UNM HOSPITAL
UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER
CLINICAL OPERATIONS

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

JUNE 30, 2012 AND 2011

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

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UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
FISCAL YEAR 2012 OFFICIAL ROSTER

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UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
FISCAL YEAR 2012 OFFICIAL ROSTER (CONTINUED)

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UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS

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Report of Independent Auditors

The University of New Mexico Health Sciences Center
Board of Trustees and
Mr. Hector Balderas, New Mexico State Auditor

We have audited the accompanying statements of net assets of UNM Hospital (the Hospital), a division of the University of New Mexico, State of New Mexico, operated by the University of New Mexico Health Sciences Center Clinical Operations, organized as the University of New Mexico Hospital, as of June 30, 2012 and 2011, and the related statements of revenues, expenses, and changes in net assets and cash flows for the years then ended. We have also audited the budget comparison (schedule 1) presented as supplementary information for the year ended June 30, 2012. These financial statements and budget comparison are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements and budget comparison based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government *Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 1, the financial statements of the Hospital, a division of the University of New Mexico, are intended to present the financial position, and the changes in financial position and cash flows of only that portion of the business-type activities of the University of New Mexico that is attributable to the transactions of the Hospital, a division of the University of New Mexico. They do not purport to, and do not, present fairly the financial position of the University of New Mexico as of June 30, 2012 and 2011, the changes in its financial position or its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of June 30, 2012 and 2011, and the changes in financial position and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the budget comparison referred to above presents fairly, in all material respects, the budgetary comparison for the year then ended June 30, 2012 in conformity with accounting principles generally accepted in the United States of America.

The University of New Mexico Health Sciences Center
Board of Trustees and
Mr. Hector Balderas, New Mexico State Auditor

In accordance with *Government Auditing Standards*, we have also issued our report dated November 2, 2012 on our consideration of the Hospital's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3 through 20 and the schedule of postemployment benefits other than pensions - schedule of funding progress (schedule 4) be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Our audits were conducted for the purpose of forming opinions on the financial statements and budget comparison that collectively comprise the Hospital's basic financial statements and budget comparison. The accompanying schedule of pledged collateral by banks and the schedule of individual deposit and investment accounts (schedules 2 and 3, respectively) are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedules of pledged collateral by banks and individual deposit and investment accounts are fairly stated in all material respects in relation to the financial statements as a whole.

Moss Adams LLP

Albuquerque, New Mexico
November 2, 2012

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
MANAGEMENT'S DISCUSSION AND ANALYSIS
June 30, 2012 and 2011

This section of the UNM Hospital's (the Hospital) annual financial report presents management's discussion and analysis of the financial performance of the Hospital during the fiscal years ended June 30, 2012 and 2011. This discussion should be read in conjunction with the accompanying financial statements and notes. Management has prepared the financial statements and the related note disclosures along with this discussion and analysis. As such, the financial statements, notes, and this discussion are the responsibility of Hospital's management.

Using the Annual Financial Report

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

The financial statements prescribed by GASB Statement No. 34 (the statements of net assets, statements of revenues, expenses, and changes in net assets, and the statements of cash flows) present financial information in a form similar to that used by commercial corporations. They are prepared under the accrual basis of accounting, whereby revenues and assets are recognized when the service is provided, and expenses and liabilities are recognized when others provide the service, regardless of when cash is exchanged.

The statements of net assets include all assets and liabilities. Over time, increases or decreases in net assets (the difference between assets and liabilities) is one indicator of the improvement or erosion of the Hospital's financial health when considered with nonfinancial facts such as patient statistics and the condition of facilities. This statement includes all assets and liabilities using the accrual basis of accounting, which is consistent with the accounting method used by private sector institutions.

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

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

Condensed Summary of Net Assets

	As of June 30		
Assets	**2012**	**2011**	**2010**
Current assets	$ 249,665,274	251,141,828	247,361,448
Capital assets, net	270,357,736	286,030,852	292,235,742
Noncurrent assets	51,195,980	47,422,338	42,716,191
Total assets	$ 571,218,990	584,595,018	582,313,381
Liabilities			
Current liabilities	$ 104,150,537	108,155,360	114,098,556
Noncurrent liabilities	185,731,050	196,892,752	198,739,060
Total liabilities	$ 289,881,587	305,048,112	312,837,616
Net Assets			
Invested in capital assets, net of related debt	$ 116,259,307	127,194,482	128,867,880
Restricted	35,444,198	30,656,581	21,912,665
Unrestricted	129,633,898	121,695,843	118,695,220
Total net assets	$ 281,337,403	279,546,906	269,475,765

At June 30, 2012, total Hospital's assets were $571.2 million compared to $584.6 million at June 30, 2011. The Hospital's most significant assets at June 30, 2012 were net capital assets of $270.4 million, followed by total net receivables of $106.0 million, and then cash and cash equivalents of $88.5 million. The Hospital manages all cash receipts and disbursements for all its affiliates, the UNM Psychiatric Center (UNMPC) and the UNM Children's Psychiatric Center (UNMCPC), which are collectively referred to as "The Center." The due to affiliates in the liability section of the statement of net assets reflects all intercompany cash transactions.

At June 30, 2011, total Hospital's assets were $584.6 million compared to $582.3 million at June 30, 2010. The Hospital's most significant asset at June 30, 2011 was net capital assets of $286.0 million, followed by cash and cash equivalents of $108.4 million.

At June 30, 2012, 2011, and 2010, the Hospital's current assets of $249.7 million, $251.1 million, and $247.4 million, respectively, were sufficient to cover current liabilities of $104.2 million (current ratio of 2.40), $108.2 million (current ratio of 2.32), and $114.1 million (current ratio of 2.17), respectively.

The Hospital's liabilities totaled $289.9 million at June 30, 2012 compared to $305.0 million at June 30, 2011. Bonds payable of $171.2 million was the largest liability, followed by accounts payable of $ 26.8 million.

The Hospital's liabilities totaled $305.0 million at June 30, 2011 compared to $312.8 million at June 30, 2010. Bonds payable of $176.3 million was the largest liability, followed by accounts payable of $26.8 million.

Total net assets as of June 30, 2012 increased by $1.8 million to $281.3 million, primarily due to the excess of revenues over expenses in fiscal year 2012, which included an operating loss of $59.8 million offset by net nonoperating revenues of $61.4 million. Unrestricted net assets totaled $129.6 million at June 30, 2012.

Total net assets as of June 30, 2011 increased by $10.1 million to $279.5 million, primarily due to the excess of revenues over expenses in fiscal year 2011, which included an operating loss of $42.6 million offset by net nonoperating revenues of $48.5 million. Unrestricted net assets totaled $121.7 million at June 30, 2011.

Condensed Summary of Revenues, Expenses, and Changes in Net Assets

	Year Ended June 30		
	2012	2011	2010
Total operating revenues	$ 633,205,357	625,049,712	600,497,552
Total operating expenses	(693,028,692)	(667,655,495)	(656,295,386)
Operating loss	(59,823,335)	(42,605,783)	(55,797,834)
Nonoperating revenues, expense and other revenues	61,613,832	52,676,924	64,820,236
Total increase in net assets	1,790,497	10,071,141	9,022,402
Net assets, beginning of year	279,546,906	269,475,765	260,453,363
Net assets, end of year	$ 281,337,403	279,546,906	269,475,765

Operating Revenues

The sources of operating revenues for the Hospital are net patient services, state and local contracts and grants, and other operating revenues, with the most significant source being net patient services revenues. Operating revenues were $633.2 million, $625.0 million, and $600.5 million for the years ended 2012, 2011, and 2010, respectively.

Net patient service revenue is comprised of gross patient revenue, net of contractual allowances, charity care, provision for doubtful accounts, and any third-party cost report settlements. Net patient services revenues were $617.7 million, $618.1 million, and $593.3 million for the years ended 2012, 2011, and 2010, respectively.

Net patient services revenues for 2012 of $617.7 million decreased $328,000 from $618.1 million in 2011, which represents a 0.1% decrease and is reflective of a full year of reductions in revenue associated with the decrease in Medicaid outpatient payment rates compared to seven months of revenue reductions in FY 2011. In addition, the Hospital final settled the 2006, 2007, 2008, and 2009 Medicaid cost reports in fiscal year 2011 which increased net patient revenue by $14.4 million in the prior year. There were no cost reports final settled during fiscal year 2012. In December 2011, the newly remodeled Clinical Neurosciences Center (CNC) opened. The 31,000 square foot clinic houses several services including neurosurgery, adult, and child neurology, neurodiagnostics lab, pain consultation and treatment center and pain and spine physical therapy clinic. The facility serves as a multidisciplinary center of excellence, serving the state of New Mexico for a broad range of neurological and chronic conditions including brain injury/pathology, epilepsy, peripheral neuropathy, movement disorders, stroke, memory disorders, Alzheimer's and neuromuscular diseases.

Net patient service revenue of $618.1 million in 2011 increased $24.8 million from 2010. On January 25, 2011, the Hospital's new Urgent Care Clinic (UCC) opened. The UCC has 21 exam rooms and two procedure rooms. In 2012, the UCC volumes increased by 76% from 6,978 in 2011 to 12,280. Much of this volume would have previously been seen in the Emergency Department (ED). Together, the ED and UCC experienced a 3.5% increase in 2012 to 84,962 visits from 82,118 visits in 2011.

On July 12, 2010, the Hospital completed renovation on a ten bed family practice unit. In addition, on August 31, 2010 and on November 30, 2010, the Hospital opened the Adult Infusion Clinics located at 1201 Camino de Salud and 715 Martin Luther King, respectively. The net patient revenue increase in fiscal year 2011 is reflective of both the opening of the ten bed family practice unit and a full years' worth of adult infusion clinic activity as well as the final settlement for the 2006, 2007, and 2008 Medicaid cost reports. See table below for key financial statistics. In December 2010 the Hospital opened the new Southwest Mesa primary care clinic located at Central and Unser. The clinic has 21 exam rooms and one procedure room. During fiscal 2010, the Hospital opened a new outpatient Digestive Disease Center which includes ten exam and four procedure rooms.

	Year ended June 30, 2012	2011	2010
Inpatient days	156,124	155,941	149,832
Discharges	27,095	27,685	27,452
Outpatient visits	474,900	465,044	462,715
Emergency visits	72,682	75,140	77,567
Urgent Care Clinic	12,280	6,978	—

Inpatient days for 2012 increased 183 from 2011, which represents a 0.1% increase. The Hospital has been running at an occupancy rate of 90% and is at capacity for adult beds.

Inpatient days for 2011 increased 6,109 from 2010, which represents a 4% increase and was primarily due to the opening of the 10 bed adult family practice unit.

On November 1, 2010, the Medical Assistance Division (MAD) implemented an Outpatient Prospective Payment System (OPPS) for Medicaid outpatient payment rates. The payment rate is at 100% of the Medicare standard rate. The Managed Care Organizations (MCOs) also implemented OPPS during fiscal year 2011. As this method of reimbursement is based at less than the recovery of cost, this change had a negative impact to the net patient services revenues for the Hospital and continued to negatively impact net patient services revenues for fiscal year 2012.

During fiscal year 2010, MAD implemented cost containment measures on December 1, 2009, including a 3% reduction in inpatient Medical Services Diagnosis Related Group (MSDRG) rates, a 3% reduction in inpatient behavioral health reimbursement rates, and converted radiology reimbursement to the Medicaid physician fee schedule.

Beginning on July 1, 2005 and effective for fiscal years 2012, 2011, and 2010, the Hospital entered into a reimbursement agreement for the State Coverage Insurance (SCI) program. This program is part of the New Mexico SCI Medicaid plan, funded in part by the New Mexico Human Services Department (HSD). Funding is modeled after a capitated payment program. Funds are remitted to the Hospital on a per member per month basis for all state approved members. For the years ended June 30, 2012, 2011, and 2010, the Hospital recognized revenue of $38.7 million, $38.3 million, and $42.8 million, respectively under the SCI program. As of June 30, 2012, 2011, and 2010, there were approximately 9,400, 9,200, and 11,100 active SCI enrollees, respectively.

The SCI program is available to low-income, uninsured working adults with family income below 200% of the Federal Poverty Level (FPL). The benefit package is a comprehensive healthcare benefit with a claims benefit maximum. Effective September 23, 2010, the claims benefit maximum was eliminated. The SCI plan features cost sharing designed to ensure that low-income participants would have access to care. The state contracts with managed care organizations to provide Medicaid services to eligible and enrolled members.

On January 10, 2012, the Human Services Division (HSD) announced approval of the UNMHSC patient-centered medical home (PCMH) pilot project. The PCMH pilot program provides a specific management model of care that focuses on improving chronic conditions including diabetes, depression, hypertension, hyperlipidemia, obesity, and metabolic syndrome. HSD expects to enroll 5,000 new individuals from the SCI waiting list into the UNMHSC State Coverage Insurance (SCI) program. Enrollment in the pilot program began April 1, 2012. Prior to pilot program approval, the HSD suspended any new enrollment into this program, although re-enrollments continued to be allowed. HSD eliminated the 30-day grace period for re-enrollment under the SCI program effective July 1, 2010. This resulted in consistent declines in enrollment from July 2010 forward until the January 2012 PCMH pilot.

For the years ended June 30, 2012 and 2011, UNM Hospital provided Intergovernmental Transfers ("IGTs") to the State of New Mexico in the amounts of $15.5 million and $14.2 million, respectively. Due to the current economic conditions in the State of New Mexico and nationally, the State was unable for fiscal years 2012 and 2011 to fund a portion of the non-federal share to obtain federal matching funds as described in the CMS Special Conditions/Approval, thereby jeopardizing the viability of the State Coverage Initiative ("SCI") program. As a result, UNM Hospital entered into a Memorandum of Understanding with the State of New Mexico under which UNM Hospital agreed to an intergovernmental transfer to fund the non-federal share of the Medicaid payment pursuant to federal Medicaid regulations at 42 CFR 433.51 (Eligible Operating Funds). The loss of the SCI program would have a large detrimental financial impact to the Hospital which provides services to the enrollees in the SCI Program, and the loss would also threaten the health, welfare and well-being of the enrollees in the SCI Program. The IGTs are recorded as a reduction of net patient service revenues in the accompanying statement of revenues and expenses.

On April 29, 2011, UNM Hospital entered into ten separate MOUs with ten counties in the State of New Mexico under which UNM Hospital agreed to transfer a total of $2.2 million of its funds as IGTs to those ten counties to preserve and protect the viability of the Sole Community Provider Fund. The IGT was a result of the current economic conditions in the State of New Mexico, which left the ten counties unable for Fiscal Year 2011 to fund their entire required portion to the Sole Community Provider Fund, thereby, jeopardizing the financial viability of the Sole Community Provider Adjustment. No IGTs were made during the fiscal year ended 2010.

