September 7, 2017 and July 17, 2017, respectively.

8. Other Assets

Other assets at October 31, 2017, 2016 and 2015 are summarized as follows:

(in thousands)	2017	2016	2015
Goodwill	$ -	$ 1,000	$ 1,000
Long-term benefit plan asset	258	-	237
Other assets	6,721	6,735	5,717
	$ 6,979	$ 7,735	$ 6,954

Under the provisions of ASC 350-10, *Intangibles-Goodwill and Other*, goodwill is not amortized. Rather, an entity's goodwill is subject to periodic impairment testing. ASC 350 requires that an entity test goodwill for impairment at least on an annual basis and between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value below its carrying amount. Accordingly, we perform our goodwill test annually in the fourth quarter and between annual tests whenever we identify certain triggering events or circumstances that would more likely than not reduce the fair value below its respective carrying value.

As described in additional detail within Note 19 - *Discontinued Operations*, in 2017, we committed to a plan to sell substantially all assets and operations of the System and concluded that the disposal groups met the required criteria for classification as held-for-sale. We identified this as a triggering event requiring an interim impairment evaluation. As a result, we performed the first step of the goodwill impairment test, which compares the disposal groups' fair value to its carrying amount to identify potential impairment after considering the need for any impairment write-downs to other assets of the disposal group in accordance with the order of impairment testing required by ASC 360-10.

We apply judgment in determining the fair value of our disposal groups and their underlying assets and liabilities, including any unrecognized intangible assets for purposes of performing the goodwill impairment test. We concluded that the carrying amount of the disposal groups exceeded their estimated fair values and our evaluation resulted in a non-cash goodwill impairment charge of $1,000,000 which is included in held-for-sale impairment charge in the consolidated statement of operations.

9. Self-Insurance

The System is self-insured with respect to medical malpractice, professional and general liability risk for claims up to $2 million per occurrence and $6 million in the aggregate per policy year. Losses from asserted and unasserted claims identified under the System's incident reporting system are accrued based on estimates that incorporate the System's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. Accrued malpractice losses have been discounted at 2%. The amount of the discount was approximately $1,030,000, $703,000 and $642,000 at October 31, 2017, 2016 and 2015, respectively.

The System has established a revocable trust fund for the payment of medical malpractice claim settlements. Professional insurance consultants have been retained to assist the System with determining amounts to be deposited in the trust fund. An actuarially determined accrual for possible losses attributable to incidents that may have occurred but have not been identified under the incident reporting system has been made. The ultimate cost to settle all the asserted and unasserted claims against the System may vary, perhaps substantially, from the amounts recorded.

The System is a nonsubscriber to the Texas Worker Compensation program, and as such, it is not subject to the requirements for providing worker compensation insurance to its employees. The System does participate in a self-insurance program for the purpose of providing injury and lost wage benefits to employees. The System administers the employee injury benefits plan and pays all claims out of operations. The System accrues an estimated liability for possible losses for claims incurred but not reported.

The System also participates in a self-insurance program for the purpose of providing group medical insurance to employees and their dependents. A third party administrator administers the plan and the amounts funded have been placed in a self-insurance fund. The System accrues an estimated liability for possible losses for claims incurred but not reported.

10. Benefit Plans

The System maintains three noncontributory, tax-qualified defined benefit pension plans. Benefits under the plans are frozen for all participants. The plans' benefit formulas generally base payments to retired employees upon their length of service and a percentage of qualifying compensation during the final years of employment. The System's funding policy is to make annual contributions to satisfy the Internal Revenue Service's funding standards. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future.

The System uses an October 31 measurement date for its plans.

The combined employee pension plans' obligations, plan assets and funded status as determined by the actuarial valuation at October 31, 2017, 2016 and 2015 are presented in the following table:

(in thousands)	2017	2016	2015
Change in benefit obligations			
Benefit obligations at beginning of year	$ 131,288	$ 129,110	$ 131,129
Service cost	1,740	1,267	685
Interest cost	4,062	4,572	5,148
Actuarial (gain) loss	1,303	7,465	4,426
Benefits paid	(3,879)	(3,229)	(2,872)
Settlements	(12,746)	(7,897)	(9,406)
Benefit obligations at end of year	$ 121,768	$ 131,288	$ 129,110
Change in plan assets			
Fair value of plan assets at beginning of year	$ 87,016	$ 94,824	$ 103,077
Actual return on plan assets	14,232	3,318	2,410
Employer contributions	4,301	-	1,616
Benefits paid	(3,879)	(3,229)	(2,872)
Settlements	(12,746)	(7,897)	(9,407)
Fair value of plan assets at end of year	$ 88,924	$ 87,016	$ 94,824
Funded status			
Accumulated benefit obligation at end of year	$ 121,768	$ 131,288	$ 129,110
Projected benefit obligation at end of year	$ 121,768	$ 131,288	$ 129,110
Fair value of plan assets	88,924	87,016	94,824
Funded status	$ (32,844)	$ (44,272)	$ (34,286)

(in thousands)	2017	2016	2015
Amounts not yet recognized as components of net periodic benefit cost			
Unrecognized net actuarial loss	$ 28,195	$ 41,230	$ 35,922
	$ 28,195	$ 41,230	$ 35,922

(in thousands)	2017	2016	2015
Amounts recognized in balance sheets			
Noncurrent asset (recorded in other assets)	$ 258	$ -	$ 237
Noncurrent liability (recorded in long-term liabilities)	(33,102)	(44,272)	(34,523)
Noncurrent liability	$ (32,844)	$ (44,272)	$ (34,286)
Net periodic benefit cost			
Service cost	$ 1,740	$ 1,267	$ 685
Interest cost	4,062	4,572	5,148
Expected return on plan assets	(6,738)	(7,089)	(8,035)
Net loss	3,891	3,427	2,679
Settlements	2,953	2,502	2,519
Net periodic benefit cost	$ 5,908	$ 4,679	$ 2,996
Other changes in plan assets and benefit obligations recognized as changes to unrestricted net assets			
Net loss	$ (6,191)	$ 11,237	$ 10,200
Amortization of net gain (loss), including settlement	(6,844)	(5,929)	(5,198)
Total change to unrestricted net assets	$ (13,035)	$ 5,308	$ 5,002

The amount recognized in unrestricted net assets that is expected to be reflected in expense during the next fiscal year is approximately $2,780,000.

Weighted-average assumptions used to determine the benefit obligation at October 31 are as follows:

	2017	2016	2015
Discount rates	3.35 %	3.20 %	4.04 %
Rates of increase in compensation levels	N/A	N/A	N/A

Weighted-average assumptions used to determine the net periodic benefit cost at October 31 are as follows:

	2017	2016	2015
Discount rate	3.20 %	4.04 %	3.91 %
Expected long-term return on plan assets	8.00%	8.00%	8.00%
Rate of compensation increase	N/A	N/A	N/A

The System determines the discount rate assumption by using a yield curve calculation for each plan. For this purpose, the Citigroup Pension Discount Curve is utilized.

The System employs a building block approach in determining the expected long-term rate of return on plan assets. Historical markets are studied and long-term historical relationships between equities and fixed-income are preserved consistent with the widely accepted capital market principle that assets with higher volatility generate a greater return over the long run. Current market factors such as inflation and interest rates are evaluated before long-term market assumptions are determined. The long-term portfolio return is established via a building block approach with proper consideration of diversification and rebalancing. Peer data and historical returns are reviewed to check for reasonability and appropriateness.

Plan Assets

The following tables show the quantitative disclosures under ASC 820 regarding the fair value of the defined benefit plan's investments as of October 31, 2017, 2016 and 2015.

	2017			
(in thousands)	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Common collective trust				
Equity securities	$ -	$ 66,723	$ -	$ 66,723
Debt securities	-	21,312	-	21,312
Other	-	889	-	889
	$ -	$ 88,924	$ -	$ 88,924

	2016			
(in thousands)	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Common collective trust				
Equity securities	$ -	$ 65,262	$ -	$ 65,262
Debt securities	-	20,884	-	20,884
Other	-	870	-	870
	$ -	$ 87,016	$ -	$ 87,016

	2015			
(in thousands)	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Common collective trust				
Equity securities	$ -	$ 71,118	$ -	$ 71,118
Debt securities	-	21,810	-	21,810
Other	-	1,896	-	1,896
	$ -	$ 94,824	$ -	$ 94,824

The System's pension plan weighted-average asset allocations held in the Texas Hospital Association Retirement Trust (THA Trust) at fair value at October 31, 2017, 2016 and 2015 by asset category are as follows:

	2017	2016	2015
Asset category			
Equity securities	75 %	75 %	75 %
Debt securities	24	24	23
Other	1	1	2
	100 %	100 %	100 %

The System employs a total return investment approach whereby a mix of equities and fixed income investments are used to maximize the long-term return on plan assets for a prudent level of risk. Risk tolerance is established through careful consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio in THA Trust contains a diversified blend of equity and fixed-income investments. Furthermore, equity investments are diversified across U.S. and non-U.S. stocks, as well as growth, value, and small and large capitalizations. Investment risk is measured and monitored on an ongoing basis through quarterly investment portfolio reviews, annual liability measurements, and periodic asset/liability studies.

The System's pension plan interest in the THA Trust is considered a Level 2 asset from the perspective of the plans; that is,its fair value is measurable with significant observable inputs for the years ended October 31, 2017, 2016 and 2015. All assets in the THA Trust are Level 1 assets from the perspective of the THA Trust; that is, the fair value of all THA Trust assets are measurable with quoted prices in active markets for identical assets.

Contributions
The System plans not to contribute to its qualified plans during 2018.

Estimated Future Benefit Payments
The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

(in thousands)

2018	9,135
2019	9,293
2020	9,347
2021	9,836
2022	7,625
2023 - 2027	35,883

Employee Defined Contribution Plan
The System maintains a defined contribution retirement plan covering all employees with one or more years of service. Employee contributions are allowed based on a percentage of the employee's salary as defined by the plan document. Participants are fully vested in their voluntary contributions plus actual earnings thereon. Employee contributions are invested in various funds held for qualified participants. The System matches up to 3% of the employees' compensation. Participants are fully vested in matching contributions after three years. For the years ended October 31, 2017, 2016 and 2015, the System contributed approximately $6,189,000, $5,975,000 and $6,200,000, respectively, to the defined contribution plan.

