Trinitas Regional Medical Center Obligated Group
Consolidated Balance Sheet
At March 31, 2018 and December 31, 2017
(Unaudited)

	March 2018	December 2017
Assets		
Current Assets:		
Cash and cash equivalents (includes certificates of deposit)	$ 122,689,340	$ 132,741,105
Assets whose use is limited	4,877,116	4,789,990
Patient accounts receivable, net	26,111,298	27,697,494
Other receivables	3,481,859	2,596,572
Other current assets	7,154,569	6,105,115
Total current assets	164,314,182	173,930,276
Assets Whose Use is Limited and Investments		
Assets whose use is limited:		
Internally designated	99,990,551	101,660,141
Other internally designated	8,560,789	8,451,871
Donor restricted	3,121,992	3,028,167
Investments	29,186,047	29,829,519
Total assets whose use is limited and investments	140,859,379	142,969,698
Beneficial Interest in Net Assets of Trinitas Health Foundation	9,664,231	9,759,389
Property and Equipment (net of accumulated depreciation of $255,525,000 in 2018 and $252,682,000 in 2017)	85,610,810	86,120,548
Other Assets	5,854,905	5,851,315
Total	$ 406,303,507	$ 418,631,226
Liabilities and Net Assets		
Current Liabilities:		
Current portion of long-term debt	$ 5,315,000	$ 5,065,000
Accounts payable, construction payable and accrued expenses	22,646,407	24,496,220
Deferred revenue	4,745,161	7,330,546
Accrued bond interest payable	1,088,843	2,241,000
Accrued salaries and wages	3,451,232	5,994,526
Estimated settlements with third-party payors	13,034,358	13,071,014
Total current liabilities	50,281,001	58,198,306
Estimated Settlements with Third-party Payors	47,480,455	49,618,391
Long-Term Debt	94,656,871	95,220,237
Other Long-Term Liabilities	18,452,636	18,378,339
Total liabilities	210,870,963	221,415,273
Net Assets		
Without donor restrictions	182,646,316	184,428,392
With donor restrictions	12,786,228	12,787,561
Total net assets	195,432,544	197,215,953
Total	$ 406,303,507	$ 418,631,226

Trinitas Regional Medical Center Obligated Group
Consolidated Statement of Operations
For the Three Months Ended March 31, 2018 and 2017
(Unaudited)

	March 2018	March 2017
Revenues		
Net patient service revenue	$ 55,118,727	$ 57,367,802
Other revenue	16,439,390	16,412,723
Net assets released from restrictions used for operations	64,362	153,756
Total revenues	71,622,479	73,934,281
Expenses		
Salaries and wages	33,131,067	34,221,524
Employee benefits	6,688,886	7,004,164
Supplies and other	28,118,806	27,594,735
Depreciation	2,843,271	2,946,706
Interest and amortization	775,479	1,571,127
Total expenses	71,557,509	73,338,256
Operating Income	64,970	596,025
Nonoperating Gains and Losses		
Interest, dividends and other	903,314	947,798
Net realized gains and losses on investments	153,922	475,076
Change in unrealized gains and losses on investments	(3,232,494)	403,620
Total nonoperating gains and losses	(2,175,258)	1,826,494
Revenues and Nonoperating Gains Over (Under) Expenses	$ (2,110,288)	$ 2,422,519

Trinitas Regional Medical Center Obligated Group
Consolidated Statement of Changes in Net Assets
For the Three Months Ended March 31, 2018 and 2017
(Unaudited)

	March 2018	March 2017
Without Donor Restrictions:		
Revenues and nonoperating gains over (under) expenses	$ (2,110,288)	$ 2,422,519
Net assets released from restrictions used for purchase of property and equipment	328,212	974,700
Increase (decrease) in without donor restrictions net assets	(1,782,076)	3,397,219
With Donor Restrictions:		
Contributions	513,452	1,093,455
Interest and dividends	(27,053)	5,411
Net assets released from restrictions	(392,574)	(1,128,456)
Change in beneficial interest in net assets of Trinitas Health Foundation	(95,158)	2,839,342
Increase (decrease) in with donor restrictions net assets	(1,333)	2,809,752
Increase (Decrease) in Net Assets	(1,783,409)	6,206,971
Net Assets		
Beginning of year	197,215,953	175,896,449
End of year	$ 195,432,544	$ 182,103,420