The Hospital offers a financial assistance program called UNM Care to which all eligible patients are encouraged to apply. This program assigns patients primary care providers and enables them to receive care throughout the Hospital and at all clinic locations. This program is available to Bernalillo County residents who also meet certain income thresholds. Prior to January 1, 2010, the income threshold was set at 235% of the FPL. Effective January 1, 2010, the income threshold was changed to 300% of the FPL. Patients may apply for this program at various locations throughout the Health Sciences Center (HSC) and various community locations. As of June 30, 2012, 2011, and 2010, there were approximately 32,500, 30,500, and 27,400 active enrollees, respectively. The Hospital does not pursue collection of amounts determined to qualify as charity care, with the exception of copayments. The cost of charity care provided under this program for fiscal years ended June 30, 2012, 2011, and 2010 was $129.5 million, $126.2 million, and $109.3 million, respectively.

The Hospital provides care to patients who are either uninsured or under-insured and who do not meet the criteria for financial assistance. The Hospital encourages patients to meet with a financial counselor to develop payment arrangements. Although the Hospital pursues collection of these accounts usually through an extended payment plan or a discounted rate, interest is not charged on these accounts, liens are not placed on property or assets, and judgments are not filed against the patients. These accounts are fully reserved and recorded as provision for uncollectible accounts. Provision expense recorded for fiscal years 2012, 2011, and 2010 was $98.1 million, $67.0 million, and $69.5 million, respectively. The cost of care provided to patients who are either uninsured or under-insured and who do not meet the criteria for financial assistance for years ended June 30, 2012, 2011, and 2010 was $48.3 million, $32.9 million, and $35.4 million, respectively.

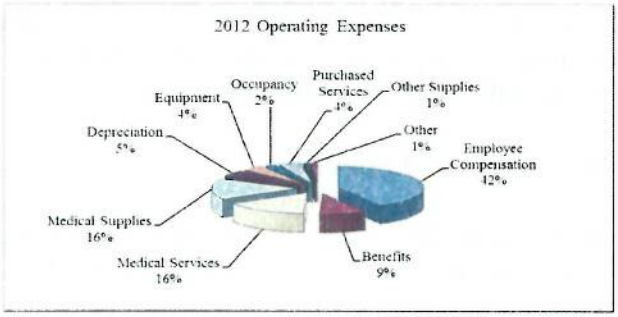
The 2009 American Recovery and Reinvestment Act (ARRA) incorporated the Health Information Technology for Economic and Clinical Health Act (HITECH). The HITECH Act included an incentive funding program meant to encourage the use of electronic health records (EHR) by providers. The funding is predicated on implementation and "meaningful use" of the EHR. The criteria for meaningful use includes: improve quality, safety and efficiency; engage patients; improve care coordination; reduce health disparities through data sharing; and to ensure privacy and security. On July 13, 2010, CMS issued the final rule for meaningful use outlining Stage 1 EHR functionality objectives as well as clinical quality measures. During fiscal year 2012, The Hospital received the first year payment for Medicaid meaningful use in the amount of $4.1 million. The first year payment for Medicare meaningful use, in the amount of $1.4 million, was received August 24, 2012 and was included in other operating revenue and receivables in the accompanying 2012 financial statements. The Hospital has attested to and expects to receive the second year Medicaid payment in the amount of $3.3 million in the second quarter of fiscal year 2013 and was included in other operating revenue and receivables in the accompanying 2012 financial statements.

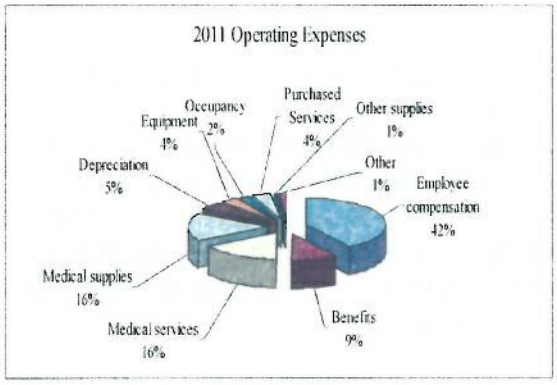
Operating Expenses

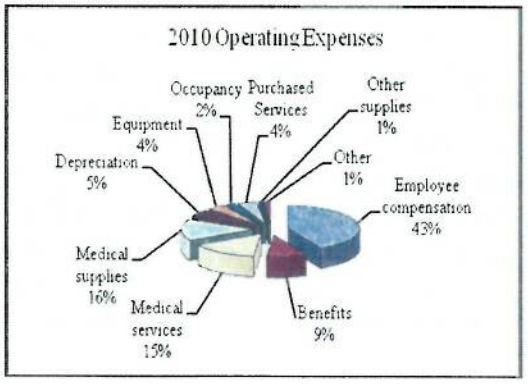
Operating expenses for the Hospital include items such as employee compensation and benefits, medical services, medical supplies, and equipment. The most significant expenditures were for employee compensation and benefits.

Compensation and benefits combined were $350.8 million, $337.1 million, and $338.9 million for the years ended June 30, 2012, 2011, and 2010, respectively.

The following pie charts depict the operating expense mix for the years ended June 30, 2012, 2011, and 2010:







For the year ended June 30, 2012, operating expenses, including depreciation of $34.2 million, totaled $693 million, an increase from 2011 of $25.4 million or 3.8%. The overall increase was attributed to an increase in employee compensation of $15.1 million (5.5%), medical services of $2.8 million (2.6%), equipment of $3.7 million (14.9%), occupancy of $1.6 million (13.4%) and purchased services of $2.8 million (10.7%). The Hospital implemented a 2.5% general wage increase in October 2011, resulting in the increase in compensation. Medical services increased as a result of increased support of physician providers and resident programs. Equipment and occupancy increased primarily due to software maintenance and licensing associated with the electronic medical record and building repair and maintenance, respectively. Purchased services increased due to an increase in costs for the provision of primary care for UNM Care patients as well as implementation of the speech recognition transcription system.

For the year ended June 30, 2011, operating expenses, including depreciation of $34.7 million, totaled $667.7 million, an increase from 2010 of $11.4 million or 1.7%. The overall increase was attributed to an increase in medical supplies of $7.7 million (7.5%) and medical services of $9.1 million (9.1%), which correlate with the increase in patient days of 6,109 (4%) coupled with the increase in outpatient visits of 2,329 (1%) from 2010, as well as the full year of activity for the Adult Infusion Clinic. An increase in surgical procedures requiring implants also contributed to the increase in medical supply cost. A decrease from 2010 of $5.1 million in employee compensation offset these increases, and was the result of reductions in contract labor and overtime utilization.

Nonoperating Revenues and Expenses

For the year ended June 30, 2012, $61.4 million has been recorded as net nonoperating revenue in the accompanying statements of revenues, expenses, and changes in net assets.

At June 30, 2012 and 2011, the Bernalillo County Mill Levy tax subsidy was the most significant nonoperating revenue, totaling $77.5 million in 2012 and $76.8 million in 2011. This tax subsidy is provided for the general operations of the Hospital. The Hospital received this tax subsidy by voter endorsement for the services the Hospital provides. The voters approved the renewal of the mill levy in the November 2008 election. The mill levy is subject to approval by the Bernalillo County voters every eight years, and will be up for renewal in the November 2016 election. During 2011, the Hospital and the Center saw a combined reduction of approximately $1.3 million in the mill levy funding.

The next largest source of nonoperating revenue in 2012 was $5.1 million of state appropriation funds compared to $5.5 million in 2011. Included in this amount for 2012 and 2011 was $4.5 million and $4.9 million for Carrie Tingley Hospital (CTH), respectively, and $524,000 and $583,000 for Young Children Health Center, respectively. State land revenue and oil and gas royalties for CTH for 2012 and 2011 were $800,825 and $842,000, respectively.

The Hospital received $2.7 million of bequests and contributions in 2012 compared to approximately $3.2 million in 2011. The primary source for donations is the annual Children's Miracle Network drive. Included in the 2011 amount is the $2.1 million draw down of donated funds held by UNM. Capital grants and gifts for 2012 was $186,801, compared to $4.2 million in 2011. Included in capital grants and gifts

are contributions for pediatric and adult equipment and in 2011, a single donation in the amount of $3 million for renovation of the administrative wing of the hospital. All donation monies are received by the UNM Hospital Foundation and are drawn upon by the hospital.

The largest nonoperating expense recorded in 2012, 2011, and 2010 was $20.2 million, $33.8 million, and $21.4 million, respectively, for strategic capital projects such as the Clinical Neurosciences and Pain Center and the Southwest Mesa primary care clinic at Central and Unser. Refer to Note 18 in the accompanying notes to the financial statements.

Included in nonoperating expense was $8.0 million and $8.1 million in interest expense on capital asset-related debt for the years ended June 30, 2012 and 2011, respectively. This debt consists of Federal Housing Administration (FHA) insured Hospital Mortgage Revenue Bonds issued on October 14, 2004, in the aggregate principal amount of $192.3 million. Interest on the bonds ranges from 2% to 5% and is payable semi-annually on each January 1 and July 1. The Series 2004 bonds were issued for the purpose of financing the construction, equipping, and furnishing of the Barbara and Bill Richardson Pavilion. The 478,000 square foot pavilion was placed into service in June 2007.

Capital Assets

At June 30, 2012, the Hospital had $270.4 million invested in capital assets, net of accumulated depreciation of $283.5 million. Depreciation charges for the year totaled $34.2 million compared to $34.7 million and $33.4 million in fiscal years 2011 and 2010, respectively.

	As of June 30,		
	2012	2011	2010
Land, building and improvements	$ 180,495,764	179,105,032	178,030,672
Building service equipment	152,380,444	145,974,304	141,518,703
Fixed equipment	15,386,603	15,288,399	15,099,920
Major moveable equipment	196,099,993	208,908,842	219,165,504
Construction in progress	9,462,680	10,080,171	5,307,157
	553,825,484	559,356,748	559,121,956
Less accumulated depreciation	(283,467,748)	(273,325,896)	(266,886,214)
Net property and equipment	$ 270,357,736	286,030,852	292,235,742

During 2012, the largest capital increases were within building service equipment ($6.4 million), and land, building and improvements, ($1.4 million). Major movable equipment decreased from 2011 ($12.8 million) due to $24.2 million in retired equipment, offsetting additions of $11.4 million. The Hospital completed Phase I of the Lawson implementation and the system was placed into service January 2, 2012 affecting Human Resources, Payroll, Accounts Payable, Materials Management, Inventory Control, Purchasing, General Ledger, Fixed Assets, and Financial Reporting functions. The Cerner Surginet module was also placed into service during fiscal year 2012. In addition, UNMH installed a boiler for central plant operations, replaced a large section of sewer line in the older portion of the hospital, renovated the Emergency Room Triage area, and renovated the Interventional Radiology Department to accommodate the new bi-plane angiographic system. The largest capital expenditure in the major movable equipment category was the purchase of a bi-plane angiographic system for the Interventional Radiology Department. Other purchases include an advanced ventilation and monitoring system for Anesthesia used in the Operating Rooms, a C-arm for the pain clinic, x-ray equipment and a prescription automation dispensing system for the family practice clinic, ultrasound machine for use at women's faculty and midwife clinic, an endobronchial ultrasound with videoscope for pulmonary services, an echocardiogram machine for the heart station, new washers and disinfectors to sterilize operating room equipment, and an eye laser.

During 2011, the largest capital increases were within building service equipment ($4.5 million), construction in process ($4.7 million), and land, building, and improvements ($1.1 million). Major moveable equipment decreased from 2010 ($10.3 million) due to $28 million in retired equipment, offsetting additions of $17.5 million. The construction of the Urgent Care Clinic located on the first floor of the hospital with 21 exam rooms and two procedure rooms was completed and the clinic opened on January 25, 2011.

During 2011, the Hospital purchased and installed 1,500 Infusion devices (IV Pumps) and related software. The Hospital also purchased 25 beds for the ICU units and 80 beds for the medical/surgical units. These beds have powered transport mechanisms that allow for easier movement of the bed, the patient and the equipment necessary to accompany the patient while being moved to another location of the hospital for surgery or a diagnostic test; a built in scale in order to monitor the patient's weight, which is one of many indications of health status (for example, retaining fluid in the lungs or body); the mattress offers a treatment pressure relief surface to reduce the incidence of bed sores. The largest capital expenditure in the major movable equipment category was the purchase of a single plane angiographic system for the Interventional Radiology Department. This

system will provide advance imaging and post reconstruction capabilities for diagnostic and therapeutic interventional procedures for Internal Medicine, Oncology and Orthopedic patients. The largest capital expenditures in construction in progress were associated with adding increased functionality for the Electronic Medical Record, specifically improvements in Surgical services and a Scheduling Management System, as well as beginning implementation of an Enterprise Resource Planning System.

Debt Activity

The Hospital's bonds payable totaled $171.2 million and $176.3 million at June 30, 2012 and 2011, respectively. The current portion of this debt was $5.0 million and $4.8 million at June 30, 2012 and 2011, respectively. This debt is related to the Federal Housing Administration (FHA) insured Hospital Mortgage Revenue Bonds, Series 2004, issued by the UNM Board of Regents for the purpose of financing the construction, equipping, and furnishing of the 478,000-square foot Bill and Barbara Richardson Pavilion. The project was placed into service June 2007.

The loan guarantee is considered federal assistance subject to the requirements of Office of Management and Budget (OMB) Circular A-133 and the Single Audit Act. Accordingly, the loan guarantee is considered a federal award for purposes of UNM's June 30, 2012 and 2011 Single Audit.

Change in Net Assets

The Hospital's total change in net assets showed a net increase for 2012 and 2011. Total net assets (assets minus liabilities) are classified by the Hospital's ability to use these assets to meet operating needs. Unrestricted net assets may be used to meet all operating needs of the Hospital. Net assets may be restricted as to their use by sponsoring agencies, donors, or other nonhospital entities. Restricted net assets are those generated by donations and gifts. The restricted net assets are further classified as to the purpose for which they must be used. Net assets increased approximately $1.8 million in 2012. Some of the major reasons for the increase include an $8.2 million increase in operating revenue and a $13.6 million decrease in capital initiatives. These are offset by a $25.4 million increase in operating expense.

Factors Impacting Future Periods

On April 29, 2011, the Centers for Medicare & Medicaid Services (CMS) issued the final rule implementing the inpatient Hospital Value-Based Purchasing (VBP) program under section 1886 (o) of the Social Security Act. As of October 1, 2012, the program, which was established by section 3001 of the Affordable Care Act, reduces hospitals' base diagnosis related group (DRG) payments by 1% and uses those funds to make value-based incentive payments to hospitals that meet designated performance standards.