11. Notes, Bonds Payable and Obligations Under Capital Leases

Notes, bonds payable and obligations under capital leases of the System consist of the following at October 31, 2017, 2016 and 2015:

(in thousands)	2017	2016	2015
Series 2007 A bonds payable with interest rates ranging from 5% to 5.37%, maturing through November 2037, collateralized by pledged revenues, deed of trust and security agreement	$ 238,000	$ 244,155	$ 250,015
Quitman revenue bonds payable with an interest rate of 6%, maturing through November 2041, collateralized by pledged revenues, deed of trust and security agreement	35,750	35,750	35,750
Pittsburg revenue bonds with interest rates ranging from 5.5% to 5.65%, maturing through November 2033, collateralized by pledged revenues, deed of trust and security agreement	30,850	31,900	32,855
Henderson revenue bonds with interest rate of 2.25%, maturing through June 2021, collateralized by pledged revenues, deed of trust and security agreement	3,740	4,052	4,346
Notes payable with interest rates ranging from 0% to 3.85%, maturing through November 2023, collateralized by equipment, buildings and land	-	643	9,194
Note payable, due September 2019, payable monthly plus interest at 3.65%, collateralized by buildings and land	-	-	854
Note payable, due January 2027, payable monthly plus interest at 3.75%, collateralized by buildings and land	-	-	4,680
Note payable, due December 2016, payable monthly plus interest at 3.4%, collateralized by buildings and land	-	-	893
Note payable, due July 2016, payable monthly plus interest at 3.85%, collateralized by equipment	-	-	1,230
Note payable, due July 2019, payable monthly plus interest at 3.85%, collateralized by buildings and land	-	-	991
Note payable, due September 2024, payable monthly plus interest at 4.85%, collateralized by buildings and land	-	-	4,180
Obligations under capital leases	10,018	22,372	31,563
Total notes, bonds payable and obligations under capital leases	318,358	338,872	376,551
Less: Current portion	309,752	16,138	22,320
Total notes, bonds payable and obligations under capital leases, net of current portion	8,606	322,734	354,231
Less: Debt issuance costs	(3,903)	(4,090)	(4,278)
Total notes, bonds payable and obligations under capital leases, net of current portion and debt issue costs	$ 4,703	$ 318,644	$ 349,953

Series 2007A Bonds
The $283,865,000 principal amount of Series 2007A Bonds were issued in November 2007 in order to (1) refund the System's Series 1993 A/B Bonds outstanding in the aggregate principal amount of $38,890,000, Series 1997 A, B, and C Bonds outstanding in the aggregate principal amount of $100,240,000, (2) advance refund the System's Series 1997 D Bonds outstanding in the aggregate principal amount of $48,750,000, (3) finance the acquisition, construction, and improvement of certain health facilities and equipment, and (4) pay certain costs of issuance of the bonds.

A portion of the Series 2007A Bonds is due each November 1, through 2037. The interest rate on the Series 2007A Bonds ranges from 5.0% to 5.375%. As security to the bondholders, the System granted to the Bond Master Trustee, a deed of trust lien on and security interest in, certain real property and equipment, in Tyler, Athens and Jacksonville. Additionally, the System granted to the Bond Master Trustee a security interest in all revenues and receipts of all of its subsidiary organizations.

The Series 2007A Bonds are subject to optional redemption by the System, in whole or in part on November 1, 2017 or on any date thereafter at a redemption price equal to the principal amount to be redeemed plus accrued unpaid interest.

Quitman Bonds
The $35,750,000 principal amount of Series 2011 Wood County Central Hospital District Revenue Bonds was issued for the purpose of providing funds to construct and equip a new hospital facility in Quitman, Texas. A portion of the bonds become due beginning November 1, 2038 through 2041. The interest rate is 6%. The bonds are collateralized in parity with the Series 2007A Bonds.

Pittsburg Bonds
Series 2007, 2008, 2009 and 2009A Camp County ETMC Pittsburg Hospital Revenue Bonds in the aggregate principal amount of $37,000,000 were issued for the purpose of providing funds to construct and equip a new hospital facility in Pittsburg, Texas. A portion of the bonds is due each November 1 through 2033. The interest rates range from 5.5% to 5.65%. The bonds are collateralized in parity with the Series 2007A Bonds.

Henderson Bonds
On September 9, 2009, the System assumed Henderson Memorial Hospital's Series 2006 Bonds. The Series 2009A Henderson Note in the principal amount of $5,831,618 was issued to evidence the obligation of the System in connection with the Series 2006 Bonds. On August 1, 2011, the System refinanced the bonds. A portion of the bonds become due monthly, maturing June 1, 2021. The interest rate is variable, set at prime plus 2%. The interest rate at October 31, 2017 was 6.25%. The note is collateralized in parity with the Series 2007A Bonds.

Debt Covenants

The Series 2007A Bonds contain certain covenants which the System is required to meet. The most significant of these covenants include a rate covenant, a capitalization covenant and a liquidity covenant.

Under the rate covenant, the System is required to maintain a ratio of available revenues to maximum annual debt service requirements that is greater than 110%. The capitalization covenant requires the System to maintain a ratio of debt to total capitalization of less than 70%. The liquidity covenant requires the System to maintain a minimum of 65 days of unrestricted cash on hand. The System was not in compliance with the rate covenant at the October 31, 2017 measurement date. As a result of this noncompliance with our debt covenants existing as of the October 31, 2017 measurement date, on March 1, 2018, our creditors have the ability to declare the principal amount then outstanding under all existing bond issuances to be due and payable immediately. Amounts outstanding under our existing bond arrangements are therefore classified as current liabilities.

On March 1, 2018, the System defeased the remaining principal then outstanding of the Series 2007A and Quitman bonds. Additionally, the System called and paid all amounts outstanding under the Pittsburg and Henderson revenue bonds in February 2018.

Long-Term Obligations Scheduled Repayments

Maturities of bonds payable and capital lease obligations are as follows:

(in thousands)	Bonds Payable	Capital Lease Obligations
Years Ending October 31,		
2018	308,340	5,605
2019	-	3,374
2020	-	1,385
2021	-	81
2022	-	-
Thereafter	-	-
Total bonds payable and capital lease obligations	308,340	10,445
Less: Amount representing interest	-	(427)
Total bonds payable and capital lease obligations, net of interest	308,340	10,018
Less: Debt issue costs	(3,903)	-
Total bonds payable and capital lease obligations, net of inerest and debt issue costs	304,437	10,018
Less: Current maturities	(304,437)	(5,315)
Total bonds payable and capital lease obligations, net of interest and current maturities	$ -	$ 4,703

In December 2017, the System terminated all capital lease agreements and repaid all amounts outstanding in full.

12. Lease Commitments

The System leases various equipment under operating leases expiring in various years. Minimum rental commitments under operating leases having initial or remaining non-cancelable terms of more than one year at October 31, 2017 are as follows:

(in thousands)

2018	$ 11,300
2019	10,814
2020	10,435
2021	9,508
2022	8,951
Thereafter	8,608
Total future minimum lease payments	$ 59,616

Total rental expense for the years ended October 31, 2017, 2016 and 2015 was $11,979,000, $12,154,000 and $12,034,000, respectively, and is included in purchased services in the accompanying consolidated statements of operations.

13. Fair Value of Financial Instruments

The carrying amounts reported in the balance sheets at October 31, 2017, 2016 and 2015 for cash and cash equivalents, assets limited as to use, patient accounts receivable, supplies, prepaid expenses and other, long-term investments, accounts payable, accrued expenses and estimated third party settlements approximate their fair value.

The fair value of the System's notes, bonds payable and capital lease obligations at October 31, 2017, 2016 and 2015 is as follows:

	2017	
(in thousands)	**Carrying Amount**	**Fair Value**
Notes, bonds payable and capital lease obligations	$ 318,358	$ 317,858

	2016	
(in thousands)	**Carrying Amount**	**Fair Value**
Notes, bonds payable and capital lease obligations	$ 338,872	$ 315,750

	2015	
(in thousands)	**Carrying Amount**	**Fair Value**
Notes, bonds payable and capital lease obligations	$ 376,551	$ 348,474

The fair value of the System's bonds payable and capital lease obligations is estimated using discounted cash flow analyses, based on the current incremental borrowing rates for similar types of borrowing arrangements.

ASC 820, "Fair Value Measurements and Disclosures," establishes a framework for measuring fair value. The framework provides 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 under ASC 820 are described below:

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

Level 2 Inputs to the valuation methodology include:

- 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; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means

Level 3 Inputs to the valuation methodology are unobservable 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.

The use of the above described methods may produce a fair value calculation that may not be indicative of the net realizable value or reflective of future fair values. Furthermore, while the System believes the valuation methods used in this report are appropriate and consistent with other market participants, the use of the different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The table below presents the assets and liabilities measured at fair value on a recurring basis at October 31, 2017, 2016 and 2015 categorized by the level of inputs used in valuation of each asset.

	2017 Fair Value Measurements			
(in thousands)	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and cash equivalents	$ 29,876	$ -	$ -	$ 29,876
Marketable securities				
Certificates of deposit		11,930	-	11,930
US government obligations	104,415		-	104,415
Municipal bonds and notes		3,554	-	3,554
Corporate bonds and notes		25,309	-	25,309
Assets limited as to use				
Money market funds	55,394		-	55,394
Certificates of deposit		6,707	-	6,707
US government obligations	10,137		-	10,137
Municipal bonds and notes		2,822	-	2,822
Corporate bonds and notes		730	-	730
Long-term investments				
Money market funds	3,096		-	3,096
Fixed income		631	-	631
Equities		4,302	-	4,302
Total assets at fair value	$202,918	$ 55,985	$ -	$258,903
Liabilities				
Interest rate swap		$ 305		$ 305
Total liabilities at fair value	$ -	$ 305	$ -	$ 305

(in thousands)	2016 Fair Value Measurements Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and cash equivalents	$ 45,855	$ -	$ -	$ 45,855
Marketable securities				
Certificates of deposit	-	19,740	-	19,740
US government obligations	127,637	-	-	127,637
Municipal bonds and notes	-	5,152	-	5,152
Corporate bonds and notes	-	44,302	-	44,302
Assets limited as to use				
Money market funds	50,072	-	-	50,072
Certificates of deposit	-	5,676	-	5,676
US government obligations	1,835	-	-	1,835
Municipal bonds and notes	-	3,137	-	3,137
Corporate bonds and notes	-	737	-	737
Long-term investments				
Money market funds	3,566	-	-	3,566
Fixed income	-	622	-	622
Equities	-	3,728	-	3,728
Total assets at fair value	$228,965	$ 83,094	$ -	$312,059
Liabilities				
Interest rate swap	$ -	$ 497	$ -	$ 497
Total liabilities at fair value	$ -	$ 497	$ -	$ 497

(in thousands)	2015 Fair Value Measurements Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Assets				
Cash and cash equivalents	$103,118	$ -	$ -	$103,118
Marketable securities				
Certificates of deposit	-	15,183	-	15,183
US government obligations	116,198	-	-	116,198
Municipal bonds and notes	-	5,101	-	5,101
Corporate bonds and notes	-	41,648	-	41,648
Assets limited as to use				
Money market funds	49,318	-	-	49,318
Certificates of deposit	-	4,988	-	4,988
US government obligations	829	-	-	829
Municipal bonds and notes	-	3,019	-	3,019
Corporate bonds and notes	-	515	-	515
Long-term investments				
Money market funds	3,220	-	-	3,220
Fixed income	-	656	-	656
Equities	-	3,682	-	3,682
Total assets at fair value	$272,683	$ 74,792	$ -	$347,475
Liabilities				
Interest rate swap	$ -	$ 588	$ -	$ 588
Total liabilities at fair value	$ -	$ 588	$ -	$ 588

As of October 31, 2017, the System maintains a swap with a notional amount of $4,026,000 that is set to expire on June 1, 2021. The liability was recorded within other liabilities and the related change in value of approximately $192,000 was recorded in other revenue within the accompanying consolidated statement of operations. The fair value of the interest rate swap is based primarily on quotes from banks.

