BON SECOURS HEALTH SYSTEM, INC.

Financial Disclosure Statement
As of and for the Three Months Ended November 30, 2017

PLEASE NOTE THAT THIS DOCUMENT INCLUDES MANAGEMENT’S DISCUSSION OF RESULTS OF OPERATIONS

For past quarterly and annual disclosures please visit www.emma.msrb.org
Direct questions regarding disclosure information to Karen_Mason@bshi.org
Bon Secours Health System, Inc.
Financial Disclosure Statement
As of and for the Three Months Ended November 30, 2017

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OVERVIEW OF THE SYSTEM

The System

The information presented in this Financial Disclosure Statement describes Bon Secours Health System, Inc., a Maryland nonprofit, non-stock membership corporation (BSHSI), and its affiliates, including Members of the Obligated Group of Bon Secours Health System (the “Obligated Group”), under the Second Amended and Restated Master Trust Indenture dated as of March 12, 2014, among the Obligated Group and The Bank of New York Mellon Trust Company, N.A., as master trustee (the Master Trust Indenture). (BSHSI and its affiliates are described collectively in this Financial Disclosure Statement as “the System”).

Bon Secours, Inc., a Maryland nonprofit, non-stock membership corporation (BSI), is the sole corporate member of BSHSI, but has no health care operations. The System was organized in June 1983 to fulfill the healthcare mission of the United States Province of the Congregation of Sisters of Bon Secours of Paris (the Sisters of Bon Secours), a congregation of religious women of the Roman Catholic Church founded in France in 1824.

The Sisters of Bon Secours have ministered to the health care needs of people in the United States since 1881. To ensure the sustainability of the ministry into the future as well as to broaden their collaboration with the laity in areas of influence, the Sisters of Bon Secours petitioned the Vatican to establish Bon Secours Ministries, an entity comprised of both lay persons and Sisters of Bon Secours to oversee the Catholic healthcare ministry of the System. Bon Secours Ministries, which is referred to as a “public juridic person” in the Catholic Church’s Code of Canon Law, was established by the Vatican on May 31, 2006 with the specific responsibility to oversee (and, as appropriate, initiate) the healthcare ministries within the System and, in particular, the System’s Catholic identity and mission. This formal relationship with the Catholic Church and the specific ministry is commonly referred to as “sponsorship.” The Sisters of Bon Secours formally transferred the responsibility of sponsorship of the System to Bon Secours Ministries on November 1, 2006. Since then, Bon Secours Ministries (of which the majority of its members are Sisters of Bon Secours) has provided an active presence of leadership and direction for the System to ensure its operations and use of resources are aligned with the mission, values and fundamentals of Catholic social teaching.

The System’s principal activities comprise health and nursing care services in the States of New York, Maryland, Virginia, Kentucky, South Carolina, and Florida.

The table included under “ORGANIZATION - Health Care Providers” lists the entities within the System that own and operate acute, skilled, long-term care, assisted living facilities, or physician practices, the names of their principal facilities (which appear in italics), a general description of the function of those facilities and their locations. (These entities are referred to in this Financial Disclosure Statement as “the Health Care Providers”.) Except as described under “Health Care Providers” and “ORGANIZATION - Joint Ventures”, BSHSI, either directly or indirectly, is the sole or majority member or shareholder of each System affiliate, and as a consequence of that membership or shareholder status, controls all such System affiliates. BSHSI provides management and administrative services to all such controlled System affiliates, and in some cases provides discrete administrative services to joint ventures in which BSHSI or an affiliate participates.

Asset Divestitures

On July 10, 2017, Bon Secours New York Health System, Inc. (BSNYHS) sold Frances Schervier Home and Hospital (dba Schervier Nursing Care Center), a subsidiary of BSNYHS, to a non-related entity. Total cash proceeds received as a result of the sale of Schervier Nursing Care Center were approximately $80.6 million, and a net operating gain of approximately $28.2 million was recognized as other operating revenue in the consolidated statements of operations and changes in unrestricted net assets for the fiscal year ending August 31, 2017. The proceeds were offset with activities resulting from the sale, including a write-off of approximately $21.7 million of net property, plant and equipment, in addition to a liability of approximately $6.3 million for withdrawal from the Archdiocese pension plan, a write down of goodwill of approximately $3.8 million, and various other working
capital items of approximately $20.6 million. Effective as of the date of the transaction, BSHSI excluded the operating results of Schervier Nursing Care Center in the consolidated statements of operations and changes in unrestricted net assets.

On March 31, 2016, Schervier Apartments, LLC, a subsidiary of Bon Secours New York Health System, Inc. (BSNYHS) that provides low income housing, entered into an agreement to sell substantially all of its assets and operations. Necessary approvals for the transaction are pending from certain New York authorities. The closing date of the sale of Schervier Apartments, LLC has not yet been finalized. Neither BSNYHS nor its subsidiaries are members of the Obligated Group.

**Financial Highlights**

During the first quarter of fiscal year 2018, the System experienced a strong quarter with increases in patient volume and operating margin while effectively managing costs and improving key quality measures. Operating income was $23.8 million, representing a 2.9% operating margin, compared to the $10.4 million of operating income and a 1.3% operating margin for the comparable prior period. Total operating revenue grew 2.3% with strong outpatient volumes including a 1.3% increase in primary care physician office visits and a 5.9% increase in outpatient visits. Strong operating expense management resulted in only a 0.6% increase in total expenses over the comparable prior year period. Now in its sixth year, the System’s Stewardship Program continues to identify savings opportunities that have offset service shifts, pharmaceutical expenses and other cost increases. This program ensures the System stays focused on achieving value-based patient goals while at the same time increasing efficiency.

The System reported an excess of revenues over expenses of $35.3 million during the three months ended November 30, 2017. In the comparable prior period, the System reported a deficit of revenues over expenses of $5.8 million. For the three months ended November 30, 2017, the System reported non-operating investment gains, net of $24.7 million as compared to non-operating investment losses, net of $6.0 million for the comparable prior period.

Days cash on hand was 176.9 at November 30, 2017 compared to 184.9 at August 31, 2017, this change is primarily due to debt defeasance payments. Net cash used in operating activities was approximately $31.6 million during the three months ended November 30, 2017. Additional cash reductions were the result of capital expenditures and timing of working capital outflows. Cash to debt was 176.6% at November 30, 2017 compared to 176.9% at August 31, 2017.

The System also saw a stabilization of physician practice patterns, continued to improve quality with zero penalties for hospital-acquired infections, lowered and de-risked the debt portfolio (see "BALANCE SHEET AND CAPITAL STRUCTURE – Indebtedness of the Obligated Group") and achieved favorable results from the robust capital markets. Due to the System’s strong enterprise risk management framework, specifically the work on disaster preparedness plans, hurricane Irma had minimal financial impact on the long term care operations in Florida while all personnel and residents were safe.

Unrestricted net assets increased by $35.6 million during the three months ended November 30, 2017, primarily the result of an excess of revenues over expenses. The System reported $1.513 billion in unrestricted net assets at November 30, 2017, compared to $1.477 billion August 31, 2017. The System’s debt to capitalization ratio of 36.1% at November 30, 2017 has improved from the 37.6% reported at August 31, 2017.

**Rating Agency Update**

In December 2016, Standard & Poor’s raised the Obligated Group’s bond rating to an ‘A’ with a stable outlook from an A- positive outlook, and Fitch affirmed its ‘A’ stable outlook bond rating on the Obligated Group. In January 2017, Moody’s affirmed the Obligated Group’s bond rating at an A2 stable outlook. In late December 2017 and early January 2018 Management presented the System’s fiscal year 2017 results to all three rating agencies. All three rating agencies are expected to issue the Bon Secours’ Obligated Group’s bond ratings by January 31, 2018.
**System Strategies**

**Population Health**

The objective of the System’s population health strategy is to provide exemplary outcomes in terms of clinical quality, patient experience and cost across the health care continuum, to successfully transition the System to value-based care and new delivery models and to build partnerships in the communities to better coordinate care for patients and populations. Achieving these goals will assist Bon Secours in advancing along its clinical transformation journey, meeting strategic priorities for quality, growth and sustainability and demonstrating results in various pay-for-performance and risk-based payer arrangements.

**Accountable Care Organizations (ACO)** – The formation of the System’s ACO to manage beneficiaries in the Medicare Shared Savings Program (MSSP) Track 1 (upside-only) was a critical initial step in the System’s population health journey and positioned the System for success in value-based care. Since the formation of a single System ACO in 2013, through the recent move to regional ACOs, the System’s ACO capabilities have grown in experience and success. This growth is best demonstrated through the increase in attributed lives to the ACO. The System ACO had 57,000 initial MSSP assigned Medicare beneficiaries in 2013, and the regional ACOs now have more than 111,000 assigned beneficiaries. Key contributors to this growth are the System’s commitment to the patient/primary care provider relationship, the focus on improving access to healthcare, and the delivery of wellness and preventative care visits. All of the key contributors to ACO growth are foundational to success in any population health or value-based care model.

Through the System’s ACOs, the System has gained experience in measuring quality performance metrics for its MSSP patients and focused efforts on engaging providers in improving performance on those metrics. In 2014, the System ACO achieved the highest quality score in the nation for MSSP plans with over 40,000 attributed lives, receiving 91% of the available quality points. The System ACO further improved this performance receiving 93% and 98% of the available quality points in the calendar years 2015 and 2016, respectively. Reporting experience, strong performance in the System ACO quality metrics, and participation in MSSP Track 1 will provide the System’s provider network with an advantage, as measurement for the Merit-Based Incentive Program (MIPS) which began in calendar year 2017, allowing the System to maintain and potentially increase reimbursement to the System’s provider networks in calendar year 2019 and beyond (see “Possible Effects of Legislative, Regulatory, Medicare, Medicaid and Managed Care Uncertainties - Medicare and Medicaid Payor Reform”).

In order to foster a more regional focus and accountability for population health, the System created regional ACOs, to replace the System ACO. Three regional ACOs were formed as wholly-owned subsidiaries of Bon Secours Richmond Health System, Bon Secours Hampton Roads Health System, Inc., and Bon Secours Kentucky Health System, Inc respectively, and one regional ACO was formed in South Carolina as a joint venture between Bon Secours St. Francis Health System, Inc. and AnMed Health which also includes Spartanburg Regional Health System as a participating provider. Effective January 1, 2017, all regional ACOs were approved by Centers for Medicare & Medicaid Services (CMS) and are managing Medicare beneficiaries through the MSSP Track 1.

The regional market approach improved alignment with the System’s 2016-2018 Strategic Quality Plan, enabled new care partnerships and increased the number of eligible Medicare beneficiaries under care management. In the new market-based model, the number of providers increased enabling leverage of the infrastructure, protocols, successes and lessons learned from the System ACO. The regional ACOs will continue to focus on quality performance with an expanded focus on utilization and cost efficiency initiatives. ACO efforts center on care partnerships with physicians and other providers delivering continuity of care across the healthcare continuum and providing a more seamless quality and experience of care for the beneficiaries while providing growth and development opportunities for the System.

**Clinically Integrated Network (CIN)** – In addition to ACOs, the System has initiated strategies to develop one or more Clinically Integrated Networks (CIN) in each market. A CIN is the collaboration between physicians, health systems and other providers to form a network committed to improving the quality and efficiency of care delivered to the patient population(s) the CIN serves. The System’s CIN efforts are focused on building market relevance, engaging affiliated providers in leadership of population health initiatives and creating an effective and comprehensive network of providers. The CINs allow BSHSI to extend risk-based arrangements beyond the MSSP to commercial, Medicare Advantage and self-insured employee health plan populations as well as direct-to-employer opportunities that exist in a community. The CINs also provide a forum for the local health systems, affiliated physicians, post-acute and ancillary providers to integrate and develop collaborative approaches to
managing care that reduce duplication, improve quality and experience, and improve the overall health of the individuals served.

Bon Secours Richmond Health System and Bon Secours St. Francis Health System, Inc. each established local CINs as wholly-owned subsidiaries within their local health systems in 2016. In addition, Bon Secours St. Francis Health System, Inc. entered into a joint venture regional CIN partnership with AnMed Health that also includes Spartanburg Regional Health System as a participating provider. This joint venture entity is also the regional ACO for the Bon Secours St. Francis Health System described above. CIN development efforts for Bon Secours Hampton Roads Health System, Inc. and Bon Secours Kentucky Health System, Inc. continue to be developed.

Diversity and Inclusion

To more effectively serve its diverse patient and resident population, the System included a goal to increase the cultural competence of its employees by 50% as part of its 2016-2018 Strategic Quality Plan. Over the past year, the System remained focused on effectively serving its diverse patient and resident population in alignment with its operating principle of having “superior understanding of those we serve.” To support this principle and advance operational excellence, the System evaluated all employees on their level of cultural competence in conjunction with its annual performance management process. The System adopted the National Quality Forum definition of “cultural competence,” which is described “as the ongoing capacity of healthcare systems and professionals to provide diverse patient populations with high-quality care that is patient and family centered, evidence-based and equitable.” The System recognizes that the more culturally competent its workforce is, the more it is able to positively impact the safety, cost and quality of the health outcomes for its patients and residents. In 2017, Diversity, Inc. recognized the System for the second year in a row as one of the top twelve best health care systems in the country for its efforts to become a more culturally competent organization. Also in 2017, the System’s Executive Council, comprised of its top 25 leaders, received the Prism Employee Resource Groups & Council Honors Award for its exemplary leadership in leading the effort to create cross cultural competency across the System.

In October, 2017, the System held its 7th Annual Diversity & Inclusion Summit with over 200 attendees including local system and Bon Secours board members, executive and emerging leaders, as well as guests from over 30 external organizations. The theme for this Summit was “Embracing Kinship: The Power of Inclusion” with objectives to: 1) increase our understanding of how Diversity and Inclusion impact every aspect of our ministry, operations, and Strategic Quality Plan; 2) hear how senior healthcare executives have achieved actual business results through leveraging Diversity and Inclusion; and 3) identify ways in which we can become more inclusive leaders and create more inclusive environments.

Clinical Transformation

The System’s journey in clinical transformation started in 2008 when it brought together clinical and financial leadership from across the System to collectively and concurrently drive improvements in clinical quality, engagement, and cost. Defining the System’s clinical transformation efforts as a comprehensive inter-disciplinary approach to achieve care delivery excellence throughout the patient care continuum that measurably improves quality, creates holistic patient centered care experiences, and reduces healthcare costs by reducing waste and optimizing the value proposition through the effective alignment of people, process, and technology that enables and supports rapid cycle tests of innovation leading to creative, effective solutions. Pre-dating health reform, clinical transformation established the infrastructure for spanning the continuum of care to improve the value proposition by increasing quality and reducing cost and remains the System’s strategy for success in healthcare reform and population health.

As work continues towards the System’s goal to build healthy communities and create extraordinary individual experiences of care and as the System transforms its health delivery system, clinical transformation strives to ensure the same high standards of care and experience in every location. Through a collaborative structure including System and local market subject matter experts, representatives from across the markets are responsible for identifying and implementing standards for best practice while allowing for innovation. The implementation and optimization of the electronic medical record, as part of the System’s clinical transformation efforts, further supported the standardization and coordination of patient care by making information readily available and accessible to providers. The Clinical Executive Management Team (CEMT) is a representative cohort of care leaders across the continuum and was launched to more quickly identify and implement standard processes and strategies for improvement. This structure is intended to streamline decision-making, reduce the time to
implementation, and accelerate improvements. This cross-section of local market clinical leaders and the centralized CEMT has accountability for making decisions for the System and ensuring full implementation.

The CEMT also oversees the clinical transformation efforts and specifically three care councils charged with building core care capabilities across the continuum. These councils: Care Coordination, Safety and Reliability, and Engagement and Loyalty, promote the delivery of clinical excellence as One Bon Secours. Additionally, four market segments have been established to focus on specific populations: Emergency Services, Primary Care, Senior Services, and Behavioral Health. This refocusing of clinical transformation with increased accountability and expectations to act as One Bon Secours emphasizes the focus on achieving the System’s strategic quality plan and goals to deliver high quality care to every patient, every day.

Mortality, hospital-acquired infections (HAIs) (as measured by the standardized infection ratio from National Healthcare Safety Network), readmissions and patient experience are continued measures of focus for fiscal year 2018 clinical transformation. Based on prior year performance, BSHSI will have no penalties assessed for hospital-acquired infections from CMS during fiscal year 2018.

The System’s commitment to patients, providers, and the community continues to be recognized by several highly regarded external organizations including the American Nurses Credentialing Center (ANCC) and the Gallup Organization. The ANCC’s Magnet Recognition Program recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice and is the ultimate credential for high quality nursing. The System has adopted the Magnet framework as a common framework for nursing practice. In addition to already having been designated a Pathways to Excellence Facility, St. Francis Medical Center achieved Magnet designation, recognized in October 2015. St. Mary’s Hospital and Memorial Regional Medical Center received re-designation as a Magnet hospital and Maryview Medical Center, Mary Immaculate Hospital, DePaul Medical Center and Richmond Community Hospital are all currently designated as Pathways to Excellence Facilities, ANCC’s sister program to Magnet. The Gallup Organization has also recognized Bon Secours as a leader in employee engagement. In 2017, Bon Secours received the Gallup Great Workplace Award for the sixth year in a row. This award honors organizations whose employee engagement results demonstrate they have some of the most productive and engaged workforces in the world. In addition, Bon Secours was also honored with the Gallup “Essence of Engagement Award,” which recognizes companies for being the epitome of an engaged culture. Another System award of distinction is the receipt of Practice Greenhealth’s System for Change Award recognizing health systems that are working cohesively to gather data, set system goals, benchmark, and share successes in environmental performance. In 2013, the System was among the first health systems to achieve the Healthcare Information and Management Systems Society (HIMSS) Analytics Stage 7 for five of its Virginia hospitals, as well as its ambulatory clinics located in Virginia. HIMSS reaffirmation of Analytics Stage 7 is currently underway.

Management believes these successes and the associated recognition for quality improvements are a result of the System’s Clinical Transformation initiatives and its commitment to creating an extraordinary individual experience of care across the continuum through the effective alignment of people, process and technology. The System’s Clinical Transformation journey is ever-evolving and continues improving care delivery, clinical outcomes, quality and cost.

**ConnectCare Electronic Health Records (EHR) System**

The System’s EHR system, an Epic product known internally as ConnectCare, is an integrated clinical information system that links acute and ambulatory clinical information and revenue cycle functionality in one common database supporting the System’s “one patient, one record” strategy. ConnectCare is used throughout the care continuum in hospitals, clinics, home health and physician practices as well as independent provider groups in the System’s ConnectCare community. While ConnectCare hospital implementations are complete, ambulatory and outpatient implementations continue in support of the provider network development strategy. All of the System’s hospitals and eligible providers have met Meaningful Use requirements for payments.

A key component of the System’s strategy to enhance patient engagement, improve continuity of care and support population care coordination is the patient’s ability to access his or her electronic health record through the ConnectCare MyChart portal. Additionally, the System has increased the exchange of patient records with other treatment providers. Using an opt-out default in states permitting this approach, records exchanged via the CareEverywhere tool have also increased dramatically. The System is implementing Epic’s Healthy Planet application in support of the Population Health IT strategy to provide tools which improve well-coordinated quality of care at lower costs. The System continues to implement upgrades to the Epic product on an ongoing basis.
Good Help Connections, LLC (GHC), a wholly-owned, taxable subsidiary limited liability company, provides Epic advisory implementation and support services to external health organizations, supporting the System’s strategy to serve communities through shared EHR technology.

Information Technology and Cyber-Security

The System allocated approximately $30.0 million of its fiscal year 2018 budgeted capital expenditures to fund information technology projects, including enhanced cyber security tools, ongoing updates to infrastructure, clinical and business systems and additional ambulatory and inpatient ConnectCare enhancements. For the three months ended November 30, 2017, the cost of the various information technology projects was within budget.

The System devotes significant resources to network security, including access controls, device encryption, and other security measures to protect its systems and data. Approximately 7% of the System’s total information system’s expense budget is allocated to information system security, which is in line with industry benchmarks.

In 2017, the System engaged an independent external auditor to review the controls associated with Trust Service Principles (Security, Availability, Processing Integrity, Confidentiality, and Privacy) in order to provide a Report on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality or Privacy opinion. The independent external auditor provided an unqualified opinion, stating that the controls tested were effective.

Despite the System’s focus on information system security, these security measures cannot provide absolute security and, as a result, the System, or its business associates, may experience a breach of its systems and may be unable to protect protected health information (PHI) or other such confidential information. Therefore, the System is investing in advanced breach-detection tools. The System uses various third party security firms, from time to time, to periodically conduct network penetration tests which simulate activities of someone attempting to breach a company. The System has also secured third-party insurance coverage to provide funding support in the event a breach occurs.

The health care industry is heavily dependent on the use and storage of protected health information (PHI) and other confidential information related to or provided by its patients. The System is defined as a covered entity according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Additionally, certain provisions of HIPAA apply to business associates (entities that handle PHI on behalf of covered entities), and business associates are subject to direct liability for violation of the regulations. A covered entity may be subject to penalties as a result of its business associate violating HIPAA, if the business associate is found to be an agent of the covered entity. Although the System takes protective measures and endeavors to modify such measures as circumstances warrant, the security of the System’s computer systems, software and networks may be vulnerable to breaches, unauthorized access, misuse, computer viruses or malicious code and other events that could impact security of PHI or other confidential information maintained by the System. Additionally, breaches of security may occur through intentional or unintentional acts by those having authorized or unauthorized access to PHI or other confidential information.

In early summer of 2016, a business associate of the System made changes to its computer server security settings, which inadvertently made the PHI of almost 655,000 System patients on the server accessible via the internet between approximately April 18, 2016 and June 13, 2016. When the System self-identified the incident, the vendor was notified of such and took immediate steps to secure the information so that the information could no longer be accessed via the internet. In compliance with obligations under the HIPAA Privacy Rule, the System notified all affected patients and offered one year of credit monitoring and identity theft protection services without charge. Steps have been taken by the System to reduce the risk of similar incidents occurring in the future and additional risk mitigation strategies are underway. In addition to notifying affected patients, the System notified the Office for Civil Rights (OCR) of the incident as required by the HIPAA regulations, as well as applicable state authorities. The OCR is conducting an investigation based on the System’s reporting of the incident and has subsequently requested information from the System. The System is responding timely to OCR requests during the ongoing investigation.

Virtual Health Visits – Bon Secours 24/7

The Bon Secours 24/7 Primary Care virtual visit platform which launched on January 7, 2016 has enrolled over 13,250 patients and completed over 3,228 visits. While external benchmarks expect 15-25% of enrollees will
complete a visit; Bon Secours 24/7 performance is at 24.4%. On September 19, 2017, a Specialty Physician virtual visit program was launched with a focus on providing virtual post hospitalization discharge visits for surgical patients. On December 5, 2017, this platform expanded to include post discharge virtual visits for Congestive Heart Failure patients. This initiative is in line with the System’s Strategic Quality Plan to provide convenient affordable access to care, prevent hospital readmissions and provide for overall patient satisfaction.

Provider Network

The System’s relationship with its employed medical groups and the members of the organized medical staffs at each facility is critical to success in a constantly changing healthcare environment. At November 30, 2017, the System employed 837 full-time equivalent physicians and advanced practice clinicians, as compared to 840 for the comparable prior period. The following chart shows the System’s employed physician and advanced practice clinician full-time equivalents:

<table>
<thead>
<tr>
<th></th>
<th>November 30, 2016</th>
<th>August 31, 2017</th>
<th>November 30, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed Physicians</td>
<td>591</td>
<td>587</td>
<td>573</td>
</tr>
<tr>
<td>Advanced Practice Clinicians</td>
<td>249</td>
<td>256</td>
<td>264</td>
</tr>
<tr>
<td>Total</td>
<td>840</td>
<td>843</td>
<td>837</td>
</tr>
</tbody>
</table>

While growth of the employed medical group employees has remained rather constant from the comparable prior periods, it represents both financial stewardship exercised by the system and the evolution of a comprehensive Provider Network development plan. To ensure the system has the right mix of employed providers delivering the right care in the right locations to most effectively meet the communities’ needs, this plan will be completed during fiscal year 2018.

Managing the health of populations represents a fundamental shift in how care has traditionally been delivered in physician practice settings. Achieving such a dramatic shift requires aligning people, process, and technology in such a way that these highly valuable individuals are fully engaged within a common culture to self-direct the improvements needed to drive the System’s Population Health strategy. To this end, the System has undertaken a number of key initiatives to facilitate this transformation through establishing an integrated medical group identity, building an infrastructure for shared success, and aligning individual behavior with strategy, a framework for high-functioning medical groups. An integrated identity for the employed medical group is being achieved through the engagement of local executives to collaborate within a System-wide structure for the achievement of the System’s population health-focused Strategic Quality Plan and goals. To support this focus, the System has reorganized its physician leadership structure to enhance accountability and responsibility for system-wide coordination of strategy and operations.

An infrastructure for shared success has been established through the implementation of key performance enhancing tools system-wide. This includes the development and implementation of a dynamic provider dashboard within the ConnectCare electronic medical record which summarizes all of the provider’s key indicators for population health performance while enabling the provider to immediately drill down to actionable levels of detail to improve performance. Likewise, a third-party practice management analytics platform has been implemented to support improvements in operations’ cost efficiencies.

Alignment of individual provider behavior with strategy has facilitated substantive improvements in quality and outcomes. Rates of “Annual Wellness Visits” for the provision of preventive care have increased from 55% of the System’s Medicare population for fiscal year 2016 to 76 % during the three months ended November 30, 2017 (compared to a national average of approximately 20%), with internal data showing a strong relationship between occurrence of this visit and improved rates of cancer screenings and immunizations. Work spanning the integrated delivery system achieved a 2.6 % improvement in continuity of care for MSSP beneficiaries, enabling more patients to benefit from the System’s strong quality performance, patient-centered resources for care coordination and management, and the efficiencies and transparency of having their information across care settings in a single electronic medical record. Furthermore, the System’s previously referenced successes in growing the number of MSSP assigned beneficiaries, increasing ACO quality performance, increasing MyChart activation, and achieving Meaningful Use attestation were all accomplished through the efforts of the provider network. By focusing on preventive services in this way, the System is positioned to acquire new patients, earn their loyalty, and improve the
quality of care they receive. In the year ahead, specific work to improve quality through strengthening the System’s continuity of care as well as work targeted to improve patients’ access to convenient care will further these ends.