Under the statute, the measures are categorized into three domains: clinical process of care, outcome, and patient experience of care measures. Examples of process of care measures include Acute Myocardial Infarction; Heart Failure; Pneumonia and Surgical Care Improvement. Examples of outcome measures are mortality and readmission rates for Medicare patients. Finally, the patient experience of care measures are called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and represent patient assessments in regards to communication with nurses and doctors, and overall cleanliness and quietness of facility. The incentive payments for fiscal year 2013 are funded through a reduction to fiscal year 2013 base operating DRG payments for each discharge of 1 percent, with the percentage increasing gradually to 2 percent in fiscal year 2017 and subsequent fiscal years. Scoring in the Hospital VBP program will be based on overall achievement relative to national benchmarks. Whether the hospital meets or exceeds the established performance standards will determine any potential quality-based financial reward for the hospital. For the period October 1, 2012 through September 30, 2013, University of New Mexico Hospital's Inpatient Prospective DRG reimbursement will be decreased by 0.17 percent.

On August 8, 2012, the CMS released the FFY2013 Inpatient Prospective Payment Rule, this final rule set the methodology for calculating the readmission adjustment factor, limited by law to a 1.0 percent reduction per hospital beginning October 1, 2012. This reduction applies to a hospital's diagnosis-related group (DRG) base operating payment. CMS has estimated that the readmission adjustment will reduce overall FFY 2013 payments to hospitals by approximately $270 million or 0.3 percent. Since the Hospital has a low readmission rate, the published readmission adjustment factor is 99.99% so the hospital's base operating DGR rate impact is immaterial for fiscal year 2013.

The Patient Protection and Affordable Care Act (PPACA) enacted on March 23, 2010 included other nation health reforms besides value-based purchasing requirements. PPACA also expanded Medicaid eligibility provisions, Medicare and Medicaid reforms, and private insurance market reforms. Medicaid expansion under PPACA includes new eligibility criteria establishing a minimum floor for Medicaid coverage to 133% of the Federal Poverty Level (FPL), (with the 5% income disregard allowed in section 2002 of PPACA, the effective rate is 138% FPL), eliminating other non-income-based criteria (such as age, disability, or asset testing). Although initially mandatory, States now have a choice to expand Medicaid and implement the new criteria due to the Supreme Court's June 28, 2012, decision. The population most impacted by the new optional eligibility criteria is expected to be childless adults. States are also prohibited from reducing Medicaid or Children's Health Insurance Program (CHIP) eligibility that was in place on the date of PPACA enactment. PPACA provides additional federal financing through the Federal Medical Assistance Percentage (FMAP) for newly eligible Medicaid patients beginning in 2014.

PPACA includes legislation on Health Exchanges. Health Exchanges are expected to facilitate the purchase of health insurance for qualified individuals and small employers. A qualified individual is a lawful resident with income between 133% and 400% of the FPL. Federal subsidies for premiums under Health Exchanges become available beginning 2014. Health Exchanges are designed to be "one-stop-shopping" where participants can compare and purchase insurance coverage. Insurance coverage will have essential health benefits that cover benefit costs ranging from 60% to 90% with out-of-pocket limits equal to health savings account current law limits.

Health Plan reforms under PPACA include a set of required essential benefits including, but not limited to, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, preventative and wellness services, and pediatric services, including oral and vision care. Plans must also not require copayment or deductible on preventative services. For plan years beginning after September 23, 2010, existing plans must provide coverage to dependent children until age 26 (unless eligible for other coverage), eliminate lifetime aggregate dollar limits and annual dollar limits on essential benefits, eliminate pre-existing condition exclusions for children up to age 19, and prohibit rescinding of coverage except in cases of fraud, intentional misrepresentation, and nonpayment of premium. Effective in 2014, existing insurance plans must eliminate annual aggregate benefit limits, provide coverage of dependents to age 26 regardless of eligibility for other coverage, eliminate pre-existing condition limitations for adults, and eliminate waiting periods of greater than 90 days.

On June 28, 2012, the US Supreme Court ruled on certain provisions of PPACA. They declared that the "individual mandate" requiring individuals to buy insurance or to pay a fine amounted to a tax and that the government has the ability to impose such a tax. The ruling also declared that states have the ability to not participate in Medicaid expansion and to avoid the penalties described in PPACA. The PPACA legislation is expected to reduce national Medicaid and Medicare Disproportionate Share Hospital (DSH) payments by $14 billion to $22 billion, respectively, from 2014 through 2019. The effect of these reductions on individual hospitals is undeterminable at this time with the Supreme Court's ruling. PPACA also reduced the annual market basket increase for Medicare inpatient and outpatient hospital services for services rendered on or after October 1, 2010.

Medicare has put a program in place to review healthcare claims in order to identify and recover inappropriate payments made to providers for fee-for-service Medicare. This program is called the Recovery Audit Contract (RAC) program and was created through the Medicare Modernization Act of 2003 (MMA). The three-year demonstration program identified over $1 billion in overpayments. In 2006, Congress mandated expansion of the RAC program to all 50 states. The RAC program encompassing New Mexico became effective in March 2009. Connolly Consulting Associates, Inc. is the contractor for this region. The RAC contractor can request up to 399 records every 45 days and can review claims from June 2008 and forward. In June 2012, the Hospital received its first large RAC request to review 399 accounts. The Hospital responded by the required deadline and submitted the medical record and billing documentation required. The Hospital is awaiting determination of the claims by the RAC Contractor.

The Deficit Reduction Act of 2005 established the Medicaid Integrity Program (MIP) to identify, collect, and prevent overpayments made under fee-for-service Medicaid. The two operational functions of MIP are 1) to review the actions of those providing Medicaid services and 2) to provide support and assistance to the states to combat Medicaid fraud, waste, and abuse. The MIP in New Mexico has been initiated, and the Hospital received a request for records in January 2010. The Hospital has neither received details regarding the outcome of the review nor has received further requests for records.

Current economic conditions in the State of New Mexico will continue to impact the Hospitals as the State seeks to identify revenue sources and expenditure reductions. The SCI Program is under consideration for possible elimination from the Medical Assistance Division Budget in subsequent years. As discussed above under net patient revenues, the State was unable for fiscal years 2012 and 2011 to fund a portion of the non-federal share to obtain federal matching funds as described in the CMS Special Conditions/Approval, thereby jeopardizing the viability of the State

Coverage Initiative ("SCI") program. As a result, the Hospital entered into Memorandums of Understanding with the State of New Mexico for each year, under which UNM Hospital agreed to an intergovernmental transfer in the amount of $15.5 million and $12.0 million, respectively, to fund the non-federal share of Medicaid payment pursuant to federal Medicaid regulations at 42 CFR 433.51.

On April 25, 2012, the New Mexico Health and Human Services Department submitted a Section 1115 Research and Demonstration waiver request to the Centers for Medicare and Medicaid Services to modernize the Medicaid Program to make sure it is sustainable now and in the future. This new Medicaid program named "Centennial Care" will pilot a new streamlined waiver format that will blend long term care and acute care services into a single delivery system, develop pilot payment reform strategies, seek administrative simplicity, and increase flexibility in the design and management of the Medicaid Program. NMHSD plans to have this program fully implemented by January 1, 2014, but timing will ultimately depend upon how quickly NMHSD and CMS work through the waiver approval process. All factors impacting the hospital are unknown at this point as the state is currently in procurement process and hopes to have Medicaid health plans selected and under contract by January 1, 2013. One factor that will impact future periods is that Medicaid Supplemental payments such as the Upper Payment Limit funding will be replaced by a Safety Net Care Pool (SNCP). The SNCP is being designed to reimburse hospitals for uncompensated care costs as well as costs incurred to implement Delivery System Reform Incentive Pools (DSRIPs). As the largest safety net hospital in New Mexico, the Hospital is working closely with NMHSD in the design of this Medicaid supplemental payment program.

The mill levy is based on property values. Given the state of the economy, it is possible that the amount of the mill levy may remain flat or potentially decrease as the result of reduced property values and slowdowns in the building construction industry.

In 1997, the Hospital contributed $2.6 million to TriWest Healthcare Alliance (TriWest), an organization formed to administer healthcare benefits to military retirees and dependents of active duty personnel in the CHAMPUS/TRICARE Western Region, in exchange for 2,613 shares of common stock, which represents an approximate 10.8% ownership of TriWest as of June 30, 2012. In July 2009, TriWest successfully bid for the T-3 Contract with TRICARE. However, United Healthcare protested the award and the contract was re-bid. In March 2012, the Contract was awarded to United Healthcare, upon which TriWest submitted a protest. On July 2, 2012, the US Government Accountability Office (GAO) announced that it had denied TriWest's protest. TriWest determined that it would not seek

further legal action regarding the loss of the contract. TriWest's contract with TRICARE will terminate on March 31, 2013. At such time, it is expected that TriWest's assets will be liquidated and any remaining investment will be returned to its shareholders.

Contacting the Hospital's Financial Management

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

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
STATEMENTS OF NET ASSETS
June 30, 2012 and 2011

		2012	2011
ASSETS			
Current Assets			
Cash and cash equivalents	$	88,524,765	108,395,432
Marketable securities		34,078,394	33,868,564
Assets limited as to use held by trustee restricted for debt service		8,524,724	8,363,589
Receivables			
Patient (net of allowance for doubtful accounts and contractual adjustments of approximately $169,929,000 in 2012 and $174,944,000 in 2011)		71,322,034	66,088,998
Due from University of New Mexico		1,505,063	521,804
Estimated third-party payor settlements		23,232,083	14,095,424
Due from Bernalillo County Treasurer		1,306,277	1,256,472
Other		8,656,244	2,576,944
Total net receivables		106,021,701	84,539,642
Prepaid expenses		2,847,710	7,761,582
Inventories		9,667,980	8,213,019
Total current assets		249,665,274	251,141,828
Noncurrent Assets			
Bond issuance costs		3,578,790	3,959,404
Assets limited as to use			
Held by trustee restricted for mortgage reserve fund		12,616,931	9,887,292
Held by trustee restricted for debt service reserve		13,513,150	13,513,150
Held by trustee restricted for collateral		3,828,000	3,828,224
Held by trustee restricted for redemption fund		2,005	2,004
Designated by UNM Hospital Board of Trustees		17,657,104	16,232,264
Total assets limited as to use		47,617,190	43,462,934
Capital assets			
Nondepreciable assets			
Land		1,747,245	1,747,245
Construction in progress		9,462,680	10,080,171
Depreciable capital assets, net		259,147,811	274,203,436
Capital assets, net		270,357,736	286,030,852
Total noncurrent assets		321,553,716	333,453,190
Total assets		571,218,990	584,595,018
LIABILITIES			
Current Liabilities			
Accounts payable	$	26,754,020	26,765,402
Accrued payroll		14,683,929	24,605,199
Due to University of New Mexico		17,976,513	14,571,800
Bonds payable - current		4,985,000	4,790,000
Interest payable bonds		4,119,659	4,224,150
Accrued compensated absences		18,062,439	16,380,408
Estimated third-party payor settlements		16,655,436	13,869,860
Other accrued liabilities		913,541	2,948,541
Total current liabilities		104,150,537	108,155,360
Noncurrent Liabilities			
Bonds payable		166,205,367	171,518,925
Due to affiliates		14,705,624	19,137,097
Net OPEB obligation		4,820,059	6,236,730
Total noncurrent liabilities		185,731,050	196,892,752
Total liabilities		289,881,587	305,048,112
NET ASSETS			
Invested in capital assets, net of related debt		116,259,307	127,194,482
Restricted, expendable			
For grants, bequests, and contributions		10,472,537	8,575,472
In accordance with the trust indenture and debt agreement		24,971,661	22,081,109
Unrestricted		129,633,898	121,695,843
Total net assets	$	281,337,403	279,546,906

See Notes to Financial Statements.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
Years Ended June 30, 2012 and 2011

	2012	2011
Operating revenues		
Net patient service	$ 617,730,781	618,058,739
State and local contracts and grants	10,000,417	1,378,638
Other operating revenues	5,474,159	5,612,335
Total operating revenues	633,205,357	625,049,712
Operating expenses		
Employee compensation	289,299,835	274,198,092
Benefits	61,509,456	62,949,779
Medical services	111,741,312	108,937,667
Medical supplies	110,251,549	110,088,899
Depreciation	34,232,544	34,724,799
Equipment	28,534,786	24,834,858
Purchased services	28,208,333	25,449,372
Occupancy	13,619,314	12,009,949
Other supplies	8,092,956	7,314,819
Other	7,538,607	7,147,261
Total operating expenses	693,028,692	667,655,495
Operating loss	(59,823,335)	(42,605,783)
Nonoperating revenues (expenses)		
Bernalillo County mill levy	77,542,303	76,782,085
State general fund and other state fund appropriations	5,057,700	5,540,700
Investment income (interest, dividends, gains, and losses)	3,547,542	4,187,645
Bequests and contributions	2,747,759	3,199,365
Equity in earnings of TriCore and TriCore Lab Service Corp.	1,429,949	1,382,920
State of New Mexico Land and Permanent Fund proceeds	800,825	842,491
Capital initiatives	(20,194,800)	(33,817,612)
Interest on capital asset-related debt	(7,958,752)	(8,133,709)
Other nonoperating revenues (expenses)	(1,545,495)	(1,484,856)
Net nonoperating revenues	61,427,031	48,499,029
Income before other revenues	1,603,696	5,893,246
Capital grants and gifts	186,801	4,177,895
Total other revenues	186,801	4,177,895
Increase in net assets	1,790,497	10,071,141
Net assets, beginning of year	279,546,906	269,475,765
Net assets, end of year	$ 281,337,403	279,546,906

See Notes to Financial Statements.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
STATEMENTS OF CASH FLOWS
Years Ended June 30, 2012 and 2011

	2012	2011
Cash Flows From Operating Activities		
Cash received from Medicaid and Medicare	$ 338,674,433	354,140,664
Cash received from commercial health insurance and patients	282,930,096	279,042,338
Cash received from contracts and grants	9,875,258	1,561,925
Cash payments to suppliers	(246,984,711)	(213,671,477)
Cash payments to employees	(297,539,074)	(270,002,832)
Cash payments to University of New Mexico	(126,213,272)	(143,595,028)
Cash payments to State of New Mexico for intergovernmental transfer	(15,457,867)	(14,235,209)
Cash payments to or received from affiliates	(4,431,473)	777,920
Other receipts	4,422,839	3,490,635
Net cash used in operating activities	(54,723,771)	(2,491,064)
Cash Flows From Noncapital Financing Activities		
Cash received from Bernalillo County mill levy	77,492,498	76,812,604
Cash received from state general fund and other state fund appropriations	5,057,700	5,540,700
Cash received from State of New Mexico Land and Permanent Fund	798,913	867,012
Cash payments to other nonoperating sources	(297,730)	(331,912)
Cash received from contributions for other-than-capital purposes	2,747,759	3,199,365
Net cash provided by noncapital financing activities	85,799,140	86,087,769
Cash Flows From Capital Financing Activities		
Interest payments on capital assets-related to debt	(8,391,801)	(8,608,277)
Principal payments of bonds	(4,790,000)	(4,570,000)
Purchases of capital assets	(18,680,905)	(28,499,005)
Cash payments to University of New Mexico	(18,994,800)	(35,186,612)
Capital grants and gifts received	186,801	4,177,895
Cash receipts (payments) for mortgage-related activities	(745,674)	(767,111)
Net cash used in capital financing activities	(51,416,379)	(73,453,110)
Cash Flows From Investing Activities		
Proceeds from sales and maturities of investments	37,779,310	50,557,077
Purchase of investments	(40,182,052)	(53,016,464)
Interest and dividends on investments	2,873,085	3,422,758
Net cash provided by investing activities	470,343	963,371
Net (decrease) increase in cash and cash equivalents	(19,870,667)	11,106,966
Cash and cash equivalents, beginning of year	108,395,432	97,288,466
Cash and cash equivalents, end of year	$ 88,524,765	108,395,432

See Notes to Financial Statements.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
STATEMENTS OF CASH FLOWS (CONTINUED)
Years Ended June 30, 2012 and 2011

		2012	2011
Reconciliation of operating loss to net cash used in operating activities			
Operating loss	$	(59,823,335)	(42,605,783)
Adjustments to reconcile operating loss to net cash provided by (used in) operating activities:			
Depreciation expense		34,232,544	34,724,799
Provision for doubtful accounts		98,082,895	67,041,989
Reduction in laboratory expenses related to investment in TriCore Service Corporation		(5,110)	(1,107,852)
Change in assets and liabilities:			
Patient receivables		(103,315,931)	(67,105,898)
Due from University of New Mexico		(983,259)	1,791,324
Estimated third-party payor settlements receivables		(9,136,659)	7,671,048
Other receivables and prepaid expenses		(1,176,479)	(1,938,413)
Inventories		(1,454,961)	413,658
Due to University of New Mexico		2,204,713	(4,502,215)
Estimated third-party payor settlements liabilities		2,785,576	(6,718,085)
Due to affiliates		(4,461,588)	777,920
Accrued expenses		(9,655,910)	6,729,260
Accounts payable		(2,016,267)	2,337,184
Net cash used in operating activities	$	(54,723,771)	(2,491,064)

See Notes to Financial Statements.