14. Income Taxes

The System has income from certain affiliated organizations and operations which are taxable for federal and state income tax purposes. The following entities are included in the consolidated group: East Texas Medical Regional Health Services, Inc., Centralized Credentialing Services, Inc., Healthfirst TPA, Inc., Graphics Plus, First Choice Management Services, Access Direct, MM Solutions, Inc., Paramedics Plus LLC, Fleet Plus LLC and Health Benefit Network. These subsidiaries follow ASC 740, *Accounting for Income Taxes*, which requires an asset and liability approach for financial accounting and reporting of income taxes. At October 31, 2017 and 2016, there was a deferred tax liability of $1,620,000 and $1,461,000, respectively, and at October 31, 2015 there was a deferred tax asset of $481,000. The increase in the net deferred tax liability between October 31, 2017 and 2016 and the decrease in the net deferred tax asset between October 31, 2016 and October 31, 2015 is primarily due to temporary tax differences. As of October 31, 2017, the System had taxes payable of $762,000. As of October 31, 2016 and 2015,

the System had prepaid taxes of $1,372,000 and $25,000, respectively. In addition, the System recorded income tax expense related to its taxable operations of approximately $771,000, $2,285,000 and $1,941,000 for the years ended October 31, 2017, 2016 and 2015, respectively. The 2017, 2016 and 2015 expenses relate primarily to federal income tax. These amounts are reflected in supplies and other expenses in the accompanying consolidated statements of operations.

As of October 31, 2017, ETMC had no uncertain tax positions. ETMC files tax returns in the U.S. federal jurisdiction, Texas, Florida, Indiana, California and Oklahoma. ETMC is generally no longer subject to U.S. federal, state and local income tax examinations by tax authorities for years prior to October 31, 2010. The System's policy is to include interest and penalties related to uncertain tax positions as a component of income tax expense.

15. Hospital Operating Agreements

The System leases the land and buildings operated by certain of its affiliated entities. Substantially all leased premises and improvements revert back to the lessors upon expiration of the leases. The net book value of the leased premises and improvements totaled approximately $87,642,000, $115,792,000 and $126,260,000 at October 31, 2017, 2016 and 2015, respectively.

Capital Lease Agreements

East Texas Medical Center Athens
On January 1, 1983, Athens leased all land, buildings, improvements and equipment from the Henderson County Hospital Authority ("HCHA"), who had leased it from Henderson County, Texas. The lease term is for thirty years with a provision for six additional ten-year extension options which may be exercised by Athens by giving six months notice prior to the initial lease term or any renewal term. Athens exercised three of the ten-year extension options in November 2005, extending the lease to December 31, 2042.

East Texas Medical Center Pittsburg
On December 1, 1983, Pittsburg leased all land, buildings, improvements, and equipment from the Camp County, City of Pittsburg, Texas, Hospital Board for an initial term of ten years with a provision for two additional ten-year automatic extensions. On December 1, 2007, Pittsburg entered into a new lease with Camp County, Texas. The new lease expires on October 31, 2037.

East Texas Medical Center Quitman
On June 1, 1998, Quitman leased substantially all land, buildings and equipment from Wood County Central Hospital District for an initial term of ten years with a provision for four additional ten-year extensions that were automatic. On November 1, 2011, Quitman entered into a new lease with Wood County Central Hospital District. The lease expires on November 1, 2051 with a provision for one ten-year extension which may be exercised by Quitman by giving twenty-four months' notice.

Lease obligations related to these capital leases are included in obligations under capital leases disclosed in Note 11 – *Notes, Bonds Payable and Obligations Under Capital Leases.*

Operating Lease Agreements

East Texas Medical Center Carthage
On December 1, 1997, Carthage leased substantially all land, buildings and equipment from Panola County, Texas, for an initial term of ten years with a provision for two additional ten-year extensions that were automatic. On November 14, 2016, Carthage renewed the lease extending the lease to December 1, 2022 with unlimited renewal options. Either party may terminate the lease agreement at any time, by giving 365 days written notice to the other party. Such lease requires the performance of certain covenants including but not limited to new purchases and upgrades at the hospital as needed and as financial constraints allow.

East Texas Medical Center Henderson
On June 1, 2009, Henderson leased substantially all land, buildings, and equipment from Henderson Memorial Hospital for an initial term of fifteen years, expiring May 31, 2024. The lease includes provision for four additional five-year extensions that are automatic unless 180 days written notice is given by Henderson. Such lease requires the performance of certain covenants including but not limited to new purchases and upgrades at the hospital in the amount of approximately $15 million within the first four years. This requirement was met by June 1, 2013.On June 27, 2017 Henderson Memorial Hospital merged with Henderson.

Lease obligations related to these operating leases are included in minimum rental commitments disclosed in Note 12 – *Lease Commitments.*

16. Commitments and Contingencies

Litigation
Malpractice claims have been asserted against the System by various claimants. The claims are in various stages and some may ultimately be brought to trial. The System, with the assistance of its professional insurance consultants, has considered these claims in arriving at the accrual for self-insured medical malpractice, professional and general liability claims asserted and incurred but not reported. This estimated liability is subject to change in future years as additional information becomes available prior to ultimate settlement.

The System is a defendant in various legal proceedings arising in the ordinary course of business. Although the results of litigation cannot be predicted with certainty, we believe that the outcome of the pending litigation will not have a material adverse effect on the System's consolidated financial statements.

The United States and the State of Oklahoma, on behalf of the Department of Health and Human Services, filed a lawsuit on January 23, 2017 against the System, Services and Paramedics Plus, alleging among other things violations of the False Claims Act and the Anti-Kickback Statute. The complaint alleges that the System and Paramedics Plus entered into an illegal kickback scheme to obtain and retain an ambulance services contract with the Emergency Medical Services Authority (EMSA), an Oklahoma public trust entity. Paramedics Plus had a contract with EMSA during the period 1998 to 2013 for ambulance services in Oklahoma City and Tulsa, Oklahoma. The United States alleges Paramedics Plus paid over $20 million in kickbacks to EMSA during the term of the contract. On February 28, 2018, the System, Services and Paramedics Plus entered into a memorandum of understanding with the United States and the State of Oklahoma that dismisses all claims against the System contained in the lawsuit. Under the terms of the settlement, a payment of $20.6 million will be made by the System to the United States and the State of Oklahoma. Upon the execution of the sale to AHS East Texas Health System, LLC, $30.0 million will be placed in Escrow which will be released to the System upon payment to the United States

and the State of Oklahoma. The settlement payment does not constitute an admission of guilt or wrongdoing by the System. A loss contingency for $20.6 million has been recorded in the financial statements as of October 31, 2017 relating to this matter.

Credit Risks

Financial instruments that potentially subject the System to concentration of credit risk consist of cash and cash equivalents and patient accounts receivable. Cash and cash equivalents used in operations consist primarily of cash in financial institution checking accounts and cash held by trustees under self-insurance funding arrangements and indenture agreements. U.S. Treasury obligations and investments in money market mutual funds are also held by trustees under self-insurance funding arrangements and indenture agreements.

At October 31, 2017, 2016 and 2015, the System had deposits in a major financial institution that exceeded Federal Deposit Insurance Corporation insurance limits. We believe that credit risk related to these deposits is minimal.

The System is located in Tyler, Texas, and operates in the surrounding east Texas area. The System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The composition of net patient accounts receivable at October 31, 2017, 2016 and 2015 is as follows:

	2017	2016	2015
Medicare	32 %	33 %	27 %
Medicaid	6	7	6
Blue Cross	16	16	17
Other third-party payors	46	44	50
	100 %	100 %	100 %

17. Related Party Transactions

The System maintains cash deposits and has approximately $6,104,000 in outstanding debt with a financial institution at October 31, 2015 and no outstanding debt with a financial institution at October 31, 2016 and 2017. An officer of the financial institution is a director of the System. In July 2016, this board member resigned.

18. Functional Expenses

The System provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended October 31, 2017, 2016 and 2015 are as follows:

(in thousands)	2017	2016	2015
Healthcare services	$ 911,428	$ 841,803	$ 786,972
General and administrative	96,758	93,057	87,652
	$ 1,008,186	$ 934,860	$ 874,624

19. Discontinued Operations

In 2017, System management, along with the Board of Directors, began to consider possible strategic alternatives related to the System's operations. Management committed to a plan to sell substantially all assets and operations of the System and concluded that the disposal group met the required criteria for classification as held-for-sale. In connection with meeting the held for sale criteria, management additionally concluded that the commitment to sell represented a strategic shift that will have a major effect on the System's operations and financial results and would thus be reported as discontinued operations.

The guidance within ASC 205 for the presentation of discontinued operations determines that in the period that a discontinued operation is classified as held for sale and for all prior periods presented, the assets and liabilities and the results of operations and gain or loss recognized on the discontinued operation shall be presented separately in the balance sheet and statement of operations, respectively. As the components qualifying as discontinued operations represent substantially all of the System operations, the assets and liabilities and related results of operations of the discontinued operations are not collapsed and separately presented on the accompanying consolidated balance sheets and statements of operations, but are disclosed within this footnote.