**Stewardship Cost Reduction Plan**

Since 2012, the Stewardship Program has continued to improve operational performance, reduce fixed cost variation and create an environment of positive, sustainable change. For the five year period ended August 31, 2017, the program generated $587 million in aggregate revenue enhancements and fixed cost reductions through “systemness” and effective use of resources while maintaining high quality care and services. For fiscal year 2018, Stewardship margin improvement initiatives, aligned with the Strategic Quality Plan, and include Many Hands One Vision, labor optimization, length of stay efficiency, outpatient costing, revenue cycle and information technology. The Many Hands One Vision program was launched with a focus on culturally operating as One Bon Secours and improving systemness while reducing fixed costs. The program is expected to reduce fixed costs by $35 million over an 18 month period or 1% of operating margin. In September 2017, the initiatives launched to achieve this goal included Clinical Transformation fixed costs, purchased services, as well as System overhead. Through the period ended November 30, 2017, the program realized over $0.3 million in revenue improvements and $14.3 million in expense reductions.

**Certain COPN Projects and Related Matters**

**Certificates of Public Need** – From time to time, various Members of the Obligated Group in the Commonwealth of Virginia and the State of South Carolina apply for certificates of public need (COPN) in connection with the proposed construction of additional facilities or the addition of new service lines. Applications can be and, from time to time are, challenged by competing facilities. Prior to the construction of any new project or the addition of any new service line for which a COPN has been received, applicable corporate approvals within the System must be obtained, including, depending on the size of the project, approval of the Board of Directors of BSHSI and BSI. In August 2015 the Boards of Directors of BSHSI and BSI approved an approximately $20 million ambulatory center for health services located in Broad Hill Centre, Richmond, Virginia. Construction is underway, and the center is anticipated to open in 2018. In August 2017, the Boards of Directors of BSHSI and BSI approved an approximately $20 million medical office center to be located near St. Mary’s Hospital, Richmond, Virginia with construction planned for late in fiscal year 2018.

**Harbour View MOB 2, LLC** - On September 1, 2017, Bon Secours Health System, Inc. established Harbour View MOB 2 LLC (LLC). Maryview Hospital, a member of the Obligated Group and a fully owned subsidiary of Bon Secours Hampton Roads Health System, Inc., which is a fully owned subsidiary of BSHSI made an initial capital contribution to Harbour View MOB 2 LLC of a medical office building with a net book value of approximately $12.7 million. This contribution represents an 84% interest in the LLC. Suffolk Investment, LLC contributed $2.1 million cash for the remaining 16% interest, which was distributed to Maryview Hospital as a capital contribution. The contribution of the building to the LLC by Maryview Hospital is recorded in the statements of operations as a transfer to affiliate.

**Subsequent Events**

Management evaluated events and transactions that occurred after November 30, 2017 and through January 15, 2018. The System did not have any material recognizable subsequent events during this period, other than as presented herein.

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1 For information related to church plan related litigation, including church plan litigation recently filed against BSHSI, See “RESULTS OF OPERATIONS – Factors Affecting Results of Operations – Possible Effects of Legislative, Regulatory, Medicare, Medicaid and Managed Care Uncertainties - Regulatory”
RESULTS OF OPERATIONS

System Results by Market

The following chart sets forth the consolidated total revenues and operating income (loss) for the System by market for the three months ended November 30, 2017 and 2016 (see further discussion below under “Management’s Discussion and Analysis of Contribution by Market”):

<table>
<thead>
<tr>
<th>Market</th>
<th>Total Revenues (In thousands)</th>
<th>%</th>
<th>Operating Income (loss) (In thousands)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Months Ended November 30, 2017</td>
<td>BS Virginia-Richmond Health System, Richmond, Virginia(^{(a)})</td>
<td>$359,007</td>
<td>43.5</td>
<td>$25,727</td>
</tr>
<tr>
<td></td>
<td>BS Virginia-Hampton Roads Health System, Hampton Roads, Virginia(^{(b)})</td>
<td>176,616</td>
<td>21.4</td>
<td>(6,010)</td>
</tr>
<tr>
<td></td>
<td>BS St. Francis Health System, Greenville, South Carolina(^{(c)})</td>
<td>187,329</td>
<td>22.7</td>
<td>3,720</td>
</tr>
<tr>
<td></td>
<td>BS Kentucky Health System, Russell, Kentucky</td>
<td>47,488</td>
<td>5.8</td>
<td>(2,043)</td>
</tr>
<tr>
<td></td>
<td>BS Baltimore Health System, Baltimore, Maryland</td>
<td>26,638</td>
<td>3.2</td>
<td>(1,682)</td>
</tr>
<tr>
<td></td>
<td>BS New York Health System, Bronx, New York(^{(d)})</td>
<td>-</td>
<td>0.0</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>BS St. Petersburg Health System, St. Petersburg, Florida</td>
<td>8,713</td>
<td>1.1</td>
<td>294</td>
</tr>
<tr>
<td></td>
<td>Other(^{(e)})</td>
<td>18,654</td>
<td>2.3</td>
<td>4,287</td>
</tr>
<tr>
<td></td>
<td>Total System</td>
<td>$ 824,445</td>
<td>100.0</td>
<td>$ 23,838</td>
</tr>
</tbody>
</table>

| Three Months Ended November 30, 2016 | BS Virginia-Richmond Health System, Richmond, Virginia\(^{(a)}\) | $338,425 | 42.0 | $10,769 | 103.7 |
| | BS Virginia-Hampton Roads Health System, Hampton Roads, Virginia\(^{(b)}\) | 172,129 | 21.4 | (7,688) | (74.1) |
| | BS St. Francis Health System, Greenville, South Carolina\(^{(c)}\) | 182,758 | 22.7 | 2,731 | 26.3 |
| | BS Kentucky Health System, Russell, Kentucky | 45,258 | 5.6 | (5,792) | (55.8) |
| | BS Baltimore Health System, Baltimore, Maryland | 27,959 | 3.5 | (2,076) | (20.0) |
| | BS New York Health System, Bronx, New York\(^{(d)}\) | 11,348 | 1.4 | (1,083) | (10.4) |
| | BS St. Petersburg Health System, St. Petersburg, Florida | 8,766 | 1.1 | 239 | 2.3 |
| | Other\(^{(e)}\) | 19,482 | 2.3 | 13,282 | 128.0 |
| | Total System | $ 806,125 | 100.0 | $ 10,382 | 100.0 |

(a) Includes St. Mary’s Hospital, Richmond Community Hospital, Memorial Regional Medical Center, St. Francis Medical Center, and Rappahannock General Hospital.
(b) Includes Maryview Medical Center, Province Place of Maryview, Province Place of DePaul, Mary Immaculate Hospital, St. Francis Nursing Care Center, DePaul Medical Center and Maryview Nursing Care Center.
(c) Includes St. Francis - Downtown Hospital and St. Francis - Eastside Hospital.
(d) Includes Schervier Nursing Care Center. See “OVERVIEW OF THE SYSTEM - The System - Asset Divestitures”
(e) Includes System-level investment income and earnings in affiliates for certain joint ventures as well as shared services costs managed for the System by the Health System Office, the System's Accountable Care Organization, and Good Help Connections, LLC.

Management’s Discussion and Analysis of Contribution by Market

The following provides a brief review of the financial performance of each local market for the three months ended November 30, 2017:

**Richmond, Virginia** - Operating income in the Richmond, Virginia market was $25.3 million for the three months ended November 30, 2017 compared to operating income of $10.8 million for the comparable prior period. Employed physician practices increased by 5.5 FTE’s (1.8%) and physician practices’ operating expenses increased by $2.1 million (3.9%). Employed physician practice office visits, births, discharges and outpatient visits increased 8.8%, 4.0%, 2.7% and 1.2%, respectively, during the three months ended November 30, 2017 versus the comparable prior period. Observation patients, emergency room visits and total surgeries decreased 12.5%, 2.7%, and 2.0%, respectively, during the three months ended November 30, 2017 versus the comparable prior period. In addition, total revenue increased by $20.6 million, or 6.1%, as compared to prior year, while strong expense management held total operating expenses to an increase of $6.1 million, or 1.9%.
Hampton Roads, Virginia - Operating losses in the Hampton Roads, Virginia market were $6.0 million during the three months ended November 30, 2017 compared to operating losses of $7.7 million in the comparable prior period. The Sentara joint venture had operating income of $2.3 million compared to operating income of $2.6 million for the comparable prior period. Employed physician practices decreased by 9.2 FTE’s (5.8%) and physician practices’ operating expenses decreased by $0.1 million (0.4%). Observation patients, primary care office visits, births, discharges, physician office visits and outpatient visits increased 9.9%, 5.4%, 3.3%, 2.0%, 0.6% and 0.4% during the three months ended November 30, 2017 versus the comparable prior period, while emergency room visits and total surgeries decreased 4.0% and 2.9%, respectively, versus the comparable prior period. Total revenue increased by $4.5 million (2.6%), as compared to prior year, while operating expenses increased by $2.8 million (1.6%). Decreases in labor costs and other variable expenses were offset by increases in pharmaceutical supply costs.

Greenville, South Carolina - Operating income in the Greenville, South Carolina market was $3.7 million during the three months ended November 30, 2017 compared to operating income of $2.7 million for the comparable prior period. Employed physician practices decreased by 1.6 FTE’s (0.5%) and physician practices’ operating expenses increased by $0.9 million (1.7%). Observation patients, outpatient visits, emergency department visits, outpatient surgeries and births increased 9.6%, 7.6%, 4.6%, 4.2% and 2.2%, respectively, during the three months ended November 30, 2017 versus the comparable prior period while inpatient surgeries, physician office visits and discharges decreased 7.6%, 5.1% and 0.1%, respectively, over the comparable prior period. An increase in outpatient volumes between the two periods offset a decrease in inpatient volumes and led to total revenue growth of $4.6 million (2.5%) however operating expenses increased by $2.8 million (2.0%) from the comparable prior period due, in part, to an increase in pharmaceutical supply costs.

Russell, Kentucky - Operating losses in the Russell, Kentucky market were $2.0 million during the three months ended November 30, 2017 compared to operating losses of $5.8 million for the comparable prior period. Employed physician practices increased by 3.2 FTE’s (4.4%) and physician practices’ operating expenses increased by $0.3 million (2.8%). Observation patients, inpatient surgeries, physician office visits and discharges increased 10.8%, 7.0%, 5.7% and 1.7%, respectively, during the three months ended November 30, 2017 versus the comparable prior period, while outpatient surgeries, outpatient visits and emergency room visits decreased 6.3%, 3.7% and 2.9%, respectively, over the comparable prior period. Total revenues increased by $2.2 million (4.9%), over the comparable prior period, primarily driven by a slight shift to inpatient services. Expenses decreased by $1.5 million (3.0%), due to a reduction in the utilization of physician locum tenens, decreases in contract labor and pharmaceutical supply costs.

Baltimore, Maryland - Operating losses in the Baltimore, Maryland market were $1.7 million during the three months ended November 30, 2017 compared to operating losses of $2.1 million for the comparable prior period. Physician practice office visits, outpatient visits, and emergency room visits increased 20.9%, 14.8% and 1.6%, respectively, over the comparable prior period, while total surgeries, observation patients and discharges decreased 24.7%, 16.3% and 2.5%, respectively, over the comparable prior period. Total revenues decreased by $1.3 million (4.7%) over the comparable prior period, and operating expenses decreased by $1.7 million (5.7%).

St. Petersburg, Florida – Operating income in the St. Petersburg, Florida market was $0.3 million during the three months ended November 30, 2017 compared to operating income of $0.2 million for the comparable prior period. Total revenues decreased $52 thousand (0.6%) over the comparable prior period, while operating expenses decreased by $107 thousand (1.3%) compared to the prior period.

Other – Other operating income was $4.3 million during the three months ended November 30, 2017 compared to operating income of $13.3 million for the comparable prior period. Good Help Connections, LLC (GHC) experienced operating income of $1.3 million during the three months ended November 30, 2017, compared to operating income of $1.4 million for the comparable prior period. The System’s Roper St. Francis Healthcare (RSFH), Innovation Institute, Envera and Charity joint ventures had aggregate operating income of $3.0 million during the three months ended November 30, 2017 compared to aggregate operating losses of $2.0 million for the comparable prior period. In addition, the Health System Office was breakeven for the three months ended November 30, 2017 compared to operating losses of $8.4 million for the comparable prior period related to System-level programs and the operations of the Health System Office, which included shared service costs managed for the System.
The contribution by market to both total revenues and operating income can and has varied materially from period to period due to specific market impacts. The relative contributions by market to total System revenues and operating income for future periods may differ from those presented above.

**Sources of Net Patient Service Revenue**

The following table shows the sources of net patient service revenue of acute care hospitals by local market. All acute care hospitals included in the following table are Members of the Obligated Group:

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Medicare (d)</th>
<th>Medicaid (d)</th>
<th>Commercial, Private Pay and Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Three Months Ended November 30, 2017</strong></td>
<td><strong>Richmond, Virginia</strong>(a)</td>
<td>56.7%</td>
<td>30.4%</td>
<td>3.8%</td>
</tr>
<tr>
<td></td>
<td>Hampton Roads, Virginia**(b)**</td>
<td>44.5%</td>
<td>33.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td></td>
<td>Greenville, South Carolina**(c)**</td>
<td>37.7%</td>
<td>38.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td></td>
<td>Ashland, Kentucky</td>
<td>40.2%</td>
<td>33.6%</td>
<td>15.7%</td>
</tr>
<tr>
<td></td>
<td>Baltimore, Maryland</td>
<td>3.8%</td>
<td>30.8%</td>
<td>52.9%</td>
</tr>
<tr>
<td><strong>Consolidated Acute Care Hospitals and Members of the Obligated Group</strong></td>
<td>47.3%</td>
<td>32.9%</td>
<td>6.4%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Medicare (d)</th>
<th>Medicaid (d)</th>
<th>Commercial, Private Pay and Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Three Months Ended November 30, 2016</strong></td>
<td><strong>Richmond, Virginia</strong>(a)</td>
<td>57.7%</td>
<td>29.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td></td>
<td>Hampton Roads, Virginia**(b)**</td>
<td>46.5%</td>
<td>32.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td></td>
<td>Greenville, South Carolina**(c)**</td>
<td>37.5%</td>
<td>37.2%</td>
<td>2.7%</td>
</tr>
<tr>
<td></td>
<td>Ashland, Kentucky</td>
<td>38.8%</td>
<td>33.9%</td>
<td>18.3%</td>
</tr>
<tr>
<td></td>
<td>Baltimore, Maryland</td>
<td>3.9%</td>
<td>28.5%</td>
<td>55.3%</td>
</tr>
<tr>
<td><strong>Consolidated Acute Care Hospitals and Members of the Obligated Group</strong></td>
<td>47.9%</td>
<td>32.1%</td>
<td>7.1%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

(a) Includes St. Mary’s Hospital, Richmond Community Hospital, Memorial Regional Medical Center, and St. Francis Medical Center. Excludes Rappahannock General Hospital, immaterial to overall results.
(b) Includes Maryview Medical Center, Mary Immaculate Hospital and DePaul Medical Center.
(c) Includes St. Francis Hospital - Downtown and St. Francis Hospital - Eastside.
(d) Medicare and Medicaid include Medicare Managed Care and Medicaid Managed Care, respectively.
Selected Summary Utilization Information

BSHSI and Subsidiaries

The following table presents selected combined utilization statistics for the health care facilities owned and operated by the Health Care Providers during the three months ended November 30, 2017 and 2016:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute/Skilled Care Facilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds in operation (*)</td>
<td>2,105</td>
<td>1,985</td>
</tr>
<tr>
<td>Discharges</td>
<td>25,146</td>
<td>24,692</td>
</tr>
<tr>
<td>Observation patients</td>
<td>7,466</td>
<td>7,812</td>
</tr>
<tr>
<td>Patient days</td>
<td>113,110</td>
<td>109,770</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td>4.50</td>
<td>4.45</td>
</tr>
<tr>
<td>Staffed bed occupancy</td>
<td>59.0%</td>
<td>60.8%</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>277,809</td>
<td>262,244</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>124,536</td>
<td>126,767</td>
</tr>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td>578,585</td>
<td>569,339</td>
</tr>
<tr>
<td><strong>Long-Term Care Facilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds in operation (*)</td>
<td>509</td>
<td>875</td>
</tr>
<tr>
<td>Patient days</td>
<td>41,509</td>
<td>73,070</td>
</tr>
<tr>
<td>Occupancy</td>
<td>90.6%</td>
<td>91.8%</td>
</tr>
</tbody>
</table>

* At end of period (Long-term care beds as of November 30, 2016 includes 366 beds for Schervier Nursing Care Center, see "OVERVIEW OF THE SYSTEM - The System - Asset Divestitures")

Obligated Group

The following table presents selected combined utilization statistics for the healthcare facilities owned and operated by the Members of the Obligated Group during the three months ended November 30, 2017 and 2016:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute/Skilled Care Facilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds in operation (*)</td>
<td>1,947</td>
<td>1,950</td>
</tr>
<tr>
<td>Discharges</td>
<td>24,854</td>
<td>24,364</td>
</tr>
<tr>
<td>Observation Patients</td>
<td>7,348</td>
<td>7,690</td>
</tr>
<tr>
<td>Patient days</td>
<td>111,648</td>
<td>108,425</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td>4.49</td>
<td>4.45</td>
</tr>
<tr>
<td>Staffed bed occupancy</td>
<td>63.0%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>252,741</td>
<td>244,749</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>121,686</td>
<td>123,612</td>
</tr>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td>555,541</td>
<td>543,653</td>
</tr>
<tr>
<td><strong>Long-Term Care Facilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds in operation (*)</td>
<td>394</td>
<td>394</td>
</tr>
<tr>
<td>Patient days</td>
<td>33,154</td>
<td>32,498</td>
</tr>
<tr>
<td>Occupancy</td>
<td>92.5%</td>
<td>90.6%</td>
</tr>
</tbody>
</table>

* At end of period
Management’s Discussion of Results of Operations

In recent years, the System has focused heavily on improving the quality, efficiency and integration of care across the continuum. This strategic effort is referred to within the System as Clinical Transformation and Population Health. Primary strategies include the implementation of the ConnectCare electronic health record and the System’s “one patient one record” strategy, acquiring and integrating primary and specialty care physician practices and intense engineering and operational efforts to understand and redesign the System’s care delivery models in all areas of practice. These strategies have required the development of clinical and financial leaders to learn, understand and design new care pathways with expected results related to quality, service and cost. As part of this effort, all of the System’s hospitals have implemented the ConnectCare electronic health records and billing system. Implementation for ambulatory/physician offices, home care, the data warehouse and other optimization opportunities continue. ConnectCare provides acute electronic medical record and computerized order entry systems, physician practice electronic medical record systems and patient portal capabilities and impacts all elements of the acute care revenue cycle. In addition, the System continues to increase population health expertise with the integration of physician services and the System’s Regional ACO’s and CINs. The physician network declined slightly, resulting in an approximate 0.4% decrease in the number of physician and advanced practice clinician full-time equivalents employed by the System for the three months ended November 30, 2017, versus the comparable prior period. The System has approximately 48 providers certified as patient-centered medical homes. This integration of physician practices provides the System an opportunity to better coordinate the quality and efficiency of care, supports its Clinical Transformation objectives, and allows the System to better respond to population health and other future healthcare changes.

The following comparative charts provide information related to changes in certain line items for the System during the three months ended November 30, 2017 and 2016. A discussion of the causes for significant variances with respect to certain of the line items between the comparable periods follows these charts. The discussion of the System’s results of operations that follows should be read in conjunction with the unaudited financial statements of Bon Secours Health System, Inc. and Subsidiaries contained herewith.
Total Revenue increased $18.3 million, or 2.3%, during the three months ended November 30, 2017 from the comparable prior period. Net patient service revenue less bad debt increased $18.5 million, or 2.4%, from the comparable prior period. This growth was driven by the increase in ambulatory volumes, including physician office visits, and improvements in revenue cycle, including managed care rate increases. In addition, the System continued to experience a shift from bad debts and charity care allowances to contractual allowances, as a result of the implementation of the ACA and increases in self pay after insurance. The System’s employed physician network declined slightly to 837 full time equivalent employed physicians and advanced practice clinicians as of November 30, 2017, from 840 for the comparable prior period. As a percentage of gross patient revenue, charity care, bad debt and customer service adjustments were 7.3% and 6.8% during the three months ended November 30, 2017 and 2016, respectively.

Salaries, Wages and Benefits Expense increased $10.3 million, or 2.4%, during the three months ended November 30, 2017 from the comparable prior period. This increase primarily resulted from increased health plan expenses with normal inflationary increases accounting for the remainder of the growth. Salaries, wages and benefits expense as a percentage of net patient service revenue was 54.9% during the three months ended November 30, 2017, compared to 55.0% for the comparable prior period.

Supplies Expense increased $7.5 million, or 5.2%, during the three months ended November 30, 2017 from the comparable prior period. Pharmaceutical supply costs increased approximately $5.4 million from the comparable prior period. Supplies expense as a percentage of net patient service revenue was 19.6% during the three months ended November 30, 2017 as compared to 19.1% for the comparable prior period.

Purchased Services and Other Expenses decreased $11.2 million, or 6.0%, during the three months ended November 30, 2017 from the comparable prior period. This decrease was primarily the result of strong expense management, particularly of purchased services. Purchased services and other expenses as a percentage of net patient service revenue were 22.4% during the three months ended November 30, 2017, as compared to 24.4% for the comparable prior period.

Depreciation and Amortization Expense decreased $1.3 million, or 3.9%, to $32.8 million during the three months ended November 30, 2017 from $34.1 million for the comparable prior period.

Interest Expense decreased by $0.5 million, or 5.3%, to $8.3 million during the three months ended November 30, 2017 from $8.8 million for the comparable prior period.

Income from Operations increased by $13.4 million to $23.8 million during the three months ended November 30, 2017 from $10.4 million for the comparable prior period, the result of the revenue and expense variances explained above.

Non-operating Investment Gains, Net increased by $30.7 million, to net gains of $24.7 million, during the three months ended November 30, 2017 from net losses of $6.0 million for the comparable prior period. Non-operating investment gains, net during the three months ended November 30, 2017 included net realized and unrealized gains generated by the System’s investment portfolio of $25.5 million, compared to the net realized and unrealized losses of $9.9 million for the comparable prior period. In addition, unrealized losses, net of payments
related to the System’s derivatives were $0.8 million during the three months ended November 30, 2017, compared to unrealized gains, net of payments related to derivatives of $3.8 million for the comparable prior period.

Other Non-operating Activities, net decreased by $3.2 million during the three months ended November 30, 2017 to a net loss of $13.3 million, compared to a net loss of $10.1 million for the comparable prior period. Included in other non-operating activities, net are contributions, as well as the activities of the System’s foundations, schools of nursing, property management/medical office buildings, and other community services, as well as frozen pension plans. Also included for the three months ended November 30, 2017 was $1.3 million loss recognized for the refinancing of debt (see “BALANCE SHEET AND CAPITAL STRUCTURE – Indebtedness of the Obligated Group”).

Other Changes in Unrestricted Net Assets, Net resulted in an increase of $0.4 million during the three months ended November 30, 2017 compared to a decrease of $0.3 million for the comparable prior period. The primary driver of the change was net assets released from restrictions used for the purchase of property, plant and equipment for the three months ended November 30, 2017 as compared to the three months ended November 30, 2016.

Non-Controlling Interest

The following table presents a reconciliation of the changes in consolidated unrestricted net assets attributable to the System’s controlling interest and non-controlling interest, including amounts such as the excess of revenues over expenses, change in pension and other postretirement adjustments and other changes in unrestricted net assets as of and for the three months ended November 30, 2017:

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted net assets - controlling interest</th>
<th>Unrestricted net assets - noncontrolling interest</th>
<th>Total unrestricted net assets (Dollars in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as of August 31, 2017</td>
<td>$1,182,153</td>
<td>$294,791</td>
<td>$1,476,944</td>
</tr>
<tr>
<td>Excess of revenues over expenses</td>
<td>27,397</td>
<td>7,882</td>
<td>35,279</td>
</tr>
<tr>
<td>Grants for capital</td>
<td>52</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>Net change in unrealized gains on other than trading securities</td>
<td>279</td>
<td>-</td>
<td>279</td>
</tr>
<tr>
<td>Net assets released from restrictions used for purchase of property, plant and equipment</td>
<td>1,158</td>
<td>-</td>
<td>1,158</td>
</tr>
<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>(1,649)</td>
<td>(1,649)</td>
</tr>
<tr>
<td>Transfers to affiliates &amp; other changes, net</td>
<td>(1,519)</td>
<td>2,047</td>
<td>528</td>
</tr>
<tr>
<td>Increase in unrestricted net assets</td>
<td>27,367</td>
<td>8,280</td>
<td>35,647</td>
</tr>
<tr>
<td>Balance as of November 30, 2017</td>
<td>$1,209,520</td>
<td>$303,071</td>
<td>$1,512,591</td>
</tr>
</tbody>
</table>

Factors Affecting Results of Operations

Critical Accounting Policies

The System considers critical accounting policies to be those that require the more significant judgments and estimates in the preparation of its consolidated financial statements, including the impairment of long-lived assets. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Actual results could differ materially from those estimates. The System did not significantly change any of its critical accounting policies during the three months ended November 30, 2017.

The risks inherent with reimbursement from federal, state and private payors require that the collectability of receivables associated with these payors is reasonably stated in the consolidated financial statements. In
evaluating the collectability of accounts receivable, the System analyzes historical collections and write-offs and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for bad debts and provision for uncollectible accounts. Management regularly reviews its estimate and evaluates the sufficiency of the allowance for bad debts. The System analyzes contractual amounts due from patients who have third-party coverage and provides an allowance for doubtful accounts and a provision for bad debts. For patient accounts receivable associated with self-pay patients, which includes those patients without existing insurance coverage for a portion of the bill (self-pay after insurance), the System records a significant provision for bad debts for patients that are unwilling to pay for the portion of the bill representing their financial responsibility. Account balances are charged off against the allowance for doubtful accounts after all means of collection have been exhausted.

In accounting for Medicare and Medicaid cost reports, the System records all third party receivables and liabilities at their estimated realizable values. Additionally, the System has a consulting arrangement with an accounting firm that is not affiliated with its independent auditors to review all cost reports submitted to third party payors and to assess the reasonableness of the System’s recorded liabilities to these payors. Management believes that adequate provisions have been made for reasonable adjustments that may result from final cost report settlements.

Under the System’s self-insurance programs (professional/general liability, workers’ compensation, and employee health benefits), claims are reflected based on actuarial estimation, including both reported and incurred but not reported claims, taking into consideration the severity of incidents and the expected timing of claim payments. BSHSI shares certain insurance risks it has underwritten through the use of reinsurance contracts. Amounts that can be claimed from BSHSI’s reinsurers are valued by an independent actuary and are included in other assets. Should BSHSI’s reinsurers be unable to reimburse BSHSI for recoverable claims, BSHSI would still be liable to pay the claims; however, BSHSI contracts with various highly rated insurance carriers to mitigate this risk.