Trinitas Regional Medical Center Obligated Group
Consolidated Statement of Cash Flows
For the Three Months Ended March 31, 2018 and 2017
(Unaudited)

	March 2018	March 2017
Cash Flows from Operating Activities		
Increase (decrease) in net assets	$ (1,783,409)	$ 6,206,971
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation	2,843,271	2,946,694
Amortization of deferred financing costs	19,815	53,706
Amortization of deferred bond premium	(333,180)	(78,669)
Restricted contributions for capital additions	(328,212)	(974,700)
Change in net unrealized gains and losses on other than trading securities	3,232,494	(403,620)
Net realized gains and losses on investments	(153,922)	(475,076)
Change in beneficial interest in net assets of Trinitas Health Foundation	95,158	(2,839,342)
Change in assets and liabilities:		
Patient accounts receivable	1,586,196	(1,380,806)
Other receivables	(885,287)	(1,297,342)
Other current assets and other assets	(1,397,105)	(1,064,728)
Accounts payable, construction payable and accrued expenses	(1,505,753)	(1,920,754)
Deferred revenue	(2,585,385)	(1,304,587)
Accrued bond interest payable	(1,152,157)	(1,261,547)
Accrued salaries and wages	(2,543,294)	(2,581,408)
Estimated settlements with third-party payors	(2,174,592)	(3,450,770)
Other long-term liabilities	74,297	422,580
Net cash provided by (used in) operating activities	(6,991,065)	(9,403,398)
Cash Flows from Investing Activities		
Acquisition of property and equipment and construction	(2,333,533)	(2,631,951)
Purchases of investments and assets whose use is limited, net	(1,055,379)	(4,155,980)
Net cash provided by (used in) investing activities	(3,388,912)	(6,787,931)
Cash Flows from Financing Activities		
Restricted contributions for capital additions	328,212	974,700
Net cash Provided by (used in) financing activities	328,212	974,700
Net Increase (Decrease) in Cash and Cash Equivalents	(10,051,765)	(15,216,629)
Cash and Cash Equivalents, Beginning	132,741,105	130,023,301
Cash and Cash Equivalents, Ending	$ 122,689,340	$ 114,806,672
Supplemental Disclosure of Cash Flow Information,		
Interest paid	$ 2,241,000	$ 2,857,706

1. Reporting Organizations

The consolidated financial statements include the accounts of Trinitas Regional Medical Center (the "Medical Center"), Marillac Corporation ("Marillac"), a wholly owned subsidiary of the Medical Center and Trinitas Physicians Practice, LLC. In 2000, Elizabeth General Medical Center and St. Elizabeth Hospital merged to form Trinitas Hospital, a not-for-profit, tax-exempt, voluntary, acute health care provider located in Elizabeth, New Jersey. Trinitas Hospital officially changed its name to Trinitas Regional Medical Center as of October 2008. The Medical Center provides inpatient, outpatient, and emergency care services for local residents. Admitting physicians are primarily practitioners from the local area.

Marillac, a not-for-profit, tax-exempt corporation pursuant to Section 501(c)(3) of the Internal Revenue Code, owns and operates a medical office building in Elizabeth, New Jersey.

Trinitas Physicians Practice, LLC, (TPP, LLC) a New Jersey professional limited liability company (LLC), a for-profit taxable entity.

The sole member of the Medical Center is Trinitas Health (the "Parent"), a tax-exempt holding company. Both the Parent and the Medical Center are tax-exempt organizations, pursuant to Section 501(c)(3) of the Internal Revenue Code.

The Medical Center is an affiliated member of the Parent, the controlling entity. Other affiliates of Trinitas Health include: Trinitas Healthcare Corporation, Trinitas Health Services Corporation and subsidiary, and Trinitas Health Foundation and Affiliate (the "Foundation"). Only the Medical Center's financial statements and its subsidiaries including Marillac and Trinitas Physicians Practice, LLC are presented herein. The Parent's affiliates, with the exception of Trinitas Health Services Corporation, are not-for-profit, tax-exempt organizations. Trinitas Health Services Corporation is a for-profit, taxable entity.