Components of assets and liabilities from discontinued operations consist of the following as of October 31, 2017, 2016, and 2015:

(in thousands)	2017	2016	2015
Assets			
Current assets			
Current portion of assets limited as to use	4,317	4,903	3,471
Accounts receivable			
Patient, net	83,624	85,531	80,551
Supplemental Medicaid receivable	12,375	10,486	19,592
Other	8,781	11,899	7,743
Supplies	13,389	13,747	13,766
Prepaid expenses and other	12,737	10,935	10,943
Total current assets from discontinued operations	135,223	137,501	136,066
Noncurrent assets			
Property and equipment, net	307,124	378,759	396,173
Total non-current assets from discontinued operations	307,124	378,759	396,173
Total assets from discontinued operations	$ 442,347	$ 516,260	$ 532,239

(in thousands)	2017	2016	2015
Liabilities			
Current liabilities			
Accounts payable and accrued expenses	$ 72,356	$ 72,199	$ 66,936
Total current liabilities from discontinued operations	72,356	72,199	66,936
Noncurrent liabilities			
Other liabilities	458	844	105
Total noncurrent liabilities from discontinued operations	458	844	105
Total liabilities from discontinued operations	$ 72,814	$ 73,043	$ 67,041

Operating results from discontinued operations consist of the following for fiscal years ended 2017, 2016 and 2015:

(in thousands)	2017	2016	2015
Revenue	$ 873,014	$ 917,114	$ 869,424
Salaries and benefits	523,250	507,583	478,311
Professional fees and purchase services	131,220	127,571	113,310
Supplies and other	221,084	231,532	211,026
Depreciation, amortization, interest and impairment	94,614	51,600	52,141
(Loss) Gain on discontinued operations	$ (97,154)	$ (1,172)	$ 14,636

20. Subsequent Events

Sale of Hospital and Texas-based EMS operations
On March 1, 2018, we completed the sale of EMS, Access Direct, Centralized Credentialing, TPA, MM Solutions and the assets and operations of each of the System's other subsidiaries as described within Note 1 - *Organization*, with the exception of Paramedics Plus and Foundation, to AHS East Texas Health System, LLC. The entities subject to the sale represent a significant portion of our operations. Upon the execution of the sale on March 1, 2018, the System has been renamed ETX Successor System and consists of the following remaining subsidiaries, as renamed:

- ETX Successor Tyler ("ETMC")
- ETX Successor Athens ("Athens")
- ETX Successor Carthage ("Carthage")
- System Foundation ("Foundation")
- ETX Successor Healthcare Associates ("501A")
- ETX Successor Henderson ("Henderson")
- ETX Successor Home Services ("Home Services")
- ETX Successor Jacksonville ("Jacksonville")
- ETX Successor Pittsburg ("Pittsburg")
- ETX Successor Quitman ("Quitman")
- ETX Successor Regional Health Services, Inc. ("Services") and Subsidiary:
  - Paramedics Plus LLC ("Paramedics Plus")
- ETX Successor Rehabilitation Hospital ("Rehab")
- ETX Successor Specialty Hospital ("Specialty")
- ETX Flight Ambulance ("Air One")

Paramedics Plus
On February 22, 2018 the System entered into an asset purchase agreement with Paramedics Logistics Operating Company, LLC to sell the assets and operations of Paramedics Plus. The agreement contains a March 31, 2018 closing date for the completion of the sale and transfer of ownership.

Settlement of liabilities and obligations
On March 1, 2018, the System defeased the remaining principal then outstanding, of the Series 2007A and Quitman bonds in the amount of $254.6 million. Additionally, in February 2018, the System called and paid $33.0 million, representing all amounts outstanding under the Pittsburg and Henderson revenue bonds. On February 28, 2018, the System purchased a loss portfolio transfer insurance policy for $18.0 million, which provides insurance coverage for any medical malpractice, professional or general liability claims incurred on or prior to February 28, 2018. Additionally, the System purchased extended tail coverage insurance policies on February 28, 2018 for $3.3 million, extending its coverage for other various insurable exposures. The combination of loss portfolio transfer insurance and extended tail coverage insurance covers all existing or new claims which may be brought against the System or its subsidiaries for events occurring prior to March 1, 2018.

Additionally, On February 28, 2018, the System, Services and Paramedics Plus entered into a memorandum of understanding with the United States and the State of Oklahoma that dismisses all claims against the System contained in the lawsuit. Under the terms of the settlement, a payment of $20.6 million will be made by the System to the United States and the State of Oklahoma. Upon the execution of the sale to AHS East Texas Health System, LLC, $30.0 million was placed in Escrow which will be released to the System upon payment to the United States and the State of Oklahoma. The settlement payment does not constitute an admission of guilt or wrongdoing by the System. A loss contingency for $20.6 million has been recorded in the financial statements as of October 31, 2017 relating to this matter.

Plan for dissolution

Upon the successful execution of management's plans to settle its remaining obligations and liabilities, all remaining assets will be contributed to the Foundation which will transfer all funds to a charitable trust with the objective of supporting the healthcare needs in the East Texas community. It is anticipated that this process will take at least two years to complete. Upon the completion of this plan, the System will be legally dissolved.

Evaluation

The System has performed an evaluation of subsequent events through March 14, 2018, which is the date the financial statements were issued. There were no other material subsequent events requiring financial statement disclosure other than those discussed in the Notes to the Consolidated Financial Statements.

pwc

Report of Independent Auditors

To the Board of Directors of
East Texas Medical Center
Regional Healthcare System

We have audited the consolidated financial statements of East Texas Medical Center Regional Healthcare System and its subsidiaries as of October 31, 2017 and for the year then ended and our report thereon appears on page one of this document. That audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, changes in net assets and cash flows of the individual companies and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, changes in net assets and cash flows of the individual companies.

PricewaterhouseCoopers LLP

Dallas, Texas
March 14, 2018

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidating Balance Sheet
October 31, 2017

(in thousands)	System	ETMC	EMS	Athens	Carthage	Fairfield	Henderson	Jacksonville	Pittsburg	Quitman
Balance Sheet										
Current assets										
Cash and cash equivalents	$ 5,324	$ 6,330	$ 354	$ 2,304	$ 378	$ -	$ 209	$ (196)	$ 391	$ 100
Marketable securities	145,208									
Current portion of assets limited as to use	50,417	-	-	-	-	-	-	-	1,964	4,587
Patient accounts receivable, net of allowance for doubtful accounts	-	39,569	2,769	6,825	1,405	-	2,625	2,345	2,456	1,788
Other accounts receivable	-	-	-	-	-	-	-	-	-	-
Supplies	-	8,363	197	1,315	287	-	487	233	734	544
Prepaid expenses and other	10,644	2,793	1,017	473	356	-	562	2,714	2,042	1,155
Total current assets	211,593	57,055	4,337	10,917	2,426	-	3,883	5,096	7,587	8,174
Assets limited as to use, net of current portion	14,505	-	-	-	-	-	-	-	-	-
Long-term investments	-	-	-	-	-	-	-	-	-	-
Property and equipment, net	118,686	32,562	9,245	34,593	3,901	-	22,663	20,548	22,594	26,555
Other assets	79,697	387,260	97	79,357	2	-	2	68	346	84
Total assets	$ 424,481	$ 476,877	$ 13,679	$ 124,867	$ 6,329	$ -	$ 26,548	$ 25,712	$ 30,527	$ 34,813
Liabilities and Net Assets										
Current liabilities										
Accounts payable and accrued expenses	$ 42,039	$ 30,534	$ 1,369	$ 4,641	$ 1,107	$ -	$ 1,072	$ 1,311	$ 2,581	$ 2,348
Current portion of bonds payable	235,443	-	-	-	-	-	3,740	-	30,696	34,558
Current portion of capital lease obligations	1,979	1,601	684	622	-	-	-	-	73	38
Supplemental Medicaid payable	3,438	(3,722)	-	(431)	1,357	-	276	615	3,911	2,055
Current portion of estimated malpractice costs	10,758	-	-	-	-	-	-	-	-	-
Deferred revenue	-	-	729	-	-	-	-	-	-	-
Estimated third party settlements	-	1,013	-	(82)	-	-	(80)	(400)	29	(80)
Total current liabilities	293,657	29,426	2,782	4,750	2,464	-	5,008	1,526	37,290	38,919
Estimated malpractice costs, net of current portion	11,736	-	-	-	-	-	-	-	-	-
Bonds payable, net of current portion	-	-	-	-	-	-	-	-	-	-
Capital lease obligations, net of current portion	1,486	1,915	407	731	-	-	-	-	25	-
Accrued pension	-	28,580	-	4,523	-	-	-	-	-	-
Other liabilities	406,980	-	18,070	52,346	(15,959)	-	34,702	78,487	(769)	1,250
Total liabilities	713,859	59,921	21,259	62,350	(13,495)	-	39,710	80,013	36,546	40,169
Net assets										
Unrestricted	(289,378)	416,956	(7,580)	62,517	19,824	-	(13,162)	(54,301)	(6,019)	(5,356)
Temporarily restricted	-	-	-	-	-	-	-	-	-	-
Permanently restricted	-	-	-	-	-	-	-	-	-	-
Total net assets	(289,378)	416,956	(7,580)	62,517	19,824	-	(13,162)	(54,301)	(6,019)	(5,356)
Total liabilities and net assets	$ 424,481	$ 476,877	$ 13,679	$ 124,867	$ 6,329	$ -	$ 26,548	$ 25,712	$ 30,527	$ 34,813

The consolidating supplemental information of the ETMC System has been prepared in a manner consistent with generally accepted accounting principles and is presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The consolidating supplemental information was derived from the accounting records used to prepare the consolidated financial statements. All material consolidating entries and intercompany eliminations have been properly recorded.

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidating Balance Sheet
October 31, 2017