**Possible Effects of Legislative, Regulatory, Medicare, Medicaid and Managed Care Uncertainties**

One of the System’s primary sources of liquidity is operating cash flow. This cash flow is at risk in the event of significant unfavorable changes in legislation and regulations affecting the funding for healthcare services, primarily in the Medicare and state Medicaid programs. Medicare and Medicaid funding changes have a significant impact on the cash flow of the System. The System’s management strives to anticipate factors that affect payment changes and develop plans to address them. Management attempts to address these issues proactively through its policies and practices that focus on areas such as charity and uninsured care as well as effective managed care contracting, accounts receivable and revenue cycle best practices and analysis of potential government payment changes. Nonetheless, future actions by federal, state, and private payors could have a significant adverse effect on the System’s operating results, cash flows, and liquidity. In addition, management pursues the highest level of compliance, but state and federal audits of claims submitted by the System by the Offices of the Inspector General do create uncertainty. At this time, the System has audits underway, the outcomes of which are uncertain and the impact cannot be reasonably estimated at this time.

The Members of the Obligated Group have entered into contracts with various health maintenance organizations, preferred provider organizations and other health insurance companies (“payors”) to provide hospital and physician services to beneficiaries of health benefit plans offered by such payors. These contracts have varying contract termination and renewal dates and may be subject to intense renegotiation of terms upon renewal. Some level of uncertainty is on-going with any contract renegotiation, and from time to time Members of the Obligated Group or the applicable payor may give notice of termination or non-renewal of contract as part of the negotiation process. Due to the number and staggered terms of the System’s payor contracts, and the varying financial significance of such contracts, the renegotiation of a payor contract deemed material to the System as a whole tends to be infrequent. The failure of the System to renew a material payor contract, or the renewal of such a contract on terms materially unfavorable to the System could have a material impact on the financial condition of the Obligated Group, taken as whole. BSHSI closely monitors the renewal and renegotiation of payor contracts.

The health care environment continues to have a migration of services from inpatient to the outpatient setting. This can result in decreased revenues depending upon the service affected. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the System. Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the System.
Medicare and Medicaid Payor Reforms

As a result of past and recently enacted federal healthcare reform legislation, substantial changes are impacting the U.S. healthcare system. This legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers, and employers. These provisions began taking effect in federal fiscal year 2013 and are currently slated to remain in place through federal fiscal year 2026. This legislation is reflective of efforts by CMS, commercial carriers, and employers’ to move healthcare reimbursements away from annually set rates to payments determined by improving quality outcomes and reducing unnecessary cost. The goal for CMS is to have 85% of healthcare reimbursements tied to value based payment programs and 50% of payments tied to population based payment models by the end of calendar year 2018.

The Medicare and Medicaid reimbursement programs represent a substantial portion of the System’s revenues. Payment rates for inpatient and outpatient services provided to program beneficiaries are governed by the applicable regulations and implementation provisions thereunder, based generally on prospectively determined rates. The System has certain portions of its Medicare payments which are outside of the prospective payment system and fee for service payment rates and are based on historical costs.

The Medicare program includes certain value based and pay for performance (PFP) incentives such as reductions in readmission and specific quality of healthcare measurements. The measurements center on quality and efficiency measurements. The System fully participates in these programs and closely monitors performance criteria. Any significant shift in not meeting these criteria can result in reduced revenues. The Medicare program will be moving to implement more value based and PFP incentives over the foreseeable future. The recently passed 2017 Tax Cuts and Jobs Act includes eliminating the individual insurance mandate. At this time it is not possible to determine if this change will affect future revenue streams.

Other Medicare Programs

CMS utilizes Recovery Audit Contractors (RACs) as part of the CMS’s further efforts to assure accurate patient payments. The System participated in a CMS RAC settlement, which adjudicated all claims prior to October 1, 2013. While additional RAC assessments against the System are ongoing, the impact of such assessments is still unknown.

The System has fully participated in the Medicare and Medicaid EHR incentive program established under the Health Information Technology for Economic and Clinical Health Act (the HITECH Act). While the incentive payments have fully expired the requirements to maintain the EHR continue and are subject to audit review.

The System has several facilities that qualify for 340B drug purchasing discounts. The qualifying criteria are strict and a facility may lose its 340B status if the qualifying criteria are not maintained. The 340B regulations are continually under review and may be subject to significant revisions in future time periods. Effective January 1, 2018 CMS implemented a reduction to 340B drug payments from Average Sales Price (ASP) plus 6% to ASP - 22.5%. This 28.5% reduction was then redistributed by CMS on a budget neutral basis to Medicare Part B payments. As a whole book of business the BSHSI system will not have a material change in overall Medicare reimbursements, but will see a 340B drug payment reduction in 340B hospitals revenues and an increase in the overall Part B payments. Additionally, 340B facilities must comply with stringent requirements in reporting the 340B drug discounts received. Each of these programs can be subjected to audit and recoupment if these requirements are not met.

Affordable Care Act (ACA)

The ACA (effective 2013) amended the adjustment provision for hospital Medicare disproportionate share ("DSH") payments. BSHSI facilities receive significant reimbursement from Disproportionate Share and Uncompensated Care Pool distributions. Both of these areas are subject to regulatory review and audit adjustments on a year by year basis. The System affiliates may from time to time be subject to other audits by state or federal agencies, including Medicaid programs. The outcome of these audits is uncertain and the impact cannot be reasonably estimated at this time. Section 603 of the Bipartisan Budget Act of 2015 significantly restricted the provider based reimbursements on a future basis. CMS continues to review provider based reimbursements and may reduce or restrict payments in the future.
In November, 2013 the System joined a group appeal to the Provider Reimbursement Review Board (PRRB) for the proper recording of Medicare Part C days in the disproportionate share calculation for its facilities. The United States Court of Appeals for the District of Columbia invalidated the regulation relied upon by the Medicare agency in 2014 but remanded the case to CMS to determine how to proceed in the face of the invalidated regulation. On remand, CMS decided to continue to apply the challenged policy and that determination is now being challenged by providers in the United States District Court for the District of Columbia. The case has two components: that CMS’s interpretation of the statute is not allowable and that CMS did not properly promulgate the rulemaking. The Medicare agency has successfully re-promulgated the regulations curing that component of the two part argument effective Oct 1, 2013. Because of this the PRRB has split the appeal into two components: a pre-October 1, 2013 and a post October 1, 2013 appeal. BSHSI has and will continue to preserve appeal rights for the pre- and post-October 1, 2013 appeals. If the providers win on appeal, CMS would have to determine how to distribute the funds to the providers. The appeal is outstanding and it is unknown when it will be resolved. Additional appeals have been filed and will continue to be filed in future years as cost reports are settled.

On July 25, 2013, the U.S. Attorney’s Office for the Southern District of New York issued a Civil Investigative Demand (CID) to Bon Secours New York Health System (“Bon Secours New York”) regarding alleged false statements and false claims made by Bon Secours New York and Schervier Long Term Home Health Care Program. The CID resulted from a complaint brought by a former employee under the False Claims Act. The complaint was made public in April 2015. The government has not elected to intervene at this time, but the plaintiff is pursuing the case on her own. Bon Secours New York filed a Motion to Dismiss in December 2015, and in May 2016 the Court dismissed five of the ten sets of false claims allegations. In September 2017, the plaintiff sought leave to file a Sixth Amendment Complaint, which the System has vigorously opposed. Bon Secours New York is in the process of discovery with respect to the remaining false claims allegations and an employment retaliation claim. It is not feasible at this time to predict the extent or range of potential outcomes of the litigation or whether the ultimate outcome, if any, would have a material impact on the financial condition of the System, taken as whole. The System has retained counsel experienced in health care litigation and regulatory matters.

In August 2016 three subcomponent medical practices of St. Francis Physician Services, Inc. (“SFPS”) in Greenville, SC received CIDs from the U.S. Attorney’s Office for the District of South Carolina. The CIDs were issued pursuant to the False Claims Act. The investigation concerns allegations that Laboratory Corporation of America Holdings (“LabCorp”) provided illegal remuneration to the subcomponent medical practices in the form of discounted draw fees for lab tests performed by laboratories other than LabCorp, including by Health Diagnostics Laboratory, Inc. (“HDL”). In March 2017, the Office of Inspector General (“OIG”) contacted the medical practices to assert that the receipt of lab specimen “processing and handling” fees constituted kickbacks. The OIG has engaged in discussion with SFPS to attempt to resolve the matter. The System has retained counsel experienced in health care litigation and regulatory matters and is fully cooperating with the U.S. Attorney’s Office and OIG in providing the requested information. On June 7, 2017, the trustee of the HDL Liquidating Trust (the “Trustee”) filed a lawsuit against BSHSI, Bon Secours St. Francis Health System (“BSSFHS”), SFPS, 40 individual practitioners currently or formerly employed by SFPS, and 13 legal entities associated with those practitioners. The Trustee alleges that approximately $520,000 in lab specimen processing and handling fees paid by HDL constitute “fraudulent transfers” that must be recouped. Most of the defendants, including BSHSI, BSSFHS, and SFPS, have formed a common interest group and intend to continue to defend against the allegations.

In November 2016, Our Lady of Bellefonte Hospital (OLBH) self-disclosed to the U.S. Health Resources and Services Administration (“HRSA”) two 340B Drug Pricing Program compliance issues. The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible entities at reduced prices. The issues relate to a potential violation of the 340B Program prohibition against purchases through a group purchasing organization or other group purchasing arrangement and the prohibition against payment of duplicate discounts. OLBH has determined that the amounts that it inadvertently received in error total approximately $1.03 million, and it has instituted corrective action. HRSA has acknowledged receipt of OLBH’s disclosure and OLBH has been providing updates to HRSA on its corrective action plan. In January 2015, Maryview Medical Center received the results of a 340B Drug Pricing Program Audit conducted by HRSA which concluded that Maryview was ineligible for the 340B Program from August 7, 2013 to March 12, 2015 due to a GPO violation. During this period, Maryview Medical Center received approximately $8 million in 340B Program discounts from manufacturers. As a result of this self-disclosure process and audit finding, respectively, it is possible that certain manufacturers may seek repayment from the hospital for discounts provided through the 340B Drug Pricing Program. The System has retained counsel experienced in 340B Drug Pricing matters.
BSHSI believes that certain of its sponsored pension plans are “church plans” under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). “Church plans” are employee benefit plans established and maintained by a church or by non-profit organizations controlled by or associated with a church, and are exempt from ERISA’s coverage. Catholic and other religious based health systems across the country have been the target of class action lawsuits, focusing on whether pension plans sponsored by the health systems qualify under the ERISA church plan exemption, primarily relating to the issue of whether only a “church” may establish and maintain a church plan. A defined benefit pension plan covered under ERISA would be subject to minimum funding rules, certain vesting rules, notice requirements, additional Internal Revenue Code requirements, and would be required to pay premiums to the Pension Benefit Guaranty Corporation. Two such class action “church plan” lawsuits were filed against BSHSI and individual defendants in the Federal District Court for the District of Maryland. These cases were consolidated into one class action lawsuit. BSHSI and plaintiffs, through counsel, met on April 11, 2017 and reached agreement on terms of a settlement of the consolidated case. The BSHSI Board has approved this settlement, which was approved and finalized by the federal district court on December 21, 2017. On June 5, 2017, the United States Supreme Court issued a decision holding that pension plans maintained by religious based health systems may qualify for the church plan exemption under ERISA.

Asset Impairment

The System regularly evaluates whether events or changes in circumstances have occurred that could indicate impairment in the value of long-lived assets. In accordance with the provisions of the Accounting Standards Codification (ASC) Topic 360-10, “Impairment or Disposal of Long-Lived Assets,” if events or changes in circumstances indicate that the carrying value of an asset is not recoverable, the System’s management estimates the projected undiscounted cash flows, excluding interest and taxes, of the related individual facilities to determine if an impairment loss should be recognized. The amount of impairment loss is determined by comparing the historical carrying value of the asset to its estimated fair value. Estimated fair value is determined through an evaluation of recent and projected financial performance of facilities using standard industry valuation techniques.

In addition to consideration of impairment upon the events or changes in circumstances described above, management regularly evaluates the remaining lives of its long-lived assets. If estimates are changed, the carrying value of affected assets is allocated over the remaining lives. In estimating the future cash flows for determining whether an asset is impaired and if expected future cash flows used in measuring assets are impaired, the System groups their assets at the lowest level for which there are identifiable cash flows independent of other groups of assets. No impairment charges were recorded during the three months ended November 30, 2017 or 2016.

Goodwill

Goodwill is an asset representing the excess of the aggregate purchase price over the fair value of the net assets acquired in a business combination. As of November 30, 2017 and 2016, the System had one reporting unit, which included all subsidiaries. Goodwill is evaluated for impairment annually using qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. Based on this qualitative assessment, the System concluded that goodwill was not impaired as of November 30, 2017 or 2016.

Net Patient Service Revenue

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payors. Retroactive reimbursement adjustments are estimated in the period in which the related services are rendered and adjusted in future periods as final settlements are determined.

The System estimates the allowance for uncollectible accounts based on the aging of the accounts receivable, historical collection experience, payor mix and other relevant factors. A significant portion of the allowance for uncollectible accounts relates to self-pay patients, as well as co-payments, co-insurance and deductibles owed by patients with insurance. Environmental factors that can impact collection trends include changes in the economy, which in turn has an impact on unemployment rates and the number of uninsured and underinsured patients. These factors continuously change and can have an impact on collection trends and the estimation process.
The activity in the allowance for uncollectible accounts is summarized as follows for the three months ended November 30, 2017 and August 31, 2017:

<table>
<thead>
<tr>
<th></th>
<th>November 30, 2017</th>
<th>August 31, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning balance</td>
<td>$146,201</td>
<td>$141,852</td>
</tr>
<tr>
<td>Provision for bad debts</td>
<td>37,545</td>
<td>179,304</td>
</tr>
<tr>
<td>Write-offs</td>
<td>(41,148)</td>
<td>(174,955)</td>
</tr>
<tr>
<td>Ending balance</td>
<td>$142,598</td>
<td>$146,201</td>
</tr>
</tbody>
</table>

(Dollars in thousands)

**BALANCE SHEET AND CAPITAL STRUCTURE**

**Indebtedness of the Obligated Group**

As of November 30, 2017, the aggregate outstanding principal amount of indebtedness of the Members of the Obligated Group that was evidenced by Obligations issued under the Master Indenture ("Obligations") was $818.1 million. The aggregate outstanding principal amount of indebtedness of the Members of the Obligated Group excludes Obligations issued under the Master Indenture to secure (i) Financial Products Agreements (as defined in the Master Indenture), (ii) obligations to credit or liquidity providers, and (iii) obligations under covenant agreements with financial institutions who have purchased revenue bonds issued for the benefit of the System (which revenue bonds are separately secured by Obligations).

As of November 30, 2017, the Members of the Obligated Group also were obligated on long-term indebtedness, including capitalized leases, in the aggregate principal amount of approximately $37.3 million that was not evidenced by Obligations issued under the Master Trust Indenture. This amount includes (i) approximately $2.0 million of capital lease obligations and (ii) approximately $15.9 million of indebtedness for two limited liability corporations consolidated by the System which own medical office buildings.

BSHSI may from time to time seek to retire or purchase its outstanding indebtedness through cash repurchases and/or exchanges, in open market purchases, privately negotiated transactions or otherwise. The amount and manner of any such repurchases or exchanges will depend on prevailing market conditions, contractual restrictions and other factors. The amounts of indebtedness repurchased or exchanged in any period may be material.

In September 2017, the System paid off the remaining $16.4 million in aggregate principal amount of the Series 2013 New York variable rate term loan.

In October 2017, the System paid off the remaining $13.8 million in aggregate principal amount of the Series 2002B tax-exempt revenue bonds issued for the benefit of BSHSI facilities in Kentucky and Florida.

Effective November 1, 2017, BSHSI refinanced approximately $250.0 million of existing tax-exempt debt with $180.0 million of taxable bank loans and $70.0 million of tax-exempt bank loans. As a result of the transaction, the System recognized a $1.3 million, net expense related to deferred financing costs which is reflected in other nonoperating activities, net in the accompanying consolidated statement of operations for the three months ending November 30, 2017. In addition, on October 30, 2017, four basis swaps were terminated; three floating to fixed-pay swaps were restructured with existing counterparties, and two floating to fixed-pay swaps were novated to new counterparties. As a result of the transaction, the System recognized an approximate $3.0 million net gain from the termination of the basis swaps and an approximate $6.0 million mark to market liability for the restructured and novated floating to fixed pay swaps.

Effective November 28, 2017, BSHSI terminated an existing revolving credit agreement with a commercial bank. Also on November 28, 2017, BSHSI entered into a $65.0 million revolving credit agreement with a three year term with a commercial bank (the Credit Agreement). Pursuant to the Credit Agreement, BSHSI, as Credit Group Representative, may either request loans or request that the bank issue letters of credit for the benefit of the
Obligated Group. The proceeds of any such loan and any such letter of credit are available for general corporate purposes. The obligations of the Obligated Group under the Credit Agreement are secured by an Obligation under the Master Indenture. As of November 30, 2017, no loans have been made under the Credit Agreement.

**Letters of Credit and Liquidity Enhancement**

The following table sets forth certain information with respect to the outstanding long-term indebtedness of the Obligated Group which bore interest at a variable rate and was secured by a letter of credit at August 31, 2017:

<table>
<thead>
<tr>
<th>Series</th>
<th>Letter of Credit Provider</th>
<th>Par Amount Outstanding at August 31, 2017 (in millions)</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Series 2002B (Venice, Florida)</td>
<td>JP Morgan Chase NA*</td>
<td>$4.2</td>
<td>November, 2017</td>
</tr>
<tr>
<td>Series 2008A (South Carolina)</td>
<td>JP Morgan Chase NA*</td>
<td>69.9</td>
<td>November, 2017</td>
</tr>
<tr>
<td>Series 2008D (South Carolina)</td>
<td>BNY Mellon</td>
<td>17.3</td>
<td>January, 2018</td>
</tr>
<tr>
<td>Series 2008D-1 (Hanover, Virginia)</td>
<td>BNY Mellon</td>
<td>18.0</td>
<td>January, 2018</td>
</tr>
<tr>
<td>Series 2008D-2 (Hanover, Virginia)</td>
<td>U.S. Bank National Association</td>
<td>76.1</td>
<td>December, 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>$195.2</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Related bonds were also insured

As described above, the Series 2002B bonds were paid off on October 2, 2017, the Series 2008A South Carolina bonds were refinanced with a new issue of direct purchase tax-exempt bonds on November 1, 2017, and the remaining bonds were refinanced with taxable loans on November 1, 2017.

As of November 1, 2017, the System terminated all of the letters of credit described above.
Liquidity of BSHSI and Subsidiaries

As depicted in the following table, the total value of the System’s unrestricted cash and cash equivalents and unrestricted board-designated funds at November 30, 2017 was $1.493 billion, a decrease of $64.2 million from August 31, 2017. Net cash used in operations was approximately $31.6 million during the three months ended November 30, 2017. Cash reductions of approximately $58.1 million were the result of capital expenditures, timing of working capital outflows, defeasance of debt and scheduled debt and swap payments. The System also recognized net non-operating investment gains (exclusive of derivatives) of $25.5 million during the three months ended November 30, 2017. Long-term indebtedness was $845.4 million, a decrease of $35.1 million. Utilization of unrestricted cash and board-designated funds to pay off the $30.2 million of aggregate outstanding principal amounts (see “BALANCE SHEET AND CAPITAL STRUCTURE – Indebtedness of the Obligated Group”) resulted in the ratio of total unrestricted cash and board-designated funds to total long-term indebtedness to remain stable at 177%.

<table>
<thead>
<tr>
<th></th>
<th>November 30, 2017</th>
<th>August 31, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted cash and cash equivalents</td>
<td>$161,117</td>
<td>$274,348</td>
</tr>
<tr>
<td>Unrestricted board-designated funds (a)</td>
<td>$1,331,896</td>
<td>$1,282,912</td>
</tr>
<tr>
<td><strong>Total unrestricted cash and board-designated funds</strong></td>
<td><strong>$1,493,013</strong></td>
<td><strong>$1,557,260</strong></td>
</tr>
<tr>
<td>Days cash on hand (b)</td>
<td>176.9</td>
<td>184.9</td>
</tr>
<tr>
<td><strong>Total long-term indebtedness (excluding bond discount/premium and deferred financing costs, net)</strong> (c)</td>
<td><strong>$845,352</strong></td>
<td><strong>$880,419</strong></td>
</tr>
<tr>
<td>Ratio of total unrestricted cash and board-designated funds to total long-term indebtedness (d)</td>
<td><strong>176.6%</strong></td>
<td><strong>176.9%</strong></td>
</tr>
</tbody>
</table>

(a) Includes mutual funds, cash and cash equivalents, debt and equity securities and alternative investments.  
(b) Total unrestricted cash and board-designated funds, divided by total operating expenses (excluding bad debt, depreciation and amortization expense) for the period divided by the number of calendar days in the period.  
(c) Includes total long-term indebtedness of both Obligated and Non-Obligated Group Members (excluding unamortized bond discount/premium and deferred financing costs, net).  
(d) Total unrestricted cash and board-designated funds, divided by total long-term debt (excluding unamortized bond discount/premium and deferred financing costs, net).

Interest Rate Risk Management

The System uses fixed and variable-rate debt to finance capital needs and develop an appropriate debt structure. Variable-rate debt exposes the System to variability in interest expense due to changes in interest rates. Conversely, fixed-rate debt obligations can be more expensive to the System in times of declining interest rates. The System manages and monitors its cost of capital on a regular basis and from time to time enters into derivative instruments with financial institutions to help manage interest rate risk.

On October 30, 2017, BSHSI terminated four basis swaps; restructured three floating to fixed pay swaps with existing counterparties and two floating to fixed pay swaps were novated to new counterparties.

At November 30, 2017, the System had five derivative instruments, which did not qualify for hedge accounting treatment under ASC Topic 815, “Derivatives and Hedging.” Fair value changes of these instruments were reflected in non-operating investment gains, net in the accompanying consolidated statements of operations and changes in unrestricted net assets in the period of change. Net settlement payments made or received on non-qualifying derivatives are also recorded as a component of non-operating investment gains, net.
The following is a summary of the derivative instruments in place at November 30, 2017:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
<th>Outstanding Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>50,000</td>
</tr>
<tr>
<td>Fixed Payer</td>
<td>1</td>
<td>$3.977%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov-2042</td>
</tr>
<tr>
<td>Collateral Posted</td>
<td>$50,000</td>
<td></td>
</tr>
<tr>
<td>Counterparties</td>
<td>Barclays</td>
<td>$(12,829)</td>
</tr>
<tr>
<td>Mark to Market</td>
<td>-</td>
<td>$(50,000)</td>
</tr>
<tr>
<td>Collateral Thresholds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The unrealized losses and gains, net of payments, of $0.7 million and $3.8 million during the three months ended November 30, 2017 and 2016, respectively, relating to non-qualifying derivative activities, are recorded within non-operating investment gains, net in the accompanying consolidated statements of operations and changes in unrestricted net assets.

The System utilizes a diversified group of swap counterparties and has sought to limit its obligations to post collateral in the agreements governing its derivative instruments. In addition, the System routinely evaluates its derivative portfolio and may decide at any time to terminate certain of the derivative instruments discussed above and/or enter into new derivative instruments. Should the System decide to terminate any of such instruments, it may be required to make termination or breakage payments under the terms of those instruments.

**Capital Market Uncertainties**

Investment market fluctuations affect the self-funded insurance plans, long term investment reserves and pension plan funds, and impact the System’s net assets. The System’s management monitors these fluctuations closely, striving to anticipate the effect of changes and develop plans to address them. Management attempts to proactively address the impact of these fluctuations through the System’s funding and investment management policies as well as cash management. Management has also attempted to offset the impact of market fluctuations by taking steps intended to strengthen operations. Nonetheless, market fluctuations could have a significant adverse or positive effect on the System’s cash flows and management of capital spending.

**Investments**

The System maintains a centralized investment program that is comprised primarily of operating funds and other unrestricted board-designated funds, all of which primarily originate from BSHSI’s subsidiary organizations. These funds are combined into a centralized investment program that is administered by BSHSI’s Treasury Services Department.

The System has incorporated an Investment Policy Statement (IPS) into its investment program. The IPS, which has been formally adopted by the BSHSI Board of Directors, contains numerous standards designed to ensure adequate diversification by asset category and geography. The IPS also limits investments by manager and position size, and limits fixed income positions based on credit ratings, which serves to further mitigate the risks associated with the investment program. At November 30, 2017 and 2016, management believes that its investment positions were in accordance with the IPS guidelines.

The BSHSI Board of Directors approves the primary investment policy, while the Pension and Investment Committee of the BSHSI Board of Directors periodically reviews and approves the investment procedures and annually reviews the asset allocation and recommends changes to the BSHSI Board of Directors as appropriate. The Pension and Investment Committee is also responsible for the ongoing oversight of the centralized investment program and approval of most other investment-related decisions, including the selection of an investment.
consultant and investment managers. BSHSI uses an outside investment consultant to provide professional investment analysis and guidance. Professional investment management firms invest all of the long-term reserves in the centralized investment program. As of November 30, 2017, BSHSI’s target allocation of its investment portfolios was 46.0% equity investments (including equity hedge funds), 23.5% alternative investments (including other hedge fund and real estate investments) and 30.5% fixed income investments. BSHSI’s asset allocation was slightly overweight equity and fixed income targets and underweight alternatives, due to the liquidation of an alternative investment, but remains within IPS specifications.

The System’s ability to generate investment income is dependent in large measure on market conditions. The market value of the System’s investment portfolio, as well as the System’s investment income, have fluctuated significantly in the past and are likely to fluctuate significantly in the future. The System’s investment portfolio assets are designated as trading securities as discussed in ASC Topic 320, “Investments in Debt and Equity Securities.” The System’s entire portfolio is managed by third-party investment managers. Trading generally reflects active and frequent buying and selling, and trading securities are generally used with the objective of generating profits on short-term differences in price. As required by U.S. GAAP, realized and unrealized gains and losses on an investment portfolio designated as a trading portfolio are accounted for as non-operating investment income and are included in excess of revenue over expenses. Because of this designation as a trading portfolio, management anticipates fluctuations in excess of revenue over expenses.