NOTE 1. DESCRIPTION OF BUSINESS

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

The Hospital's facilities are leased from Bernalillo County (the County) by UNM. The lease provides for a $1 annual rental payment, an allocation of the County mill levy, and medical treatment for American Indians as required by a 1952 agreement with the federal government, and is contingent on approval of the mill levy by the electorate every eight years with the last voter approval in November 2008. Effective as of November 18, 2004, the UNM Board of Regents and the Board of County Commissioners entered into a First Amendment to the Original Lease, as amended, (the Lease), under which, among other things, (i) the term of the Original Lease was extended until June 30, 2055, which is after the maturity of the Department of Housing and Urban Development (HUD)-insured loan (refer to Note 10, Bonds Payable); (ii) the Hospital was authorized to obtain the HUD insured loan; (iii) the Hospital was authorized to encumber the Lease with a leasehold mortgage; and (iv) the actions that are to be taken concerning the operations of the Hospital in the event of a default under the HUD-insured loan were described.

The UNM Board of Regents is the ultimate governing authority of the Hospital, but it has delegated certain oversight responsibilities to the UNM HSC Board of Trustees. The Hospital is governed by the UNM HSC Board of Trustees, which consists of nine members, including seven members appointed by the UNM Board of Regents, one of whom is nominated by the All Indian Pueblo Council, and two members appointed by the County Commission.

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

NOTE 1. DESCRIPTION OF BUSINESS (CONTINUED)

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

Total operating revenues	$ 10,447,921	9,844,990
Total operating expenses	(17,002,584)	(15,675,687)
Operating loss	(6,554,663)	(5,830,697)
Nonoperating revenue	5,782,845	5,902,990
Total (decrease) increase in net assets	(771,818)	72,293
Net assets, beginning of year	4,326,319	4,254,026
Net assets, end of year	$ 3,554,501	4,326,319

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation. The accompanying financial statements have been prepared using the economic resource measurement focus and the accrual basis of accounting, in accordance with U.S. generally accepted accounting principles for healthcare organizations, and are presented in accordance with the reporting model as prescribed in Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments*, as amended by GASB Statement No. 37, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments: Omnibus*; and GASB Statement No. 38, *Certain Financial Statement Note Disclosures*. The Hospital follows the business-type activities' requirements of GASB Statement No. 34. This approach requires the following components of the Hospital's financial statements:

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

- GASB Statement No. 34 established standards for external financial reporting and requires that resources be classified for accounting and reporting purposes into the following three net asset categories:
- *Invested in Capital Assets, Net of Related Debt* – Capital assets, net of accumulated depreciation and outstanding principal balances of debt attributable to the acquisition, construction, or improvement of those assets.
- *Restricted Net Assets – Expendable* – Net assets whose use by the Hospital is subject to externally imposed constraints that can be fulfilled by actions of the Hospital pursuant to those constraints or that expire by the passage of time.
- *Unrestricted* – Net assets that are not subject to externally imposed constraints. Unrestricted net assets may be designated for specific purposes by action of the Board of Trustees or the UNM Board of Regents or may otherwise be limited by contractual agreements with outside parties.

Changes in Accounting Policies and Statements. Effective July 1, 2010, the Hospital adopted GASB Statement No. 62, *Codification of Accounting and Financial Reporting Contained in Pre-November 30, 1989 and AICPA Pronouncements*, which incorporates into the GASB's authoritative literature certain accounting and financial reporting guidance that is included in pronouncements issued on or before November 30, 1989, which does not conflict with or contradict GASB pronouncements. The adoption of GASB 62 had no impact on the Hospital's accounting policies, as the Hospital had previously elected to not apply Financial Accounting Standards Board (FASB) pronouncements issued after November 30, 1989, and applicable FASB pronouncements issued on or before November 30, 1989 have now been incorporated into GASB pronouncements.

Use of Estimates. The preparation of financial statements in accordance with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the financial statement dates, and the reported amount of revenues and expenses during the reporting periods. Due to uncertainties inherent in the estimation process, actual results could differ from those estimates.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

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

Nonoperating Revenues and Expenses. Nonoperating revenue includes activities that have the characteristics of nonexchange transactions, such as appropriations, gifts, investment income, and government levies. These revenue streams are recognized under GASB Statement No. 33, *Accounting and Financial Reporting for Nonexchange Transactions.* Appropriations are recognized in the year they are appropriated, regardless of when actually received. Bequests and contributions are recognized when all applicable eligibility requirements have been met. Investment income is recognized in the period when it is earned. The mill levy is recognized in the period it is collected by the County. Capital initiatives expense is recognized in the period in which the Hospital incurs an obligation to make payments to UNM HSC as evidenced by executed Memorandum of Understanding (MOU) between UNM HSC and the Hospital.

Intergovernmental Transfers. Intergovernmental transfers are recognized in the period in which the Hospital incurs an obligation to make payments to other governmental entities as evidenced by executed Memorandums of Understanding (MOU) between the State of New Mexico or various counties within the State of New Mexico and the Hospital. All obligations occurring during fiscal year 2012 and 2011 were paid in fiscal year 2012 and 2011, respectively. In 2012, due to the recurring nature of the MOU to fund a portion of the non-federal share to obtain federal matching funds for the State Care Initiative (SCI) program and since the SCI program is for the provision of patient care, intergovernmental transfers (IGT) were recorded as a reduction of net patient service revenues for fiscal years 2012 and 2011. The statement of revenues, expenses and changes in net assets for 2011 reflects the reclassification of IGT from nonoperating expenses to net patient service revenue.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

Investments and Investment Return. Investments are recorded at fair market value. At June 30, 2012 and 2011, investments consist of obligations of the U.S. government and U.S. government agencies. Investment income includes interest and realized and unrealized gains and losses on investments. Investment income is reported as nonoperating revenue when earned.

The Hospital follows GASB Statement No. 40, *Deposit and Investment Risk Disclosures – an amendment of GASB Statement No. 3.* This statement addresses common deposit and investment risks related to credit risk, concentration of risk, interest rate risk, and foreign currency risk, and also requires certain disclosures of investments at fair values that are highly sensitive to changes in interest rates, as well as deposit and investment policies related to the risks identified in the statement.

Assets Limited as to Use by UNM Hospital Board of Trustees. The investment in TriWest Healthcare Alliance Corporation (TriWest) is accounted for using the cost method. The investment in TriCore Reference Laboratories (TRL or TriCore) is accounted for using the equity method. A portion of the Hospital's investment in TriCore Laboratory Service Corporation (TLSC) is reflected as a reduction in laboratory expense based on the ratio of the Hospital's laboratory service volume to total laboratory services provided by TLSC to its members. The remaining ownership percentage is accounted for using the equity method and is recorded as nonoperating revenue.

A portion of assets limited as to use is classified in the accompanying statements of net assets as current assets as these assets are restricted by the Federal Housing Administration (FHA) and the UNM Hospital Board of Trustees to cover the current portion of long-term debt and are subject to approval by the respective parties.

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Bond Issuance Costs. Bond issuance costs represent the bond issuance costs for the Federal Housing Administration Insured Hospital Mortgage Revenue Bond. The bond issuance costs are amortized over the terms of the related indebtedness using the interest method.

Capital Assets. Capital assets are stated at cost or at estimated fair value on date of acquisition. Donated property and equipment are stated at fair market value when received. The Hospital's capitalization policy for assets includes all items with a unit cost of more than $5,000. Depreciation on capital assets is calculated using the straight-line method over the estimated useful lives of the assets as indicated in the "Estimated Useful Lives of Depreciable Hospital Assets," Revised 2008 Edition published by the American Hospital Association. Repairs and maintenance costs are charged to expense as incurred. On a quarterly basis, the Hospital assesses long-lived assets in order to determine whether or not it is necessary to retire, replace, or impair based on condition of the assets and their intended use.

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

Contractual adjustments resulting from agreements with various organizations to provide services for amounts that differ from billed charges, including services under Medicare, Medicaid, and certain managed care programs, are recorded as deductions from patient revenues. The Hospital is eligible for and receives additional Medicaid reimbursement for the gap between the amount that would be equal to the Medicare reimbursement per discharge compared to the Medicaid payment per discharge. This upper payment limit (UPL) is based on the reimbursement that would use Medicare reimbursement principles. This amount is recorded as an offset to contractual adjustments. With respect to the State Coverage Initiative (SCI) program, funding is modeled after a capitated payment program. Funds are remitted to the Hospital on a per member per month basis for all state-approved members. Therefore, contractual adjustments are recorded as a deduction from patient revenue in its entirety.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Capitated payments are received on a monthly basis and are recorded as an offset to contractual adjustments in the amount of approximately $39,061,000 and $38,293,000 for years ended June 30, 2012 and 2011, respectively. Accounts, when determined to be uncollectible, are charged against the allowance for doubtful accounts.

Charity Care. The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Hospital does not pursue collection of amounts determined to qualify as charity care; therefore, they are deducted from gross revenue, with the exception of copayments.

Bernalillo County Taxes. The amount of the property tax levy is assessed annually on November 1 on the valuation of property as determined by the County Assessor and is due in equal semi-annual installments on November 10 and April 10 of the next year. Taxes become delinquent 30 days after the due date unless the original levy date has been formally extended. Taxes are collected on behalf of the Hospital by the County Treasurer and are remitted to the Hospital in the month following collection. Revenue is recognized in the fiscal year the levy is collected by the County.

Bond Premium. The premium associated with the issuance of the FHA Insured Hospital Revenue Bonds is amortized using the effective-interest method over the life of the series of bonds.

Income Taxes. As part of a state institution of higher education, the income of the Hospital is generally excluded from federal and state income taxes under Section 115(1) of the Internal Revenue Code. However, income generated from activities unrelated to the Hospital's exempt purpose is subject to income taxes under Internal Revenue Code, Section 511(a)(2)(B).

Invested in Capital Assets, Net of Related Debt. Invested in capital assets, net of related debt, represents the Hospital's total investment in capital assets, net of outstanding debt related to those capital assets. To the extent debt has been incurred but not yet expended for capital assets, such amounts are not included as a component of invested in capital assets, net of related debt. There are $13.5 million in unspent bond proceeds at June 30, 2012 and 2011, reserved for debt service as required by the trustee.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Risk Management. The Hospital sponsors a self-insured health plan in which the Center (UNM Psychiatric Center and UNM Children's Psychiatric Center, collectively, the Center) also participate, as all employees are under the centralized umbrella of the Hospital. Blue Cross and Blue Shield of New Mexico and HMO New Mexico (BCBSNM and HMONM) provide administrative claim payment services for the Hospital's plan. Liabilities are based on an estimate of claims that have been incurred but not reported and invoices received but not yet paid. At June 30, 2012 and 2011, the estimated amount of the Hospital's claims and accrued invoices was $4.1 million and $4.2 million, respectively, which is included in accrued payroll. As the Hospital receives all cash and pays all obligations of the Center, the estimated amount of the Center's claims and accrued invoices recorded in the Hospital's accrued payroll was approximately $410,000 and $412,000 at June 30, 2012 and 2011, respectively. The liability for claims incurred but not reported was based on actuarial analysis calculated using information provided by BCBSNM.

Changes in the reported liability during fiscal years 2012 and 2011 resulted from the following:

	Beginning of fiscal year liability	Current year claims and changes in estimates	Claim payments	Balance at fiscal year-end
2011 - 2012	$ 4,156,180	28,739,109	(28,759,851)	4,135,438
2010 - 2011	$ 2,899,425	28,589,177	(27,332,422)	4,156,180

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Estimates for 2012 were based upon the 2011 actuarial calculations, as permitted by GASB 45. In 2011, the OPEB obligation estimate was actuarially determined individually for each entity (the Hospital and the Center), and the liabilities and expenses were allocated to each reporting entity based on the applicable full-time equivalent (FTE) based on the information from the 2010 report.

Due to Affiliates. The UNM Hospital (the Hospital) receives all cash on behalf of the Behavioral Health Operations (the Center) and pays all obligations. Amounts due to affiliates consist mainly of cash collected in excess of expenses paid and do not bear interest.

State Appropriation. The funding for the state appropriation is included in the General Appropriation Act, which is approved by the House and Senate of the State Legislature and signed by the governor before going into effect. Total funds appropriated for 2012 include $6,006,900 in the General Fund. Included in the General Fund is $949,200 of Out-of-County Indigent funds, which are reported in net patient service revenue. The General Fund is designated as a nonreverting fund, per House Bill 2, Section 4. Sub-section J. Higher Education. Other State Funds are defined as nonreverting in House Bill 2, Section 2, Sub-section I Definitions.

Capital Appropriation. There were no Capital Appropriations made by the State Legislature for UNM Hospitals in 2012 or 2011 for the Hospital's fiscal year ending in 2012 and 2011.

Classification. Certain 2011 amounts have been reclassified to conform to the 2012 presentation.

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS

Cash and Cash Equivalents

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

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

The carrying amounts of the Hospital's deposits with financial institutions at June 30, 2012 and 2011 are $88,524,765 and $108,395,432, respectively.