2. Presentation

The consolidated financial statements are unaudited and include all adjustments which are, in the opinion of Management, necessary for a fair presentation of the Obligated Group's financial position at March 31, 2018 and 2017, its result of operations and its changes in net assets and cash flows for the three months ended March 31, 2018 and 2017 in conformity with accounting principles generally accepted in the United States of America. Certain information and footnote disclosures normally included in financial statements prepared in accordance with such accounting principles have been omitted.

These consolidated financial statements should be read in conjunction with Trinitas Regional Medical Center's audited consolidated financial statements and notes thereto for the years ended December 31, 2017.

3. Net Patient Service Revenue

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

Performance obligations are determined based on the nature of the services provided by the Medical Center. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Medical Center believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in the Medical Center receiving inpatient acute care services. The Medical Center measures the performance obligation from admission into the facility to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time are recognized when goods or services are provided and the Medical Center does not believe it is required to provide additional goods or services to the patient.

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

The Medical Center determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Medical Center's policy, and /or implicit price concessions provided to uninsured patients. The Medical Center determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. The Medical Center determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- Medicare: Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic and other factors. Certain services are paid based on cost-reimbursement methodologies subject to certain limits. Physician services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates. Reimbursements for cost reimbursable items are received at tentative interim rates, with final settlement determined after submission of annual cost reports by the Medical Center and audits thereof by the Medicare fiscal intermediary. The Medical Center's Medicare cost reports have been settled by the Medicare fiscal intermediary through December 31, 2009.

- Medicaid: Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of service or per covered member. Outpatient services are paid based on a cost reimbursement methodology. The Hospital's Medicaid cost reports have been settled by the Medicaid fiscal intermediary through December 31, 2015.

Revenue received under third-party arrangements is subject to audit and retroactive adjustments. Net patient service revenue on the consolidated statement of operations includes no adjustments for the three months ended March 31, 2018 and 2017, respectively, related to tentative and final settlements of prior year cost reports and other settlements.

- Other: Payment agreements with certain commercial managed care and Medicare and Medicaid managed care insurance carriers, health maintenance organizations and preferred provider organizations provide for payment using prospectively determined rates per discharge, or per diem, or discounts from established charges and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Medical Center's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Medical Center. In addition, the contracts the Medical Center has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Medical Center's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price were not significant for the three months ended March 31, 2018 and 2017, respectively.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Medical Center also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Medical Center estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction prices is determined by reducing the standard charge by any contractual adjustments, discounts and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the three months ended March 31, 2018 and 2017, (additional) and reduction in revenue of ($257,736) and $158,244, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt. Bad debt expense based on subsequent changes for the three months ended March 31, 2018 and 2017, respectively, was not significant.

Consistent with the Medical Center's mission, care is provided to patients regardless of their ability to pay. Therefore, the Medical Center has determined it has provided implicit price concessions to uninsured patients and patient with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Medical Center expects to collect based on its collection history with those patients.

Patients who meet the Medical Center's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue. Charges for charity care rendered were $33,338,602 and $32,234,210 for the three months ended March 31, 2018 and 2017, respectively.

The composition of patient care service revenue by payor for the three months ended March 31 is as follows:

	2018	2017
Medicare	$ 21,119,848	$ 22,001,442
Medicaid	19,819,989	21,343,788
Other third party payors	13,367,074	13,129,192
Self-pay and other	811,816	893,380
Total	$ 55,118,727	$ 57,367,802

The composition of patient care service revenue based on its lines of business for the three months ended March 31 is as follows:

	2018	2017
Medical Center	$ 51,948,676	$ 54,258,936
Long-term care	1,641,047	1,774,000
Physicians practice	1,529,004	1,334,866
Total	$ 55,118,727	$ 57,367,802

4. Healthcare Payment Proposals

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. Compliance with these laws and regulations is subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Government activity continues to increase with respect to investigations and allegations concerning possible violations by healthcare providers of fraud and abuse statues and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. Management is not aware of any material incidents of noncompliance that have not been provided for in the accompanying financial statements; however, the possible future financial effects of this matter on the Medical Center, if any, are not presently determinable.

5. Subsequent Events

The Medical Center evaluated subsequent events for recognition or disclosure through May 14, 2018, the date the financial statements were available to be issued.