The following table provides an analysis of non-operating investment gains, net during the three months ended November 30, 2017 and 2016:

<table>
<thead>
<tr>
<th></th>
<th>November 30, 2017 (In thousands)</th>
<th>November 30, 2016 (In thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Realized investment gains, net</td>
<td>$23,789</td>
<td>$2,191</td>
</tr>
<tr>
<td>Unrealized investment gains (losses), net</td>
<td>1,700</td>
<td>(12,071)</td>
</tr>
<tr>
<td>Unrealized derivative gains, net</td>
<td>700</td>
<td>6,876</td>
</tr>
<tr>
<td>Interest rate derivative payments</td>
<td>(1,475)</td>
<td>(3,042)</td>
</tr>
<tr>
<td>Non-operating investment gains (losses), net</td>
<td>$24,714</td>
<td>$(6,046)</td>
</tr>
</tbody>
</table>

Management believes that the realized and unrealized investment gains in both periods were consistent with the trading styles of the managers and the overall change in market values.

For a description of the System’s derivative instruments, see “Interest Rate Risk Management” above.

**Fair Value of Financial Instruments**

The System determines the fair values of its financial instruments based on the fair value hierarchy established in ASC Topic 820, *Fair Value Measurement*, which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include cash and cash equivalents, debt and equity securities and mutual funds that are traded in an active exchange market, as well as government and agency securities.

Level 2: Observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted market prices that are traded less frequently than exchange-traded instruments. This category generally includes certain equity mutual funds, corporate-debt securities, equity commingled funds, fixed income commingled funds, and interest rate swaps.

Level 3: Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as...
instruments for which the determination of fair value requires significant management judgment or estimation. This category generally includes certain private debt and equity instruments.

The following table presents the System’s fair value hierarchy for those assets and liabilities measured at fair value on a recurring basis as of November 30, 2017: (Dollars in thousands)

<table>
<thead>
<tr>
<th>Assets limited or restricted as to use:</th>
<th>Fair Value</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$118,131</td>
<td>118,131</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity mutual funds</td>
<td>117,221</td>
<td>117,221</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity commingled funds</td>
<td>145,929</td>
<td>—</td>
<td>145,929</td>
<td>—</td>
</tr>
<tr>
<td>Common and preferred stocks</td>
<td>255,456</td>
<td>253,958</td>
<td>1,498</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income mutual funds</td>
<td>96,804</td>
<td>96,804</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income commingled funds</td>
<td>353,361</td>
<td>—</td>
<td>353,361</td>
<td>—</td>
</tr>
<tr>
<td>Government and agency bonds</td>
<td>17,781</td>
<td>14,152</td>
<td>3,629</td>
<td>—</td>
</tr>
<tr>
<td>Corporate obligations</td>
<td>20,760</td>
<td>2,457</td>
<td>18,303</td>
<td>—</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
<td>$1,125,444</td>
<td>602,723</td>
<td>522,721</td>
<td>—</td>
</tr>
<tr>
<td>Liabilities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Rate Swaps</td>
<td>$46,699</td>
<td>—</td>
<td>46,699</td>
<td>—</td>
</tr>
<tr>
<td>Total Liabilities</td>
<td>$46,699</td>
<td>—</td>
<td>46,699</td>
<td>—</td>
</tr>
</tbody>
</table>

Fair value measurements at November 30, 2017 using:

<table>
<thead>
<tr>
<th>Assets limited or restricted as to use:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
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<td>—</td>
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<td>Equity mutual funds</td>
<td>117,221</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity commingled funds</td>
<td>145,929</td>
<td>—</td>
<td>—</td>
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<tr>
<td>Common and preferred stocks</td>
<td>253,958</td>
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<td>Government and agency bonds</td>
<td>14,152</td>
<td>3,629</td>
<td>—</td>
</tr>
<tr>
<td>Corporate obligations</td>
<td>2,457</td>
<td>18,303</td>
<td>—</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
<td>602,723</td>
<td>522,721</td>
<td>—</td>
</tr>
<tr>
<td>Liabilities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Rate Swaps</td>
<td>46,699</td>
<td>—</td>
<td>46,699</td>
</tr>
<tr>
<td>Total Liabilities</td>
<td>46,699</td>
<td>—</td>
<td>46,699</td>
</tr>
</tbody>
</table>

The following table presents the System’s fair value hierarchy for those assets and liabilities measured at fair value on a recurring basis as of August 31, 2017: (Dollars in thousands)

<table>
<thead>
<tr>
<th>Assets limited or restricted as to use:</th>
<th>Fair Value</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$113,851</td>
<td>113,851</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity mutual funds</td>
<td>84,244</td>
<td>84,244</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity commingled funds</td>
<td>84,375</td>
<td>—</td>
<td>84,375</td>
<td>—</td>
</tr>
<tr>
<td>Common and preferred stocks</td>
<td>317,899</td>
<td>317,899</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income mutual funds</td>
<td>96,995</td>
<td>96,995</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income commingled funds</td>
<td>353,496</td>
<td>—</td>
<td>353,496</td>
<td>—</td>
</tr>
<tr>
<td>Government and agency bonds</td>
<td>23,884</td>
<td>20,654</td>
<td>3,230</td>
<td>—</td>
</tr>
<tr>
<td>Corporate obligations</td>
<td>19,453</td>
<td>1,181</td>
<td>18,272</td>
<td>—</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
<td>$1,094,197</td>
<td>634,824</td>
<td>459,373</td>
<td>—</td>
</tr>
<tr>
<td>Liabilities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest rate swaps</td>
<td>46,843</td>
<td>—</td>
<td>46,843</td>
<td>—</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>46,843</td>
<td>—</td>
<td>46,843</td>
<td>—</td>
</tr>
</tbody>
</table>

Fair value measurements at August 31, 2017 using:

<table>
<thead>
<tr>
<th>Assets limited or restricted as to use:</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>113,851</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity mutual funds</td>
<td>84,244</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity commingled funds</td>
<td>84,375</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Common and preferred stocks</td>
<td>317,899</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income mutual funds</td>
<td>96,995</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income commingled funds</td>
<td>353,496</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Government and agency bonds</td>
<td>20,654</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Corporate obligations</td>
<td>1,181</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
<td>634,824</td>
<td>459,373</td>
<td>—</td>
</tr>
<tr>
<td>Liabilities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest rate swaps</td>
<td>46,843</td>
<td>—</td>
<td>46,843</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>46,843</td>
<td>—</td>
<td>46,843</td>
</tr>
</tbody>
</table>

During the three months ended November 30, 2017, the System sold approximately $60 million of Level 1, common and preferred stocks, and reinvested the proceeds in Level 2, equity commingled funds in accordance with the System’s investment strategy. There were no other significant transfers of Level 1, 2 and 3 during the three months ended November 30, 2017. The System had no activity in Level 3 assets during the three months ended November 30, 2017.
INSURANCE AND PENSION PLANS

Insurance

The System’s affiliates, including the Members of the Obligated Group, maintain insurance coverages which management believes are customary for health care providers of similar size and location.

The System maintains self-funded insurance programs for professional and general liability through Bon Secours Assurance Company, Ltd, a Cayman Islands insurance company, the sole shareholder of which is BSHSI. The System’s workers’ compensation program primarily consists of self-funded insurance programs in various states with excess coverage obtained through commercial insurers. Under the System’s self-funded insurance programs, claims are reflected as based upon actuarial estimation, including both reported and incurred but not reported claims, taking into consideration the severity of incidents and the expected timing of claim payments.

Pension Plans

The System’s employees are covered either by one of the System’s several noncontributory defined benefit pension plans, or are covered by defined contribution retirement plans. The System’s noncontributory defined benefit plans provide benefits based upon age at retirement, years of credited services, and average earnings. Seven of the System’s eight defined benefit plans are deemed to be church plans under the Internal Revenue Code (the IRC).² For defined benefit pension plans deemed to be church plans under the IRC, the System’s funding policy is to make contributions to fund the annual service cost of the plans plus a seven year amortization of the unfunded Accumulated Benefit Obligation plus two additional days cash on hand, discretionary. The defined benefit pension plan that is subject to the Employee Retirement Income Security Act of 1974 (ERISA) guidelines is funded in accordance with those guidelines. The service cost and projected benefit obligation is based upon the projected unit credit actuarial method.

The investment policy and objectives for defined benefit plan assets, which are recommended by BSHSI’s Pension and Investment Committee and approved by BSHSI’s Board of Directors, are based on a long-term perspective. An investment advisory firm engaged by BSHSI reviews asset performance and allocation on a periodic basis throughout the fiscal year. The percentage allocation to each asset class may vary depending upon market conditions and is adjusted when it falls outside the established ranges set for each asset class.

During the three months ended November 30, 2017 and 2016, the System contributed $15.0 million and $15.1 million, respectively, to its defined benefit pension plans. Defined benefit pension plan contributions are made on a monthly basis based upon the annual actuarial valuations of each plan.

The Plan adopted ASU 2017-07 as of August 31, 2017. As a result of the adoption of this ASU, the components of net benefit cost other than the service cost are recorded in other nonoperating activities, net in the consolidated statements of operations and changes in net assets for the three months ending November 30, 2017. Service cost is included as a component of fringe benefits recorded as salaries, wages, and benefits in the accompanying consolidated statements of operations and changes in unrestricted net assets.

² For information related to church plan related litigation, including church plan litigation recently filed against BSHSI. See “OPERATING RESULTS – Factors Affecting Results of Operations – Possible Effects of Legislative, Regulatory, Medicare, Medicaid and Managed Care Uncertainties”
The following table presents the System’s fair value hierarchy for the pension plan assets measured at fair value on a recurring basis as of November 30, 2017: (Dollars in thousands)

<table>
<thead>
<tr>
<th>Fair value measurements</th>
<th>Fair Value</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>NAV(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$46,362</td>
<td>46,362</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity mutual funds</td>
<td>12,001</td>
<td>12,001</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity commingled funds</td>
<td>241,815</td>
<td>—</td>
<td>241,815</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Common and preferred stocks</td>
<td>300,915</td>
<td>300,223</td>
<td>692</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income commingled funds</td>
<td>109,001</td>
<td>—</td>
<td>109,001</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Government and agency bonds</td>
<td>4,616</td>
<td>1,864</td>
<td>2,752</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Corporate obligations</td>
<td>113,811</td>
<td>—</td>
<td>113,811</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Alternative investments</td>
<td>32,101</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>32,101</td>
</tr>
<tr>
<td><strong>Total plan assets</strong></td>
<td>$860,622</td>
<td>360,450</td>
<td>468,071</td>
<td>—</td>
<td>32,101</td>
</tr>
</tbody>
</table>

\(^1\) Fund investments reported at NAV as practical expedient estimate

The following table presents the System’s fair value hierarchy for the pension plan assets measured at fair value on a recurring basis as of August 31, 2017: (Dollars in thousands)

<table>
<thead>
<tr>
<th>Fair value measurements</th>
<th>Fair Value</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>NAV(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$44,208</td>
<td>44,208</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity mutual funds</td>
<td>11,680</td>
<td>11,680</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Equity commingled funds</td>
<td>121,754</td>
<td>—</td>
<td>121,754</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Common and preferred stocks</td>
<td>381,995</td>
<td>381,184</td>
<td>811</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Fixed income commingled funds</td>
<td>108,182</td>
<td>—</td>
<td>108,182</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Government and agency bonds</td>
<td>5,283</td>
<td>2,768</td>
<td>2,515</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Corporate obligations</td>
<td>112,033</td>
<td>—</td>
<td>112,033</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Alternative investments</td>
<td>31,603</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>31,603</td>
</tr>
<tr>
<td><strong>Total plan assets</strong></td>
<td>$816,738</td>
<td>439,840</td>
<td>345,295</td>
<td>—</td>
<td>31,603</td>
</tr>
</tbody>
</table>

\(^1\) Fund investments reported at NAV as practical expedient estimate

The System applies ASU No. 2009-12, *Fair Value Measurements and Disclosures (Topic 820): Investments in Certain Entities That Calculate Net Asset per Share (or Its Equivalent)*, to its pension plan asset portfolio. The guidance amends ASC Topic 820 and permits, as a practical expedient, fair value of investments within its scope to be estimated using net asset value or its equivalent. The alternative investments classified within Level 3 of the fair value hierarchy have been recorded using Net Asset Value (NAV).

During the three months ended November 30, 2017, the System sold approximately $80 million of Level 1, common and preferred stocks and reinvested the proceeds in Level 2 equity commingled funds in accordance with the System’s investment strategy. There were no other transfers of Level 1 and Level 2 during the three months ended November 30, 2017.
**Health Care Providers**

BSHSI and the 14 Health Care Providers identified in bold in the table below are currently, and have been, Members of the Obligated Group throughout the three months ended November 30, 2017 and 2016. These 14 Healthcare Providers operate eleven acute care facilities, three long-term care facilities and two physician practices in Florida, Kentucky, Maryland, South Carolina and Virginia. None of the Healthcare Providers in New York are Members of the Obligated Group.

<table>
<thead>
<tr>
<th>State</th>
<th>Entity Name and Facilities (in italics)</th>
<th>Description of Facility</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td><strong>Bon Secours-Maria Manor Nursing Care Center, Inc.</strong>&lt;br&gt;<strong>Bon Secours-St. Petersburg</strong></td>
<td>Long-Term Care</td>
<td>St. Petersburg</td>
</tr>
<tr>
<td></td>
<td>Bon Secours Place at St. Petersburg, L.L.P.&lt;br&gt;<strong>Bon Secours Place at St. Petersburg</strong></td>
<td>Assisted Living</td>
<td>St. Petersburg</td>
</tr>
<tr>
<td>Kentucky</td>
<td><strong>Our Lady of Bellefonte Hospital, Inc.</strong>&lt;br&gt;<strong>Our Lady of Bellefonte Hospital</strong></td>
<td>Acute Care</td>
<td>Ashland</td>
</tr>
<tr>
<td></td>
<td><strong>Bellefonte Physician Services, Inc.</strong></td>
<td>Physician Services</td>
<td>Ashland</td>
</tr>
<tr>
<td>Maryland</td>
<td><strong>Bon Secours Hospital Baltimore, Inc.</strong>&lt;br&gt;<strong>Bon Secours Hospital Baltimore</strong></td>
<td>Acute/Skilled Care</td>
<td>Baltimore</td>
</tr>
<tr>
<td>New York</td>
<td>Frances Schervier Home and Hospital[1]&lt;br&gt;<strong>Schervier Nursing Care Center</strong></td>
<td>Long-Term Care</td>
<td>Riverdale</td>
</tr>
<tr>
<td></td>
<td>Bon Secours Charity Health System, Inc.[2]&lt;br&gt;<strong>Good Samaritan Hospital of Suffern, N.Y.</strong>[2]&lt;br&gt;<strong>Good Samaritan Hospital</strong>[2]</td>
<td>Acute Care</td>
<td>Suffern</td>
</tr>
<tr>
<td></td>
<td>Bon Secours Community Hospital[2]&lt;br&gt;<strong>Bon Secours Community Hospital</strong>[2]</td>
<td>Acute Care/ Skilled Care</td>
<td>Port Jervis</td>
</tr>
<tr>
<td></td>
<td>St. Anthony Community Hospital, Warwick, New York[2]&lt;br&gt;<strong>St. Anthony Community Hospital</strong>[2]</td>
<td>Acute Care</td>
<td>Warwick</td>
</tr>
<tr>
<td></td>
<td>Villa Frances at the Knolls, Inc.[2]&lt;br&gt;<strong>Schervier Pavilion</strong>[2]</td>
<td>Long-Term Care</td>
<td>Warwick</td>
</tr>
<tr>
<td></td>
<td>St. Francis Center at the Knolls, Inc.[2]&lt;br&gt;<strong>Mount Alverno Center</strong>[2]</td>
<td>Assisted Living</td>
<td>Warwick</td>
</tr>
<tr>
<td>South Carolina</td>
<td><strong>St. Francis Hospital, Inc.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>St. Francis Hospital - Downtown</strong></td>
<td>Acute Care</td>
<td>Greenville</td>
</tr>
<tr>
<td></td>
<td><strong>St. Francis Hospital - Eastside</strong></td>
<td>Acute Care</td>
<td>Greenville</td>
</tr>
<tr>
<td></td>
<td><strong>St. Francis Physician Services, Inc.</strong></td>
<td>Physician Services</td>
<td>Greenville</td>
</tr>
<tr>
<td></td>
<td>Care Alliance Health Services[2]&lt;br&gt;<strong>Bon Secours – St. Francis Xavier Hospital, Inc.</strong>[2]&lt;br&gt;<strong>Roper Hospital, Inc.</strong>[2]&lt;br&gt;<strong>Roper St. Francis Mt. Pleasant Hospital, Inc.</strong>[2]</td>
<td>Acute Care</td>
<td>Charleston</td>
</tr>
</tbody>
</table>

31
<table>
<thead>
<tr>
<th>State</th>
<th>Entity Name and Facilities (in italics)</th>
<th>Description of Facility</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia</td>
<td><strong>Bon Secours-St. Mary’s Hospital of Richmond, Inc.</strong> <em>(b)</em>&lt;br&gt;&lt;br&gt;St. Mary’s Hospital <em>(b)</em></td>
<td>Acute Care</td>
<td>Richmond</td>
</tr>
<tr>
<td></td>
<td><strong>Bon Secours-Richmond Community Hospital, Incorporated</strong> <em>(b)</em>&lt;br&gt;&lt;br&gt;Richmond Community Hospital <em>(b)</em></td>
<td>Acute Care</td>
<td>Richmond</td>
</tr>
<tr>
<td></td>
<td><strong>Bon Secours-Memorial Regional Medical Center, Inc.</strong> <em>(b)</em>&lt;br&gt;&lt;br&gt;Memorial Regional Medical Center <em>(b)</em></td>
<td>Acute Care</td>
<td>Mechanicsville (Hanover County)</td>
</tr>
<tr>
<td></td>
<td>Chesapeake Hospital Corporation <em>(b)</em>&lt;br&gt;&lt;br&gt;Rappahannock General Hospital <em>(b)</em></td>
<td>Acute Care</td>
<td>Kilmarnock</td>
</tr>
<tr>
<td></td>
<td><strong>Bon Secours-St. Francis Medical Center, Inc.</strong> <em>(b)</em>&lt;br&gt;&lt;br&gt;St. Francis Medical Center <em>(b)</em></td>
<td>Acute Care</td>
<td>Midlothian (Chesterfield County)</td>
</tr>
<tr>
<td></td>
<td><strong>Maryview Hospital</strong>&lt;br&gt;&lt;br&gt;Maryview Medical Center</td>
<td>Acute Care</td>
<td>Portsmouth</td>
</tr>
<tr>
<td></td>
<td><strong>Bon Secours Maryview Behavioral Medical Center</strong></td>
<td>Behavioral Medicine</td>
<td>Portsmouth</td>
</tr>
<tr>
<td></td>
<td>Province Place of Maryview, L.L.C.&lt;br&gt;&lt;br&gt;Province Place of Maryview</td>
<td>Assisted Living</td>
<td>Portsmouth</td>
</tr>
<tr>
<td></td>
<td><strong>Mary Immaculate Hospital, Incorporated</strong> <em>(b)</em>&lt;br&gt;&lt;br&gt;Mary Immaculate Hospital <em>(b)</em></td>
<td>Acute Care</td>
<td>Newport News</td>
</tr>
<tr>
<td></td>
<td><strong>Mary Immaculate Nursing Care Center, Inc. (d/b/a St. Francis Nursing Care Center)</strong> <em>(b)</em></td>
<td>Long-Term Care</td>
<td>Newport News</td>
</tr>
<tr>
<td></td>
<td><strong>Bon Secours-DePaul Medical Center, Inc.</strong>&lt;br&gt;&lt;br&gt;DePaul Medical Center</td>
<td>Acute Care</td>
<td>Norfolk</td>
</tr>
<tr>
<td></td>
<td>Province Place of DePaul, L.L.C.&lt;br&gt;&lt;br&gt;Province Place of DePaul</td>
<td>Assisted Living</td>
<td>Norfolk</td>
</tr>
<tr>
<td></td>
<td><strong>Sentara Princess Anne Hospital</strong> <em>(b)</em></td>
<td>Acute Care</td>
<td>Virginia Beach</td>
</tr>
<tr>
<td></td>
<td><strong>Bon Secours-Maryview Nursing Care Center</strong></td>
<td>Long-Term Care</td>
<td>Suffolk</td>
</tr>
</tbody>
</table>

(a) Facility sold on July 10, 2017. See “OVERVIEW OF THE SYSTEM – The System – Asset Divestitures”.
(b) Not solely owned, directly or indirectly, by BSHSI. For additional information on certain of the joint ventures identified in this table, see “Joint Ventures” below.
Exemption from Federal Income Taxation

BSHSI, the Healthcare Providers which provide acute or long-term care, and the physician practices are exempt from federal income taxation under Section 501(a) of the IRC, as organizations described in Section 501(c)(3) of the IRC, but are not private foundations as defined in Section 509(a) of the IRC.

Shared Sponsorship Arrangements

Bon Secours Charity Health System, Inc.

Bon Secours Charity Health System, Inc. (“Charity”) is the sole member of five Healthcare Providers that own and operate three acute care hospitals, an acute care/skilled care hospital, a long-term care facility and an assisted living facility, and an affiliated medical group in the cities of Warwick, Port Jervis and Suffern, New York (such Healthcare Providers referred to collectively as Charity New York). The Sisters of Charity, an otherwise unaffiliated entity, along with Bon Secours Ministries, are the religious co-sponsors of Bon Secours Charity Health System, Inc. The Sisters of Charity and BSHSI hold a minority interest in Charity and its subsidiaries. See “Joint Ventures – Minority-Interest Joint Ventures – Bon Secours Charity Health System, Inc.”

Interest of Diocese of Richmond, Virginia in Certain Facilities

Prior to March 1984, the Catholic Bishop and certain parish priests of the Diocese of Richmond, Virginia were the sole members of Maryview Hospital, a Healthcare Provider and Member of the Obligated Group, which owns and operates Maryview Medical Center in Portsmouth, Virginia. Pursuant to a membership transfer agreement between the Sisters of Bon Secours and the Diocese of Richmond, the Diocese of Richmond transferred all of the membership rights in Maryview Hospital to the Sisters of Bon Secours in 1984, giving it full and complete membership rights in Maryview Hospital. The transfer agreement also confirmed pre-existing membership rights of the Sisters of Bon Secours in Bon Secours – St. Mary’s Hospital of Richmond, Inc., also a Healthcare Provider and Member of the Obligated Group, which owns and operates St. Mary’s Hospital, located in Richmond, Virginia. Under the transfer agreement, the membership rights in Maryview Hospital and Bon Secours – St. Mary’s Hospital of Richmond, Inc. may, independent of each other, revert to the Diocese of Richmond if the Sisters of Bon Secours attempt to transfer either of such membership rights to a third party, cease to operate either hospital or cease to operate either hospital in conformity with the philosophy and teachings of the Roman Catholic Church. Notwithstanding the foregoing, by agreement dated March 14, 2003, the Diocese of Richmond agreed that the transfer by the Sisters of Bon Secours of its rights, including membership rights, with respect to Maryview Hospital and Bon Secours – St. Mary’s Hospital of Richmond, Inc. to Bon Secours Ministries did not trigger the reversion of any membership rights in either of those hospitals to the Diocese of Richmond.

Joint Ventures

The System has adopted strategies and procedures to review, from time to time, the venturing with individual institutions, regional systems, product lines and other health care assets. Similarly, the System periodically examines its current affiliates and operating assets to determine whether those affiliates and assets are consistent with the System’s current operating strategies. As a result of those strategies, the System may from time to time divest itself of business lines that may not be consistent with the System’s current strategies. Likewise, the System from time to time evaluates its opportunities for strategic affiliations. Management of the System anticipates that it may enter into additional joint venture arrangements in the future.

The System has invested in a number of joint ventures, limited liability corporations and other entities to provide speciality healthcare services or engage in other activities. These investments range from minority investments with no control to majority investments or investments with control. The most significant of these investments are presented below.
Majority-Interest Joint Ventures

**Bon Secours – Richmond Health System** (“BSRHS”) BSHSI is the sole corporate member of Bon Secours Richmond, LLC (“BS Richmond, LLC”). BS Richmond, LLC and Richmond Memorial Health Foundation, an otherwise unaffiliated entity, are the corporate members of BSRHS. BSRHS is the sole corporate member of Bon Secours – St. Mary’s Hospital of Richmond, Inc. and Bon Secours – Richmond Community Hospital, Incorporated, and is the sole stockholder of Bon Secours – Memorial Regional Medical Center, Inc. and Bon Secours – St. Francis Medical Center, Inc., all of which are Members of the Obligated Group. BS Richmond, LLC, Richmond Memorial Health Foundation and BSRHS are not Members of the Obligated Group. Pursuant to a members’ agreement, BS Richmond, LLC has the right to receive 83% of the surplus capital (defined as contributed capital and earnings less a working capital reserve equal to 30 days cash on hand) of BSRHS and is obligated to provide 83% of any further capital contribution to BSRHS. Richmond Memorial Health Foundation is entitled to 17% of the surplus capital and is obligated to provide 17% of any capital contribution. The members’ agreement provides that any distributions of surplus capital are to be made upon the consent of both members, at the request of either member or upon dissolution of BSRHS. The results of operations, cash flows, assets and liabilities of BSRHS are included in BSHSI’s consolidated financial statements. The interest of Richmond Memorial Health Foundation in BSRHS is reflected as a non-controlling interest in such consolidated financial statements.

**Mary Immaculate Hospital, Incorporated** - BSHSI and the Congregation of Bernardine Franciscan Sisters, an otherwise unaffiliated entity, are the corporate members of Mary Immaculate Hospital, Incorporated, a Health Care Provider and Member of the Obligated Group. The Congregation of Bernardine Sisters is not a Member of the Obligated Group. BSHSI is entitled to receive a distribution of 50% of an amount equal to the cash and cash equivalents generated from the operations of Mary Immaculate Hospital, Incorporated, less 30 days cash on hand. The Congregation of Bernardine Sisters has the right to receive a distribution of the remaining 50%. BSHSI is obligated to provide 100% of any capital contribution to Mary Immaculate Hospital, Incorporated. The results of operations, cash flows, assets and liabilities of Mary Immaculate Hospital, Incorporated are included in BSHSI’s consolidated financial statements. The interest of the Congregation of Bernardine Sisters therein is reflected as a non-controlling interest in such consolidated financial statements.

Minority-Interest Joint Ventures

The System accounts for its interest in these entities under the equity method of accounting and includes its interest in the excess of revenues over expenses of these entities in its consolidated statements of operations and changes in unrestricted net assets as other revenue. None of these entities are otherwise affiliated with BSHSI and are not members of the Obligated Group.

**Bon Secours Charity Health System, Inc.** - BSHSI, the Sisters of Charity and Westchester Medical Center (Westchester), are members of Bon Secours Charity Health System, Inc. (Charity). Westchester holds a 60% controlling interest and BSHSI holds the remaining 40% interest in Charity. The System recorded gains of $0.4 million and $0.7 million in operating revenue related to its equity interest in Charity for the three months ended November 30, 2017 and 2016, respectively. As of November 30, 2017 and August 31, 2017, the System’s investment in Charity was $53.4 million and $53.0, respectively.