(in thousands)	Rehab Center	Specialty	Trinity	501A	Foundation	Air One	Home Services	ETMCRH Services	Eliminations	Total Combined System
Balance Sheet										
Current assets										
Cash and cash equivalents	$ 190	$ 559	$ -	$ (2,633)	$ 2,895	$ 133	$ 178	$ 13,360	$ -	$ 29,876
Marketable securities										145,208
Current portion of assets limited as to use	-	-	-	-	-	-	-	4,317		61,285
Patient accounts receivable, net of allowance for doubtful accounts	2,876	2,796	-	5,866	-	870	1,713	9,797	(76)	83,624
Other accounts receivable	-	-	-	-	-	-	-	8,781		8,781
Supplies	137	157	-	-	-	-	21	914		13,389
Prepaid expenses and other	96	12	-	2,245	3	21	117	1,648	(1,166)	24,732
Total current assets	3,299	3,524	-	5,478	2,898	1,024	2,029	38,817	(1,242)	366,895
Assets limited as to use, net of current portion	-	-	-	-	-	-	-	-		14,505
Long-term investments	-	-	-	-	8,029	-	-	-		8,029
Property and equipment, net	807	169	-	-		4,031	23	10,747		307,124
Other assets	268	(15)	-	-	-	(24)	-	-	(540,163)	6,979
Total assets	$ 4,374	$ 3,678	$ -	$ 5,478	$ 10,927	$ 5,031	$ 2,052	$ 49,564	$ (541,405)	$ 703,532
Liabilities and Net Assets										
Current liabilities										
Accounts payable and accrued expenses	$ 1,065	$ 354	$ -	$ 2,448	$ -	$ 337	$ 474	$ 11,469	$ (1,241)	$ 101,908
Current portion of bonds payable	-	-	-	-	-	-	-	-		304,437
Current portion of capital lease obligations	-	-	-	-	-	-	-	318		5,315
Supplemental Medicaid payable	-	-	-	-	-	-	-	-		7,499
Current portion of estimated malpractice costs	-	-	-	-	-	-	-	-		10,758
Deferred revenue	-	-	-	-	-	-	-	158		887
Estimated third party settlements	57	(64)	-	-	-	-	-	-		393
Total current liabilities	1,122	290	-	2,448	-	337	474	11,945	(1,241)	431,197
Estimated malpractice costs, net of current portion	-	-	-	-	-	-	-	-		11,736
Bonds payable, net of current portion	-	-	-	-	-	-	-	-		-
Capital lease obligations, net of current portion	-	-	-	-	-	-	-	17,265	(17,126)	4,703
Accrued pension	-	-	-	-	-	-	-	-		33,103
Other liabilities	(42,291)	(32,766)	-	82,623	3	6,122	(6,442)	458	(581,965)	849
Total liabilities	(41,169)	(32,476)	-	85,071	3	6,459	(5,968)	29,668	(600,332)	481,588
Net assets										
Unrestricted	45,543	36,154	-	(79,593)	2,895	(1,428)	8,020	19,896	58,927	213,915
Temporarily restricted	-	-	-	-	5,005	-	-	-		5,005
Permanently restricted	-	-	-	-	3,024	-	-	-		3,024
Total net assets	45,543	36,154	-	(79,593)	10,924	(1,428)	8,020	19,896	58,927	221,944
Total liabilities and net assets	$ 4,374	$ 3,678	$ -	$ 5,478	$ 10,927	$ 5,031	$ 2,052	$ 49,564	$ (541,405)	$ 703,532

The consolidating supplemental information of the ETMC System has been prepared in a manner consistent with generally accepted accounting principles and is presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The consolidating supplemental information was derived from the accounting records used to prepare the consolidated financial statements. All material consolidating entries and intercompany eliminations have been properly recorded.

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidating Balance Sheet
October 31, 2017

(in thousands)	Services	Access Direct	Centralized Credentialing	TPA	MM Solutions	Paramedics	Elimination Entry	Services Combined
Balance Sheet								
Current assets								
Cash and cash equivalents	$ 4,589	$ 280	$ 253	$ 5,551	$ 333	$ 2,354	$ -	$ 13,360
Current portion of assets limited as to use	-	-	-	-	-	4,317	-	4,317
Patient accounts receivable, net of allowance for doubtful accounts	-	-	-	-	-	9,797	-	9,797
Other accounts receivable	162	14	62	3,392	149	5,002	-	8,781
Supplies	581	-	-	-	-	333	-	914
Prepaid expenses and other	21	-	9	168	28	1,422	-	1,648
Total current assets	5,353	294	324	9,111	510	23,225	-	38,817
Assets limited as to use, net of current portion	-	-	-	-	-	-	-	-
Long-term investments	-	-	-	-	-	-	-	-
Property and equipment, net	43	9	13	728	5	9,949	-	10,747
Other assets	38,886	-	-	(1,930)	-	-	(36,956)	-
Total assets	$ 44,282	$ 303	$ 337	$ 7,909	$ 515	$ 33,174	$ (36,956)	$ 49,564
Liabilities and Net Assets								
Current liabilities								
Accounts payable and accrued expenses	$ 2,971	$ 34	$ 28	$ 2,950	$ 53	$ 5,433	$ -	$ 11,469
Current portion of capital lease obligations	-	-	-	-	-	318	-	318
Supplemental Medicaid payable	-	-	-	-	-	-	-	-
Current portion of estimated malpractice costs	-	-	-	-	-	-	-	-
Deferred revenue	-	-	-	158	-	-	-	158
Estimated third party settlements	-	-	-	-	-	-	-	-
Total current liabilities	2,971	34	28	3,108	53	5,751	-	11,945
Estimated malpractice costs, net of current portion	-	-	-	-	-	-	-	-
Capital lease obligations, net of current portion	17,126	-	-	-	-	139	-	17,265
Accrued pension	-	-	-	-	-	-	-	-
Other liabilities	(21,629)	(1,466)	(447)	780	(265)	15,173	8,312	458
Total liabilities	(1,532)	(1,432)	(419)	3,888	(212)	21,063	8,312	29,668
Net assets								
Unrestricted	45,814	1,735	756	4,021	727	12,111	(45,268)	19,896
Temporarily restricted	-	-	-	-	-	-	-	-
Permanently restricted	-	-	-	-	-	-	-	-
Total net assets	45,814	1,735	756	4,021	727	12,111	(45,268)	19,896
Total liabilities and net assets	$ 44,282	$ 303	$ 337	$ 7,909	$ 515	$ 33,174	$ (36,956)	$ 49,564

The consolidating supplemental information of the ETMC System has been prepared in a manner consistent with generally accepted accounting principles and is presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The consolidating supplemental information was derived from the accounting records used to prepare the consolidated financial statements. All material consolidating entries and intercompany eliminations have been properly recorded.

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidating Statement of Operations
October 31, 2017

(in thousands)	System	ETMC	EMS	Athens	Carthage	Fairfield	Henderson	Jacksonville	Pittsburg	Quitman
Income statement										
Unrestricted revenue and other support										
Patients service revenue (net of contractual allowances and discounts)	$ -	$ 387,357	$ 33,072	$ 96,215	$ 21,221	$ (13)	$ 40,527	$ 35,034	$ 28,415	$ 26,951
Provisions for bad debt	-	(48,297)	(12,138)	(18,606)	(4,456)	(580)	(9,112)	(5,040)	(4,644)	(4,338)
Net patient service revenue less provisions for bad debt	-	339,060	20,934	77,609	16,765	(593)	31,415	29,994	23,771	22,613
Other revenue	74,361	12,985	4,901	1,508	1,618	(1,926)	1,428	1,226	908	497
Total revenue and other support	74,361	352,045	25,835	79,117	18,383	(2,519)	32,843	31,220	24,679	23,110
Expenses										
Salaries and wages	25,164	125,976	16,429	28,398	7,040	682	8,579	10,238	9,601	8,052
Employee benefits	6,237	37,889	3,476	7,179	1,849	177	2,287	2,595	2,931	2,115
Professional fees	9,219	15,640	1,337	7,507	2,540	436	3,787	4,684	4,901	4,024
Supplies and other expenses	32,034	137,313	5,581	25,503	5,433	363	13,938	10,709	6,960	6,206
Purchased services	9,208	24,396	1,462	5,894	1,898	217	4,206	3,040	2,406	2,267
Depreciation and amortization	6,942	10,788	2,192	3,562	723	67	2,632	1,803	2,656	2,557
Held-for-sale impairment charge	57,748	-		1,000						
Interest	3,802	5,520	70	2,420	2	1	362	1,269	1,643	2,161
Total expenses	150,354	357,522	30,547	81,463	19,485	1,943	35,791	34,338	31,098	27,382
Loss from operations	(75,993)	(5,477)	(4,712)	(2,346)	(1,102)	(4,462)	(2,948)	(3,118)	(6,419)	(4,272)
Nonoperating losses										
Other than temporary impairment on marketable securities	(1,820)									
Revenue and other support in deficit of expenses	(77,813)	(5,477)	(4,712)	(2,346)	(1,102)	(4,462)	(2,948)	(3,118)	(6,419)	(4,272)
Defined benefit pension adjustment	-	10,321	-	2,091	-	-	-	-	623	-
Unrealized losses on investments	301	-	-	-	-	-	-	-	-	-
Increase in unrestricted net assets	$ (77,512)	$ 4,844	$ (4,712)	$ (255)	$ (1,102)	$ (4,462)	$ (2,948)	$ (3,118)	$ (5,796)	$ (4,272)

The consolidating supplemental information of the ETMC System has been prepared in a manner consistent with generally accepted accounting principles and is presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The consolidating supplemental information was derived from the accounting records used to prepare the consolidated financial statements. All material consolidating entries and intercompany eliminations have been properly recorded.

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidating Statement of Operations
October 31, 2017

(in thousands)	Rehab Center	Specialty	Trinity	501A	Foundation	Air One	Home Services	ETMCRH Services	Eliminations	Combined System
Income statement										
Unrestricted revenue and other support										
Patients service revenue (net of contractual allowances and discounts)	$ 24,406	$ 15,562	$ 4,631	$ 88,596	$ -	$ 14,156	$ 12,480	$ 119,953	$ -	$ 948,563
Provisions for bad debt	-	-	(2,321)	(21,233)	-	(5,397)	(96)	(60,036)		(196,294)
Net patient service revenue less provisions for bad debt	24,406	15,562	2,310	67,363	-	8,759	12,384	59,917	-	752,269
Other revenue	5,490	-	(191)	15,344	1,385	3	5	87,357	(97,729)	109,170
Total revenue and other support	29,896	15,562	2,119	82,707	1,385	8,762	12,389	147,274	(97,729)	861,439
Expenses										
Salaries and wages	14,638	5,674	2,293	74,666	-	2,591	8,204	76,236		424,461
Employee benefits	2,817	996	471	8,277	-	433	1,434	17,626		98,789
Professional fees	267	160	1,334	13,992	-	345	54	8,172	(14,952)	63,447
Supplies and other expenses	6,940	2,906	1,076	16,976	1,340	662	1,583	28,431	(66,077)	237,877
Purchased services	3,121	4,993	770	4,471	11	4,533	827	8,839	(14,786)	67,773
Depreciation and amortization	222	30	185	10	-	796	10	4,518		39,693
Held-for-sale impairment charge	-	-	-	-	-	-	-	-		58,748
Interest	-	-	2	-	-	105	-	1,955	(1,914)	17,398
Total expenses	28,005	14,759	6,131	118,392	1,351	9,465	12,112	145,777	(97,729)	1,008,186
Loss from operations	1,891	803	(4,012)	(35,685)	34	(703)	277	1,497	-	(146,747)
Nonoperating losses										
Other than temporary impairment on marketable securities	-	-	-	-	-	-	-	-		(1,820)
Revenue and other support in deficit of expenses	1,891	803	(4,012)	(35,685)	34	(703)	277	1,497	-	(148,567)
Defined benefit pension adjustment	-	-	-	-	-	-	-	-		13,035
Unrealized losses on investments	-	-	-	-	-	-	-	-		301
Increase in unrestricted net assets	$ 1,891	$ 803	$ (4,012)	$ (35,685)	$ 34	$ (703)	$ 277	$ 1,497	$ -	$ (135,231)

The consolidating supplemental information of the ETMC System has been prepared in a manner consistent with generally accepted accounting principles and is presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The consolidating supplemental information was derived from the accounting records used to prepare the consolidated financial statements. All material consolidating entries and intercompany eliminations have been properly recorded.