The State of New Mexico requires that securities underlying repurchase agreements have a market value of at least 102% of the cost of the repurchase agreement. The market value of the securities underlying the repurchase agreements was at or above the required level during the year ended June 30, 2011, and there were no repurchase agreements as of June 30, 2012.

Bank balances are categorized as follows:

	2012	2011
Amount insured by the Federal Deposit Insurance Corporation (FDIC)	$ 250,000	250,000
Repurchase agreements	—	1,638,567
Amount collateralized with securities held in the Hospital's name	102,912,464	123,585,848
Other cash	16,863	16,895
	$ 103,179,327	125,491,310

Interest-bearing deposit accounts are subject to FDIC's standard deposit insurance amount of $250,000. Cash in excess of FDIC insurance is collateralized at June 30, 2012 and 2011 by U.S. government agency securities held by the financial institution in the Hospital's name.

Custodial Credit Risk-Deposits. Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to it. The Hospital has a custodial risk policy for deposits that requires collateral in an amount greater than or equal to 50% of the deposit not insured by the FDIC. A greater amount of collateral is required when the Hospital determines it is prudent. As of June 30, 2012 and 2011, the Hospital's bank deposits were not exposed to custodial credit risk.

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

Marketable Securities

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

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

	June 30, 2012		
	Fair value	Less than 1 year	1 - 5 years
Items not subject to interest rate risk:			
Money market deposits	$ 3,794	3,794	—
Items subject to interest rate risk:			
Money market funds	2,696,006	2,696,006	—
U.S. Treasury notes	12,643,827	4,010,835	8,632,992
U.S. government agency obligations:			
FHLMC	6,125,895	1,179,342	4,946,553
FNMA	12,608,872	2,083,242	10,525,630
Total items subject to interest rate risk	34,074,600	9,969,425	24,105,175
Total marketable securities	$ 34,078,394	9,973,219	24,105,175

	June 30, 2011		
	Fair value	Less than 1 year	1 - 5 years
Items not subject to interest rate risk:			
Money market deposits	$ —	—	—
Items subject to interest rate risk:			
Money market funds	515,346	515,346	—
U.S. Treasury notes	19,298,096	2,642,616	16,655,480
U.S. government agency obligations:			
FHLMC	5,453,278	2,204,308	3,248,970
FNMA	8,601,844	1,389,740	7,212,104
Total items subject to interest rate risk	33,868,564	6,752,010	27,116,554
Total marketable securities	$ 33,868,564	6,752,010	27,116,554

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

Custodial Credit Risk – Debt Investments – For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Hospital will not be able to recover the value of its investments or collateral that is in the possession of an outside party. Marketable securities of $31,378,594 and $33,353,218 at 2012 and 2011, respectively, are insured, registered, and held by the counterparty's agent in the Hospital's name.

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

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

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

A summary of the marketable securities at June 30, 2012 and 2011 and their exposure to credit risk is as follows:

	2012		2011	
	Rating	Fair Value	Rating	Fair Value
Items not subject to credit risk:				
U.S. Treasury securities:				
Treasury notes	N/A	$ 12,643,827	N/A	$ 19,298,096
Items subject to credit risk:				
Money market deposits	Not rated	3,794	Not rated	—
Money market funds	Not rated	2,696,006	Not rated	515,346
U.S. government agency obligations:				
FHLMC	Fitch – AAA	6,125,895	Fitch – AAA	5,453,278
FNMA	Fitch – AAA	12,608,872	Fitch – AAA	8,601,844
Total items subject to credit risk		21,434,567		14,570,468
Total marketable securities		$ 34,078,394		$ 33,868,564

Concentration of Credit Risk – Investments – Concentration of credit risk is the risk of loss attributed to investments in a single issuer. Investments in any one issuer that represent 5% or more of all total investments are considered to be exposed to concentrated credit risk and are required to be disclosed. Investments issued or explicitly guaranteed by the U.S. government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement.

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

The Hospital's exposure to concentrated credit risk is as follows: $6,125,895, which is invested in Federal Home Loan Mortgage Corporation (FHLMC) securities and equates to 18.0% of marketable securities held at June 30, 2012. An additional $12,608,872 is invested in Federal National Mortgage Association (FNMA) securities, which equates to 37.0% of marketable securities held as of June 30, 2012.

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

Short-Term Investments

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

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

	June 30, 2012	
	Fair Value	Less than 1 Year
Items not subject to interest rate risk:		
Money market deposits	$ 383,734	383,734
Items subject to interest rate risk:		
Money market fund	2,834,449	2,834,449
U.S. government agency obligations:		
FNMA	5,306,541	5,306,541
Total items subject to interest rate risk	8,140,990	8,140,990
Total short-term investments	$ 8,524,724	8,524,724

	June 30, 2011	
	Fair Value	Less than 1 Year
Items not subject to interest rate risk:		
Money market deposits	$ 358,420	358,420
Items subject to interest rate risk:		
Money market fund	2,698,257	2,698,257
U.S. government agency obligations:		
FNMA	3,184,413	3,184,413
FHLMC	2,122,499	2,122,499
Total items subject to interest rate risk	8,005,169	8,005,169
Total short-term investments	$ 8,363,589	8,363,589

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

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

Custodial Credit Risk – Debt Investments – For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Hospital will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. At June 30, 2012 and 2011, the short-term investments of $5,306,541 and $5,306,912, respectively, in U.S. government obligations were insured, registered, and held by the counterparty's agent in the Hospital's name.

The Hospital's custodial risk policy for the bond proceeds conforms to the Trust Indenture, and the Trustee holds the investments in safekeeping.

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

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

A summary of the short-term investments at June 30, 2012 and 2011 and their exposure to credit risk is as follows:

	2012		2011	
	Rating	Fair Value	Rating	Fair Value
Items not subject to credit risk:				
U.S. Treasury notes	N/A	$ —	—	$ —
Items subject to credit risk:				
Money market deposits	Not rated	383,734	Not rated	358,420
Money market fund	Not rated	2,834,449	Not rated	2,698,257
U.S. government agency obligations:				
FNMA	Fitch - AAA	5,306,541	Fitch - AAA	3,184,413
FHLMC	Fitch - AAA	—	Fitch - AAA	2,122,499
Total items subject to credit risk		8,524,724		8,363,589
Total short-term investments		$ 8,524,724		$ 8,363,589

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

Long-Term Investments

Interest Rate Risk – Debt Investments - Currently, the Hospital does not have a specific policy to limit its exposure to interest rate risk.

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

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

	June 30, 2012	
	Fair Value	Less than 1 Year
Items not subject to interest rate risk:		
Cost and equity method investments*	$ 17,657,104	—
Money market deposits	135	135
Items subject to interest rate risk:		
Money market fund	16,529,232	16,529,232
Repurchase agreements	13,430,719	13,430,719
Items subject to interest rate risk	29,959,951	29,959,951
Total long-term investments	$ 47,617,190	29,960,086

	June 30, 2011	
	Fair Value	Less than 1 Year
Items not subject to interest rate risk:		
Cost and equity method investments*	$ 16,232,264	—
Money market deposits	2,575	2,575
Items subject to interest rate risk:		
Money market fund	13,794,426	13,794,426
Repurchase agreements	13,433,669	13,433,669
Items subject to interest rate risk	27,228,095	27,228,095
Total long-term investments	$ 43,462,934	27,230,670

* Cost and equity method investments noted are investments in TriWest (recorded at cost) and TRL and TLSC (recorded by the equity method).

Custodial Credit Risk – Debt Investments – As of June 30, 2012 and 2011, the Hospital held no U.S. government obligations for long-term investment purposes.

The Hospital's custodial risk policy for the bond proceeds conforms to the Trust Indenture, and the Trustee holds the investments in safekeeping.

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

The State of New Mexico requires that securities underlying repurchase agreements have a market value of at least 102% of the cost of the repurchase agreement. The market value of the securities underlying the repurchase agreements was at or above the required level during the years ended June 30, 2012 and 2011.

The repurchase agreement for the Reserve Account was $13,430,719 and $13,433,669 at June 30, 2012 and 2011, respectively. This is an American International Group (AIG) Matched Funding Corporation agreement collateralized by five agency securities held by the Trustee in the Hospital's name. As of July 31, 2012, the market value of the repurchase agreement was $1,126,000 in excess of the investment principal resulting in a security ratio of 108.3% collateralization.

Credit Risk – Debt Investments – The Hospital is required to disclose credit ratings of its debt investments in order to assess credit risk. U.S. obligations, investments explicitly guaranteed by the U.S. government, and nondebt investments are excluded from this requirement. Currently, the Hospital has a policy that restricts long-term investments to specific investment ratings issued by nationally recognized statistical rating organizations. The policy states that cash equivalent reserves shall consist of interest-bearing or discount instruments of the U.S. government or agencies thereof.

NOTE 3. CASH, CASH EQUIVALENTS AND INVESTMENTS (CONTINUED)

A summary of the investments at June 30, 2012 and 2011 and their exposure to credit risk is as follows:

	2012		2011	
	Rating	Fair Value	Rating	Fair Value
Items not subject to credit risk:				
Cost and equity method investments*	N/A	$ 17,657,104	N/A	$ 16,232,264
Items subject to credit risk:				
Money market deposits	Not rated	135	Not rated	2,575
Money market fund	Not rated	16,529,232	Not rated	13,794,426
Repurchase agreements	Moody's - Baa1	13,430,719	Moody's - Baa1	13,433,669
Total items subject to credit risk		29,960,086		27,230,670
Total long-term investments		$ 47,617,190		$ 43,462,934

* Cost and equity method investments noted are investments in TriWest (recorded at cost) and TRL and TLSC (recorded using the equity method of accounting).

The fair values of U.S. Treasury and U.S. government mortgage-backed securities investments are based on quoted market prices.

NOTE 4. CONCENTRATION OF RISK

The Hospital receives payment for services rendered to patients under payment arrangements with payors, which include: (i) Medicare and Medicaid, (ii) other third-party payors including commercial carriers and health maintenance organizations, and (iii) others. The following summarizes patient accounts receivable and the percentage of gross accounts receivable from all payors as of June 30:

	2012		2011	
Medicare and Medicaid	$ 120,668,799	50%	$ 115,529,198	48%
Other third-party payors	82,924,057	34	87,206,184	36
Others	37,792,133	16	38,297,180	16
Total patient accounts receivable	241,384,989	100%	241,032,562	100%
Less allowance for uncollectible accounts and contractual adjustments	(170,062,955)		(174,943,564)	
Patient accounts receivable, net	$ 71,322,034		$ 66,088,998	

NOTE 5. ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS

The Hospital is reimbursed by the Medicare and Medicaid programs on a prospective payment basis for hospital services, with certain items reimbursed at an interim rate with final settlement determined after submission of annual cost reports by the Hospital (Note 11). The annual cost reports are subject to audit by the Medicare Administrative Contractor and the Medicaid audit agent. Cost reports through 2009 have been final settled for the Medicaid programs. Cost reports through 2007 have been final settled for the Medicare program. Retroactively calculated contractual adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

NOTE 6. ASSETS LIMITED AS TO USE

The following summarizes assets limited as to use as of June 30:

	2012	2011
Current:		
Held by trustee for debt service	$ 8,524,724	8,363,589
Noncurrent:		
Held by trustee for mortgage reserve fund	12,616,931	9,887,292
Held by trustee for debt service reserve	13,513,150	13,513,150
Held by trustee for collateral	3,828,000	3,828,224
Held by trustee for redemption fund	2,005	2,004
By UNM Hospital Board of Trustees	17,657,104	16,232,264
	$ 56,141,914	51,826,523

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

As of June 30, 2012, $4.1 million of the $8.5 million balance in the held by trustee for debt service account represents the bond interest payment due July 1, 2012. As of June 30, 2011, $4.2 million of the $8.4 million balance in the held by trustee for debt service account represents the bond interest payment due July 1, 2012.

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

The Hospital has established a "Debt Service Reserve Fund" (consists of noncurrent assets held by trustee for debt service reserve and held by trustee for collateral accounts) and has agreed to maintain this fund for as long as any of the bonds are outstanding. The amount of the Debt Service Reserve Fund is $17.3 million and is closely related to the total annual obligation under the bond repayment schedule for the fiscal years 2012 through 2028.

NOTE 6. ASSETS LIMITED AS TO USE (CONTINUED)

Assets Limited as to Use by Board of Trustees – In 1997, the Hospital contributed $2,612,500 to TriWest, an organization formed to administer healthcare benefits to military retirees and dependents of active duty personnel in the CHAMPUS/TriCare Central Region, in exchange for 2,613 shares of common stock, which represents an approximate 10.8% ownership of TriWest as of June 30, 2012. The investment in TriWest is accounted for using the cost method.

The Hospital has an affiliation agreement with Presbyterian Healthcare Services for the operation of a consolidated clinical laboratory (TriCore) to optimize the quality, performance, and delivery of routine and specialized clinical laboratory tests for patients throughout the State of New Mexico in a cost-effective and timely manner. The Hospital contributed $3,999,965 in cash and equipment during 1998 related to the affiliation agreement, titled TriCore. During 2004, TriCore reorganized its business activities into two entities: TriCore whose business consists of laboratory testing services for nonmembers; and TLSC, which organized solely to perform laboratory services, on a centralized basis, for its members, the Hospital, and Presbyterian Healthcare Services. TLSC is a tax-exempt, cooperative hospital service organization under Section 501(e) of the Internal Revenue Code of 1986.

UNM, through the Hospital, has a 50% interest in TriCore totaling approximately $8,172,000 and $6,740,000 at June 30, 2012 and 2011, respectively, which is being accounted for using the equity method.

The Hospital has a 50% interest in TLSC totaling approximately $6,873,000 and $6,879,000 at June 30, 2012 and 2011, respectively. Approximately 38% of the net earnings of TLSC in fiscal years 2012 and 2011 is recorded as a reduction to laboratory expense in each year. This is based on the estimated ratio of the Hospital's volume of total laboratory services provided by TLSC to its members. The remaining 12% is accounted for as equity earnings under the equity method. The Hospital recorded laboratory expenses of approximately $27,600,000, net of the 38% reduction in laboratory expense, which totaled $5,000 in 2012. The Hospital recorded laboratory expenses of approximately $27,300,000, net of the 38% reduction in laboratory expense, which totaled $1,108,000 in 2011.