**Roper St. Francis Healthcare – South Carolina** - BSHSI, The Medical Society of South Carolina, and the Carolinas Health System, Inc. are members of Care Alliance Health Services (d/b/a Roper St. Francis Healthcare). Roper St. Francis Healthcare is the sole member of and operates Bon Secours – St. Francis Xavier Hospital, Roper Hospital, a supporting foundation and physician practices located in Charleston, South Carolina. BSHSI is obligated to provide 27% of any capital contribution to Roper St. Francis Healthcare and is entitled to 27% of any surplus capital.

The System recorded income of $2.4 million and income of $1.2 million related to its equity interest for the three months ended November 30, 2017 and 2016, respectively. Included in these amounts were the System’s allocated share of investment gains of $1.6 million and losses of $0.2 million for the three months ended November 30, 2017 and 2016, respectively. In addition, adjustments of $16 thousand and $1.0 million were recorded as net change in equity of joint ventures in 2017 and 2016, respectively, to reflect the System’s 27% interest in the net assets of the joint venture. As of November 30, 2017 and August 31, 2017, the System’s investment in Roper St. Francis Healthcare was $96.9 million and $94.5 million, respectively.
Sentara Princess Anne - BSHSI, DePaul Medical Center and Bon Secours Hampton Roads Health System (referred to as Bon Secours Hampton Roads) and Sentara Healthcare (Sentara) are members in a Virginia not-for-profit, nonstock, corporation that owns and operates Sentara Princess Anne Hospital located in Virginia Beach, Virginia. Sentara holds a 70% membership interest and DePaul Medical Center holds a 30% membership interest in the corporation. The joint venture is managed by Sentara and the agreements provide the members with rights to “put” and “call” the Bon Secours Hampton Roads’ membership interest at fair market value terms upon the occurrence of certain events and dates.

The System recorded income of $2.3 million and $2.6 million related to its equity interest during the three months ended November 30, 2017 and 2016, respectively. As of November 30, 2017 and August 31, 2017, the System’s investment in the joint venture was $30.1 million and $27.8 million, respectively.

Enterprise Risk Management

As part of the System’s strategic quality plan, the BSHSI Board of Directors, local system boards and management have adopted Enterprise Risk Management (“ERM”) methodologies to further refine the identification and management of critical risks to and opportunities for the System. The System has staff resources dedicated to ERM which support risk identification, awareness and mitigation. These efforts have proven beneficial in aligning board and management attention to those critical risks and opportunities that have the greatest effect on the mission and ministry of the System. Central to this effort is providing ongoing risk assessments to help identify key risk areas, and assure that controls and activities are effective in properly mitigating these risks. Enterprise risks are regularly updated, ranked by the Board and assigned to various Board committees and executive management. This process includes an assessment of risk areas and controls by the Board, executive management and key staff functions including operations, risk management, finance, legal, internal audit and compliance. The multitude of risks inherent within non-profit healthcare extends to all parts of the System. The System continues to implement and monitor ERM activities at both the Board and management level to help manage and support the mission interests of the System.

Compliance

The System has implemented a Corporate Responsibility Program (“CRP”) that is designed to assist the organization in carrying out its healthcare ministry in a manner consistent with the BSHSI Code of Conduct, in alignment with the System’s mission and values and responsive to the System’s legal, regulatory and ethical risks.

The CRP provides leadership, oversight and resources for the development, implementation and maintenance of a standardized, mission-based corporate responsibility program that includes:

- administering a comprehensive conflict of interest oversight and review process;
- providing education focused on risk areas that are specific to the System and customized to the BSHSI Code of Conduct, organizational culture and management structure;
- performing annual risk assessment procedures focused on proactive identification and mitigation of compliance risk;
- implementing an objective, System-wide reporting process to help ensure alignment with guidance promulgated by the U.S. Department of Health and Human Services Office of Inspector General, federal sentencing guidelines and industry best practices; and
- overseeing the development and implementation of a System-wide HIPAA privacy program.
Conflict of Interest

The System regularly monitors compliance with the BSHSI Conflict of Interest Policy. On an annual basis, all persons subject to the policy, including all officers, directors and key employees, are required to make certain disclosures relating to, among other things, certain personal, financial and organizational relationships that may present a conflict of interest, or the appearance of such a conflict, with the System. All disclosures go through a three-part review process. First, disclosures are reviewed by the BSHSI Corporate Responsibility Officer and the appropriate Corporate Responsibility Officer at the relevant entity. Second, a governance team comprised of the entity’s Chief Executive Officer, Board President, Board Chair and Corporate Responsibility Officer, as well as the BSHSI Corporate Responsibility Officer, participates in a second review of all disclosures during which recommendations are made as to the resolution of any conflicts or potential conflicts. Depending on the facts and circumstances, resolutions may include ongoing disclosure, recusal or removal of the conflict. Third, all disclosures and recommendations are reviewed by a committee of the BSHSI Board of Directors (the Audit and Compliance Committee reviews the disclosures with respect to management and the Governance Committee reviews the disclosures with respect to board members).

Community Benefits

The System exists to benefit the people in the communities it serves. In pursuing its mission, the System advocates for and provides services to help meet healthcare and related socioeconomic needs of poor and disadvantaged individuals and the broader community. The System provides services in the communities served by holistically ministering to the patients with respect and without regard to their ability to pay.

Programs and services for the uninsured and underinsured represent the financial commitment of the System to everyone in the community. The System’s financial assistance policy ensures that all members of the community receive this basic human right to access healthcare.

The categories included as programs and services for the poor and disadvantaged are as follows:

(i)  **Charitable Services – Financially Disadvantaged Persons**

The System provides care to patients regardless of their ability to pay all or a portion of the charges incurred. This care is classified as charity care based upon the System’s established policies. In accordance with Catholic Health Association guidelines, charity care represents the unpaid costs of free or discounted health services provided to persons who cannot afford to pay and who meet the organization’s criteria for financial assistance.

In assessing a patient’s ability to pay, the System utilizes generally recognized poverty income levels, financially supporting 100% of the healthcare services provided to patients with annual family income at or below 200% of the federal poverty guidelines. Additional assistance is provided by a reduction in charges for medically necessary services through a community service adjustment.

(ii) **Charitable Services – State Programs**

The System provides services to indigent patients under various state programs, including state Medicaid, that generally pay healthcare providers amounts that are less than the cost of the services provided to the recipients. Estimated unreimbursed costs of the care provided to these disadvantaged patients are also reported as charitable services.

(iii) **Other Community Benefits**

Other community benefits include community services for the poor and disadvantaged as well as the broader community. The programs cover a broad spectrum of services and are financially supported by the System:

- **Primary care access** – providing free community-based preventive and primary care services through free-standing clinics and mobile health vehicles;
• **Health screenings and immunizations** – providing free health screenings and immunizations for a variety of health conditions for women, children and senior residents;

• **Child programs** – providing oral healthcare, asthma and childhood obesity interventions;

• **Caregiver and senior programs** – focusing on support, health screenings and services to assist older adult populations;

• **Education** – providing medical and other health professional programs; and

• **Leadership activities** – providing a full-time healthy community leader in each community served who works to expand community capacity, identify community health needs and address social health conditions.

The cost of charitable services and community benefits provided by the System is determined in accordance with the System’s accounting policies. These costs are estimated by using the cost to charge ratio applied by Medicaid and other state programs as well as specific patient visits identified under the System’s charity care policies. The estimated cost of these services is as follows for the three months ended November 30, 2017 and 2016:

<table>
<thead>
<tr>
<th>Charitable services and other community benefits:</th>
<th>November 30,</th>
<th>November 30,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of services to financially disadvantaged persons</td>
<td>35,725</td>
<td>29,145</td>
</tr>
<tr>
<td>Unpaid cost of state programs (e.g., Medicaid) to financially disadvantaged persons</td>
<td>17,716</td>
<td>19,311</td>
</tr>
<tr>
<td>Cost of other community benefits</td>
<td>14,603</td>
<td>14,317</td>
</tr>
<tr>
<td>Total community benefits, at cost</td>
<td><strong>$ 68,044</strong></td>
<td><strong>$ 62,773</strong></td>
</tr>
</tbody>
</table>

**Corporate Governance**

**Bon Secours Ministries**

Bon Secours Ministries is a formally recognized entity established by the Roman Catholic Church to sponsor ministries in the name of the Catholic Church. The Sisters of Bon Secours transferred the sponsorship of the System to Bon Secours Ministries on November 1, 2006.

Bon Secours Ministries, an unincorporated association, has two classes of Members. The Class A Members are appointed by the Sisters of Bon Secours and currently consist of four of the Sisters of Bon Secours. The Class B Members are appointed by the Class A Members and currently consist of the Chairperson of the Board of Directors of BSHSI and two other lay persons.

Bon Secours Ministries provides direction and canonical oversight to the spiritual and charitable works of the System to ensure that the System is faithful to its mission and Catholic identity. As a sponsor of the System, Bon Secours Ministries holds certain reserved powers over BSI and its subsidiaries in accordance with the Catholic Church’s Code of Canon Law.

The sponsorship model described above reflects the commitment of the Sisters of Bon Secours to collaborate with laity and is in consideration of the decrease in the number of women religious.
Bon Secours, Inc.

BSI is the sole corporate member of BSHSI. There are two classes of Members of BSI. The Class A Members of Bon Secours Ministries are, *ex officio*, the Class A Members of BSI. The Class B Members of Bon Secours Ministries are, *ex officio*, the Class B Members of BSI.

The members of the Board of Directors of BSI are the Class A and Class B Members of Bon Secours Ministries. Under its articles of incorporation and bylaws, BSI has, with respect to actions of any entity which it controls, either directly or indirectly, specified reserved powers which are discussed below. The entities over which BSI may exercise those powers include all of the Members of the Obligated Group, although with respect to certain Members of the Obligated Group, as described elsewhere in this Financial Disclosure Statement, some of these reserved powers are shared with an unrelated third party.

Bon Secours Health System, Inc.

Except for powers reserved to BSI and, pursuant to the Catholic Church’s *Code of Canon Law*, Bon Secours Ministries, as described below under the sub-caption “Reserved Powers,” the affairs of BSHSI are governed by its Board of Directors. The Board of Directors of BSHSI is appointed by BSI, with the number of directors determined periodically by BSI through its appointment process. The Board of Directors of BSHSI currently consists of 20 directors. The Chief Executive Officer/President of BSHSI is an *ex officio* director of BSHSI with voting power. The Chairperson of the BSHSI Board of Directors is appointed by Bon Secours Ministries.

The Board of Directors of BSHSI, subject to BSI’s reserved powers, directly or indirectly exercises certain reserved powers over all of the System’s affiliates. The Board functions generally in areas of policy development, quality improvement, goal setting, strategic planning and budgeting and general oversight. Any action by the Board of Directors of BSHSI with respect to which BSI holds a reserved power may be superseded by action of BSI.

The Board of Directors of BSHSI, subject to approval by BSI, appoints the Chief Executive Officer/President of BSHSI and exercises the power delegated to it from BSI to appoint the members of the boards of directors of many System entities, including members of the boards of the other Members of the Obligated Group. BSHSI controls the appointment of the Senior Vice Presidents of Sponsorship for the members of the System in accordance with applicable policies. BSI controls the appointment of the Presidents of all entities under its direct or indirect control, with the exception of Mary Immaculate Hospital, Incorporated, which is a Healthcare Provider and a Member of the Obligated Group, as described elsewhere in this Financial Disclosure Statement.

BSHSI is the sole corporate member of each Local Parent, which are described below under the sub-caption “Reserved Powers.” All other powers of the Local Parents are vested in their respective boards of directors, which are selected by the Board of Directors of BSHSI, except as described below. The President of each of these corporations, who is appointed by BSI, except as described above, and the Executive Vice President and/or Chief Executive Officer of each of these corporations, who is appointed by BSHSI, except as provided above, serve *ex officio* as voting members of the respective boards.
Healthcare Providers

BSHSI is the sole corporate member of the Healthcare Providers, except for those Healthcare Providers whose sole corporate member is a Local Parent (of which BSHSI is the sole corporate member) and except for the Healthcare Providers discussed under “Joint Ventures.” According to the governing documents of the Healthcare Providers, the operations of the Healthcare Providers are governed by their respective boards of directors, with specified powers reserved to the Local Parents or to BSHSI if there is no Local Parent for a Healthcare Provider. In certain instances in which BSHSI and another entity which is not a member of the System are the corporate members of a Healthcare Provider or Local Parent, certain specified reserved powers are shared by BSHSI and the other corporate member. The bylaws of the Healthcare Providers generally provide for 9 to 19 directors and, as to each Healthcare Provider that operates a hospital, require that at least one director be a physician.

Reserved Powers

In general, “reserved powers” refers to the requirement of approval by a higher level entity within the System when certain significant activities are to be undertaken by a System affiliate. The reserved powers arise out of the Catholic Church’s Code of Canon Law, contractual requirements and policy considerations. The reserved powers flow throughout all levels of the System through interlocking provisions of the articles of incorporation, bylaws and, in certain instances, the joint operating agreements of each System affiliate and apply to, among other actions, amendments to governing documents, merger, consolidation or dissolution, selection of principal officers and members of the governing body and incurrence of indebtedness above certain threshold amounts. Some reserved powers are, in certain cases, held by BSI and Bon Secours Ministries, which are not Members of the Obligated Group, and, in certain other cases, shared with various joint venture partners. Reserved powers shared with joint venture partners may include powers relating to amendments of the joint-venture entity’s governing documents, the appointment of a certain number of board members, the appointment of certain officers (including as described under the subcaption “Bon Secours Health System, Inc.” above), the admission of additional members into the joint venture, certain significant transactions (including the divestiture of facilities or dissolution of the joint-venture entity) and the incurrence of indebtedness and/or conveyance of assets in excess of certain amounts.

In addition to the formal reserved powers, various approval powers are reserved by Local Parents for such matters as capital and operating budget approvals, unbudgeted expenditures in excess of specified dollar amounts, long range and strategic planning, acquisition of real property interests above specified dollar amounts and capital campaigns or other fund-raising activities. Further, by corporate policy, the power to review and approve certain activities of the Healthcare Providers and the Local Parents, such as operating and capital budgets, strategic plans, unbudgeted expenditures in excess of specific dollar amounts, new projects and programs and borrowings over a specified amount, are also reserved to BSHSI.
The following table lists the names, offices and principal occupations of the individuals who served on the Board of Directors of BSHSI as of November 30, 2017:

<table>
<thead>
<tr>
<th>Board Member/Office</th>
<th>Principal Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Allen (Chairperson)</td>
<td>Board Chairperson, Bon Secours Health System, Inc.; Executive Director/CEO, Authority Health, Detroit, Michigan</td>
</tr>
<tr>
<td>Charles H. Brown, III</td>
<td>Consultant, Ellin and Tucker, Chartered, Baltimore, Maryland</td>
</tr>
<tr>
<td>Denise Brooks-Williams</td>
<td>President and Chief Executive Officer, Henry Ford Wyandotte Hospital, Wyandotte, Michigan</td>
</tr>
<tr>
<td>Marcia Dush</td>
<td>Retired Actuary, Austin, Texas</td>
</tr>
<tr>
<td>Sr. Frances Gorsuch, C.B.S.</td>
<td>Coordinator, Trauma Informed Care, Bon Secours Hospital, Baltimore, Maryland</td>
</tr>
<tr>
<td>Stephanie L. Ferguson, PhD</td>
<td>President, Stephanie L. Ferguson, Inc.</td>
</tr>
<tr>
<td>Lizanne C. Gottung</td>
<td>Retired Human Resources Executive, Atlanta, Georgia</td>
</tr>
<tr>
<td>A. David Jimenez</td>
<td>Retired Health Care Executive, McDonald, Tennessee</td>
</tr>
<tr>
<td>Clarion Johnson M.D.</td>
<td>Retired Medical Director, Exxon Mobil, Chevy Chase, Maryland</td>
</tr>
<tr>
<td>Gerard Kells</td>
<td>Retired Human Resources Executive, Naples, Florida</td>
</tr>
<tr>
<td>Robert Kuramoto, M.D.</td>
<td>Partner, Christie Clinic, Chicago, Illinois</td>
</tr>
<tr>
<td>Peter F. Maddox</td>
<td>Partner, Royer-Maddox-Herron Advisors, San Antonio, Texas</td>
</tr>
<tr>
<td>Jennifer O’Brien</td>
<td>Chief Compliance Officer, United Healthcare Medicare and Retirement</td>
</tr>
<tr>
<td>Dina Richard</td>
<td>SVP Treasury and Chief Investment Officer, Trinity Health, Livonia, Michigan</td>
</tr>
<tr>
<td>Susan Sandlund</td>
<td>Founding Partner, Veritas Partners, New York, New York</td>
</tr>
<tr>
<td>Sr. Mary Shimo, C.B.S.</td>
<td>Secretary, Congregation of Bon Secours Paris, Marriottsville, Maryland</td>
</tr>
<tr>
<td>John M. Starcher, Jr. Esq.</td>
<td>President and CEO, Mercy Health, Cincinnati, Ohio</td>
</tr>
<tr>
<td>Richard Statuto</td>
<td>Chief Executive Officer/President, Bon Secours Health System, Inc., Marriottsville, Maryland</td>
</tr>
<tr>
<td>Sr. Alice Talone, C.B.S.</td>
<td>Sister of Bon Secours, Ellicott City, Maryland</td>
</tr>
<tr>
<td>Carol Taylor, RN, Ph.D.</td>
<td>Professor, Georgetown University, Washington, D.C.</td>
</tr>
</tbody>
</table>
Pursuant to BSHSI’s bylaws, the following standing Board committees have been created: Governance Committee, Audit and Compliance Committee, Human Resources Committee, Compensation Committee, Quality Improvement Committee, Finance Committee and Pension and Investment Committee. These committees consist of both independent board members as well as “advisory” (non-board) members. The responsibilities of each of these Committees are discussed below:

- The Governance Committee assists the Board in helping ensure sound corporate governance through education, orientation, evaluation and board and committee succession planning, including recommending to the board persons to be appointed and reappointed to, or removed from, the Board and committees of BSHSI and the boards of other System affiliates.

- The Audit and Compliance Committee assists the Board in its oversight responsibilities relating to the financial reporting process, the system of internal controls, the audit process (both internal and external), risk management and the process for monitoring compliance with laws, regulations and the BSHSI Code of Conduct.

- The Human Resources Committee assists the Board in ensuring that human resource programs model BSHSI’s values and operating principles and improve organizational performance through strategic objectives pertaining to talent management and development.

- The Compensation Committee approves and maintains processes for the regular review of the performance, development, compensation and benefits of the BSHSI Chief Executive Officer and Chairperson of the BSHSI Board of Directors, as well as other senior and executive leaders throughout the System.

- The Quality Improvement Committee assists the Board with oversight of the System’s strategic quality plan, provides System-wide guidance and oversight of quality improvement initiatives and supports local system boards with local system-specific quality initiatives.

- The Finance Committee assists the Board with consolidated System-level strategic financial planning and oversight in areas that include financial operations and performance, planning and budgeting and capital structuring.

- The Pension and Investment Committee assists the Board in its efforts to optimize investment returns within established risk parameters for the System’s short- and long-term investable assets. The Pension and Investment Committee also oversees the stewardship of assets set aside to provide long-term retirement benefits under defined benefit plans and provides a reasonable range of defined contribution investment options from which individual participants may select.

**Executive Officers**

Information with respect to the executive officers of BSHSI is set forth below.

**Richard Statuto, Chief Executive Officer/President, age 60.** Mr. Statuto was appointed Chief Executive Officer/President in February 2005. Prior to joining BSHSI, Mr. Statuto was President and Chief Executive Officer of St. Joseph Health System, Orange, California, since 1995. Previously, Mr. Statuto served as Chief Operating Officer of the St. Joseph Health System during 1994 and as Vice President of Marketing from 1990 to 1994. Mr. Statuto was Vice President for Business Development, Marketing and Planning of BSHSI from 1987 to 1990. Mr. Statuto also previously was a consultant with Touche Ross & Company. Mr. Statuto was previously the Chair of the Catholic Health Association and Vice Chairman of the Board of Christus Health, Dallas, Texas. Mr. Statuto currently serves as Chairman of the Board of Premier, Inc. Mr. Statuto received his Bachelor’s Degree in Engineering from Vanderbilt University in 1980 and his Master’s Degree in Business Administration from Xavier University in 1983.

**Janice Burnett, Executive Vice President and Chief Financial Officer, age 60.** Ms. Burnett was appointed Chief Financial Officer in March 2012 after serving as Vice President, Operations Finance of BSHSI since October 2007. Prior to joining BSHSI, Ms. Burnett served as Senior Director, Strategic Finance and Operations at Ascension Health, located in St. Louis, Missouri, since June 2003. Prior experience includes 11 years
as Director of Finance at BJC Health System, Inc., located in St. Louis, Missouri, and five years of public accounting with Ernst & Young. Ms. Burnett received her CPA certification in 1988 and is a Chartered Global Management Accountant. She has been a member of the American Institute of Certified Public Accountants and Health Financial Management Association since 1988. Ms. Burnett received her Master’s in Business Administration from Maryville University, St. Louis, Missouri, in 1998 and her Bachelor’s Degree of Science in Accounting from Wright State University, Dayton, Ohio, in 1988.

Sr. Anne Lutz, Executive Vice President, Sponsorship, age 77. Sr. Anne currently serves as Executive Vice President for Sponsorship. Sr. Anne has been a member of the Sisters of Bon Secours since 1960 and has more than 30 years of experience in both acute care and geriatric care at both staff and management levels. Sr. Anne is the senior officer currently responsible for sponsorship, mission and community health functions within BSHSI. She also has oversight responsibility for Bon Secours Baltimore Health System in Maryland. Sr. Anne presently serves on the boards of Bon Secours Baltimore Health System, Bon Secours Charity Health System and Bon Secours Assurance Company Ltd. She is Treasurer of the Sisters of Bon Secours USA, and currently also serves on the Finance Committees and Investment Committees of the Sisters of Bon Secours USA and Sisters of Bon Secours Paris. Sr. Anne is a graduate of the Bon Secours School of Nursing. She received her Bachelor’s Degree in Administration and Arts from the University of Detroit in 1976.

Christine A. Lay, Senior Vice President, Governance and Sponsorship, age 60. Ms. Lay was appointed Senior Vice President, Governance and Sponsorship in December 2016. Ms. Lay currently serves as chief governance officer and is corporate secretary for BSHSI. Previously, Ms. Lay served as Vice President and Deputy General Counsel, as well as Director in the BSHSI Legal Department, assisting with the management of legal affairs and legal policy within the System. Prior to joining BSHSI in 2000, Ms. Lay was a Senior Attorney with the Detroit Medical Center in Detroit, Michigan. Before entering the practice of law, she was a recreational therapist. Ms. Lay received her Bachelor’s Degree from Towson University in 1978, her Master’s Degree in Therapeutic Recreation from the University of Maryland in 1988 and her Law Degree from Rutgers University School of Law in 1997.

Matthew J. Toddy, Executive Vice President, General Counsel, age 58. Mr. Toddy was appointed Executive Vice President, General Counsel in February 2010 and prior to that was Senior Vice President, General Counsel since June 2005. Mr. Toddy is responsible for oversight and management of the legal affairs of the System. Prior to joining BSHSI, Mr. Toddy was a partner at the law firm of Jones Day in Atlanta, Georgia. Mr. Toddy received his Bachelor’s Degree from the University of Notre Dame in 1982 and his Law Degree from The Ohio State University in 1985.

Tim Davis, Executive Vice President, Chief Administrative Officer, age 64. Mr. Davis was appointed Executive Vice President, Chief Administrative Officer in January 2010. Mr. Davis joined BSHSI in October 2007 as the Executive Vice President, Organization Effectiveness after a 31-year career with General Electric (GE) where he served in progressively more responsible human resource leadership positions within GE’s national and international divisions. For six years, Mr. Davis served on the Board of Directors of BSHSI and was a member and past Chair of the board’s Human Resources Committee and Compensation Committee. Mr. Davis has served on numerous boards and councils over the years including the United Way, Massachusetts Private Industry Council and the Chambers of Commerce of North Central Massachusetts, Albany, New York and Bethlehem, New York. Mr. Davis received his Bachelor’s Degree in Biology from Massachusetts College and his Master’s Degree in Administration from St. Michael’s College.

Dr. Marlon Priest, Executive Vice President and Chief Medical Officer, age 65. Dr. Priest was appointed Executive Vice President and Chief Medical Officer in February 2010 and joined BSHSI as Chief Medical Officer in November 2006. He is responsible for leading Clinical Transformation as well as achieving the strategic goals related to physician integration and ambulatory care services. Prior to joining BSHSI he was Professor of Emergency Medicine and Surgery at the University of Alabama at Birmingham and Senior Associate Chief of Staff for the University Hospital. He is an honors graduate of the University of Alabama School of Medicine and has earned board certification in both emergency medicine and internal medicine.

Laishy Williams-Carlson, Senior Vice President and Chief Information Officer, age 57. Ms. Williams-Carlson was appointed Senior Vice President and Chief Information Officer in 2014, and joined BSHSI in 1984 in Hampton Roads. Ms. Williams-Carlson transitioned to information services in the Hampton Roads’ market in 1997 and in 2005 to the Health System Office as Regional Chief Information Officer. Ms. Williams-Carlson co-led Bon Secours’ ConnectCare system implementation, the system’s electronic health record application. Under her leadership, Bon Secours’ attained the Healthcare Information and Management Systems Society (HIMSS)
Electronic Medical Record Adoption Model (EMRAM) Stage 7 status for several hospitals and ambulatory clinics in Virginia. Bon Secours is also noted as a “Most Wired” health system. Ms. Williams-Carlson is active in the College of Healthcare Information Management Executives and HIMSS, and past Chapter President in Virginia. She holds a Masters of Science in Health Administration from Virginia Commonwealth University, Richmond, Virginia, and a Bachelor of Science degree in Accounting from Old Dominion University, Norfolk, Virginia, and is also a Certified Professional in Health Information Management Systems and a Six Sigma Black Belt.

Dr. Thomas Morris, Senior Vice President, Sponsorship & Theology, age 61. Dr. Morris was appointed Senior Vice President, Sponsorship and Theology and Executive Director of Bon Secours Ministries in December 2009. He also serves as Senior Vice President, Sponsorship for Bon Secours St. Francis Health System in Greenville, South Carolina. Dr. Morris has been with the System since 1998. He assists the Chair of Bon Secours Ministries and the Chief Executive Officer of BSHSI by planning, developing and coordinating the sponsorship infrastructure for Bon Secours Ministries and BSHSI. Dr. Morris received a Bachelor of Arts Degree from The Catholic University of America in Washington, D.C. and a Master’s Degree in Theology from the Washington Theological Union. He also has a Master’s Degree and Doctorate in religious studies from the School of Religious Studies of The Catholic University of America.