East Texas Medical Center Regional Healthcare System and Subsidiaries
Consolidating Statement of Operations
October 31, 2017

(in thousands)	Services	Access Direct	Centralized Credentialing	TPA	MM Solutions	Paramedics Plus	Elimination Entry	Services Combined
Income statement								
Unrestricted revenue and other support								
Patients service revenue (net of contractual allowances and discounts)	$ -	$ -	$ -	$ -	$ -	$ 119,953	$ -	$ 119,953
Provisions for bad debt	-	-	-	-	-	(60,036)	-	(60,036)
Net patient service revenue less provisions for bad debt	-	-	-	-	-	59,917	-	59,917
Other revenue	7,316	769	579	11,427	1,602	65,664	-	87,357
Total revenue and other support	7,316	769	579	11,427	1,602	125,581	-	147,274
Expenses								
Salaries and wages	1,190	174	262	3,588	695	70,327	-	76,236
Employee benefits	468	76	98	906	173	15,905	-	17,626
Professional fees	137	73	114	(230)	153	7,925	-	8,172
Supplies and other expenses	2,221	259	98	4,993	252	20,608	-	28,431
Purchased services	342	46	53	799	186	7,413	-	8,839
Depreciation and amortization	11	3	-	199	2	4,303	-	4,518
Interest	1,092	-	-	62	3	798	-	1,955
Total expenses	5,461	631	625	10,317	1,464	127,279	-	145,777
Excess of revenue and other support over expenses	1,855	138	(46)	1,110	138	(1,698)	-	1,497
Defined benefit pension adjustment	-	-	-	-	-	-	-	-
Increase in unrestricted net assets	$ 1,855	$ 138	$ (46)	$ 1,110	$ 138	$ (1,698)	$ -	$ 1,497

The consolidating supplemental information of the ETMC System has been prepared in a manner consistent with generally accepted accounting principles and is presented only for purposes of additional analysis and not as a presentation of financial position and results of operations of each component of the consolidated group. The consolidating supplemental information was derived from the accounting records used to prepare the consolidated financial statements. All material consolidating entries and intercompany eliminations have been properly recorded.

ACCOUNT MANAGEMENT TEAM OVERVIEW

Rachel Robertson

Rachel Robertson joined HealthFirst in 2013 as an account manager, and now serves as an account executive. Responsible for generating new business, enhancing broker relationships and ensuring growth of existing accounts, Rachel also consults and maintains relationships with existing clients. Serving as an advisor to clients, she is well-versed in cost containment and health-plan benefits. Prior to joining HealthFirst, Rachel was an account executive for a pathology lab, maximizing opportunities using her product knowledge and technical selling skills to make recommendations to clients and prospects.

Rachel holds a General Lines License for Life, Accident, Health and HMO and is a Certified Self Funding Specialist.

Frances Brown

Joining HealthFirst in 2011, Frances Brown assisted clients and members in the Customer Service department, serving as team lead, supervisor and assistant manager. Moving from customer service into the appeals department, she handled provider/member appeals. Frances is now a part of the Client Services team in her role of Client Coordinator.

Frances began her journey in the insurance industry with Aetna where she processed claims and eventually transitioned to Customer Service, as team lead and mentor. She also has experience in cost containment working closely with vendors, clients, providers and attorneys.

Trish Terrell

Trish joined HealthFirst in 2014 as the director of communications, responsible for external and internal communications and events, including client and plan member education, digital communications and marketing efforts. She also took a strategic role in the RFP process, developing new business and retaining clients. In her current role, she manages the account executive/account management team and oversees communications and marketing.

She earned her bachelor's degree in journalism from the University of Missouri. She holds a Texas General Lines Life, Annuities and Health license.

Jolene Jackson

Jolene joined HealthFirst in 2004 to manage services that directly affect the health of our plan participants. Her team of registered nurses works closely with members and performs case management, utilization management, disease management, and health coaching. She also oversees our population risk management program, which helps members at risk of developing a serious health problem control their conditions.

A registered nurse, Jolene has more than 30 years of experience in the healthcare industry, including hospitals and HMOs. Jolene received a BS degree from East Texas State University and an MS in healthcare administration from Texas Woman's University.

Monica Bauman

Monica Bauman was promoted to Director of Plan Management. Her responsibilities include overseeing claims processing, fund management, benefits eligibility, customer service, reinsurance and building plans for clients. She started with HealthFirst in 1998 working in several departments until settling in the fund management department. She's been a department manager for five years.

Denise Andrew

Denise Andrew was promoted to Director of Product Management. She is responsible for new product development and research. In her new role, Denise will also help members better manage and understand their health care plans by developing strategic reports and analytics and developing new products to help clients better manage their plan costs. She will be responsible for overseeing compliance and working with vendors to always ensure members have the best products available in the marketplace.

She joined HealthFirst in 2008 as an account executive and has more than 16 years of progressive experience in the self-funded insurance industry, having previously held roles at PPO networks, a claims software company and a large international consulting firm. She earned her BBA in business management from Sam Houston State University.

Janis High

Janis High, marketing and communications manager for HealthFirst, has worked extensively in marketing for more than 20 years. Working for companies in technology, education and healthcare sectors provides her the opportunity to understand clients' needs from different vantage points. This, along with career involvement with customer service and customer success, contributes to her responsibility of creating meaningful messages for external and internal communications, client education, events and other marketing efforts for HealthFirst.

Janis joined HealthFirst in 2018 and earned her BBA in marketing from Texas Woman's University.

HEALTHFIRST
P.O. BOX 132317
Tyler TX 75713-2317

HealthFIRST

[DR-]

Forwarding Service Requested

11,026

MEMBER NAME
MEMBER ADDRESS

THIS IS NOT A BILL

Customer Service

Group Name: COUNTY OF UPSHUR
EOB: 20190327-115
Date: 04/01/19
Provider: JOHN F PRIDDY MD

Questions? Please contact HealthFirst Customer Service.
903-581-2600 or 866-219-1592
customerservice@hfbenefits.com
www.hfbenefits.com
Para obtener asistencia en español, llame al número de arriba.

GO GREEN! Visit www.hfbenefits.com to go paperless.

Explanation of Benefits

For the Service Period: 01/22/2019 through 03/27/2019

Dear MEMBER NAME ,

The information below is a summary of the healthcare claims you incurred for the period 01/22/2019 through 03/27/2019. This information is commonly referred to as an ***"Explanation of Benefits" (EOB).*** This is not a bill.
It is a summary, followed by the claim details, of how your recent claims were processed. It includes any copay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the SIHO Member Services at the number listed above.

Total Amount Billed

$4,157.20

This is the total amount billed for the dates of service of 01/22/2019 through 03/27/2019.

Total Amount Paid By Plan

$1,239.51

This is the amount the plan paid in total for services rendered from 01/22/2019 through 03/27/2019. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$968.56

This is the amount the provider(s) of service may bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, copay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.
If you receive services from a non-participating provider, your responsibility may be greater than your financial responsibility noted above.

Reference Info

Enrollee: MEMBER NAME
Group#: UPSH

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: JOHN F PRIDDY MD

Member ID: XXXXXXXXXXXXX
Patient ID: XXXXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
01/22-01/22/2019	11044-RT,Q7	$805.00	$268.92	$268.92	ADP	$536.08	$536.08	$0.00	0%	$0.00
01/22-01/22/2019	99213-25	$160.00	$90.27	$90.27	ADP	$69.73	$0.00	$30.00	100%	$39.73
01/22-01/22/2019	73630-RT	$85.00	$46.84	$46.84	ADP	$38.16	$3.78	$0.00	80%	$27.50

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: JOHN F PRIDDY MD

Member ID: XXXXXXXXXX
Patient ID: XXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
01/22-01/22/2019	L4386-KX,RT	$198.00	$49.50	$49.50	ADP	$148.50	$0.00	$0.00	80%	$118.80
Column Totals		$1,248.00	$455.53	$455.53		$792.47	$539.86	$30.00		$186.03
									Other Credits or Adjustments	$0.00
									Total Net Payment	$186.03

Patient Responsibility: $606.44

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: ALEKSANDR KORNIYENKO MD

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
01/25-01/25/2019	99213	$160.00	$85.00	$85.00	ADP	$75.00	$0.00	$30.00	100%	$45.00
Column Totals		$160.00	$85.00	$85.00		$75.00	$0.00	$30.00		$45.00
									Other Credits or Adjustments	$0.00
									Total Net Payment	$45.00

Patient Responsibility: $30.00

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: JOHN F PRIDDY MD

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
02/19-02/19/2019	11042-RT	$289.00	$180.27	$180.27	ADP	$108.73	$108.73	$0.00	0%	$0.00
02/19-02/19/2019	99213-25	$160.00	$90.27	$90.27	ADP	$69.73	$0.00	$30.00	100%	$39.73
Column Totals		$449.00	$270.54	$270.54		$178.46	$108.73	$30.00		$39.73
									Other Credits or Adjustments	$0.00
									Total Net Payment	$39.73

Patient Responsibility: $138.73

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: TESSA VANNATTA NP

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/14-03/14/2019	99213	$120.00	$50.27	$50.27	ADP	$69.73	$0.00	$30.00	100%	$39.73
Column Totals		$120.00	$50.27	$50.27		$69.73	$0.00	$30.00		$39.73
									Other Credits or Adjustments	$0.00
									Total Net Payment	$39.73

Patient Responsibility: $30.00

Reference Info
Enrollee: MEMBER NAME
Group#: UPSH

[DR-]

ıment No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: STEPHEN C SPAIN MD
Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/14-03/14/2019	87804-QW	$35.00	$17.48	$17.48	ADP	$17.52	$0.00	$0.00	80%	$14.02
03/14-03/14/2019	87804-QW,59	$35.00	$17.48	$17.48	ADP	$17.52	$0.00	$0.00	80%	$14.02
Column Totals		$70.00	$34.96	$34.96		$35.04	$0.00	$0.00		$28.04
								Other Credits or Adjustments		$0.00
Patient Responsibility:		**$7.00**						**Total Net Payment**		$28.04

Reference Info
Enrollee: MEMBER NAME
Group#: UPSH

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: KEVIN A SHORT MD
Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/20-03/20/2019	73030-26,LT	$39.00	$24.14	$24.14	ADP	$14.86	$0.00	$0.00	100%	$14.86
Column Totals		$39.00	$24.14	$24.14		$14.86	$0.00	$0.00		$14.86
								Other Credits or Adjustments		$0.00
Patient Responsibility:		**$0.00**						**Total Net Payment**		$14.86