NOTE 7. CAPITAL ASSETS

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

	Year ended June 30, 2012				
	Beginning Balance	Additions	Transfers	Retirements	Ending Balance
UNM Hospital Capital Assets not being depreciated:					
Land	$ 1,747,245	-	-	-	1,747,245
Construction in Progress	10,080,171	9,457,912	(10,075,403)	-	9,462,680
	$ 11,827,416	9,457,912	(10,075,403)		11,209,925
UNM Hospital depreciable capital assets:					
Land Improvements	$ 11,198,093	23,367	123,786	-	11,345,246
Building and building improvements	166,159,694	-	1,243,579	-	167,403,273
Building Service Equipment	145,974,304	144,009	6,262,131	-	152,380,444
Fixed Equipment	15,288,399	-	98,204	-	15,386,603
Major Movable Equipment	208,908,842	9,026,127	2,392,336	(24,227,312)	196,099,993
Total depreciable capital assets	547,529,332	9,193,503	10,120,036	(24,227,312)	542,615,559
Less Accumulated depreciation for:					
Land Improvements	(4,380,808)	(882,187)	-	-	(5,262,995)
Building and building improvements	(63,046,822)	(5,547,392)	(3,691)	-	(68,597,905)
Building Service Equipment	(46,764,856)	(8,736,760)	(5,936)	-	(55,507,552)
Fixed Equipment	(9,422,686)	(646,489)		-	(10,069,175)
Major Movable Equipment	(149,710,724)	(18,419,716)	(5,516)	24,105,835	(144,030,121)
Total Accumulated depreciation	(273,325,896)	(34,232,544)	(15,143)	24,105,835	(283,467,748)
UNM Hospital depreciable capital assets, net	$ 274,203,436	(25,039,041)	10,104,893	(121,477)	259,147,811
UNM Hospital Capital Assets not being depreciated	$ 11,827,416	9,457,912	(10,075,403)	-	11,209,925
UNM Hospital total cost of capital assets	559,356,748	18,651,415	44,633	(24,227,312)	553,825,484
Less Accumulated Depreciation	(273,325,896)	(34,232,544)	(15,143)	24,105,835	(283,467,748)
UNM Hospital capital assets, net	$ 286,030,852	(15,581,129)	29,490	(121,477)	270,357,736

NOTE 7. CAPITAL ASSETS (CONTINUED)

	Year ended June 30, 2011				
	Beginning Balance	Additions	Transfers	Retirements	Ending Balance
UNM Hospital Capital Assets not being depreciated:					
Land	$ 1,747,245	-	-	-	1,747,245
Construction in progress	5,307,157	10,664,086	(5,891,072)	-	10,080,171
	$ 7,054,402	10,664,086	(5,891,072)	-	11,827,416
UNM Hospital depreciable capital assets:					
Land Improvements	$ 11,130,591	17,781	49,721	-	11,198,093
Buildings and building improvements	165,152,836	-	1,006,858	-	166,159,694
Building service equipment	141,518,703	253,492	4,202,109	-	145,974,304
Fixed Equipment	15,099,920	40,468	148,011	-	15,288,399
Major Movable equipment	219,165,504	17,523,178	484,373	(28,264,213)	208,908,842
Total depreciable capital assets	552,067,554	17,834,919	5,891,072	(28,264,213)	547,529,332
Less Accumulated depreciation for:					
Land Improvements	(3,466,866)	(913,942)	-	-	(4,380,808)
Buildings and building improvements	(57,505,958)	(5,540,864)	-	-	(63,046,822)
Building service equipment	(38,192,660)	(8,572,196)	-	-	(46,764,856)
Fixed Equipment	(8,777,028)	(645,658)	-	-	(9,422,686)
Major Movable equipment	(158,943,702)	(19,052,139)	-	28,285,117	(149,710,724)
Total Accumulated depreciation	(266,886,214)	(34,724,799)	-	28,285,117	(273,325,896)
UNM Hospital depreciable capital assets, net	$ 285,181,340	(16,889,880)	5,891,072	20,904	274,203,436
UNM Hospital Capital Assets not being depreciated	$ 7,054,402	10,664,086	(5,891,072)	-	11,827,416
UNM Hospital total cost of capital assets	559,121,956	28,499,005	-	(28,264,213)	559,356,748
Less Accumulated Depreciation	(266,886,214)	(34,724,799)	-	28,285,117	(273,325,896)
UNM Hospital capital assets, net	$ 292,235,742	(6,225,794)	-	20,904	286,030,852

NOTE 8. COMPENSATED ABSENCES

Qualified hospital employees are entitled to accrue sick leave and annual leave based on their Full-Time Equivalent (FTE) status.

Sick Leave. Full-time employees accrue four hours of sick leave each two-week pay period (13 days per annum) up to a maximum of 1,040 hours to be used for major and minor sick leave. Seven of these days are accumulated into a minor sick leave bank. Part-time employees who are at least 0.5 FTE earn sick leave on a prorated basis each pay period. At June 30 of each year, employees have the opportunity to exchange for annual leave or major sick leave or cash all hours accumulated in excess of 24 hours on an hour-for-hour basis. At termination, only employees who retire from the Hospital and qualify under the Hospital's policy or estates of employees who die as the result of a compensable occupational illness or injury are eligible for payment of unused accumulated hours. Accrued sick leave as of June 30, 2012 and 2011 of $2,836,000 and $2,180,000, respectively, is computed by multiplying each employee's current hourly rate by the number of hours accrued.

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

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

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

NOTE 8. COMPENSATED ABSENCES (CONTINUED)

Annual Leave. Full-time employees accrue annual leave based on their length of employment up to a maximum of 480 hours. Part-time employees who are at least 0.5 FTE earn annual leave on a prorated basis each pay period. At June 30 of each year, employees have the opportunity to exchange for cash up to 80 annual leave hours accumulated in excess of 240 hours. At termination, employees are eligible for payment of unused accumulated hours, not to exceed 480 hours. Accrued annual leave as of June 30, 2012 and 2011 of approximately $14,836,000 and $13,865,000, respectively, is computed by multiplying each employee's current hourly rate by the number of hours accrued.

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

During the years ended June 30, 2012 and 2011, the following changes occurred in accrued compensated absences:

	Balance July 1, 2011	Increase	Decrease	Balance June 30, 2012
$	16,380,408	30,041,954	(28,359,923)	18,062,439

	Balance July 1, 2010	Increase	Decrease	Balance June 30, 2011
$	15,450,874	25,560,479	(24,630,945)	16,380,408

The balances above include annual leave and sick leave, disclosed above, in addition to compensatory time and holiday, totaling approximately $391,000 and $335,000 in fiscal years 2012 and 2011, respectively. The portion of accrued compensated absences due after one year is not material and, therefore, is not presented separately.

NOTE 9. OTHER ACCRUED LIABILITIES

At June 30, other accrued liabilities consisted of the following:

	2012	2011
SCI Program incurred but not reported (IBNR)	$ 816,852	2,731,203
Deferred rent	—	86,043
Other	96,689	131,295
	$ 913,541	2,948,541

NOTE 10. BONDS PAYABLE

On October 14, 2004, UNM Board of Regents issued FHA insured Hospital Mortgage Revenue Bonds (University of New Mexico Hospital Project), Series 2004 in the aggregate principal amount of $192,250,000. Interest on the bonds ranges from 2% to 5% and is payable semi-annually on each January 1 and July 1, commencing January 1, 2005. The Series 2004 bonds were issued for the purpose of financing the construction, equipping, and furnishing of the CHCCP, which provides care to patients requiring trauma, children's and women's services, funding the Debt Service Reserve Fund, and paying costs of issuance associated with the bonds.

In conjunction with this construction project, the U.S. HUD, under Section 242 CFDA No. 14.128, issued a loan guarantee for the mortgage amount of $183,399,000.

The bonds are limited obligations of the UNM Board of Regents, and have a claim for payment solely from: (1) the trust revenues pursuant to Trust Indenture, dated as of November 1, 2004 by and between the UNM Board of Regents and Wells Fargo Bank National Association, as trustee, including without limitation, payments or prepayments to be made on the Mortgage Note (the Series 2004 Note); (2) payments made under the Mortgage and Series 2004 Note; (3) in the event of default by the UNM Board of Regents under the Series 2004 Note or the Mortgage and the assignment thereof to FHA, from proceeds of the mortgage insurance paid by the HUD, acting by and through the FHA under Section 242 of Title II of the National Housing Act; (4) moneys and investments held by the Trustee under the Trust Indenture; and (5) under certain circumstances, proceeds from insurance and condemnation awards and sales consummated under threat of condemnation.

NOTE 10. BONDS PAYABLE (CONTINUED)

Interest expense associated with the bonds payable was approximately $7,959,000 and $8,134,000, net of amortization of bond premium totaling approximately $329,000 and $368,000 for the years ended June 30, 2012 and 2011, respectively. Interest income earned from the investment of the bond proceeds was approximately $812,000 and $787,000 for the years ended June 30, 2012 and 2011, respectively.

Bonds payable consist of the following:

	As of June 30, 2012				
	Beginning Balance	Additions	Deductions	Ending Balance	Amounts due Within One Year
FHA Insured Hospital Mortgage Revenue:					
Bonds Series 2004	$ 174,435,000	—	(4,790,000)	169,645,000	4,985,000
Bond premium	1,873,925	—	(328,558)	1,545,367	—
	$ 176,308,925	—	(5,118,558)	171,190,367	4,985,000

	As of June 30, 2011				
	Beginning Balance	Additions	Deductions	Ending Balance	Amounts due Within One Year
FHA Insured Hospital Mortgage Revenue:					
Bonds Series 2004	$ 179,005,000	—	(4,570,000)	174,435,000	4,790,000
Bond premium	2,242,153	—	(368,228)	1,873,925	—
	$ 181,247,153	—	(4,938,228)	176,308,925	4,790,000

Per Section 5.02 of the related Trust Indenture, the three bonds in the 2004 Series maturing on July 1, 2030, 2031, and 2032 are subject to sinking fund redemption in part prior to maturity. Excess funds in the debt service account and investment income received can be used for bond sinking fund redemption.

NOTE 10. BONDS PAYABLE (CONTINUED)

Per Section 5.01(B) of the related Trust Indenture, excess funds in the investment income account can be used for a special mandatory redemption.

Future debt service (not including sinking fund redemptions) as of June 30, 2012 for the bonds follows:

Years ending June 30,	Principal	Interest	Total
2013	$ 4,985,000	$ 8,085,213	$ 13,070,213
2014	5,240,000	7,871,938	13,111,938
2015	5,495,000	7,617,650	13,112,650
2016	5,770,000	7,332,650	13,102,650
2017	6,065,000	7,033,150	13,098,150
2018 - 2022	35,255,000	30,114,125	65,369,125
2023 - 2027	45,105,000	20,110,209	65,215,209
2028 - 2032	34,870,000	10,333,613	45,203,613
2033	26,860,000	—	26,860,000
	$ 169,645,000	98,498,548	268,143,548

On November 15, 2004, the Hospital established a mortgage reserve fund in accordance with the requirements and conditions of the FHA Regulatory Agreement. Future Mortgage Reserve Fund contributions are summarized as follows:

Years ending June 30,	Annual Contribution
2013	$ 2,325,566
2014	2,420,313
2015	2,518,921
2016	2,621,545
2017	2,728,351
	$ 12,614,696

NOTE 11. NET PATIENT SERVICE REVENUES

The majority of the Hospital's revenue is generated through agreements with third-party payors that provide for reimbursement to the Hospital at amounts different from its established charges. Approximately 40% and 42% of the Hospital's gross patient revenue for the fiscal years ended June 30, 2012 and 2011, respectively, was derived from the Medicare and Medicaid programs, the continuation of which are dependent upon governmental policies. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded revenue estimates could change as a result of regulatory review. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's billings at established charges for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement from major third-party payors follows:

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

Medicaid – Inpatient acute care services rendered to Medicaid Fee-for-Service (FFS) program beneficiaries are paid at prospectively determined rates per discharge based upon the MS-DRG system. These rates vary according to clinical factors and patient diagnosis. The Hospital is eligible for and receives additional Medicaid reimbursement (UPL) for the gap between the Medicaid reimbursement per discharge and the Medicare reimbursement per discharge. The Hospitals recorded UPL for the fiscal years ended June 30, 2012 and 2011 in the amounts of approximately $40.5 million and $40.7 million, respectively. For outpatients, beginning November 1, 2011, payments are made based upon an Outpatient Prospective Payment System (OPPS). Prior to that, payments were made at an interim rate that was then settled through the cost report by the State Medicaid agency.

NOTE 11. NET PATIENT SERVICE REVENUES (CONTINUED)

In addition, the Hospital has reimbursement agreements with certain Managed Care Organizations (MCOs) that have contracted with the State of New Mexico SALUD! program to administer services to enrolled Medicaid beneficiaries. The basis for reimbursement under these agreements includes prospectively determined rates (MS-DRG) or per diem for inpatient services, and as of November 1, 2011, prospectively determined payments for outpatient services. Prior to that time, a percentage of charge was used for outpatient services, except for lab and radiology, for which payments were based upon predetermined fee schedules.

The Hospital entered into a reimbursement agreement for the SCI program during fiscal year 2007. This program is part of the New Mexico SCI Medicaid plan, funded in part by the State of New Mexico HSD. Funding is modeled after a capitated payment program. Funds are remitted to the Hospital on a per-member-per-month basis for all state-approved members. The Hospital's funding under the SCI program for the fiscal years ended June 30, 2012 and 2011 was $39.1 million and $38.3 million, respectively, and is included in net patient service revenue.

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

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

		2012	2011
Charges at established rates	$	1,425,371,069	1,375,937,231
Charity care		(263,114,525)	(251,915,498)
Contractual adjustments		(446,442,868)	(438,921,005)
Provision for doubtful accounts		(98,082,895)	(67,041,989)
Net patient revenues	$	617,730,781	618,058,739

NOTE 11. NET PATIENT SERVICE REVENUES (CONTINUED)

Current year estimates, settlements of prior-year cost reports, and changes in prior-year estimates resulted in net increases to net patient service revenue of approximately $5,415,000 and $15,306,000 for the years ended June 30, 2012 and 2011, respectively. During the fiscal year ended June 30, 2012, $3,293,000 liability for Medicare and $483,000 receivable for Medicaid, were accrued as estimates for the fiscal year 2012 cost report. UNM Hospital's cost reports are typically filed by November 30. During fiscal year 2012, the hospital received aggregate settlements of $1,787,000 from Tri-Care, and U.S. Public Health Services which are included in the totals above. During the fiscal year ended June 30, 2011, $3,230,000 for Medicare and $952,000 for Medicaid, were accrued as estimates for the fiscal year 2011 cost report. Management believes these estimates are adequate. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Estimates are continually monitored and reviewed, and as settlements are made or more information is available to improve estimates, differences are reflected in current operations.