6. New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU No. 2014-09 supersedes the revenue recognition requirements in Topic 605, Revenue Recognition, and most industry-specific guidance. Under the requirements of ASU No. 2014-09, the core principle is that entities should recognize revenue to depict the transfer of promised goods or services to customers (residents) in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Medical Center will be required to retrospectively adopt the guidance in ASU No. 2014-09 for the years beginning after December 15, 2017. The Medical Center has adopted ASU No. 2014-09 on its financial statements for 2018.

In January 2016, the FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Liabilities (Subtopic 825-10).* The new guidance requires equity investments (except equity method investments or those that result in consolidation) to be measured at fair value with changes in fair value recognized in net income. Finally, ASU 2016-01 requires other specific investment presentation and disclosures in the financial statements for certain financial instruments. ASU 2016-01 is effective for the fiscal year ending December 31, 2018. The Medical Center adopted ASU No. 2016-01 on its financial statements for 2018. As part of the adoption of ASU No. 2016-01, the Medical Center for its debt and equity investments has moved changes in unrealized (losses) of ($3,232,494) and unrealized gains of $403,620 for the three month period ended March 31, 2018 and 2017, respectively, above the performance indicator. The Medical Center manages its investments in totality and separating debt and equity unrealized gains and losses was not meaningful.

In August 2016, the FASB issued ASU No. 2016-14, Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities. The new guidance is intended to improve and simplify the current net asset classification requirements and information presented in financial statements and notes that is useful in assessing a not-for-profit's liquidity, financial performance and cash flows. ASU 2016-14 is effective for the fiscal year beginning July 1, 2018, with early adoption permitted. ASU 2016-14 is to be applied retroactively with transition provisions. Net assets have been reclassified into two categories, without donor restrictions and with donor restrictions, from three categories. The Medical Center has adopted ASU No. 2016-14 on its financial statements for 2018.

In February 2016, the FASB issued Accounting Standards Update ASU No. 2016-02, *Leases* (Topic 842). ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheet. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Medical Center's leasing activities. The Medical Center will be required to retrospectively adopt the guidance in ASU No. 2016-02 for years beginning after December 15, 2018. The Medical Center has not yet determined the impact of adoption of ASU No. 2016-02 on its financial statements.

7. Charity Care and Subsidy Payments

The Medical Center receives subsidy payments from the State of New Jersey to partially fund charity care and certain other program costs. Subsidy payments included in other revenue for the three months ended March 31, 2018 and 2017 are as follows:

	2018	2017
Charity care	$ 7,286,280	$ 8,086,167
Delivery System Reform Incentive Payment	1,947,315	1,115,489
Mental health	452,877	452,878
Total	$ 9,686,472	$ 9,654,534

In October 2017, the Medical Center received an incentive payment in the amount of $7,789,257 for Year 5 and an appeal for Year 4 and, in July 2016, received an incentive payment in the amount of $2,602,760 for Year 4 for the Delivery System Reform Incentive Payment (DSRIP) whereby the amounts are amortized over the DSRIP fiscal year ending June 30, 2018 and 2017, respectively.

For the three months ended March 31, 2018 and 2017, the incentive payment in the amount of $1,947,315 and $673,848 was recognized in other revenue in the consolidated statement of operations, respectively, and the remainder in the amount of $1,947,315 and $887,807 was recognized as deferred revenue in balance sheet, respectively.

The Medical Center, as part of its mission, provides medical care without charge or at reduced charges to residents of its community through the provision of charity care. The Medical Center's definition of charity care is in accordance with state regulations and includes services provided at no or partial charge to the uninsured or underinsured.

8. Long-term Debt

On April 3, 2017, the Authority issued, on behalf of the Medical Center, $82,970,000 in Refunding Bonds, Series 2017A (the "Series 2017A Bonds"), at an interest rate of 5% percent. The proceeds from the sale of the Series 2017A Bonds combined with the debt service reserve funds were released by the trustee relating to the Series 2007A Bonds and Series 2007B Bonds, and used to refund Series 2007A Bonds and Series 2007B Bonds and pay debt issuance costs. The Medical Center will be required to fund the principal and interest payments on the bonds. The principal amounts are payable annually on July 1, and interest is payable semiannually on January 1 and July 1 through 2030. The Series 2017A Bonds are collateralized by substantially all of the Obligated Group's property and equipment and gross receipts. The 2017A Bonds refinanced and extinguished the 2007 Bonds resulting in a loss on bond refinancing in the amount of $1,238,343 reflected in the consolidated statement of operations.