Reference Info
Enrollee: MEMBER NAME
Group#: UPSH

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: ROGER KENT WALKER MD
Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/20-03/20/2019	72040-26	$39.00	$21.15	$21.15	ADP	$17.85	$17.85	$0.00	0%	$0.00
Column Totals		$39.00	$21.15	$21.15		$17.85	$17.85	$0.00		$0.00
								Other Credits or Adjustments		$0.00
Patient Responsibility:		**$17.85**						**Total Net Payment**		$0.00

Reference Info
Enrollee: MEMBER NAME
Group#: UPSH

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: JOHN F PRIDDY MD
Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/22-03/22/2019	11043-RT	$566.00	$173.32	$173.32	ADP	$392.68	$0.00	$0.00	80%	$314.14
03/22-03/22/2019	99214-25	$200.00	$94.77	$94.77	ADP	$105.23	$0.00	$30.00	100%	$75.23
Column Totals		$766.00	$268.09	$268.09		$497.91	$0.00	$30.00		$389.37
								Other Credits or Adjustments		$0.00
Patient Responsibility:		**$108.54**						**Total Net Payment**		$389.37

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: NANCY S LIEB MD

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/26-03/26/2019	99395	$287.00	$71.75	$71.75	ADP	$215.25	$0.00	$0.00	100%	$215.25
Column Totals		$287.00	$71.75	$71.75		$215.25	$0.00	$0.00		$215.25
								Other Credits or Adjustments		$0.00
Patient Responsibility: $0.00								Total Net Payment		$215.25

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: THOMAS J LAMBERT MD

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/27-03/27/2019	99202	$148.70	$76.74	$76.74	ADP	$71.96	$0.00	$30.00	100%	$41.96
Column Totals		$148.70	$76.74	$76.74		$71.96	$0.00	$30.00		$41.96
								Other Credits or Adjustments		$0.00
Patient Responsibility: $30.00								Total Net Payment		$41.96

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: CLINICAL PATHOLOGY LAB

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/27-03/27/2019	36415	$5.25	$0.75	$0.75	ADP	$4.50	$0.00	$0.00	100%	$4.50
03/27-03/27/2019	80053	$78.25	$56.66	$56.66	ADP	$21.59	$0.00	$0.00	100%	$21.59
03/27-03/27/2019	80061	$90.75	$63.39	$63.39	ADP	$27.36	$0.00	$0.00	100%	$27.36
03/27-03/27/2019	81001	$29.25	$22.77	$22.77	ADP	$6.48	$0.00	$0.00	100%	$6.48
03/27-03/27/2019	82043	$138.50	$127.11	$127.11	ADP	$11.39	$0.00	$0.00	100%	$11.39
03/27-03/27/2019	83036	$82.00	$62.17	$62.17	ADP	$19.83	$0.00	$0.00	100%	$19.83
03/27-03/27/2019	85025	$41.50	$25.61	$25.61	ADP	$15.89	$0.00	$0.00	100%	$15.89
03/27-03/27/2019	87086	$79.00	$62.50	$62.50	ADP	$16.50	$0.00	$0.00	100%	$16.50
Column Totals		$544.50	$420.96	$420.96		$123.54	$0.00	$0.00		$123.54
								Other Credits or Adjustments		$0.00
Patient Responsibility: $0.00								Total Net Payment		$123.54

Document No:
Patient: PATIENT NAME

Employee: MEMBER NAME
Provider: STEPHEN P RYDZAK MD

Member ID: XXXXXXXXXXXX
Patient ID: XXXXXXXXXX

Dates of Service	Procedure Code	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
03/27-03/27/2019	99396	$286.00	$170.00	$170.00	ADP	$116.00	$0.00	$0.00	100%	$116.00
Column Totals		$286.00	$170.00	$170.00		$116.00	$0.00	$0.00		$116.00
								Other Credits or Adjustments		$0.00
Patient Responsibility: $0.00								Total Net Payment		$116.00

Message Code/Description

ADP ADP* - ACCESS DIRECT PLATINUM NETWORK DISCOUNT
FAP - FAP - THIS IS A FINANCIAL ADJUSTMENT WITH ADDITIONAL PAYMENT ISSUED.

[DR-

Accumulators Statement for the Benefit Year

Your current medical deductible satisfied is $0
Your current medical deductible satisfied is $17.85
Your current medical deductible satisfied is $1000.00
$0
$0
$0
$0
$0
$0
$0
$0

Payment Details

Paid To	Amount
CLINICAL PATHOLOGY LAB	$123.54
STEPHEN C SPAIN MD	$39.73
UT HEALTH EAST TEXAS P	$45.00
AZALEA ORTH & SPORT CL	$39.73
AZALEA ORTH & SPORT CL	$186.03
LAMBERT DERMATOLOGY CL	$41.96
STEPHEN C SPAIN MD	$28.04
AZALEA ORTH & SPORT CL	$389.37
UT HEALTH EAST TEXAS P	$116.00
TYLER OBSTETRICS & GYN	$215.25
TYLER RADIOLOGY ASSOCI	$14.86

Appeal Rights

For ERISA plans, written request for review must be provided within 180 days after the member's receipt of an adverse benefit determination. A member or authorized representative may also request to review documents pertinent to the claim. For Non-ERISA plans, a member or authorized representative may appeal an adverse benefit determination if a claim that was not paid in whole or in part. To initiate an appeal, the member or authorized representative must submit a request in writing to the HealthFirst address on this form. The request should include the employer group name, the member's name and identification number, and the issues or additional documentation to be considered. Written requests for review must be received within 60 days following this benefit determination (unless a longer period is so specified in the Plan Document). Plan participants and beneficiaries are covered and benefits are payable in accordance with the Plan Document, as amended. Provider bills may be audited, adjusted, and/or repriced in accordance with the Plan document. The Employee Retirement Income Security Act of 1974 (ERISA), and its appeal procedures apply.

Translation services are available upon request.
Servicios de traducción están disponibles bajo petición.

SUBMISSION FORM PERFORMANCE COMMITMENTS AND PENALTIES

CARRIER PROPOSAL

Please give "at risk" amounts in percentages or dollars (whichever applies) for each of the below commitment categories and list the parameters surrounding the guarantee for each category:

1. Claim Time-to-Process
2. Call Center
3. Account Management
4. Network Discount
5. Claim Target Turn-Around Time
6. Clinical Management
7. Implementation

The guarantees included above are based upon the current plan of benefits.

HealthFirst

Name of Organization

Cynthia Klem

Signature of Officer

EXHIBIT "D" – PERFORMANCE GUARANTEES

Performance measurements delivered during at mid-year and end-of-year unless otherwise stated

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Account Management	HealthFirst will guarantee that the services provided by the Account Management Staff during the guarantee period will be satisfactory to the County of Upshur. Via mid-year and end-of year responses to an Account Management Evaluation Tool, the County of Upshur agrees to make HealthFirst aware of possible sources of dissatisfaction throughout the guarantee period. Each measured category will be given a rating of 1 – 5 with 1 = lowest and 5 = highest. HealthFirst will populate results for the evaluation tool when received. If all surveys are not completed within 15 days after being published, it will be assumed the service provided is satisfactory and the guarantee is met. If HealthFirst maintains an average evaluation score of 3.0 or higher, no credit is due.	Average evaluation score of 3.0 or higher.	2% of Admin Fee – below a score of 3.0
Claims Processing Turnaround Time – All Claims	Claims Processing Turnaround Time means the period beginning on the date the Claim Administrator receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Claim Administrator. The performance guarantee is measured as a percent of all Claims processed within 30 calendar days. Method of Measurement: The number of Claims processed in 30 calendar days divided by the total number of claims. Measurement is based on Employer-specific Claims.	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	4% of Admin Fee - Applies only to clean claims for below 95%
Claim Procedural & Payment Accuracy	Claim Procedural and Payment Accuracy is defined as tracked by existing external audit process currently in place at HealthFirst. The audit is across all groups rather than being group specific but is random and is a good gauge of HealthFirst performance in this area. Items such as the following are measured: 1. Coding - incorrect claim data entry. 2. Failure to adhere to the Employer's health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors.	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	4% of Admin Fees - below 97%

	5. Excluding: a. Any administrative inaccuracies that do not impact claims disposition or customer reporting; b. Errors entered by providers of service; c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Claim Administrator.		
Claim Financial Accuracy	Claim Financial Accuracy Method of measurement is based on existing external audit process currently in place at HealthFirst. The audit is across all groups rather than being group specific but is random and is a good gauge of HealthFirst performance in this area.	98.0% - 100% 97.0% - 97.9% 0% - 96.9%	4% of Admin Fees for below 97%
Customer Service	Abandoned Calls are defined as calls, calculated over the complete business day, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a customer advocate becomes available. Any calls abandoned or terminated by the caller prior to 30 seconds will not be counted as Abandoned Calls. Standard is measured using member calls across all groups.	0% - 3.0% 3.1% - 5.0% 5.1% - 100%	3% of Admin Fees at risk for abandoned rates over 7%
Clinical Management	Clinical Management guarantees to turn around pre-authorizations, if all information necessary for review is received, within 3 business days.	3 day turn-around of pre-authorizations	2% of Admin Fee at risk
Implementation	ID Card Production & Distribution HealthFirst guarantees that it will produce and mail 95% of ID cards to plan participants prior to the effective date of 10/1/2019 pending the receipt of complete, accurate and viable electronic enrollment files in-house, to HealthFirst, by 9/1/2019. In addition,	95% of ID cards to plan participants prior to the effective date of 10/1/2019, upon	1% of Admin Fee at risk

	plan design must be finalized at least 60 days prior to the effective date.	receiving complete, accurate eligibility files by 9/1/2019.	
SERVICE - Network Discounts	**Defined Performance Guarantees**	**Performance Guarantee**	**Percentage of the Administrative Charge at Risk**
Claim Type Inpatient Outpatient Professional	Discount Guarantee (UT Health Providers Only) Due to differing uses of terms such as "eligible" and "allowed", we use the phrases PreDiscount and PostDiscount. PreDiscount is the amount of charges after any non-covered amounts have been removed. You should assume all PreDiscount amounts are eligible for payment.	75% 72% 40%	10% of Admin fees at risk
Total Fee(s) at Risk			**30%**

Performance Guarantee Conditions:

- Performance Guarantees begin 90 days after plan effective date.
- Performance Guarantees are measured mid-year and end-of-year.
- Performance Penalties will be credited on the invoice following the mid-year and end-of-year measurement.
- Performance Guarantees are not in effect until a signed administrative service contract is received.