NOTE 12. CHARITY CARE

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following information measures the level of charity care provided during the years ended June 30:

	2012	2011
Charges foregone, based on established rates	$ 263,114,525	251,915,498
Estimated costs and expenses incurred to provide charity care	129,452,346	126,209,664
Equivalent percentage of charity care charges forgone to total gross revenue	18%	18%

NOTE 13. MALPRACTICE INSURANCE

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

The New Mexico Tort Claims Act provides that total liability for all claims that arise out of a single occurrence shall not exceed $750,000 set forth as follows: (a) $200,000 for real property; (b) up to $300,000 for past and future medical and medically related expenses; and (c) up to $400,000 for past and future noneconomic losses (such as pain and suffering) incurred or to be incurred by the claimant. The language of the New Mexico Tort Claims Act does not provide for claims of loss of consortium; however, New Mexico appellate court decisions have allowed claimants to seek consortium. Risk Management Division of the State of New Mexico General Services Department (State RMD) and UNM contend that these damages are contained within the $750,000 cap. The New Mexico Tort Claims Act prohibits the award of punitive or exemplary damages against the Hospital. The New Mexico Tort Claims Act requires the State RMD to provide coverage to the Hospital for those torts where the Legislature has waived the State's sovereign immunity up to the damages limits of the New Mexico Tort Claims Act plus the cost incurred in defending any claims and/or lawsuits (including attorney's fees and expenses), with no deductible and with no self-insured retention by the Hospital. As a result of the foregoing, the Hospital is fully covered for claims and/or lawsuits relating to medical malpractice or professional liability.

NOTE 14. RELATED-PARTY TRANSACTIONS

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

	2012	2011
UNM Health Sciences Center	$ 1,268,893	4,196,305
UNM Cancer Center	9,178	9,873
	$ 1,278,071	4,206,178

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

	2012	2011
UNM	$ 12,981,641	14,865,903
UNM Health Sciences Center	114,453,085	126,018,234
	$ 127,434,726	140,884,137

NOTE 15. BENEFIT PLANS

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

NOTE 15. BENEFIT PLANS (CONTINUED)

The Hospital also has a deferred compensation plan, called the UNM Hospital 457(b) Deferred Compensation Plan, which provides employees with additional retirement savings plan. The Hospital does not contribute to this plan. Employees can make voluntary contributions to this plan. The plan was established by the UNM Hospital Board of Trustees and can be amended at its discretion. The plan is administered by the Hospital's Human Resources Department.

In addition, the Hospital has a 401(a) defined contribution plan, called the UNM Hospital 401(a) Plan, which was established for the purpose of providing retirement benefits for eligible participants and their beneficiaries. The 401(a) plan allows for tax-deferred employer contributions on a percentage-of-salary basis. The plan was established by the UNM Hospital Board of Trustees and can be amended at its discretion. All assets of the plan are held in a trust fund, are not considered hospital assets, and are under the direction of a Plan Administrator.

The Hospital also has a defined benefit plan that covers all employees who were members of the clerical and service worker collective bargaining unit as of June 30, 1977 and had completed a year of service prior to June 30, 1977. The plan provides monthly pension benefits based on service before July 1, 1977. The name of the plan is University of New Mexico/BCMC Retirement Plan B. There are currently 119 participants included in this plan. Actuarial pension data for this plan may be obtained by writing to UNM Hospital's Human Resources Department, P.O. Box 80600, Albuquerque, NM 87198-0600.

A small portion (approximately 35) of the Hospital's full-time employees participate in a public employee retirement system authorized under the Educational Retirement Act (Chapter 22, Article 11, NMSA 1978). The Educational Retirement Board (ERB) is the administrator of the plan, which is a cost-sharing multiple-employer defined benefit retirement plan. The plan provides for retirement benefits, disability benefits, survivor benefits, and cost-of-living adjustments to plan members (certified teachers and other employees of state public school districts, colleges and universities) and beneficiaries. ERB issues a separate, publicly available financial report that includes financial statements and required supplementary information for the plan. That report may be obtained by writing to the ERB, P.O. Box 26129, Santa Fe, NM 87502. The report is also available on ERB's Web site at www.nmerb.org.

NOTE 15. BENEFIT PLANS (CONTINUED)

Funding Policy. The expense for the defined contribution plan was $11,747,000, $9,761,000, and $10,507,000 in fiscal years 2012, 2011 and 2010, respectively. Total employee contributions under this plan were $13,513,000, $12,630,000, and $11,358,000 in fiscal years 2012, 2011, and 2010, respectively. In 2012, a Roth 403b defined contribution plan option was added. Total employee contributions in 2012 were $5,071.

There was no expense for the deferred compensation plan in 2012, 2011, and 2010, respectively, as the Hospital does not contribute to this plan. Total employee contributions under this plan were $2,146,000, $2,055,000, and $1,923,000 in 2012, 2011, and 2010, respectively.

The expense for the 401(a) defined contribution plan was $344,000, $285,000, and $250,000 in fiscal years 2012, 2011, and 2010, respectively. Only the Hospital contributes to this plan.

Plan members of the public ERB earning $20,000 or less annually are required by statute to contribute 7.9% of their gross salary. Plan members earning over $20,000 annually were required to contribute 11.15% of their gross salary in fiscal year 2012 and will be required to contribute 9.4% of their gross salary in fiscal year 2013. The Hospital has been and is required to contribute 12.4% of the gross covered salary for employees earning $20,000 or less, in fiscal years 2012 and 2013. In fiscal year 2013 the Hospital will contribute 10.9% of the gross covered salary of employees earning more than $20,000 annually. The contribution requirements of plan members and the Hospital are established in State statute under Chapter 22, Article 11, NMSA 1978. The requirements may be amended by acts of the legislature. The Hospital's contributions to ERB for the fiscal years ended June 30, 2012, 2011, and 2010 were $157,000, $182,000, and $202,000, respectively, which equal the amount of the required contributions for each fiscal year.

NOTE 16. OTHER POSTEMPLOYMENT BENEFIT PLAN

Plan Description. The Hospital and the Center employees and retirees participate under the same benefit plan administered by the Hospital. The Hospital administers a single employer defined benefit postemployment benefit plan that offers postemployment healthcare coverage to eligible retirees and their dependents. Eligible retired employees are offered combined medical/prescription drug benefits through the Hospital's self-insured health plan administered by BCBSNM. Eligible retired employees are also offered dental insurance through the Hospital's self-insured dental plan insurance. The authority to establish and amend benefit provisions to the benefit policy is recommended by the Human Resource Administrator and approved by the Chief Executive Officer.

Beginning July 1, 2009, the actuarial valuations are prepared biennially for the Hospital as allowed for under GASB Statement No. 45.

Employees are eligible to retire from the Hospital and receive these post-employment benefits when:

- The employee reaches the minimum age of fifty (50);
- The employee has at least five years of continuous employment; and
- The employee has a combined age plus year of service sum of at least seventy (70) (hire date prior to July 1, 2009), seventy-five (75) (hire date after July 1, 2009) and eighty (80) (hire date after July 1, 2011).

At the date of valuation, July 1, 2011, there were a total of 27 Hospital and one Center retirees receiving benefits, 471 active employees fully eligible to receive benefits, and 4,386 active employees currently not fully eligible to receive benefits.

Funding Policy. The contribution requirements of the plan members and the Hospital are established, and may be amended by recommendation of the Human Resource Administrator and approval by the Chief Executive Officer. The retired employees that elect to participate in the postemployment benefit plan are required to make contributions in the form of monthly premiums based on current rates established under the health and dental plans. For the medical and dental plans, there are both implicit and explicit subsidies provided by the Hospital. The explicit subsidy is for employees that retire with sick and annual leave (compensated absence) accruals. The Hospital subsidizes for the retiree only, the current "employee only" premium amount for the health and dental plans for the period of

NOTE 16. OTHER POSTEMPLOYMENT BENEFIT PLAN (CONTINUED)

the length of leave (compensated absence) accrual. The implicit subsidy arises because the retiree pays a contribution that is based on a combined active and retiree claim experience. If the retirees were to pay based solely on retiree claim experience, they would be paying a higher amount as typically retirees incur higher claims. This "discount" is called the implicit subsidy.

The applicable monthly retiree contribution rates are provided in the tables below:

	Retiree (coverage extension/ compensated absence accrual period)			Retiree (after coverage extension)		
	Standard Network	Extended Network	Delta Dental	Standard Network	Extended Network	Delta Dental
Rate tier:						
Retiree only	$ 495.00	1,044.00	30.68	441.80	682.30	30.68
Retiree + Spouse/DP	1,015.00	2,138.00	65.65	905.60	1,398.50	65.68
Retiree + Children	743.00	1,564.00	—	662.60	1,023.30	—
Retiree + family	1,065.00	2,244.00	97.68	949.80	1,466.70	97.68

The Hospital does not use a trust fund to administer the financing and payment of benefits. Instead, the Hospital funds the plan on a pay-as-you-go basis. The pay-as-you-go expense is the net expected cost of providing retiree benefits. This expense includes all expected claims and related expenses and is offset by the retiree contribution. Expected monthly claim costs were developed from a combination of historical claim experience and manual claim cost developed using a representative database. Nonclaim expenses are based on the current amounts charged to employees. The Hospital's and Center's pay-as-you-go expense for the period of July 1, 2010 to June 30, 2012 is approximately $277,500. The pay-as-you-go expense includes the medical and dental claims, administration expenses, and implicit subsidy and is net of any retiree contributions.

Actuarial Methods and Assumptions. Actuarial calculations reflect a long-term perspective and employ methods and assumptions that are designed to reduce short-term volatility in actuarial accrued liabilities (AALs) and the actuarial value of assets. The actuarial method used is the Unit Credit method, as the Unit Credit method provides a logical correlation between accruing and expensing of retirees' benefits.

NOTE 16. OTHER POSTEMPLOYMENT BENEFIT PLAN (CONTINUED)

A 4.5% annual discount rate was used assuming the Hospital will fund the postemployment benefit on a pay-as-you-go basis. For an unfunded plan, the investment return assumption is based on the expected return on employer assets that generally consist of short-term liquid investments.

The July 1, 2011 actuarial valuation considers an annual healthcare cost trend on a select (10%) and ultimate (5%) basis. Select rates are reduced 0.5% each year until reaching the ultimate rate. The unfunded AAL is amortized over the maximum acceptable period of 30 years. It is calculated assuming a level percentage of projected payroll, with a 3.5% per annum salary increase.

Annual retirement probabilities and the rate of withdrawal for reasons other than death and retirement have been determined based on the New Mexico Educational Retirement Board ("NMERB") Actuarial Valuation as of June 30, 2011. It is assumed that 30% of future pre-retirees and post-retirees, under 65 and 5% over 65 participate in the Hospital's post/retirement health program.

The following changes in assumptions have occurred since the valuation date of July 1, 2009. These assumptions include both the Hospital and the Center as reported at the valuation date of July 1, 2011. The prior valuations were based upon the NMERB assumptions, however, when comparing the actual number of retirements to the expected retirements it was found that hospital employees do not retire as early as the NMERB assumptions would suggest. The NMERB was adjusted to reflect the Hospital's experience rate. The impact of this adjustment was a reduction of $2.8 million in the AAL. Another factor impacting the reduction in AAL was that the per capita claim cost did not increase as much as expected, thus causing a slower rate of increase in retiree contributions resulting in a net reduction in AAL of approximately $950,000. Final key factors lowering the AAL are the valuation of the explicit subsidy and updated demographic information. The Hospital provides two months of subsidy rather than one year as assumed in the valuation dated July 1, 2009. These factors reduced the AAL by another $800,000.

Annual OPEB Cost and Net OPEB Obligation. The annual OPEB cost (expense) is calculated based on the annual required contribution of the employer (ARC), an amount actuarially determined in accordance with the parameters of GASB Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities (UAALs) over a 30-year period.

NOTE 16. OTHER POSTEMPLOYMENT BENEFIT PLAN (CONTINUED)

The Hospital's postemployment benefit plan includes employees from the Center. The OPEB cost and net OPEB obligation (NOO) were calculated and allocated to each reporting entity based on the Hospital's and Center's employee data as of June 30, 2011. The allocation is as follows: the Hospital – 93% and the Center – 7%. The OPEB cost and NOO information presented below are the Hospital's calculated portion.

The NOO is the cumulative difference between the ARC and the employer's contribution to the plan. The Hospital's NOO as of July 1, 2011 is equal to $4,820,059, which was determined based on the applicable FTE of the entity as of June 30, 2011.

The plan is funded on a pay-as-you-go basis; the NOO follows as of June 30:

	Unfunded 2012	Unfunded 2011
NOO – beginning of year	$ 6,236,730	3,702,730
ARC	1,571,462	2,579,206
Interest on prior year NOO	363,552	43,240
Adjustment to ARC	(398,058)	(36,800)
Annual OPEB cost	1,536,956	2,585,646
Employer contributions	(277,511)	(51,646)
Increase in NOO	1,259,445	2,534,000
Adjustment to 2011 Estimate	(2,676,116)	-
NOO – end of year	$ 4,820,059	6,236,730

The annual OPEB cost, the percentage of annual OPEB cost contributed to the plan, and the NOO for fiscal years ended June 30, 2012 and 2011 are as follows:

Fiscal Year Ended	Annual OPEB Cost	Percentage of Annual OPEB Cost Contributed	Net OPEB Obligation
June 30, 2012	$ 1,536,956	18.0%	$ 4,820,059
June 30, 2011	2,585,646	2.0%	6,236,730

NOTE 16. OTHER POSTEMPLOYMENT BENEFIT PLAN (CONTINUED)

Funding Status and Progress. As of July 1, 2011, the most recent actuarial valuation date, the plan was not funded. The plan's actuarial accrued liability (AAL, the present value of all future expected postretirement medical payments and administrative cost, which are attributable to past service) is $3,748,000 and the actuarial value of assets was $0, resulting in an unfunded actuarial accrued liability (UAAL) of $3,748,000. The UAAL is applicable to all reporting entities based on the percentage noted above.

	Unit Credit Method Unfunded Plan June 30, 2012
AAL	$ 3,748,000
Actuarial value of plan assets	—
UAAL	3,748,000
Funded ratio (actuarial value of plan assets/AAL)	0%
Covered payroll (active plan members)	219,171,000
UAAL as a percentage of covered payroll	1.7%

The projection of future benefit payments for an ongoing plan involves estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, current and future retirees and their dependents, mortality, and healthcare cost trends. Amounts determined regarding the funded status of the plan and the ARCs of the employer are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress (Schedule 4), presented as RSI following the notes to the financial statement, presents information about the actuarial value of plan assets relative to the AALs for benefits.

NOTE 17. COMMITMENTS AND CONTINGENCIES

Lease Commitments. The Hospital is committed under various leases for building and office space and data processing equipment. Rental expenses on operating leases and other nonlease equipment amounted to $8,569,000 in 2012 and $6,795,000 in 2011.

NOTE 17. COMMITMENTS AND CONTINGENCIES (CONTINUED)

The Hospital has entered into an MOU with UNM to lease the medical facility referred to as the Ambulatory Care Center and usage of the related parking structure through fiscal year 2019. The Hospital pays semiannual installments of approximately $971,000 under this MOU.