Sr. Anne Marie Mack, Senior Vice President, Sponsorship, age 70. Sr. Anne Marie graduated from the University of Delaware and Wayne State University in Detroit with degrees in Nursing. She is currently the Senior Vice President of Sponsorship in Richmond and the President of the Bon Secours – Richmond Health System Board of Directors. Sr. Anne Marie has also worked in BSHSI’s local systems in Baltimore and Michigan. She served as President of the Sisters of Bon Secours in the U.S. from 1996 until 2003. She has been a Sister of Bon Secours for 45 years.

Br. Arthur Caliman, Senior Vice President, Sponsorship, age 69. Br. Arthur was appointed Senior Vice President for Sponsorship in September 2008. Br. Arthur has been a member of the Xaverian Brothers since 1965 and has served as both General Superior (2001-2007) and Director of Sponsorship (1988-1994). He has 40 years of experience in health care and social services at both staff and management levels. Br. Arthur serves as the Sponsorship leader for local Bon Secours systems in New York and Hampton Roads, Virginia. He is a graduate of the Catholic University of America, where he received both his Bachelor’s Degree (1970) and Master’s Degree (1971).

Mark Nantz, Executive Vice President for Strategy and Growth of Bon Secours Health System and Market Leader of Bon Secours St. Francis Health System, age 53. Mr. Nantz is the Executive Vice President for Strategy and Growth for the System. Mr. Nantz was appointed Chief Executive Officer of Bon Secours St. Francis Health System in December 2009. In this role, he had responsibility for leading, directing and managing two acute care hospitals, a number of outpatient and ancillary businesses and St. Francis Physician Services, Inc. In addition, prior to the joint venture with WMC (see “Acquisitions and Disposals – Bon Secours Charity Health System, Inc.”), Mr. Nantz served as the Market Leader for the Bon Secours Charity Health System in Suffern, New York, providing executive leadership for three acute care hospitals, a long-term care facility and a nursing home. Prior to Bon Secours, Mr. Nantz served as President of Carolinas Medical Center-Northeast in Concord, North Carolina. Mr. Nantz earned his Masters of Health Administration from Pfeiffer University and a Bachelor of Science in Accounting from the University of North Carolina at Charlotte. He is a Certified Public Accountant, a Fellow in the American College of Healthcare Executives, and a Member - American Institute of Certified Public Accountants and the Healthcare Financial Management Association.

Dr. Samuel Lee Ross, Chief Executive Officer of Bon Secours Baltimore Health System and Market Leader of Bon Secours Kentucky Health System, age 63. Dr. Ross is the Chief Executive Officer for Bon Secours Baltimore Health System, and is the Market Leader for Bon Secours Kentucky Health System. He also serves on the System’s executive management team. Dr. Ross joined the System in August 2006. Dr. Ross is a member of the Board of Directors of the Federal Reserve Bank of Richmond, Baltimore branch. Dr. Ross was previously the Executive Vice President and Chief Medical Officer of Parkland Health and Hospital System, in Dallas, Texas. Dr. Ross received his Medical Degree from the University of Texas Health Science Center Medical School in San Antonio, Texas, and a Master of Science in Medical Management from the University of Texas at Dallas, Richardson, Texas.

Toni Ardabell, Chief Executive Officer of Bon Secours Virginia Health System, age 62. As the Chief Executive Officer of Bon Secours Virginia and Bon Secours Richmond Health System, Ms. Ardabell is responsible for the strategic planning and operational oversight for eight acute care hospitals, a number of ambulatory care
services, and five senior care service centers in the Richmond, Rappahannock, and Hampton Roads areas. Prior to joining Bon Secours as the Chief Executive Officer of St. Mary’s Hospital in 2009, Ms. Ardabell was with the Inova Health System for 27 years. Ms. Ardabell earned her bachelor of science in nursing from Pennsylvania State University in State College, Pennsylvania, her master of science in nursing from Catholic University of America, in Washington, D.C., and her master in business administration from Marymount University in Arlington, Virginia.

**Dr. John Wallenhorst, Vice President Mission and Ethics, age 63.**  Dr. Wallenhorst is Senior Vice President, Mission and Ethics for Bon Secours Health System, and is a member of the system Executive Management Team. He is responsible for oversight of the organization’s Mission Department and Ethics Program, and leadership of Mission activities throughout the system, including mission integration, community benefit services, clinical and organizational ethics, spiritual care, advocacy and government relations, and ecological stewardship and global ministries. Dr. Wallenhorst is also Senior Vice President of Sponsorship, and in that capacity serves as the President of the Bon Secours Charity Board of Directors. Additionally, he is adjunct assistant professor at Georgetown University where he teaches undergraduate and graduate courses in health care ethics. With advanced degrees in philosophy and theology, including a Ph.D. in systematic theology from the University of Toronto (St. Michael’s College), and a Master of Science in organization development and strategic human resources from the Johns Hopkins University, John’s areas of professional interest include foundational theology, Catholic Social Teaching, ethics integration, and leadership formation.

**Employees**

The System employed approximately 17,300 full-time equivalents at November 30, 2017. Certain employees providing professional technical and support services at the Baltimore and New York Healthcare Providers are represented by labor unions. No other employees are unionized. BSHSI believes relations with employees throughout the System are good.
## Bon Secours Health System, Inc. and Subsidiaries

Unaudited Consolidated Balance Sheets  
November 30, 2017 and August 31, 2017  
(In thousands)

<table>
<thead>
<tr>
<th>Assets</th>
<th>November 30,</th>
<th>August 31,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$161,117</td>
<td>274,348</td>
</tr>
<tr>
<td>Accounts receivable, net:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and third-party payors</td>
<td>376,075</td>
<td>361,892</td>
</tr>
<tr>
<td>Other</td>
<td>30,747</td>
<td>32,546</td>
</tr>
<tr>
<td>Total accounts receivable, net</td>
<td>406,822</td>
<td>394,438</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
<td>77,858</td>
<td>66,984</td>
</tr>
<tr>
<td>Inventories</td>
<td>62,793</td>
<td>61,939</td>
</tr>
<tr>
<td>Prepaid expenses and other current assets</td>
<td>43,680</td>
<td>44,372</td>
</tr>
<tr>
<td>Total current assets</td>
<td>752,270</td>
<td>842,081</td>
</tr>
<tr>
<td>Assets limited or restricted as to use, less current portion</td>
<td>1,408,883</td>
<td>1,376,059</td>
</tr>
<tr>
<td>Property, plant and equipment, net</td>
<td>976,642</td>
<td>979,057</td>
</tr>
<tr>
<td>Other long-term assets, net</td>
<td>366,058</td>
<td>368,926</td>
</tr>
<tr>
<td>Total assets</td>
<td>$3,503,853</td>
<td>3,566,123</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities and Net Assets</th>
<th>November 30,</th>
<th>August 31,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current portion of long-term debt</td>
<td>$22,888</td>
<td>59,656</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>165,606</td>
<td>207,280</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
<td>171,880</td>
<td>175,068</td>
</tr>
<tr>
<td>Other accrued expenses</td>
<td>112,803</td>
<td>118,453</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>473,177</td>
<td>560,457</td>
</tr>
<tr>
<td>Long-term debt, less current portion</td>
<td>832,586</td>
<td>830,192</td>
</tr>
<tr>
<td>Other long-term liabilities and deferred credits</td>
<td>632,565</td>
<td>646,871</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>1,938,328</td>
<td>2,037,520</td>
</tr>
<tr>
<td>Net assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted-controlling interest</td>
<td>1,209,520</td>
<td>1,182,153</td>
</tr>
<tr>
<td>Unrestricted-noncontrolling interest</td>
<td>303,071</td>
<td>294,791</td>
</tr>
<tr>
<td>Total unrestricted</td>
<td>1,512,591</td>
<td>1,476,944</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>39,910</td>
<td>38,783</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>13,024</td>
<td>12,876</td>
</tr>
<tr>
<td>Total net assets</td>
<td>1,565,525</td>
<td>1,528,603</td>
</tr>
<tr>
<td>Total liabilities and net assets</td>
<td>$3,503,853</td>
<td>3,566,123</td>
</tr>
</tbody>
</table>

Bon Secours Health System, Inc. and Subsidiaries
<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>$821,143</td>
<td>$812,061</td>
</tr>
<tr>
<td>before bad debts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision for patient bad debts</td>
<td>(37,545)</td>
<td>(46,996)</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>783,598</td>
<td>765,065</td>
</tr>
<tr>
<td>Other revenue</td>
<td>40,847</td>
<td>41,060</td>
</tr>
<tr>
<td>Total revenues</td>
<td>824,445</td>
<td>806,125</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages and benefits</td>
<td>430,523</td>
<td>420,231</td>
</tr>
<tr>
<td>Supplies</td>
<td>153,718</td>
<td>146,178</td>
</tr>
<tr>
<td>Purchased services and other</td>
<td>175,276</td>
<td>186,466</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>32,768</td>
<td>34,084</td>
</tr>
<tr>
<td>Interest</td>
<td>8,322</td>
<td>8,784</td>
</tr>
<tr>
<td>Total expenses</td>
<td>800,607</td>
<td>795,743</td>
</tr>
<tr>
<td>Income from operations</td>
<td>23,838</td>
<td>10,382</td>
</tr>
<tr>
<td><strong>Nonoperating gains (losses), net:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonoperating investment gains (losses), net</td>
<td>24,714</td>
<td>(6,046)</td>
</tr>
<tr>
<td>Other nonoperating activities, net</td>
<td>(13,273)</td>
<td>(10,116)</td>
</tr>
<tr>
<td>Total nonoperating gains (losses), net</td>
<td>11,441</td>
<td>(16,162)</td>
</tr>
<tr>
<td><strong>Excess of revenues over expenses</strong></td>
<td>$35,279</td>
<td>(5,780)</td>
</tr>
</tbody>
</table>
### Bon Secours Health System, Inc. and Subsidiaries

Unaudited Consolidated Statement of Changes in Net Assets

For the Three Months Ended November 30, 2017

(In thousands)

<table>
<thead>
<tr>
<th>Description</th>
<th>Unrestricted net assets</th>
<th>Temporarily restricted net assets</th>
<th>Permanently restricted net assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at August 31, 2017</td>
<td>$1,476,944</td>
<td>38,783</td>
<td>12,876</td>
<td>1,528,603</td>
</tr>
<tr>
<td>Excess of revenue over expenses</td>
<td>35,279</td>
<td>-</td>
<td>-</td>
<td>35,279</td>
</tr>
<tr>
<td>Grants and restricted contributions</td>
<td>-</td>
<td>3,597</td>
<td>148</td>
<td>3,745</td>
</tr>
<tr>
<td>Grants for capital</td>
<td>52</td>
<td>-</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>Net change in unrealized gains on other-than-trading securities</td>
<td>279</td>
<td>60</td>
<td>-</td>
<td>339</td>
</tr>
<tr>
<td>Investment income</td>
<td>-</td>
<td>320</td>
<td>-</td>
<td>320</td>
</tr>
<tr>
<td>Net assets released from restrictions used for purchase of property, plant and equipment</td>
<td>1,158</td>
<td>(1,158)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net assets released from restrictions used for operations</td>
<td>-</td>
<td>(1,692)</td>
<td>-</td>
<td>(1,692)</td>
</tr>
<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>(1,649)</td>
<td>-</td>
<td>-</td>
<td>(1,649)</td>
</tr>
<tr>
<td>Transfers to affiliates and other changes, net</td>
<td>528</td>
<td>-</td>
<td>-</td>
<td>528</td>
</tr>
<tr>
<td>Increase in net assets</td>
<td>35,647</td>
<td>1,127</td>
<td>148</td>
<td>36,922</td>
</tr>
<tr>
<td>Balance at November 30, 2017</td>
<td>$1,512,591</td>
<td>39,910</td>
<td>13,024</td>
<td>1,565,525</td>
</tr>
</tbody>
</table>
### Unaudited Consolidated Statements of Cash Flows
For the Three Months Ended November 30, 2017 and 2016

*(in thousands)*

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase (decrease) in net assets</td>
<td>$36,922</td>
<td>(6,907)</td>
</tr>
<tr>
<td>Provision for bad debts</td>
<td>37,545</td>
<td>46,996</td>
</tr>
<tr>
<td>Depreciation &amp; amortization, including $1,117 and $1,258 reported in nonoperating activities, net in 2017 and 2016, respectively</td>
<td>33,885</td>
<td>35,342</td>
</tr>
<tr>
<td>Amortization of deferred financing costs and bond premium/discount, net</td>
<td>(277)</td>
<td>(271)</td>
</tr>
<tr>
<td>Cash distribution to noncontrolling interest owners and affiliates</td>
<td>1,177</td>
<td>2,813</td>
</tr>
<tr>
<td>Equity in (income) loss of joint ventures</td>
<td>(5,227)</td>
<td>11,031</td>
</tr>
<tr>
<td>Distributions received from investments in joint ventures</td>
<td>-</td>
<td>(50)</td>
</tr>
<tr>
<td>Unrealized losses (gains) on investment in joint ventures</td>
<td>7,316</td>
<td>(456)</td>
</tr>
<tr>
<td>Contributions restricted by donor</td>
<td>(3,745)</td>
<td>(2,176)</td>
</tr>
<tr>
<td>Grants received for capital expenditures</td>
<td>(52)</td>
<td>-</td>
</tr>
<tr>
<td>Net realized/unrealized (gains) losses on certain investments and derivatives</td>
<td>(26,619)</td>
<td>5,288</td>
</tr>
<tr>
<td>Net change in accounts receivable</td>
<td>(49,929)</td>
<td>(60,686)</td>
</tr>
<tr>
<td>Net change in accounts payable and other current liabilities</td>
<td>(49,152)</td>
<td>(22,005)</td>
</tr>
<tr>
<td>Net change in inventories, prepaid expenses, and other current assets</td>
<td>(162)</td>
<td>(8,789)</td>
</tr>
<tr>
<td>Net change in other long-term assets, net</td>
<td>341</td>
<td>(19,795)</td>
</tr>
<tr>
<td>Net change in other long-term liabilities &amp; deferred credits</td>
<td>(13,606)</td>
<td>(7,413)</td>
</tr>
<tr>
<td><strong>Net cash used in operating activities</strong></td>
<td>(31,583)</td>
<td>(27,078)</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of land held for investment</td>
<td>(1,121)</td>
<td>-</td>
</tr>
<tr>
<td>Property, plant &amp; equipment additions, net of disposals</td>
<td>(31,032)</td>
<td>(36,415)</td>
</tr>
<tr>
<td>Sales (purchases) of securities, net</td>
<td>38,216</td>
<td>(6,776)</td>
</tr>
<tr>
<td>Purchases of equity and fixed income commingled funds</td>
<td>(53,570)</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from sale of alternative investments</td>
<td>172</td>
<td>8,901</td>
</tr>
<tr>
<td>Payments related to interest rate swaps</td>
<td>(1,475)</td>
<td>(3,042)</td>
</tr>
<tr>
<td><strong>Net cash used in investing activities</strong></td>
<td>(48,811)</td>
<td>(37,332)</td>
</tr>
<tr>
<td><strong>Cash flows from financing activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments of long-term debt</td>
<td>(7,817)</td>
<td>(27,651)</td>
</tr>
<tr>
<td>Proceeds from issuance of long-term debt</td>
<td>249,925</td>
<td>-</td>
</tr>
<tr>
<td>Retirement of long-term debt</td>
<td>(246,950)</td>
<td>-</td>
</tr>
<tr>
<td>Defeasance of debt</td>
<td>(30,225)</td>
<td>-</td>
</tr>
<tr>
<td>Payment of deferred financing fees</td>
<td>(390)</td>
<td>-</td>
</tr>
<tr>
<td>Cash distributions to noncontrolling interest owners and affiliates</td>
<td>(1,177)</td>
<td>(2,813)</td>
</tr>
<tr>
<td>Grants received for capital expenditures</td>
<td>52</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from contributions restricted by donor</td>
<td>3,745</td>
<td>2,176</td>
</tr>
<tr>
<td><strong>Net cash used in financing activities</strong></td>
<td>(32,837)</td>
<td>(28,288)</td>
</tr>
<tr>
<td><strong>Net decrease in cash &amp; cash equivalents</strong></td>
<td>(113,231)</td>
<td>(92,698)</td>
</tr>
<tr>
<td><strong>Cash &amp; cash equivalents, beginning of year</strong></td>
<td>274,348</td>
<td>217,931</td>
</tr>
<tr>
<td><strong>Cash &amp; cash equivalents, end of period</strong></td>
<td>$161,117</td>
<td>125,233</td>
</tr>
</tbody>
</table>
### Bon Secours Health System, Inc. and Subsidiaries

#### Obligated Group Members

Unaudited Consolidated Balance Sheets
As of November 30, 2017 and August 31, 2017
(in thousands)

<table>
<thead>
<tr>
<th>Assets</th>
<th>November 30,</th>
<th>August 31,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$ 345,171</td>
<td>430,792</td>
</tr>
<tr>
<td>Accounts receivable, net:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and third-party payors</td>
<td>357,094</td>
<td>340,251</td>
</tr>
<tr>
<td>Other</td>
<td>23,078</td>
<td>23,396</td>
</tr>
<tr>
<td>Total accounts receivable, net</td>
<td>380,172</td>
<td>363,647</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
<td>44,979</td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>60,573</td>
<td>59,451</td>
</tr>
<tr>
<td>Prepaid expenses and other current assets</td>
<td>57,543</td>
<td>51,938</td>
</tr>
<tr>
<td>Total current assets</td>
<td>888,438</td>
<td>934,543</td>
</tr>
<tr>
<td>Assets limited or restricted as to use, less current portion</td>
<td>1,274,722</td>
<td>1,243,187</td>
</tr>
<tr>
<td>Property, plant and equipment, net</td>
<td>886,027</td>
<td>900,667</td>
</tr>
<tr>
<td>Other long-term assets, net</td>
<td>400,776</td>
<td>403,431</td>
</tr>
<tr>
<td>Total assets</td>
<td>$ 3,449,963</td>
<td>3,481,828</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities and Net Assets</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current portion of long-term debt</td>
<td>$ 20,040</td>
<td>40,412</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>139,660</td>
<td>175,049</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
<td>169,874</td>
<td>173,011</td>
</tr>
<tr>
<td>Other accrued expenses</td>
<td>115,071</td>
<td>109,489</td>
</tr>
<tr>
<td>Due from affiliates, net</td>
<td>(3,459)</td>
<td>(3,296)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>441,186</td>
<td>494,665</td>
</tr>
<tr>
<td>Long-term debt, less current portion</td>
<td>798,093</td>
<td>794,985</td>
</tr>
<tr>
<td>Other long-term liabilities and deferred credits</td>
<td>619,750</td>
<td>632,328</td>
</tr>
<tr>
<td>Due from affiliates, less current portion, net</td>
<td>(18,963)</td>
<td>(18,747)</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>1,840,066</td>
<td>1,903,231</td>
</tr>
<tr>
<td>Net assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted-controlling interest</td>
<td>1,303,856</td>
<td>1,279,906</td>
</tr>
<tr>
<td>Unrestricted-noncontrolling interest</td>
<td>296,663</td>
<td>289,544</td>
</tr>
<tr>
<td>Total unrestricted</td>
<td>1,600,519</td>
<td>1,569,450</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>9,204</td>
<td>8,973</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>174</td>
<td>174</td>
</tr>
<tr>
<td>Total net assets</td>
<td>1,609,897</td>
<td>1,578,597</td>
</tr>
<tr>
<td>Total liabilities and net assets</td>
<td>$ 3,449,963</td>
<td>3,481,828</td>
</tr>
</tbody>
</table>
### Bon Secours Health System, Inc. and Subsidiaries
#### Obligated Group Members

#### Unaudited Consolidated Statements of Operations
For the Three Months Ended November 30, 2017 and 2016
(in thousands)

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue before bad debts</td>
<td>$791,387</td>
<td>768,739</td>
</tr>
<tr>
<td>Provision for patient bad debts, net</td>
<td>(36,767)</td>
<td>(44,194)</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>754,620</td>
<td>724,545</td>
</tr>
<tr>
<td>Other revenue</td>
<td>28,629</td>
<td>32,675</td>
</tr>
<tr>
<td><strong>Total revenues</strong></td>
<td>783,249</td>
<td>757,220</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages and benefits</td>
<td>403,118</td>
<td>385,858</td>
</tr>
<tr>
<td>Supplies</td>
<td>147,072</td>
<td>139,631</td>
</tr>
<tr>
<td>Purchased services and other</td>
<td>164,138</td>
<td>169,461</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>30,611</td>
<td>31,509</td>
</tr>
<tr>
<td>Interest</td>
<td>8,094</td>
<td>8,491</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>753,033</td>
<td>734,950</td>
</tr>
<tr>
<td>Income from operations</td>
<td>30,216</td>
<td>22,270</td>
</tr>
<tr>
<td>Nonoperating gains (losses), net:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonoperating investment gains (losses), net</td>
<td>24,414</td>
<td>(5,793)</td>
</tr>
<tr>
<td>Other nonoperating activities, net</td>
<td>(10,508)</td>
<td>(5,614)</td>
</tr>
<tr>
<td><strong>Total nonoperating gains (losses), net</strong></td>
<td>13,906</td>
<td>(11,407)</td>
</tr>
<tr>
<td><strong>Excess of revenues over expenses</strong></td>
<td>$44,122</td>
<td>10,863</td>
</tr>
</tbody>
</table>
### Bon Secours Health System, Inc. and Subsidiaries
#### Obligated Group Members

Unaudited Consolidated Statements of Changes in Net Assets
For the Three Months Ended November 30, 2017
(in thousands)

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted net assets</th>
<th>Temporarily restricted net assets</th>
<th>Permanently restricted net assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at August 31, 2017</strong></td>
<td>$1,569,450</td>
<td>8,973</td>
<td>174</td>
<td>1,578,597</td>
</tr>
<tr>
<td><strong>Excess of revenues over expenses</strong></td>
<td>44,122</td>
<td>-</td>
<td>-</td>
<td>44,122</td>
</tr>
<tr>
<td><strong>Grants and restricted contributions</strong></td>
<td>-</td>
<td>619</td>
<td>-</td>
<td>619</td>
</tr>
<tr>
<td><strong>Grants for capital</strong></td>
<td>52</td>
<td>-</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td><strong>Net change in unrealized gains on other-than-trading securities</strong></td>
<td>82</td>
<td>-</td>
<td>-</td>
<td>82</td>
</tr>
<tr>
<td><strong>Net assets released from restrictions used for purchase of property, plant and equipment</strong></td>
<td>21</td>
<td>(21)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net assets released from restrictions used for operations</strong></td>
<td>-</td>
<td>(367)</td>
<td>-</td>
<td>(367)</td>
</tr>
<tr>
<td><strong>Transfers to affiliates and other changes, net</strong></td>
<td>(13,208)</td>
<td>-</td>
<td>-</td>
<td>(13,208)</td>
</tr>
<tr>
<td><strong>Increase in net assets</strong></td>
<td>31,069</td>
<td>231</td>
<td>-</td>
<td>31,300</td>
</tr>
<tr>
<td><strong>Balance at November 30, 2017</strong></td>
<td>$1,600,519</td>
<td>9,204</td>
<td>174</td>
<td>1,609,897</td>
</tr>
<tr>
<td>Cash flows from operating activities:</td>
<td>2017</td>
<td>2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in net assets</td>
<td>$31,300</td>
<td>11,246</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision for bad debts</td>
<td>36,767</td>
<td>44,194</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation &amp; amortization, including $688 and $829 reported in nonoperating activities, net in 2017 and 2016, respectively</td>
<td>31,299</td>
<td>32,338</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization of deferred financing costs and bond discount/premium, net</td>
<td>(433)</td>
<td>(285)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash distribution to noncontrolling interest owners and affiliates</td>
<td>1,574</td>
<td>1,551</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity in (income) loss of joint ventures</td>
<td>(5,049)</td>
<td>11,031</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized losses (gains) on investment in joint ventures</td>
<td>7,316</td>
<td>456</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants received for capital expenditures</td>
<td>(52)</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions restricted by donor</td>
<td>618</td>
<td>334</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net realized/unrealized (gains) losses on certain investments and derivatives</td>
<td>(25,466)</td>
<td>5,051</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss on disposal of assets</td>
<td>-</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in accounts receivable</td>
<td>(53,292)</td>
<td>(60,238)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in accounts payable and other current liabilities</td>
<td>(31,694)</td>
<td>(17,959)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in inventories, prepaid expenses, and other current assets</td>
<td>(6,727)</td>
<td>(9,083)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in other long-term assets, net</td>
<td>388</td>
<td>18,188</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in other long-term liabilities &amp; deferred credits</td>
<td>(11,878)</td>
<td>(7,335)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net cash used in operating activities</strong></td>
<td><strong>(26,565)</strong></td>
<td><strong>(8,447)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash flows from investing activities:</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase of land held for investment</td>
<td>(1,121)</td>
<td>(8,938)</td>
</tr>
<tr>
<td>Property, plant and equipment additions, net of disposals</td>
<td>(29,170)</td>
<td>(30,873)</td>
</tr>
<tr>
<td>Investment in Harborview MOB II LLC</td>
<td>12,661</td>
<td>-</td>
</tr>
<tr>
<td>Sales (purchases) of securities, net</td>
<td>32,961</td>
<td>(3,814)</td>
</tr>
<tr>
<td>Purchases of equity and fixed income commingled funds</td>
<td>(53,570)</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from sale of alternative investments</td>
<td>172</td>
<td>8,901</td>
</tr>
<tr>
<td>Payments related to interest rate swaps</td>
<td>(1,475)</td>
<td>(3,042)</td>
</tr>
<tr>
<td><strong>Net cash used in investing activities</strong></td>
<td><strong>(39,542)</strong></td>
<td><strong>(37,766)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash flows from financing activities:</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in due from affiliates, net</td>
<td>(379)</td>
<td>(1,430)</td>
</tr>
<tr>
<td>Payments of long-term debt</td>
<td>(6,991)</td>
<td>(23,107)</td>
</tr>
<tr>
<td>Proceeds from issuance of long-term debt</td>
<td>249,925</td>
<td>-</td>
</tr>
<tr>
<td>Retirement of long-term debt</td>
<td>(246,950)</td>
<td>-</td>
</tr>
<tr>
<td>Defeasance of debt</td>
<td>(13,825)</td>
<td>-</td>
</tr>
<tr>
<td>Payment of deferred financing fees</td>
<td>(390)</td>
<td>-</td>
</tr>
<tr>
<td>Cash distributions to noncontrolling interest owners and affiliates</td>
<td>(1,574)</td>
<td>(1,551)</td>
</tr>
<tr>
<td>Grants for capital expenditures</td>
<td>52</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from contributions restricted by donor</td>
<td>618</td>
<td>334</td>
</tr>
<tr>
<td><strong>Net cash used in financing activities</strong></td>
<td><strong>(19,514)</strong></td>
<td><strong>(25,754)</strong></td>
</tr>
</tbody>
</table>