9. Meaningful Use

Under certain provisions of the American Recovery and Reinvestment Act of 2009, federal incentive payments are available to hospitals, physicians and certain other professionals ("providers") when they adopt certified electronic health record ("EHR") technology or become "meaningful users" of EHRs in ways that demonstrate improved quality, safety and effectiveness of care. Medicare and Medicaid providers can receive their initial incentive payment by adopting implementing or upgrading certified EHR technology, but must demonstrate meaningful use of EHRs in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments. The Medical Center accounts for EHR payments using the contingency method, whereby, revenue is recognized when all contingencies are satisfied. At March 31, 2018 and 2017, the EHR incentive payments received from the Medicare and Medicaid programs is reflected in estimated settlements with third party payors on the balance sheet in the amount of $3.3 million and $3.4 million, respectively, which will be recognized as non-operating revenue when the Medical Center has satisfied the statutory and regulatory requirements. For the three months ended March 31, 2018 and 2017, no amounts were recognized as non-operating revenue, respectively, in the consolidated statement of operations.

10. Cogeneration Energy Project

The Medical Center has submitted an application and has received preliminary approval from the Energy Resilience Bank ("ERB"), for a plant electrical and steam generation project. The project would provide additional energy production which will be powered by natural gas during prolonged electrical outages. The project has an estimated cost of $10.1 million. The financing of the project would consist of a combination of grants for $6.6 million and a loan from the Department of Housing and Urban Development ("HUD") for approximately $3.5 million. A portion of the grants, approximately $520,000, will have to be repaid over ten years, interest free. Final construction and engineering costs are being finalized for approval by ERB and HUD, which is expected for mid-2018.

11. Community Mental Health Center

The Medical Center had signed a non-binding letter of intent to acquire a community mental health center ("the Center") with the intention of further expanding its behavioral health services in 2017. The Center operates an outpatient mental health clinic, outpatient addiction treatment center, adult partial care services program and employee assistance program. The Center will be operated as an outpatient department of the Medical Center. The Medical Center will assume the Center's mortgage on the facility, with an outstanding mortgage of approximately $91,000. The Medical Center subsequently signed an asset purchase agreement to execute the aforementioned transaction with an effective date of April 12, 2018.

TRINITAS REGIONAL MEDICAL CENTER
FOR THE THREE MONTHS ENDED MARCH 31, 2018 AND 2017
INPATIENT STATISTICS

	MARCH 2018 ACTUAL	MARCH 2017 ACTUAL
ADMISSIONS		
MEDICAL	1,711	1,887
SURGICAL	428	434
OBSTETRICS	385	483
NEWBORN	370	471
ADULT & ED PSYCH	425	413
ADOLESCENT PSYCH	147	150
DEVELOP DISABLED	66	71
	3,532	3,909
SAME DAY SURGERY	1,150	1,259
	4,682	5,168
INTERMEDIATE PSYCH	44	50
RESIDENTIAL UNIT	2	3
LONG TERM CARE	86	101
	132	154
PATIENT DAYS		
MEDICAL	9,159	9,630
SURGICAL	2,962	3,164
OBSTETRICS	1,069	1,360
NEWBORN	1,006	1,469
ADULT & ED PSYCH	3,833	4,034
ADOLESCENT PSYCH	1,633	1,140
DEVELOP DISABLED	764	785
	20,426	21,582
SAME DAY SURGERY	1,150	1,259
	21,576	22,841
INTERMEDIATE PSYCH	1,597	1,912
RESIDENTIAL UNIT	1,343	1,326
LONG TERM CARE	9,914	10,631
	12,854	13,869
ALOS		
MEDICAL	5.4	5.1
SURGICAL	6.9	7.3
OBSTETRICS	2.8	2.8
NEWBORN	2.7	3.1
ADULT & ED PSYCH	9.0	9.8
ADOLESCENT PSYCH	11.1	7.6
DEVELOP DISABLED	11.6	11.1
TOTAL W/O SDS	5.8	5.5
INTERMEDIATE PSYCH	36.3	38.2
RESIDENTIAL UNIT	671.5	442.0
LONG TERM CARE	115.3	105.3
	97.4	90.1
CARDIAC CATH LAB I/P		
CARDIAC CATHS	78	95
EMERGENCY ANGIO	13	14
ELECTIVE ANGIO	32	28
OTHER	35	48
TOTAL	158	185