Future minimum lease commitments for operating leases for the years subsequent to June 30, 2012, under noncancelable operating leases and memorandums of understanding, are as follows:

	Amount
Years ending June 30,	
2013	$ 5,262,242
2014	4,866,236
2015	3,602,394
2016	3,167,955
2017	3,166,030
2018 - 2022	7,808,443
2023 - 2027	4,544,867
2028 - 2032	4,690,661
2033 - 2037	3,413,563
2038 - 2042	2,157
	$ 40,524,548

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

NOTE 18. CAPITAL INITIATIVES

The Hospital and the UNM HSC entered into an MOU, for a seventh year, to collaborate on strategic capital projects. Per the agreement, the Hospital recorded a nonoperating expense of approximately $20.2 million and $33.8 million in 2012 and 2011, respectively, to provide for the development of clinical facilities pursuant to the agreement. All capital facilities are owned by UNM HSC for use by the Hospital. Capital project disbursements from capital initiatives funds held by UNM HSC in 2012 and 2011 and the ending balances for each year are reflected in the table below.

	July 1 Beginning Balance	UNMH Contributions to Fund	Capital Project Disbursements From Fund	June 30 Ending Balance
Fiscal Year 2011	$ 61,858,336	33,817,612	(28,380,179)	67,295,769
Fiscal Year 2012	$ 67,295,769	20,194,800	(6,813,654)	80,676,915

NOTE 19. RISKS AND UNCERTAINTIES

The Hospital's investments are exposed to various risks, such as interest rate, credit, and overall market volatility risks. Due to the level of risk associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
COMPARISON OF BUDGETED AND ACTUAL REVENUES AND EXPENSES
Year Ended June 30, 2012

Schedule 1

	Budget (Original)	Budget (Final)	Actual	Budget Variance
Operating revenues:				
Net patient service	$ 580,608,373	596,183,465	617,730,781	21,547,316
Other operating revenue	6,350,480	6,350,480	15,474,576	9,124,096
Total operating revenues	586,958,853	602,533,945	633,205,357	30,671,412
Operating expenses	656,915,032	684,455,057	693,028,692	8,573,635
Operating loss	(69,956,179)	(81,921,112)	(59,823,335)	22,097,777
Nonoperating revenues and other revenues, net	69,961,078	81,961,077	61,613,832	(20,347,245)
Increase in net assets	$ 4,899	39,965	1,790,497	1,750,532

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

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
PLEDGED COLLATERAL BY BANKS
Year Ended June 30, 2012

Schedule 2

	Pledged Collateral			Bank Balance		
	Safekeeping Location	Type of Security	CUSIP	Bank of America Albuquerque, New Mexico	US Bank Albuquerque, New Mexico	Total
Funds on deposit:						
Demand deposits				$ 103,162,464	16,863	103,179,327
Less repurchase agreements at cost	Bank of America					
FDIC insurance				(250,000)	(16,863)	(266,863)
Total uninsured public funds				$ 102,912,464	-	102,912,464
50% collateral requirement per Section 6-10-17 NMSA				$ 51,456,232	-	51,456,232
Pledged collateral	Tri-Party Collateral Management					
		FNMA	31404AQY3	372	-	372
		FNMA	31404LV80	4,144	-	4,144
		FNMA	31405FHQ8	2,697,520	-	2,697,520
		FNMA	31405FHW5	1,946	-	1,946
		FNMA	31410GZC0	1,057,114	-	1,057,114
		FNMA	31415VYB5	1,058,552	-	1,058,552
		FNMA	31416BL63	4,212,359	-	4,212,359
		FNMA	31416BL71	437,482	-	437,482
		FNMA	31416W7L0	3,735,031	-	3,735,031
		FNMA	31416WZ39	36,452,941	-	36,452,941
		FNMA	31418P3U7	201,037	-	201,037
		FNMA	31418Q7L0	512,156	-	512,156
		FNMA	31419GB94	12,285,665	-	12,285,665
		FNMA	36230UCZ0	7,259,959	-	7,259,959
Total pledged collateral				69,916,278	-	69,916,278
(Excess) of pledged collateral over the required amount				$ (18,460,046)	-	(18,460,046)

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
SCHEDULE OF INDIVIDUAL DEPOSIT AND INVESTMENT ACCOUNTS
Year Ended June 30, 2012

Schedule 3

Name of Bank/Broker	Account Type	Balance per Bank Statement	Reconciled Balance per Financial Statement
UNM Hospital cash:			
Bank of America:			
Operating	Checking	$ 48,830,000	34,143,783
Consolidated Automated Overnight Investment	Repurchase agreement	54,332,464	54,332,465
First Community Bank:			
UNM Hospital Change Campaign	Checking	16,862	16,862
Petty Cash	Cash on hand	-	31,655
Total UNM Hospital cash		$ 103,179,326	88,524,765
UNM Hospital short-term investments:			
Morgan Stanley Smith Barney	Money market deposits	3,794	3,794
Wells Fargo	Money market deposits	330,030	383,734
Morgan Stanley Smith Barney	Money market funds	2,696,006	2,696,006
Wells Fargo	Money market funds	2,834,449	2,834,449
Morgan Stanley Smith Barney	U.S. Treasury notes	12,643,827	12,643,827
Wells Fargo	FNMA	5,306,541	5,306,541
Morgan Stanley Smith Barney	FHLMC	6,125,895	6,125,895
Morgan Stanley Smith Barney	FNMA	12,608,872	12,608,872
Total UNM Hospital short-term investments		$ 42,549,414	42,603,118
UNM Hospital long-term investments:			
Wells Fargo	Money market deposits	$ -	135
Wells Fargo	Money market funds	16,529,232	16,529,232
Wells Fargo	Collateralized repurchase agreement	13,430,719	13,430,719
Investment in TriWest	Equity securities	2,612,500	2,612,500
Investment in TriCore Reference Lab (TRL)	Equity securities	8,171,909	8,171,909
Investment in TLSC	Equity securities	6,872,695	6,872,695
Total UNM Hospital long-term investments		$ 47,617,055	47,617,190

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS SCHEDULE OF FUNDING PROGRESS
Years Ended June 30, 2012 and 2011
(Unaudited)

Schedule 4

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) – Unit Credit Method (b)	Unfunded AAL (UAAL) (b-a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll ((b-a)/c)
July 1, 2011	$ -	3,748,000	3,748,000	-	$ 219,171,000	1.7%
July 1, 2009	-	18,899,000	18,899,000	-	213,671,000	8.8%
July 1, 2008	-	5,305,000	5,305,000	-	227,182,000	2.3%
July 1, 2007	-	3,830,640	3,830,640	-	194,842,000	2.0%

Note A: The above AAL and covered payroll balances represents UNM Hospital portion of the plan.
Note B: For fiscal years beginning July 1, 2009, the Hospital's actuarial valuations are prepared biennially.

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements In Accordance With *Government Auditing Standards*

The University of New Mexico Health Sciences Center
Board of Trustees and
Mr. Hector Balderas, New Mexico State Auditor

We have audited the financial statements of the UNM Hospital (the Hospital) and the budgetary comparison presented as supplementary information as of and for the year ended June 30, 2012, and have issued our report thereon dated November 2, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Management of the Hospital is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered the Hospital's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

The University of New Mexico Health Sciences Center
Board of Trustees and
Mr. Hector Balderas, New Mexico State Auditor

Compliance and Other Matters

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

We noted certain matters that are required to be reported per section 12-6-5 NMSA 1978 and are described in the accompanying schedule of findings and responses as items 2012-01 and 2012-02.

The Hospital's responses to the findings identified in our audit are described in the accompanying schedule of findings and responses. We did not audit the Hospital's responses and, accordingly, we express no opinion on them.

This report is intended solely for the information and use of the Board of Trustees, the Finance and Audit Committee, management, the New Mexico State Auditor, federal awarding agencies, and pass-through entities, and is not intended to be and should not be used by anyone other than these specified parties.

Moss Adams LLP

Albuquerque, New Mexico
November 2, 2012

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
SUMMARY SCHEDULE OF PRIOR YEAR FINDINGS
Year Ended June 30, 2012

Prior Year Audit Finding:

2011-01 Excluded Provider – UNM School of Medicine.

The finding has been resolved as of June 30, 2012.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
SCHEDULE OF FINDINGS AND RESPONSES
Year Ended June 30, 2012

2012 – 01 – Purchasing, authorization and approvals

Condition
The following exceptions were identified through testing a sample of purchases during the year:

- HVAC and fire prevention services were procured from General Services Administration-approved (GSA) suppliers. Five of the invoices tested, totaling $346,958 did not contain sufficient detail on the invoices to permit recalculation to ensure pricing was compliant with the appropriate GSA labor and materials pricing.
- Seven facilities and maintenance invoices tested, totaling $98,968 had invoice dates and service dates where work was provided to UNMH prior to the issuance of a purchase order.
- One construction invoice tested, in the amount of $139,500, did not have services inspected and validated prior to approval to pay.
- One construction invoice tested, in the amount of $138,422, was not approved by the using department prior to payment
- Two construction invoices tested, totaling $18,406, were for door installations that should have been processed under the capital procurement policy; however, they were processed as operating purchases.

Criteria

- UNMH has the ability to purchase goods and services from qualified contractors that possess a current GSA contract pursuant to [13-1-129 NMSA 1978], as long as the vendor is willing to pass equal to or better pricing to UNMH.
- In accordance with UNMH's Purchase Approval Policy, pre-approval through submission of purchase requisitions and purchase orders must be obtained prior to the purchase and payment of goods and/or services.
- UNMH requires the Facilities Services Department to approve invoices for construction services, certifying that the work has been performed according to the specifications provided to the contractor, prior to payment.
- Prior to payment, the New Mexico State Procurement Code 13-1-158 Payment for Purchases states the following: "No Warrant, check or other negotiable instruments shall be issued in payment for any purchase of services, construction or items of tangible personal property unless the central purchasing office or the using agency certifies that the services, construction or items of tangible personal property have been received and meet specifications...".

2012 – 01 – Purchasing, authorization and approvals (continued)

- The Audit Act (Section 12-6-10 NMSA 1978) requires and UNMH's policy requires that assets with a value of $5,000 and a useful life of three years be capitalized. Further, UNMH procurement guidelines require that capital procurements be routed through a capital committee charged with control and approval of capital procurements.

Cause
UNMH staff did not follow the established policies and procedures.

Effect
UNMH was charged for services and materials at rates higher than the GSA contract. UNMH could potentially incur substantial costs for substandard work, for work that was not performed, or that damaged existing property, or for materials that were not received. Consequently, UNMH could be exposed to the risk of unnecessary, unauthorized or fraudulent costs. Additionally, capital costs were incurred without proper oversight or evaluation of the UNMH Capital Committee's authorization or control.

Recommendation
The procurement and purchasing processes and polices should be reviewed with facilities department management to ensure compliance with established internal controls. Purchasing should report infractions to the administrator in accordance with the General Purchasing policy. UNMH may consider updating purchasing policies to explicitly state that using departments must certify that services, construction or items of tangible personal property have been received and meet specifications through inspection of the acquired services and property, and such certification in the form of a proper signature authorization must be present on the invoice prior to payment.

Response
Management is revising the Purchasing policies to require separate listings of materials and labor on quotes and invoices. The Facilities department is developing a "contract specialist" position that will be responsible for ensuring all required documentation is obtained prior to the submission of a purchase order ("PO"). Upon receipt of the purchase requisition reviewed by facilities, the Purchasing department will validate that documentation is complete and verify the vendor's GSA contract and ensure that the pricing is equivalent to or better than the GSA contract prior to issuing the PO.

2012 – 01 – Purchasing, authorization and approvals (continued)

Management will revise the Purchasing policies to clearly state that a purchase order is required prior to the delivery of goods and/or services and require a signature on the invoice as authorization to pay for the purchase of services or a three-way match (purchase order, receiver, and matching invoice) for goods prior to the payment of all invoices. The Purchasing department will track purchase orders that are completed after the fact and report to Administration. Additional approval will be required by the area administrator prior to the issuance of a purchase order in the event of emergency purchases.

Stamps have been obtained and distributed that state, "I certify that work has been completed satisfactorily and in accordance with contract/quote terms including, but not limited to, pricing and scope. Invoice is approved for payment." This statement along with signature and date will be required for service and capital project invoices to be paid.

Management has provided education on the "Capital Assets – Fixed and Major Movable Equipment" policy at the September 20, 2012 Capital Committee / Executive Director meeting. Management reviewed with all attendees what qualifies as capital and the procedures to process capital purchase requisitions. Attendees were required to acknowledge attendance at this training session through signature on a roster.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
SUMMARY SCHEDULE OF CURRENT YEAR FINDINGS
Year Ended June 30, 2012

2012 – 02 –Kronos signoff without review of timesheets and edits.

Condition
In the testing of three employees' Kronos records, there were multiple instances of deleted lunches entered at the beginning of the shift. Another day tested for this employee had five call back punches that occurred within a 4-hour window, which allowed for the employee to be credited with two hours at double time for each punch that occurred for a total of ten hours. Another employee tested was eligible for on-call pay; however, the Kronos editor for the department did not enter the appropriate pay code to allow payment of the on-call. The individual's time card was approved by management and the employee did not receive the on-call pay.

Criteria
UNM HSC Policy number HR 205-Kronos Time System requires the department supervisor, manager, director and/or administrator to approve all edits and time worked for their direct reports.

Cause
Management is not reviewing hours worked and hours paid in detail before electronically approving time cards in Kronos.

Effect
Without review of individual time cards by management, unauthorized edits may be approved for payment and unnecessary costs may be incurred by the organization. In addition, employees may not be appropriately reimbursed for time worked.

Recommendation
It is recommended that Management require electronic signoff in the Kronos system at the time card level and not allow global sign off by department management.

Response
Management will provide education to departments on the proper use of on-call pay. Departments will be required to write up specific departmental procedures regarding on-call use. The Kronos policy will be modified to require electronic review and signoff at the individual time card level by department management (removing the option for global signoff). Periodic Kronos audits will be conducted to verify proper use of pay types and that no global signoffs have occurred.

UNM HOSPITAL
UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER
CLINICAL OPERATIONS
EXIT CONFERENCE
Year Ended June 30, 2012

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

An exit conference was conducted on October 25, 2012 with the Finance and Audit Committee of the Board of Trustees and members of the Hospital's management. During this meeting, the contents of this report were discussed with the following committee members, management personnel, and Moss Adams LLP representatives present:

Steve McKernan	Chief Executive Officer
Ella Watt	Chief Financial Officer
Michelle Coons	Chair, Finance and Audit Committee
Jerry Geist	Member, Finance and Audit Committee
Roxane Bly	Member, Finance and Audit Committee
Michael Olguin	Member, Finance and Audit Committee
Manu Patel	Director, Internal Audit, UNM
JoAnn Woolrich	Executive Director, Compliance and Internal Audit
Jim Pendergast	Administrator, Human Resources
Shawna Gonzales	Executive Director of Finance/Controller
Sandra Long Mendoza	Finance Director
Roberta Reinhardt	Finance Director
Pauline Romero	Finance Director
Brandon Fryar	Engagement Partner, Moss Adams LLP
Purvi Mody	Senior Manager, Moss Adams LLP