**Net decrease in cash & cash equivalents** | **(85,621)** | **(71,967)** |

**Cash & cash equivalents, beginning of year** | 430,792 | 355,854 |

**Cash & cash equivalents, end of period** | $345,171 | 283,887 |
### Assets

<table>
<thead>
<tr>
<th></th>
<th>Combined Obligated Group</th>
<th>Combined Non-Obligated Group</th>
<th>Combining Eliminations</th>
<th>Consolidated Bon Secours Health System, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash and cash equivalents</strong></td>
<td>$345,171</td>
<td>11,939</td>
<td>(195,993)</td>
<td>161,117</td>
</tr>
<tr>
<td><strong>Accounts receivable, net</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and third-party payors</td>
<td>357,094</td>
<td>18,981</td>
<td>-</td>
<td>376,075</td>
</tr>
<tr>
<td>Other</td>
<td>23,078</td>
<td>14,784</td>
<td>(7,115)</td>
<td>30,747</td>
</tr>
<tr>
<td><strong>Total accounts receivable, net</strong></td>
<td>380,172</td>
<td>33,765</td>
<td>(7,115)</td>
<td>406,822</td>
</tr>
<tr>
<td><strong>Assets limited or restricted as to use</strong></td>
<td>44,979</td>
<td>32,879</td>
<td>-</td>
<td>77,858</td>
</tr>
<tr>
<td><strong>Inventories</strong></td>
<td>60,573</td>
<td>2,220</td>
<td>-</td>
<td>62,793</td>
</tr>
<tr>
<td><strong>Prepaid expenses and other current assets</strong></td>
<td>57,543</td>
<td>12,133</td>
<td>(25,996)</td>
<td>43,680</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>888,438</td>
<td>92,936</td>
<td>(229,104)</td>
<td>752,270</td>
</tr>
<tr>
<td><strong>Assets limited as to use and restricted, less current portion</strong></td>
<td>1,274,722</td>
<td>134,161</td>
<td>-</td>
<td>1,408,883</td>
</tr>
<tr>
<td><strong>Property, plant and equipment, net</strong></td>
<td>886,027</td>
<td>90,615</td>
<td>-</td>
<td>976,642</td>
</tr>
<tr>
<td><strong>Other long-term assets, net</strong></td>
<td>400,776</td>
<td>49,839</td>
<td>(84,557)</td>
<td>366,058</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>$3,449,963</td>
<td>367,551</td>
<td>(313,661)</td>
<td>3,503,853</td>
</tr>
</tbody>
</table>

### Liabilities and Net Assets

<table>
<thead>
<tr>
<th></th>
<th>Combined Obligated Group</th>
<th>Combined Non-Obligated Group</th>
<th>Combining Eliminations</th>
<th>Consolidated Bon Secours Health System, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current portion of long-term debt</td>
<td>$20,040</td>
<td>2,848</td>
<td>-</td>
<td>22,888</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>139,660</td>
<td>31,223</td>
<td>(5,277)</td>
<td>165,606</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
<td>169,874</td>
<td>2,007</td>
<td>(1)</td>
<td>171,880</td>
</tr>
<tr>
<td>Other accrued expenses</td>
<td>115,071</td>
<td>23,991</td>
<td>(26,259)</td>
<td>112,803</td>
</tr>
<tr>
<td>Due (from) to affiliates, net</td>
<td>(3,459)</td>
<td>3,452</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>441,186</td>
<td>63,521</td>
<td>(31,530)</td>
<td>473,177</td>
</tr>
<tr>
<td><strong>Long-term debt, less current portion</strong></td>
<td>798,093</td>
<td>34,493</td>
<td>-</td>
<td>832,586</td>
</tr>
<tr>
<td><strong>Other long-term liabilities and deferred credits</strong></td>
<td>619,750</td>
<td>87,948</td>
<td>(75,133)</td>
<td>632,565</td>
</tr>
<tr>
<td>Due (from) to affiliates, less current portion, net</td>
<td>(18,963)</td>
<td>214,956</td>
<td>(195,993)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td>1,840,066</td>
<td>400,918</td>
<td>(302,656)</td>
<td>1,938,328</td>
</tr>
<tr>
<td><strong>Net assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted-controlling interest</td>
<td>1,303,856</td>
<td>(83,330)</td>
<td>(11,006)</td>
<td>1,209,520</td>
</tr>
<tr>
<td>Unrestricted-noncontrolling interest</td>
<td>296,663</td>
<td>6,408</td>
<td>-</td>
<td>303,071</td>
</tr>
<tr>
<td><strong>Total unrestricted</strong></td>
<td>1,600,519</td>
<td>(76,922)</td>
<td>(11,006)</td>
<td>1,512,591</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>9,204</td>
<td>30,705</td>
<td>1</td>
<td>39,910</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>174</td>
<td>12,850</td>
<td>-</td>
<td>13,024</td>
</tr>
<tr>
<td><strong>Total net assets</strong></td>
<td>1,609,897</td>
<td>(33,367)</td>
<td>(11,005)</td>
<td>1,565,525</td>
</tr>
<tr>
<td><strong>Total liabilities and net assets</strong></td>
<td>$3,449,963</td>
<td>367,551</td>
<td>(313,661)</td>
<td>3,503,853</td>
</tr>
</tbody>
</table>
## BON SECOURS HEALTH SYSTEM, INC. AND SUBSIDIARIES

### Combining Schedule - Balance Sheet Information

Obligated Group Members

(in thousands)

November 30, 2017

Schedule 1.2

1 of 3

<table>
<thead>
<tr>
<th>Assets</th>
<th>Bon Secours Hospital Baltimore</th>
<th>Maryview Medical Center</th>
<th>Bon Secours Maryview Nursing Care Center</th>
<th>St. Mary’s Hospital of Richmond, Inc.</th>
<th>Richmond Community Hospital</th>
<th>Memorial Regional Medical Center</th>
<th>Bon Secours Richmond Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td>$ (78,652)</td>
<td>(44,126)</td>
<td>14,870</td>
<td>376,934</td>
<td>115,395</td>
<td>187,285</td>
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</tr>
<tr>
<td>Cash and cash equivalents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable, net:</td>
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<td>36,318</td>
<td>1,424</td>
<td>73,487</td>
<td>20,012</td>
<td>36,119</td>
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<tr>
<td>Patient and third-party payors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td>962</td>
<td>2,517</td>
<td>41</td>
<td>91</td>
<td>13</td>
<td>1,461</td>
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<td>38,835</td>
<td>1,465</td>
<td>73,578</td>
<td>20,025</td>
<td>37,580</td>
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<tr>
<td>Assets limited or restricted as to use</td>
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<td>76</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Inventories</td>
<td>1,025</td>
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<td>-</td>
<td>8,067</td>
<td>2,120</td>
<td>5,509</td>
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<tr>
<td>Prepaid expenses and other current assets</td>
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<td>6,734</td>
<td>49</td>
<td>2,838</td>
<td>2,688</td>
<td>2,229</td>
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<td>(64,907)</td>
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<td>461,417</td>
<td>140,128</td>
<td>232,603</td>
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<td>Assets limited as to use and restricted, less current portion</td>
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<td>127,142</td>
<td>50</td>
<td>430,129</td>
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<td>17,329</td>
<td>-</td>
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<tr>
<td>Property, plant and equipment, net</td>
<td>28,245</td>
<td>59,762</td>
<td>1,413</td>
<td>136,264</td>
<td>13,549</td>
<td>80,936</td>
<td>6,960</td>
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<td>Other long-term assets, net</td>
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<td>19,458</td>
<td>371</td>
<td>14,272</td>
<td>1,567</td>
<td>8,989</td>
<td>876</td>
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<tr>
<td>Total assets</td>
<td>$ (13,301)</td>
<td>216,478</td>
<td>18,218</td>
<td>1,042,082</td>
<td>155,244</td>
<td>339,857</td>
<td>7,836</td>
</tr>
</tbody>
</table>

### Liabilities and Net Assets

<table>
<thead>
<tr>
<th>Liabilities and Net Assets</th>
<th>Bon Secours Hospital Baltimore</th>
<th>Maryview Medical Center</th>
<th>Bon Secours Maryview Nursing Care Center</th>
<th>St. Mary’s Hospital of Richmond, Inc.</th>
<th>Richmond Community Hospital</th>
<th>Memorial Regional Medical Center</th>
<th>Bon Secours Richmond Health System</th>
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</thead>
<tbody>
<tr>
<td>Current Liabilities:</td>
<td>$ 565</td>
<td>1,100</td>
<td>200</td>
<td>3,275</td>
<td>-</td>
<td>4,390</td>
<td>-</td>
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<td>Current portion of long-term debt</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>7,519</td>
<td>12,474</td>
<td>561</td>
<td>20,946</td>
<td>1,265</td>
<td>12,453</td>
<td>-</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
<td>18,246</td>
<td>19,379</td>
<td>159</td>
<td>45,279</td>
<td>33</td>
<td>1,606</td>
<td>-</td>
</tr>
<tr>
<td>Other accrued expenses</td>
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<td>4,079</td>
<td>103</td>
<td>5,069</td>
<td>789</td>
<td>4,415</td>
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<tr>
<td>Due (from) to affiliates, net</td>
<td>(2,924)</td>
<td>1,914</td>
<td>-</td>
<td>-</td>
<td>(1)</td>
<td>-</td>
<td>(1,133)</td>
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<tr>
<td>Total current liabilities</td>
<td>21,069</td>
<td>38,946</td>
<td>1,028</td>
<td>74,569</td>
<td>2,087</td>
<td>22,563</td>
<td>(1,133)</td>
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<tr>
<td>Long-term debt, less current portion</td>
<td>196</td>
<td>18,246</td>
<td>2,865</td>
<td>30,268</td>
<td>-</td>
<td>-</td>
<td>(58)</td>
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<td>Other long-term liabilities and deferred credits</td>
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<td>30,166</td>
<td>371</td>
<td>186,310</td>
<td>2,299</td>
<td>81,017</td>
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<td>Due to (from) affiliates, less current portion, net</td>
<td>17,485</td>
<td>(11,934)</td>
<td>-</td>
<td>37,699</td>
<td>2,584</td>
<td>41,880</td>
<td>(172)</td>
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<td>328,836</td>
<td>6,970</td>
<td>145,702</td>
<td>(1,305)</td>
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### Net assets:

<table>
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<tr>
<th>Net assets</th>
<th>Bon Secours Hospital Baltimore</th>
<th>Maryview Medical Center</th>
<th>Bon Secours Maryview Nursing Care Center</th>
<th>St. Mary’s Hospital of Richmond, Inc.</th>
<th>Richmond Community Hospital</th>
<th>Memorial Regional Medical Center</th>
<th>Bon Secours Richmond Health System</th>
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</thead>
<tbody>
<tr>
<td>Unrestricted-controlling interest</td>
<td>(87,330)</td>
<td>140,915</td>
<td>13,954</td>
<td>713,246</td>
<td>148,274</td>
<td>194,035</td>
<td>(166,691)</td>
</tr>
<tr>
<td>Unrestricted-noncontrolling interest</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>175,832</td>
</tr>
<tr>
<td>Total unrestricted</td>
<td>(87,330)</td>
<td>140,915</td>
<td>13,954</td>
<td>713,246</td>
<td>148,274</td>
<td>194,035</td>
<td>9,141</td>
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<tr>
<td>Temporarily restricted</td>
<td>353</td>
<td>139</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>120</td>
<td>-</td>
</tr>
<tr>
<td>Total net assets</td>
<td>(86,977)</td>
<td>141,054</td>
<td>13,954</td>
<td>713,246</td>
<td>148,274</td>
<td>194,155</td>
<td>9,141</td>
</tr>
<tr>
<td>Total liabilities and net assets</td>
<td>$ (13,301)</td>
<td>216,478</td>
<td>18,218</td>
<td>1,042,082</td>
<td>155,244</td>
<td>339,857</td>
<td>7,836</td>
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</table>
## Current Liabilities:

<table>
<thead>
<tr>
<th></th>
<th>St. Francis Medical Center</th>
<th>RHS Shared Services</th>
<th>Our Lady of Bellefonte Hospital, Inc.</th>
<th>Bellefonte Physician Services</th>
<th>Mary Immaculate Hospital, Inc.</th>
<th>Bon Secours DePaul Medical Center, Inc.</th>
<th>Hampton Roads Shared Services</th>
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<tbody>
<tr>
<td>Accounts payable</td>
<td>7,750</td>
<td>4,997</td>
<td>7,289</td>
<td>482</td>
<td>7,653</td>
<td>6,950</td>
<td>2,903</td>
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<td>Accrued salaries, wages and benefits</td>
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<td>-</td>
<td>6,689</td>
<td>390</td>
<td>1,577</td>
<td>2,509</td>
<td>1,378</td>
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<tr>
<td>Other accrued expenses</td>
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<td>133</td>
<td>2,416</td>
<td>6</td>
<td>1,021</td>
<td>927</td>
<td>-</td>
</tr>
<tr>
<td>Due (from) to affiliates, net</td>
<td>-</td>
<td>1</td>
<td>(110)</td>
<td>135</td>
<td>235</td>
<td>446</td>
<td>(216)</td>
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<td>Total current liabilities</td>
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<td>5,131</td>
<td>18,284</td>
<td>1,013</td>
<td>10,496</td>
<td>10,832</td>
<td>4,065</td>
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<td>Long-term debt, less current portion</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other long-term liabilities and deferred credits</td>
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<td>323</td>
<td>67,437</td>
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<td>7,296</td>
<td>10,123</td>
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<td>Due to (from) affiliates, less current portion, net</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>(2,691)</td>
<td>46,739</td>
<td>-</td>
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<td>Total liabilities</td>
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<td>83,721</td>
<td>1,027</td>
<td>15,091</td>
<td>46,794</td>
<td>4,075</td>
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</table>

### Net assets:

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted-controlling interest</th>
<th>Unrestricted-noncontrolling interest</th>
<th>Temporarily restricted</th>
<th>Permanently restricted</th>
<th>Total net assets</th>
<th>Total liabilities and net assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>76,761</td>
<td>(13,449)</td>
<td>66,616</td>
<td>(108,857)</td>
<td>241,663</td>
<td>(111,216)</td>
</tr>
<tr>
<td></td>
<td>76,761</td>
<td>(13,449)</td>
<td>66,616</td>
<td>(108,857)</td>
<td>241,663</td>
<td>(111,216)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>916</td>
<td>7</td>
</tr>
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<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>76,761</td>
<td>(13,449)</td>
<td>66,616</td>
<td>(108,857)</td>
<td>242,633</td>
<td>(111,223)</td>
</tr>
<tr>
<td></td>
<td>76,761</td>
<td>(13,449)</td>
<td>66,616</td>
<td>(108,857)</td>
<td>242,633</td>
<td>(111,223)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>916</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td>Total net assets</td>
<td>180,933</td>
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<td>150,338</td>
<td>(107,830)</td>
<td>257,724</td>
<td>(43,529)</td>
</tr>
<tr>
<td>Total liabilities and net assets</td>
<td>$180,933</td>
<td>(7,995)</td>
<td>150,338</td>
<td>(107,830)</td>
<td>257,724</td>
<td>(43,529)</td>
</tr>
</tbody>
</table>
Combining Schedule - Balance Sheet Information
Obligated Group Members

(in thousands)

November 30, 2017

Schedule 1.2

3 of 3

Assets

Current assets:
- Cash and cash equivalents $174,859
- Accounts receivable, net:
  - Patient and third-party payors 72,509
  - Other 192
- Total accounts receivable, net 72,701
- Inventories 17,362
- Prepaid expenses and other current assets 6,928
- Total current assets 271,850

- Assets limited or restricted as to use:
  - Inventories 192
  - Other 1,529
  - Total assets limited or restricted as to use 1,721

- Total assets limited as to use and restricted, less current portion 23,078

- Property, plant and equipment, net 357,094
- Other long-term assets, net 23,078
- Total assets 888,438

Liabilities and Net Assets

Current Liabilities:
- Current portion of long-term debt $120,831
- Accrued salaries, wages and benefits 23,950
- Other accrued expenses 44,669
- Due (from) to affiliates, net 18
- Total current liabilities 144,669

- Long-term debt, less current portion 746,577
- Other long-term liabilities and deferred credits 8,662
- Due to (from) affiliates, less current portion, net 259,300
- Total liabilities 941,196

Net assets:
- Unrestricted-controlling interest 245,395
- Unrestricted-noncontrolling interest
- Total unrestricted 245,395
- Temporarily restricted
- Permanently restricted
- Total net assets 245,395

Total liabilities and net assets $558,026
### Bon Secours Health System, Inc. and Subsidiaries

**Combining Schedule - Balance Sheet Information**

**Non-Obligated Group Members**

(in thousands)

November 30, 2017

<table>
<thead>
<tr>
<th>Assets</th>
<th>Bon Secours of Maryland Foundation</th>
<th>Bon Secours Baltimore Health System Foundation</th>
<th>Bon Secours Maryview Health Care Corporation</th>
<th>Professional Health Care Services</th>
<th>Bon Secours Richmond Health Corp.</th>
<th>Hampton Roads Good Help ACO LLC</th>
<th>HarbourView MOB II LLC</th>
<th>Total net assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
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<td>(3,101)</td>
<td>338</td>
<td>(10,218)</td>
<td>593</td>
<td>(152)</td>
<td>(30)</td>
<td>7,433</td>
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<tr>
<td>Accounts receivable, net</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patient and third-party payors</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>826</td>
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<td>(1)</td>
<td>195</td>
<td>-</td>
<td>1,840</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total accounts receivable, net</td>
<td>826</td>
<td>-</td>
<td>35</td>
<td>195</td>
<td>-</td>
<td>1,840</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
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<td>-</td>
<td>-</td>
<td>2,893</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inventories</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepaid expenses and other current assets</td>
<td>3,496</td>
<td>-</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
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<td>(10,168)</td>
<td>3,681</td>
<td>(152)</td>
<td>1,810</td>
<td>7,433</td>
</tr>
<tr>
<td>Long-term debt, less current portion</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Due to (from) affiliates, net</td>
<td>2,923</td>
<td>-</td>
<td>(150)</td>
<td>(1,605)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total liabilities</td>
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<td>(3,514)</td>
<td>5,038</td>
<td>(152)</td>
<td>14,472</td>
<td>7,433</td>
</tr>
</tbody>
</table>

### Liabilities and Net Assets

<table>
<thead>
<tr>
<th>Liabilities and Net Assets</th>
<th>Bon Secours of Maryland Foundation</th>
<th>Bon Secours Baltimore Health System Foundation</th>
<th>Bon Secours Maryview Health Care Corporation</th>
<th>Professional Health Care Services</th>
<th>Bon Secours Richmond Health Corp.</th>
<th>Hampton Roads Good Help ACO LLC</th>
<th>HarbourView MOB II LLC</th>
<th>Total liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current portion of long-term debt</td>
<td>$64</td>
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<td>(4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>328</td>
<td>11</td>
<td>172</td>
<td>-</td>
<td>-</td>
<td>1,666</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
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<td>-</td>
<td>124</td>
<td>-</td>
<td>-</td>
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<td>Other accrued expenses</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>-</td>
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<td>(150)</td>
<td>1,980</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Total current liabilities</td>
<td>8,777</td>
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<td>(150)</td>
<td>(1,273)</td>
<td>-</td>
<td>1,680</td>
<td>-</td>
<td>-</td>
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<td>Long-term debt, less current portion</td>
<td>16,026</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other long-term liabilities and deferred credits</td>
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### Net assets:

| Unrestricted-controlling interest | (4,467)                           | 3,933                                         | 1,338                                       | (6,059)                         | 2,295                           | (152)                           | 10,745          | 7,433           |
| Unrestricted-noncontrolling interest | 13,422                           | -                                             | -                                           | -                               | -                               | -                               | 2,047           | -               |
| Total unrestrictd                 | 8,955                             | 3,933                                         | 1,338                                       | (6,059)                         | 2,295                           | (152)                           | 12,792          | 7,433           |
| Temporarily restricted            | 1,857                             | 806                                           | -                                           | 2,115                           | -                               | -                               | -               | -               |
| Permanently restricted            | -                                 | -                                             | -                                           | 628                             | -                               | -                               | -               | -               |
| Total net assets                  | 10,812                            | 4,739                                         | 1,338                                       | (6,059)                         | 5,038                           | (152)                           | 12,792          | 7,433           |
| Total liabilities and net assets  | $44,826                           | 4,750                                         | 1,188                                       | (3,514)                         | 5,038                           | (152)                           | 14,472          | 7,433           |
## Combining Schedule - Balance Sheet Information

### Non-Obligated Group Members

November 30, 2017

### Assets

<table>
<thead>
<tr>
<th>Bon Secours</th>
<th>Bon Secours</th>
<th>Laburnum</th>
<th>RHS Enterprises</th>
<th>Bon Secours</th>
<th>Bon Secours</th>
<th>Rappahannock</th>
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<td>Inc.</td>
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<tr>
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<td>Inc.</td>
<td>Center,</td>
<td>Inc.</td>
<td>LLC</td>
<td>LLC</td>
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#### Current assets:

- **Cash and cash equivalents**: $3,379, (89,166), (4,461), (16,081), (2,153), (3,363), (18,061), (24,081)

#### Accounts receivable, net:

- **Patient and third-party payors**: (4,625)
- **Other**: 2,316
- **Total accounts receivable, net**: 2,316, 4,758, 47, 200, 7, 197, 3,191, 6,955

#### Assets limited or restricted as to use:

- **Inventories**: -
- **Prepaid expenses and other current assets**: 38, 10,662, 8, -
- **Total current assets**: 1,566, (73,047), (4,406), (15,881), (2,038), (3,149), (14,854), (15,573)

#### Assets limited as to use and restricted, less current portion:

- **Property, plant and equipment, net**: 14,104
- **Other long-term assets, net**: 2,492
- **Total assets**: 18,214, (52,205), 3,912, (15,784), (1,966), (2,085), (7,205), (192)

### Liabilities and Net Assets

#### Current Liabilities:

- **Current portion of long-term debt**: -
- **Accounts payable**: 166
- **Accrued salaries, wages and benefits**: 8
- **Due to (from) affiliates, net**: -
- **Total current liabilities**: 174, 2,781, 51, -

#### Long-term debt, less current portion:

- **Other long-term liabilities and deferred credits**: 6
- **Due to (from) affiliates, less current portion, net**: -
- **Total liabilities**: 180, 8,806, 1,454, 150, 43, 206, 1,312, 3,007

#### Net assets:

- **Unrestricted-controlling interest**: (3,463), (64,996), 2,458, (15,934), (2,009), (2,291), (8,517), (3,381)
- **Unrestricted-noncontrolling interest**: -
- **Total un restricted**: (3,463), (61,011), 2,458, (15,934), (2,009), (2,291), (8,517), (3,381)
- **Temporarily restricted**: 16,638
- **Permanently restricted**: 4,859
- **Total net assets**: 18,034, (61,011), 2,458, (15,934), (2,009), (2,291), (8,517), (3,199)
- **Total liabilities and net assets**: 18,214, (52,205), 3,912, (15,784), (1,966), (2,085), (7,205), (192)
### Assets

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<th>IVNA Health Services</th>
<th>Richmond Good Help ACO LLC</th>
<th>Tidewater Diversified, Inc.</th>
<th>Bayley Properties, Inc.</th>
<th>DePaul Health Foundation</th>
<th>St. Francis Nursing Care Center, Inc.</th>
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#### Liabilities and Net Assets

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<th>IVNA Health Services</th>
<th>Richmond Good Help ACO LLC</th>
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<th>Bayley Properties, Inc.</th>
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<th>St. Francis Nursing Care Center, Inc.</th>
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#### Net assets:

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<th>Richmond Good Help ACO LLC</th>
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<th>Bayley Properties, Inc.</th>
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<th>St. Francis Nursing Care Center, Inc.</th>
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<td>(5,835)</td>
<td>7,527</td>
<td>(198)</td>
<td>(123)</td>
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<tr>
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<td>(198)</td>
<td>(123)</td>
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<td>86</td>
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<td>-</td>
<td>233</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>-</td>
<td>-</td>
<td>3,214</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>-</td>
<td>-</td>
<td>591</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total net assets</td>
<td>(4,494)</td>
<td>1,725</td>
<td>10,697</td>
<td>(1,307)</td>
<td>(6)</td>
<td>15,591</td>
<td>-</td>
<td>233</td>
</tr>
<tr>
<td>Total liabilities and net assets</td>
<td>$ 984</td>
<td>1,976</td>
<td>10,697</td>
<td>(1,098)</td>
<td>(6)</td>
<td>10,576</td>
<td>(5)</td>
<td>302</td>
</tr>
</tbody>
</table>
## Combining Schedule - Balance Sheet Information

**Non-Obligated Group Members**

<table>
<thead>
<tr>
<th>(in thousands)</th>
<th>November 30, 2017</th>
</tr>
</thead>
</table>

### Assets

<table>
<thead>
<tr>
<th>Current assets:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
</tr>
<tr>
<td>Accounts receivable, net:</td>
</tr>
<tr>
<td>Patient and third-party payors</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total accounts receivable, net</td>
</tr>
<tr>
<td>Assets limited or restricted as to use</td>
</tr>
<tr>
<td>Inventories</td>
</tr>
<tr>
<td>Prepaid expenses and other current assets</td>
</tr>
<tr>
<td>Total current assets</td>
</tr>
<tr>
<td>Assets limited as to use and restricted, less current portion</td>
</tr>
<tr>
<td>Property, plant and equipment, net</td>
</tr>
<tr>
<td>Other long-term assets, net</td>
</tr>
<tr>
<td>Total assets</td>
</tr>
</tbody>
</table>

### Liabilities and Net Assets

<table>
<thead>
<tr>
<th>Current Liabilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current portion of long-term debt</td>
</tr>
<tr>
<td>Accounts payable</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
</tr>
<tr>
<td>Other accrued expenses</td>
</tr>
<tr>
<td>Due to (from) affiliates, net</td>
</tr>
<tr>
<td>Total current liabilities</td>
</tr>
<tr>
<td>Long-term debt, less current portion</td>
</tr>
<tr>
<td>Other long-term liabilities and deferred credits</td>
</tr>
<tr>
<td>Due to (from) affiliates, less current portion, net</td>
</tr>
<tr>
<td>Total liabilities</td>
</tr>
</tbody>
</table>