TRINITAS REGIONAL MEDICAL CENTER
FOR THE THREE MONTHS ENDED MARCH 31, 2018 AND 2017
OUTPATIENT STATISTICS

	MARCH 2018 YTD	MARCH 2017 YTD
EMERGENCY ROOM		
NEWPOINT-PSYCH O/P VISITS	446	515
WILLIAMSON O/P VISITS	13,703	13,938
TOTAL O/P	14,149	14,453
NEWPOINT ADMISSIONS	424	443
WILLIAMSON ADMISSIONS	1,892	1,942
TOTAL ADMISSIONS	2,316	2,385
% Total ADMISSIONS FROM ER	65.57%	61.01%
TOTAL EMERGENCY ROOM VISITS	16,465	16,838
OBSERVATION		
WSC OBSERVATON CASES	639	346
NPC OBSERVATON CASES	37	66
TOTAL OBSERVATION	676	412
CLINICS		
ADULT OP SERVICES	18,701	20,238
PC (PARTIAL HOSP) SERVICES	2,067	1,897
CHILD/ADOL OP SERVICES	8,493	8,403
YIP (AFTER SCHOOL)	1,675	1,789
IOP SERVICES	722	504
OTHER CHILD/ADOL SERVICES	17,434	21,405
BAYONNE MH CLINIC	0	0
TOTAL PSYCH CLINICS (1)	49,092	54,236
D.B.HERSH CLINIC	2,210	2,257
PEDIATRIC HEALTH CENTER	1,879	1,707
WOMENS HEALTH CENTER	5,203	5,111
WOUND HEALING CENTER	954	1,004
MEDICAL CLINIC (EID)	383	372
TOTAL MEDICAL CLINICS	10,629	10,451
TOTAL CLINICS	59,721	64,687
CANCER CENTER		
OFFICE VISITS	1,681	1,851
INFUSION TREATMENTS	1,901	2,135
RADIATION TREATMENTS	1,447	1,170
CANCER CENTER TOTAL	5,029	5,156
PRIVATE AMBULATORY		
SLEEP CENTER	311	330
OTHER PRIVATE REFFERRED (2)	14,212	13,832
TOTAL PRIVATE AMBULATORY	14,523	14,162
O/P RENAL TREATMENTS		
O/P HEMODIALYSIS	5,194	5,093
HOME DIALYSIS	435	288
LINDEN SATELLITE	3,169	3,122
TOTAL RENAL TREATMENTS	8,798	8,503
AMBULANCE RUNS	1,523	1,622
SCTU RUNS	52	49
MICU RUNS	912	938
SDS (FROM IP SCHEDULE)	1,150	1,259
TOTAL O/P VISITS (INCLUDING SDS)	106,533	111,241
CARDIAC CATH LAB O/P		
CARDIAC CATHS	105	117
ELECTIVE ANGIOPLASTY	27	29
OTHER	22	26
TOTAL	154	172

Trinitas Regional Medical Center Obligated Group

Debt Service Calculation Certificate

(Twelve Month Rolling Average)

(Unaudited)

		March 2018
Funds Available for Debt Service		
Net increase in unrestricted net assets	$	13,500,336
Reconciling items:		
Depreciation		10,389,450
Interest and amortization		3,809,518
Net assets released from restrictions used for purchase of property and equipment		(5,210,418)
Loss on bond refinancing		1,238,343
Change in net unrealized gains and losses on investments		384,886
Total	$	24,112,115
Maximum annual debt service	$	9,549,000
Actual ratio		2.53
Required ratio		1.25

Trinitas Regional Medical Center Obligated Group

Cushion Ratio Calculation Certificate
(Twelve Month Rolling Average)
(Unaudited)

		March 2018
Cushion Ratio		
Cash and investments	$	153,634,281
Internally designated funds		100,056,853
Total	$	253,691,134
Maximum annual debt service		
Series 2016A and 2017A bonds payable	$	9,549,000
Total maximum annual debt service	$	9,549,000
Cushion ratio		26.57
Required ratio		1.25