DEVIATIONS FROM SPECIFICATIONS

1. Does your organization agree to the Specifications as outlined in the RFP?

2. Describe, in detail, any deviations from the specifications.

HealthFirst
Name of Organization

Cynthia Klein
Signature of Officer

SUMMARY CONDITIONS & SPECIFICATIONS

In submitting this proposal, the respondent agrees and certifies to the following conditions:

1. Non-Inducement Statement: The respondent certifies that no employee, representative or agent of the firm offered or gave gratuities in any form (gifts, entertainment, etc) to any County employee or elected or appointed County official in order to secure favorable treatment or consideration in awarding, negotiating, amending or concluding a final agreement for this proposal.

2. Non-Debarment Statement: The respondent hereby certifies that he/she is not included on the U.S. Comptroller General's Consolidated List of Persons or Firms currently debarred for violations of various contracts incorporating labor standard/provisions.

3. Validity Statement: If this proposal is accepted and a firm contract is entered, the undersigned offers and agrees, within one-hundred twenty (120) calendar days from the proposal date, to supply any or all items/services upon which prices are offered at the designated point and within the time specified.

4. Non-Collusion Statement: The respondent hereby certifies that he/she has made this quote independently, without consultation, communication or agreement, for the purpose of restricting competition as to any matter relating to this proposal, with any other respondent or with any other competitor.

5. Conflict of Interest Statement: The respondent agrees that and warrants that no employee, official, or member of the County Commissioners Court is, or will be, peculiarly benefited, directly or indirectly, in this proposal or any ensuing contract that may follow.

6. Conduct Statement: The respondent certifies by signing below that all of the above statements are true, and he/she has read the entire proposal document and agrees to abide by the terms, certifications and conditions outlined.

7. Ethics Form: Form 1295, CIQ, HB 89 and SB 252.

Company Name: HealthFirst, TPA
Printed Name of Officer: Cynthia Klein
Title: Chief Operating Officer
Email Address: cklein@hfbenefits.com

Signature of Officer: Cynthia Klein

CONFLICT OF INTEREST QUESTIONNAIRE
For vendor doing business with local governmental entity

A complete copy of Chapter 176 of the Local Government Code may be found at http://www.statutes.legis.state.tx.us/Docs/LG/htm/LG.176.htm. For easy reference, below are some of the sections cited on this form.

Local Government Code § 176.001(1-a): "Business relationship" means a connection between two or more parties based on commercial activity of one of the parties. The term does not include a connection based on:

(A) a transaction that is subject to rate or fee regulation by a federal, state, or local governmental entity or an agency of a federal, state, or local governmental entity;

(B) a transaction conducted at a price and subject to terms available to the public; or

(C) a purchase or lease of goods or services from a person that is chartered by a state or federal agency and that is subject to regular examination by, and reporting to, that agency.

Local Government Code § 176.003(a)(2)(A) and (B):

(a) A local government officer shall file a conflicts disclosure statement with respect to a vendor if:

***

(2) the vendor:

(A) has an employment or other business relationship with the local government officer or a family member of the officer that results in the officer or family member receiving taxable income, other than investment income, that exceeds $2,500 during the 12-month period preceding the date that the officer becomes aware that

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor;

(B) has given to the local government officer or a family member of the officer one or more gifts that have an aggregate value of more than $100 in the 12-month period preceding the date the officer becomes aware that:

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor.

Local Government Code § 176.006(a) and (a-1)

(a) A vendor shall file a completed conflict of interest questionnaire if the vendor has a business relationship with a local governmental entity and:

(1) has an employment or other business relationship with a local government officer of that local governmental entity, or a family member of the officer, described by Section 176.003(a)(2)(A);

(2) has given a local government officer of that local governmental entity, or a family member of the officer, one or more gifts with the aggregate value specified by Section 176.003(a)(2)(B), excluding any gift described by Section 176.003(a-1); or

(3) has a family relationship with a local government officer of that local governmental entity.

(a-1) The completed conflict of interest questionnaire must be filed with the appropriate records administrator not later than the seventh business day after the later of:

(1) the date that the vendor:

(A) begins discussions or negotiations to enter into a contract with the local governmental entity; or

(B) submits to the local governmental entity an application, response to a request for proposals or bids, correspondence, or another writing related to a potential contract with the local governmental entity; or

(2) the date the vendor becomes aware:

(A) of an employment or other business relationship with a local government officer, or a family member of the officer, described by Subsection (a);

(B) that the vendor has given one or more gifts described by Subsection (a); or

(C) of a family relationship with a local government officer.

CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor doing business with local governmental entity

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session.

This questionnaire is being filed in accordance with Chapter 176, Local Government Code, by a vendor who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the vendor meets requirements under Section 176.006(a).

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. *See* Section 176.006(a-1), Local Government Code.

A vendor commits an offense if the vendor knowingly violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor.

OFFICE USE ONLY

Date Received

1 **Name of vendor who has a business relationship with local governmental entity.**

HealthFirst

2 ☐ **Check this box if you are filing an update to a previously filed questionnaire.** (The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date on which you became aware that the originally filed questionnaire was incomplete or inaccurate.)

3 **Name of local government officer about whom the information is being disclosed.**

Cynthia Klein

Name of Officer

4 **Describe each employment or other business relationship with the local government officer, or a family member of the officer, as described by Section 176.003(a)(2)(A). Also describe any family relationship with the local government officer. Complete subparts A and B for each employment or business relationship described. Attach additional pages to this Form CIQ as necessary.**

A. Is the local government officer or a family member of the officer receiving or likely to receive taxable income, other than investment income, from the vendor?

☐ Yes ☒ No

B. Is the vendor receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer or a family member of the officer AND the taxable income is not received from the local governmental entity?

☐ Yes ☒ No

5 **Describe each employment or business relationship that the vendor named in Section 1 maintains with a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership interest of one percent or more.**

N/A

6 ☐ Check this box if the vendor has given the local government officer or a family member of the officer one or more gifts as described in Section 176.003(a)(2)(B), excluding gifts described in Section 176.003(a-1).

7 Cynthia Klein

Signature of vendor doing business with the governmental entity

7/9/19

Date

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

OFFICE USE ONLY
CERTIFICATION OF FILING

Certificate Number:
2019-511997

Date Filed:
07/01/2019

Date Acknowledged:

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.
HealthFirst
Tyler, TX United States

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.
County of Upshur

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.
2019-1001
TPA Services

4 Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
		Controlling	Intermediary
HealthFirst	Tyler, TX United States	X	

5 Check only if there is NO Interested Party. ☐

6 UNSWORN DECLARATION

My name is Cynthia Klein, and my date of birth is 5/9/66.

My address is 821 ESE Loop 323, Ste 200, Tyler, TX, 75701, USA
(street) (city) (state) (zip code) (country)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Smith County, State of TX, on the 8 day of July (month), 2019 (year).

Cynthia Klein
Signature of authorized agent of contracting business entity
(Declarant)

HOUSE BILL 89 VERIFICATION

I, Cynthia Klein, the undersigned representative of Healthfirst hereafter referred to as "Company"; being an adult over the age of eighteen (18) years of age, do hereby depose and verify under oath that the company named above under the provisions of Subtitle F, Title 10, Government Code Chapter 2270:

1. Does not boycott Israel currently; and
2. Will not boycott Israel during the term of this contract.

Pursuant to Section 2270.0014, Texas Government Code:

1. "Boycott Israel" means refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic hart on or limit commercial relations specifically with Israel, or with a person or entity doing business in Israel or in an Israeli-controlled territory, but does not include an action made for ordinary business purposes; and
2. "Company" means a for-profit sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, or any limited liability company, including a wholly-owned subsidiary, majority-owned subsidiary, parent company or affiliate of those entities or business associations that exist to make a profit.

Cynthia Klein

Signature of Company Officer

7.9.2019

Date

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY) 03/01/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

Holder Identifier :

PRODUCER	CONTACT NAME:	
Aon Risk Services South, Inc. Franklin TN Office 501 Corporate Centre Drive Suite 300 Franklin TN 37067 USA	PHONE (A/C. No. Ext): (866) 283-7122	FAX (A/C. No.): (800) 363-0105
	E-MAIL ADDRESS:	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
AHP Health Partners, Inc.: East Texas Health System, LLC Incl Health First TPA, Inc. 821 E. Southeast Loop, Ste 200 Tyler TX 75701 USA	INSURER A: Ironshore Specialty Insurance Company	25445
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** 570075245196 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. **Limits shown are as requested**

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	
							MED EXP (Any one person)	
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	
	☐ POLICY ☐ PRO-JECT ☐ LOC						GENERAL AGGREGATE	
	OTHER:						PRODUCTS - COMP/OP AGG	
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	ANY AUTO						BODILY INJURY (Per person)	
	OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	
	UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	
	DED ☐ RETENTION							
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A (Mandatory in NH)						E.L. EACH ACCIDENT	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-EA EMPLOYEE	
							E.L. DISEASE-POLICY LIMIT	
A	ManageCare Liab			003475600 Claims Made SIR applies per policy terms & conditions	03/01/2018	08/04/2019	Each Claim SIR Aggregate	$3,000,000 $25,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Certificate No : 570075245196

CERTIFICATE HOLDER

Georgia Office of Insurance and
Safety Fire Commissioner
West Tower, Ste 708
2 Martin Luther King Jr. Dr.
Atlanta GA 30334 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services South Inc

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
03/01/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Aon Risk Services South, Inc. Franklin TN Office 501 Corporate Centre Drive Suite 300 Franklin TN 37067 USA	CONTACT NAME: PHONE (A/C. No. Ext): (866) 283-7122 FAX (A/C. No.): (800) 363-0105 E-MAIL ADDRESS:
INSURED AHP Health Partners, Inc.: East Texas Health System, LLC Incl Health First TPA, Inc. 821 E. Southeast Loop, Ste 200 Tyler TX 75701 USA	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Ironshore Specialty Insurance Company — 25445 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES **CERTIFICATE NUMBER:** 570075245195 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION						EACH OCCURRENCE AGGREGATE	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N N/A If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE-EA EMPLOYEE E.L. DISEASE-POLICY LIMIT	
A	ManageCare Liab			003475600 Claims Made SIR applies per policy terms & conditions	03/01/2018	08/04/2019	Each Claim SIR Aggregate	$3,000,000 $25,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

HealthFirst RX Solutions, Access Direct, MM Solutions, Inc. and Centralized Credentialing Services are included as Additional Insured in accordance with the policy provisions of the Managed Care Errors & Omissions Liability policy.

CERTIFICATE HOLDER

HealthFirst TPA, Inc.
821 ESE Loop 323, Suite 200
Tyler TX 75713 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services South Inc

FILED
BUD SMITH
SMITH COUNTY, TEXAS
2019 JUL 15 AM 12:57
DEPUTY

Holder Identifier

Certificate Number: 570075245195