### Net assets:

| Unrestricted-controlling interest | (19) | (3,691) | 1,044 | (118) | 2,900 | 1,040 | (1,514) | 1,721 |
| Unrestricted-noncontrolling interest | - | - | - | - | - | - | - | - |
| Total unsecured | (19) | (3,691) | 1,044 | (118) | 2,900 | 1,040 | (1,514) | 1,721 |
| Temporarily restricted | - | - | 1,944 | - | - | - | - | - |
| Permanently restricted | - | - | 1,421 | - | - | - | - | - |
| Total net assets | (19) | (3,691) | 4,409 | (118) | 2,900 | 1,040 | (1,514) | 1,721 |
| Total liabilities and net assets | $ | 17,107 | 4,384 | (118) | 7,572 | 1,000 | (407) | 1,721 |
### Assets

**Current assets:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Bon Secours Good HelpCare LLC</th>
<th>BSB MOB Partnership 1</th>
<th>Good Help Connections, LLC</th>
<th>Bon Secours Assurance Company, Ltd.</th>
<th>Combining Eliminations</th>
<th>Combined Non-Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$424</td>
<td>$461</td>
<td>(4,082)</td>
<td>(8,061)</td>
<td>-</td>
<td>$181,949</td>
</tr>
<tr>
<td>Accounts receivable, net</td>
<td>$1,901</td>
<td>$1,230</td>
<td>749</td>
<td>2,196</td>
<td>-</td>
<td>$18,696</td>
</tr>
<tr>
<td>Inventories</td>
<td>$6,797</td>
<td>$914</td>
<td>1,011</td>
<td>18,696</td>
<td>-</td>
<td>$49,839</td>
</tr>
<tr>
<td>Prepaid expenses and other current assets</td>
<td>$23,325</td>
<td>$13,104</td>
<td>(3,734)</td>
<td>(1,005)</td>
<td>-</td>
<td>$13,104</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32,879</td>
</tr>
<tr>
<td>Total accounts receivable, net</td>
<td>$424</td>
<td>$461</td>
<td>(4,082)</td>
<td>(8,061)</td>
<td>-</td>
<td>$181,949</td>
</tr>
<tr>
<td>Assets limited as to use and restricted, less current portion</td>
<td>$1,901</td>
<td>$1,230</td>
<td>749</td>
<td>2,196</td>
<td>-</td>
<td>$18,696</td>
</tr>
<tr>
<td>Property, plant and equipment, net</td>
<td>$23,325</td>
<td>$13,104</td>
<td>(3,734)</td>
<td>(10,005)</td>
<td>-</td>
<td>$13,104</td>
</tr>
<tr>
<td>Other long-term assets, net</td>
<td>$17,998</td>
<td>$10,919</td>
<td>1,455</td>
<td>18,696</td>
<td>-</td>
<td>$49,839</td>
</tr>
<tr>
<td>Total assets</td>
<td>$23,325</td>
<td>$13,104</td>
<td>(3,734)</td>
<td>(10,005)</td>
<td>-</td>
<td>$13,104</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>$424</td>
<td>$461</td>
<td>(4,082)</td>
<td>(8,061)</td>
<td>-</td>
<td>$181,949</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32,879</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td>$424</td>
<td>$461</td>
<td>(4,082)</td>
<td>(8,061)</td>
<td>-</td>
<td>$181,949</td>
</tr>
</tbody>
</table>

### Liabilities and Net Assets

**Current liabilities:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Shannon Health MOB Partnership 1</th>
<th>BSB MOB Partnership 2</th>
<th>Good HelpCare LLC</th>
<th>Bon Secours Assurance Company, Ltd.</th>
<th>Combining Eliminations</th>
<th>Combined Non-Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current portion of long-term debt</td>
<td>$1,608</td>
<td>$826</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$2,848</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>293</td>
<td>404</td>
<td>303</td>
<td>1,455</td>
<td>-</td>
<td>31,223</td>
</tr>
<tr>
<td>Accrued salaries, wages and benefits</td>
<td>-</td>
<td>-</td>
<td>446</td>
<td>101</td>
<td>-</td>
<td>2,007</td>
</tr>
<tr>
<td>Other accrued expenses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>640</td>
<td>18,696</td>
<td>23,991</td>
</tr>
<tr>
<td>Due to (from) affiliates, net</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>3,452</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>$1,901</td>
<td>$1,230</td>
<td>749</td>
<td>2,196</td>
<td>18,696</td>
<td>$63,521</td>
</tr>
<tr>
<td>Long-term debt, less current portion</td>
<td>7,759</td>
<td>5,679</td>
<td>-</td>
<td>-</td>
<td>10,923</td>
<td>34,493</td>
</tr>
<tr>
<td>Other long-term liabilities and deferred credits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>81,597</td>
<td>(14,983)</td>
<td>87,948</td>
</tr>
<tr>
<td>Due to (from) affiliates, less current portion, net</td>
<td>6,868</td>
<td>2,598</td>
<td>-</td>
<td>-</td>
<td>186,782</td>
<td>214,956</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>$16,528</td>
<td>$12,190</td>
<td>749</td>
<td>2,196</td>
<td>$100,293</td>
<td>$400,918</td>
</tr>
</tbody>
</table>

**Net assets:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Shannon Health MOB Partnership 1</th>
<th>BSB MOB Partnership 2</th>
<th>Good HelpCare LLC</th>
<th>Bon Secours Assurance Company, Ltd.</th>
<th>Combining Eliminations</th>
<th>Combined Non-Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted-controlling interest</td>
<td>6,797</td>
<td>768</td>
<td>(4,483)</td>
<td>(3,201)</td>
<td>-</td>
<td>(83,330)</td>
</tr>
<tr>
<td>Unrestricted-noncontrolling interest</td>
<td>146</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6,408</td>
</tr>
<tr>
<td>Total unrestricted</td>
<td>6,797</td>
<td>914</td>
<td>(4,483)</td>
<td>(3,201)</td>
<td>-</td>
<td>(76,922)</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>30,705</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12,850</td>
</tr>
<tr>
<td>Total net assets</td>
<td>6,797</td>
<td>914</td>
<td>(4,483)</td>
<td>(3,201)</td>
<td>(10,884)</td>
<td>(33,367)</td>
</tr>
<tr>
<td>Total liabilities and net assets</td>
<td>$23,325</td>
<td>$13,104</td>
<td>(3,734)</td>
<td>(10,005)</td>
<td>$100,293</td>
<td>$367,551</td>
</tr>
</tbody>
</table>
## Combining Schedule - Operating Information

**Obligated and Non-Obligated Group Members**

(in thousands)

<table>
<thead>
<tr>
<th></th>
<th>Combined Obligated Group</th>
<th>Combined Non-Obligated Group</th>
<th>Combining Eliminations</th>
<th>Consolidated Bon Secours Health System, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue before bad debts $</td>
<td>791,387</td>
<td>31,306</td>
<td>(1,550)</td>
<td>821,143</td>
</tr>
<tr>
<td>Provision for patient bad debts, net</td>
<td>(36,767)</td>
<td>(778)</td>
<td></td>
<td>(37,545)</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>754,620</td>
<td>30,528</td>
<td>(1,550)</td>
<td>783,596</td>
</tr>
<tr>
<td>Other revenue</td>
<td>28,629</td>
<td>16,528</td>
<td>(4,310)</td>
<td>40,847</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td>783,249</td>
<td>47,056</td>
<td>(5,860)</td>
<td>824,445</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages and benefits</td>
<td>403,118</td>
<td>27,993</td>
<td>(588)</td>
<td>430,523</td>
</tr>
<tr>
<td>Supplies</td>
<td>147,072</td>
<td>6,646</td>
<td>-</td>
<td>153,718</td>
</tr>
<tr>
<td>Purchased services and other</td>
<td>164,138</td>
<td>16,321</td>
<td>(5,183)</td>
<td>175,276</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>30,611</td>
<td>2,198</td>
<td>(41)</td>
<td>32,768</td>
</tr>
<tr>
<td>Interest</td>
<td>8,094</td>
<td>276</td>
<td>(48)</td>
<td>8,322</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>753,033</td>
<td>53,434</td>
<td>(5,860)</td>
<td>800,607</td>
</tr>
<tr>
<td>Income (loss) from operations</td>
<td>30,216</td>
<td>(6,378)</td>
<td></td>
<td>23,838</td>
</tr>
<tr>
<td><strong>Nonoperating gains (losses), net:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonoperating investment gains, net</td>
<td>24,414</td>
<td>300</td>
<td></td>
<td>24,714</td>
</tr>
<tr>
<td>Other nonoperating activities, net</td>
<td>(10,508)</td>
<td>(2,776)</td>
<td>11</td>
<td>(13,273)</td>
</tr>
<tr>
<td>Excess (deficit) of revenues over expenses</td>
<td>44,122</td>
<td>(8,854)</td>
<td>11</td>
<td>35,279</td>
</tr>
<tr>
<td><strong>Other changes in net assets:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants for capital</td>
<td>52</td>
<td>-</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>Net change in unrealized gains on other-than-trading securities</td>
<td>82</td>
<td>197</td>
<td></td>
<td>279</td>
</tr>
<tr>
<td>Net assets released from restrictions used for the purchase of property, plant, and equipment</td>
<td>21</td>
<td>1,137</td>
<td>-</td>
<td>1,158</td>
</tr>
<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>(1,649)</td>
<td>-</td>
<td>(1,649)</td>
</tr>
<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
<td>(13,208)</td>
<td>13,785</td>
<td>(49)</td>
<td>528</td>
</tr>
<tr>
<td>Increase (decrease) in unrestricted net assets $</td>
<td>31,069</td>
<td>4,616</td>
<td>(38)</td>
<td>35,647</td>
</tr>
<tr>
<td>Revenues:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Net patient service revenue before bad debts</td>
<td>$ 26,250</td>
<td>84,618</td>
<td>2,447</td>
<td>141,508</td>
</tr>
<tr>
<td>Provision for patient bad debts, net</td>
<td>(1,043)</td>
<td>(6,157)</td>
<td>(88)</td>
<td>(4,725)</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>25,207</td>
<td>78,461</td>
<td>2,359</td>
<td>136,783</td>
</tr>
<tr>
<td>Other revenue</td>
<td>712</td>
<td>2,588</td>
<td>6</td>
<td>990</td>
</tr>
<tr>
<td>Total revenue</td>
<td>25,919</td>
<td>81,049</td>
<td>2,365</td>
<td>137,773</td>
</tr>
<tr>
<td>Expenses:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages and benefits</td>
<td>13,116</td>
<td>36,889</td>
<td>1,406</td>
<td>52,593</td>
</tr>
<tr>
<td>Supplies</td>
<td>1,741</td>
<td>16,183</td>
<td>311</td>
<td>26,183</td>
</tr>
<tr>
<td>Purchased services and other</td>
<td>10,632</td>
<td>30,757</td>
<td>863</td>
<td>44,183</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>1,641</td>
<td>3,072</td>
<td>47</td>
<td>3,766</td>
</tr>
<tr>
<td>Interest</td>
<td>347</td>
<td>722</td>
<td>13</td>
<td>1,539</td>
</tr>
<tr>
<td>Total expenses</td>
<td>27,477</td>
<td>87,623</td>
<td>2,640</td>
<td>128,268</td>
</tr>
<tr>
<td>(Loss) income from operations</td>
<td>(1,558)</td>
<td>(6,574)</td>
<td>(275)</td>
<td>9,505</td>
</tr>
<tr>
<td>Nonoperating gains (losses), net:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonoperating investment gains (losses), net</td>
<td>339</td>
<td>2,931</td>
<td>26</td>
<td>11,342</td>
</tr>
<tr>
<td>Other nonoperating activities, net</td>
<td>(258)</td>
<td>480</td>
<td>(2)</td>
<td>(2,887)</td>
</tr>
<tr>
<td>(Deficit) excess of revenues over expenses</td>
<td>(1,477)</td>
<td>(3,193)</td>
<td>(251)</td>
<td>17,960</td>
</tr>
<tr>
<td>Other changes in net assets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants for capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
<td>-</td>
<td>(3)</td>
<td>-</td>
<td>(3)</td>
</tr>
<tr>
<td>Net assets released from restrictions used for the purchase</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>of property, plant, and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
<td>(252)</td>
<td>(11,215)</td>
<td>(10)</td>
<td>(1,434)</td>
</tr>
<tr>
<td>(Decrease) increase in unrestricted net assets</td>
<td>$(1,729)</td>
<td>(14,411)</td>
<td>(261)</td>
<td>16,523</td>
</tr>
<tr>
<td>St. Francis Medical Center</td>
<td>RHS Shared Services</td>
<td>Our Lady of Bellefonte Hospital, Inc.</td>
<td>Bellefonte Physician Services</td>
<td>Mary Immaculate Hospital, Inc.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Revenues:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue before bad debts</td>
<td>$ 66,306</td>
<td>-</td>
<td>42,716</td>
<td>6,630</td>
</tr>
<tr>
<td>Provision for patient bad debts, net</td>
<td>(2,719)</td>
<td>-</td>
<td>(2,682)</td>
<td>(304)</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>63,587</td>
<td>-</td>
<td>40,034</td>
<td>6,326</td>
</tr>
<tr>
<td>Other revenue</td>
<td>629</td>
<td>56,203</td>
<td>921</td>
<td>206</td>
</tr>
<tr>
<td>Total revenue</td>
<td>64,216</td>
<td>56,203</td>
<td>40,955</td>
<td>6,532</td>
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<td>Expenses:</td>
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<td></td>
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<tr>
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<td>24,700</td>
<td>23,425</td>
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<td>4,180</td>
<td>7,352</td>
<td>591</td>
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<td>22,300</td>
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<td>2,513</td>
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<tr>
<td>Interest</td>
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<td>(Loss) income from operations</td>
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<td>-</td>
<td>2,043</td>
<td>(3,967)</td>
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<td>Nonoperating gains (losses), net:</td>
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<td>Nonoperating investment gains (losses), net</td>
<td>35</td>
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<td>300</td>
<td>(48)</td>
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<td>Other nonoperating activities, net</td>
<td>(377)</td>
<td>20</td>
<td>(1,422)</td>
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<td>(Deficit) excess of revenues over expenses</td>
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<td>-</td>
<td>921</td>
<td>(4,045)</td>
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<tr>
<td>Grants for capital</td>
<td>-</td>
<td>-</td>
<td>52</td>
<td>-</td>
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<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net assets released from restrictions used for the purchase of property, plant, and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
<td>(858)</td>
<td>-</td>
<td>(491)</td>
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<td>(Decrease) increase in unrestricted net assets $</td>
<td>3,692</td>
<td>-</td>
<td>482</td>
<td>(4,045)</td>
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</table>
### Revenues:

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<thead>
<tr>
<th></th>
<th>St. Francis Hospital, Inc.</th>
<th>St. Francis Physician Services</th>
<th>Maria Manor Nursing Care Center, Inc.</th>
<th>Bon Secours Health System Office</th>
<th>Combining Eliminations</th>
<th>Combined Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Net patient service revenue before bad debts</td>
<td>$152,596</td>
<td>37,872</td>
<td>6,703</td>
<td>-</td>
<td>(2)</td>
<td>791,387</td>
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<td>Provision for patient bad debts, net</td>
<td>(8,013)</td>
<td>(794)</td>
<td>(78)</td>
<td>-</td>
<td></td>
<td>(36,767)</td>
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<tr>
<td>Net patient service revenue</td>
<td>144,583</td>
<td>37,078</td>
<td>6,625</td>
<td>-</td>
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<td>754,620</td>
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<td>Other revenue</td>
<td>659</td>
<td>2,557</td>
<td>225</td>
<td>80,325</td>
<td>(145,830)</td>
<td>28,629</td>
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<tr>
<td><strong>Total revenue</strong></td>
<td>145,242</td>
<td>39,635</td>
<td>6,850</td>
<td>80,325</td>
<td>(145,830)</td>
<td>783,249</td>
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### Expenses:

<table>
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<tr>
<th></th>
<th>St. Francis Hospital, Inc.</th>
<th>St. Francis Physician Services</th>
<th>Maria Manor Nursing Care Center, Inc.</th>
<th>Bon Secours Health System Office</th>
<th>Combining Eliminations</th>
<th>Combined Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>50,035</td>
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<td>3,391</td>
<td>46,990</td>
<td>85</td>
<td>403,118</td>
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<td>Supplies</td>
<td>34,863</td>
<td>3,970</td>
<td>728</td>
<td>(2,793)</td>
<td>1</td>
<td>147,072</td>
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<td>33,424</td>
<td>9,030</td>
<td>1,955</td>
<td>24,913</td>
<td>(138,795)</td>
<td>164,138</td>
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<td>Depreciation and amortization</td>
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<td>601</td>
<td>149</td>
<td>9,618</td>
<td>(8,184)</td>
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<td>-</td>
<td>116</td>
<td>(327)</td>
<td></td>
<td>8,094</td>
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<td><strong>Total expenses</strong></td>
<td>125,201</td>
<td>55,907</td>
<td>6,339</td>
<td>78,401</td>
<td>(146,893)</td>
<td>753,033</td>
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</table>

**Loss income from operations**: 20,041 (16,272) 511 1,924 1,063 30,216

**Nonoperating gains (losses), net:**

<table>
<thead>
<tr>
<th></th>
<th>St. Francis Hospital, Inc.</th>
<th>St. Francis Physician Services</th>
<th>Maria Manor Nursing Care Center, Inc.</th>
<th>Bon Secours Health System Office</th>
<th>Combining Eliminations</th>
<th>Combined Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonoperating gains (losses), net</strong></td>
<td>826</td>
<td>(10)</td>
<td>(14)</td>
<td>6,676</td>
<td>1</td>
<td>24,414</td>
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<tr>
<td>Other nonoperating activities, net</td>
<td>(87)</td>
<td>-</td>
<td>(529)</td>
<td>(1,237)</td>
<td>(1,189)</td>
<td>(10,508)</td>
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<tr>
<td><strong>(Deficit) excess of revenues over expenses</strong></td>
<td>20,780</td>
<td>(16,282)</td>
<td>(32)</td>
<td>7,363</td>
<td>(125)</td>
<td>44,122</td>
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</table>

**Other changes in net assets:**

<table>
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<tr>
<th></th>
<th>St. Francis Hospital, Inc.</th>
<th>St. Francis Physician Services</th>
<th>Maria Manor Nursing Care Center, Inc.</th>
<th>Bon Secours Health System Office</th>
<th>Combining Eliminations</th>
<th>Combined Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants for capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
<td>-</td>
<td>-</td>
<td>81</td>
<td>-</td>
<td>-</td>
<td>82</td>
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<td>Net assets released from restrictions used for the purchase of property, plant, and equipment</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>21</td>
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<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
<td>(1,683)</td>
<td>-</td>
<td>(87)</td>
<td>4,719</td>
<td>(304)</td>
<td>(13,208)</td>
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<tr>
<td><strong>(Decrease) increase in unrestricted net assets</strong></td>
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<td>(16,282)</td>
<td>(119)</td>
<td>12,163</td>
<td>(429)</td>
<td>31,069</td>
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<td>Bon Secours Baltimore Health System Foundation</td>
<td>Bon Secours Maryview Health Corporation</td>
<td>Professional Health Care Management Services</td>
<td>Bon Secours Maryview Foundation</td>
<td>Hampton Roads Good Health ACO LLC</td>
<td>HarbourView MOB II LLC</td>
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<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Revenues:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net patient service revenue before bad debts</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Provision for patient bad debts, net</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Net patient service revenue</td>
<td>-</td>
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<td>1</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Other revenue</td>
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<td>-</td>
<td>1,050</td>
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<td>1,051</td>
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<td>Expenses:</td>
<td></td>
<td></td>
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<td></td>
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<td>Salaries, wages and benefits</td>
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<td>906</td>
<td>4</td>
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<td>-</td>
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<td>148</td>
<td>77</td>
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<td>1,309</td>
<td>-</td>
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<td>(258)</td>
<td>-</td>
<td>(152)</td>
<td>(2)</td>
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<tr>
<td>Nonoperating gains (losses), net:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonoperating investment gains (losses), net</td>
<td>-</td>
<td>199</td>
<td>(1)</td>
<td>10</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Other nonoperating activities, net</td>
<td>(174)</td>
<td>(191)</td>
<td>(48)</td>
<td>(82)</td>
<td>-</td>
<td>-</td>
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<tr>
<td>(Deficit) excess of revenues over expenses</td>
<td>(704)</td>
<td>-</td>
<td>(307)</td>
<td>(72)</td>
<td>(152)</td>
<td>(2)</td>
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<tr>
<td>Other changes in net assets:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>160</td>
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<tr>
<td>Distributions to noncontrolling interest owners</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
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<td>3</td>
<td>87</td>
<td>-</td>
<td>12,794</td>
</tr>
<tr>
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<td>-</td>
<td>(304)</td>
<td>205</td>
<td>(152)</td>
<td>12,792</td>
</tr>
</tbody>
</table>

November 30, 2017
### Non-Obligated Group Members

<table>
<thead>
<tr>
<th>Revenues:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bon Secours Richmond Healthcare Foundation</td>
<td>Bon Secours Virginia HealthSource, Inc.</td>
<td>Laburnum Properties, Inc.</td>
<td>Chesterfield Community Healthcare Center, Inc.</td>
<td>RHS Enterprises, Inc.</td>
<td>Bon Secours Ambulatory Services, LLC</td>
<td>Bon Secours Home Health Services LLC</td>
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<td>Net patient service revenue before bad debts</td>
<td>-</td>
<td>12,736</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>600</td>
<td>4,319</td>
</tr>
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<td>-</td>
<td>-</td>
<td>(103)</td>
<td>(64)</td>
</tr>
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<td>Net patient service revenue</td>
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<td>-</td>
<td>-</td>
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<td>4,255</td>
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<td>-</td>
<td>-</td>
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<td>40</td>
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<td>-</td>
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<td>18</td>
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<td>-</td>
<td>-</td>
<td>45</td>
<td>144</td>
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<td>50</td>
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<td>-</td>
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<td>-</td>
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<td>683</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>(12)</td>
<td>(146)</td>
</tr>
<tr>
<td>Nonoperating gains (losses), net:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonoperating investment gains (losses), net</td>
<td>(9)</td>
<td>(159)</td>
<td>115</td>
<td>(28)</td>
<td>(4)</td>
<td>(6)</td>
<td>(29)</td>
</tr>
<tr>
<td>Other nonoperating activities, net</td>
<td>(2,277)</td>
<td>(394)</td>
<td>(51)</td>
<td>2</td>
<td>-</td>
<td>(5)</td>
<td>-</td>
</tr>
<tr>
<td>(Deficit) excess of revenues over expenses</td>
<td>(2,286)</td>
<td>(2,808)</td>
<td>64</td>
<td>(26)</td>
<td>(16)</td>
<td>(157)</td>
<td>(1,892)</td>
</tr>
<tr>
<td>Other changes in net assets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net assets released from restrictions used for the purchase of property, plant, and equipment</td>
<td>970</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>(1,649)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
<td>334</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(Decrease) increase in unrestricted net assets</td>
<td>(982)</td>
<td>(4,457)</td>
<td>64</td>
<td>(26)</td>
<td>(16)</td>
<td>(157)</td>
<td>(1,892)</td>
</tr>
</tbody>
</table>
### Combining Schedule - Operating Information
### Non-Obligated Group Members
#### (in thousands)

**November 30, 2017**

<table>
<thead>
<tr>
<th></th>
<th>Chesapeake Medical Group, Inc.</th>
<th>Rappahannock General Hospital Foundation, Inc.</th>
<th>IVNA Health Services</th>
<th>Richmond Good Help ACO LLC</th>
<th>Tidewater Diversified, Inc.</th>
<th>Bayley Properties, Inc.</th>
<th>DePaul Health Foundation</th>
<th>St. Francis Nursing Care Center, Inc.</th>
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</thead>
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<tr>
<td><strong>Net patient service revenue before bad debts</strong></td>
<td>$1,175</td>
<td>-</td>
<td>454</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,181</td>
</tr>
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<td><strong>Provision for patient bad debts, net</strong></td>
<td>(28)</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<td>(652)</td>
<td>215</td>
<td>36</td>
<td>(473)</td>
<td>(73)</td>
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<td>Maria Manor Health Resources</td>
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<td>(121)</td>
<td>(118)</td>
<td>(140)</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
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<td>-</td>
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<td>-</td>
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<td>Net assets released from restrictions used for the purchase of property, plant, and equipment</td>
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<td>120</td>
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<tr>
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<td>335</td>
<td>58</td>
<td>(118)</td>
<td>(140)</td>
<td>-</td>
<td>(149)</td>
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### Revenues:

<table>
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<th>Shannon Health MOB Partnership 1</th>
<th>BSB MOB Partnership 2</th>
<th>Bon Secours Good HelpCare Connections, LLC</th>
<th>Good Help Connections, LLC</th>
<th>Bon Secours Assurance Company, Ltd.</th>
<th>Combining Eliminations</th>
<th>Combined Non-Obligated Group</th>
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<tbody>
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<td>(778)</td>
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### Expenses:

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<th>Bon Secours Assurance Company, Ltd.</th>
<th>Combining Eliminations</th>
<th>Combined Non-Obligated Group</th>
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### Nonoperating gains (losses), net:

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<th>Combined Non-Obligated Group</th>
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<td>-</td>
<td>(9)</td>
<td>300</td>
</tr>
<tr>
<td>Other nonoperating activities, net</td>
<td>(65)</td>
<td>(24)</td>
<td>-</td>
<td>1,289</td>
<td>-</td>
<td>260 (8,854)</td>
</tr>
</tbody>
</table>

### Other changes in net assets:

<table>
<thead>
<tr>
<th>Shannon Health MOB Partnership 1</th>
<th>BSB MOB Partnership 2</th>
<th>Bon Secours Good HelpCare Connections, LLC</th>
<th>Good Help Connections, LLC</th>
<th>Bon Secours Assurance Company, Ltd.</th>
<th>Combining Eliminations</th>
<th>Combined Non-Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net change in unrealized (losses) gains on other-than-trading securities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>197</td>
</tr>
<tr>
<td>Net assets released from restrictions used for the purchase of property, plant, and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6 (1,137)</td>
</tr>
<tr>
<td>Distributions to noncontrolling interest owners</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(1,649)</td>
</tr>
<tr>
<td>Transfers (to) from affiliates and other changes, net</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>354 (13,785)</td>
</tr>
<tr>
<td>(Decrease ) increase in unrestricted net assets</td>
<td>(65)</td>
<td>(24)</td>
<td>-</td>
<td>1,289</td>
<td>-</td>
<td>620 (4,616)</td>
</tr>
</tbody>
</table>