# Cambridge Health Alliance

**(A Component Unit of the City of Cambridge, Massachusetts)**

## Reports on Federal Awards in Accordance with the Uniform Guidance

**June 30, 2019**

**EIN#043320571**

# Cambridge Health Alliance
**(A Component Unit of the City of Cambridge, Massachusetts)**
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## Report of Independent Auditors

To the Board of Trustees of
the Cambridge Public Health Commission d/b/a Cambridge Health Alliance

**Report on the Financial Statements**

We have audited the accompanying financial statements of the Cambridge Public Health Commission d/b/a Cambridge Health Alliance (the "Alliance"), a component unit of the City of Cambridge, Massachusetts, which comprise the statements of net position as of June 30, 2019 and 2018, and the related statements of revenue, expenses, and changes in net position and of cash flows for the years then ended, and the related notes to the financial statements, which collectively comprise the Alliance's basic financial statements.

***Management's Responsibility for the Financial Statements***

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

***Auditors' Responsibility***

Our responsibility is to express an opinion on the financial statements 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 audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

***Opinion***

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Cambridge Public Health Commission d/b/a Cambridge Health Alliance as of June 30, 2019 and 2018, and the changes in its financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

***Other Matters***

*Required Supplementary Information*

Accounting principles generally accepted in the United States of America require that the accompanying management's discussion and analysis on pages 4 through 19 and the schedules of the Alliance's proportionate share of the net pension liability, of the Alliance's contributions, and of changes in the Alliance's total OPEB liability and related ratios on pages 52 through 54 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the *Governmental Accounting Standards Board* who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

*Other Information*

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Alliance's basic financial statements. The accompanying schedule of expenditures of federal awards for the year ended June 30, 2019 is presented for purposes of additional analysis as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) and is not a required part of the basic financial statements. The accompanying schedule of expenditures of federal awards is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole.

**Other Reporting Required by *Government Auditing Standards***

In accordance with *Government Auditing Standards*, we have also issued our report dated October 31, 2019 on our consideration of the Alliance'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 for the year ended June 30, 2019. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Alliance's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Alliance's internal control over financial reporting and compliance.

PricewaterhouseCoopers LLP

Boston, Massachusetts
October 31, 2019

The following discussion and analysis provides an overview of the financial position and activities of the Cambridge Public Health Commission d/b/a Cambridge Health Alliance (the "Alliance" or "CHA"), a component unit of the City of Cambridge, Massachusetts, as of and for the years ended June 30, 2019 and 2018. This discussion has been prepared by management and should be read in conjunction with the financial statements and the notes thereto, which follow this section.

**Organization**

The Alliance is a public instrumentality created by special act of the Massachusetts Legislature. The following entities are subsidiaries of the Alliance: Somerville Hospital, Whidden Memorial Hospital, Inc. Cambridge Health Alliance Physicians Organization, Inc., CHA Management Services, Inc. (formerly Network Health, Inc.), the Institute for Community Health, and Cambridge Health Alliance Foundation, Inc., each of which is a non-profit organization exempt from taxation under Section 501(c)(3) of the Internal Revenue Code.

The Alliance is an award-winning integrated academic healthcare delivery system with three hospital campuses and an extensive primary care network serving patients in Cambridge, Somerville, and Boston's Metro-North communities. CHA serves more than 140,000 patients each year, specializing in the services people need most during their lives—primary care, specialty care, emergency services, maternity, overnight hospital care, and behavioral health.

CHA is committed to providing the very best care, filling unmet health needs, and collaborating with the community to address broad and pervasive health issues. CHA cares for people from all backgrounds and has particular strength in caring for patients experiencing economic, linguistic, and/or cultural barriers to care.

CHA has a clinical affiliation with Beth Israel Deaconess Medical Center ("BIDMC"), giving patients streamlined access to coordinated services at one of the best academic medical centers in the country. CHA is also affiliated with Massachusetts General Hospital for Children and is a teaching hospital of Harvard Medical School and Tufts University School of Medicine.

**Improve Quality and Patient Safety**

The medical staff at the Alliance now represents more than 30 specialty areas. CHA is a teaching affiliate of Harvard Medical School, Harvard School of Public Health, Harvard School of Dental Medicine, and the Tufts University School of Medicine.

CHA has a strong quality governance and management structure that includes a Board-level Quality Committee, an extensive set of dashboards, indicators and reports, and clear goals and priorities for improving quality and patient safety. CHA continues to focus on leadership core competencies; planning, strategy and setting operational priorities; improving operational coherence and integration, introducing new technologies, reducing costs, communicating and sharing information electronically, being patient centered, using measurement of performance to drive change. These efforts are to meet our mission and vision, achieve a more efficient and effective system of care and maintaining market advantage.

CHA recently has undergone a vigorous process for defining the strategic direction for the organization involving key leaders of the organization and board members. In addition, CHA leadership sets annual priorities and goals that are consistent with leadership and strategic planning processes, including establishing specific goals and targets to focus improvement efforts. These high-level goals are the basis for the entire organization's improvement goals, thus achieving the alignment required to achieve and sustain change. The Patient Care Improvement Committee reviews progress toward goals of each service delivery line. In addition, CHA has also embarked on a Performance Improvement journey using Lean tools and processes. Various workflows such as referrals, templates and patient flow issues are

being addressed under the Value Stream "Access." Projects are supported by the leadership with engagement from the staff, providers and relevant multi-disciplinary stakeholders. The Patient Safety Committee reviews safety and quality performance including both qualitative and quantitative analysis of safety events and makes recommendations for improvement. The Medical Executive Committee also reviews these CHA goals and assures the quality of the medical staff. The Board governs these efforts especially via the Board Quality committee.

In response to the rising demand for high-quality primary care, the Alliance is actively growing, expanding our footprint to serve more people in the communities around us and north of Boston. CHA plays a critical role in providing quality of care with particular expertise serving patients fluent in other languages than English as well as vulnerable populations. Its Primary care sites have been designated as advanced Patient Centered Medical Homes (Level III NCQA designation), known nationally as the gold standard for team based care. By growing its primary care footprint, CHA is able to meet the needs of the diverse metro-north communities while providing better access to specialty care. In addition, Behavioral Health integration, expanded substance use treatment and expanded psychiatric services have increased access to these services in these same communities.

Management of the performance associated with the organization's priorities and goals is governed by a quality management system of dashboards and indicator detail reports. Results are reported monthly and quarterly through multiple committees and reviewed by the Board Quality Committee. Performance results become the focus of improvement teams throughout the organization. Many of these scorecards are readily accessible by all staff through the organization's intranet.

CHA is fully accredited by the Joint Commission. CHA is committed to providing the highest quality of care, and Joint Commission accreditation and certification is a nationally recognized symbol of quality.

**Promote Population Health**
Through a contract with the City of Cambridge, CHA also operates the Cambridge Public Health Department (the "Department"), which strives to improve the quality of life for all who live, learn, work, and play in the city by preventing illness and injury; encouraging healthy behaviors; and ensuring safe and healthy environments. The Department has the legal authority to make and enforce public health regulations within the City of Cambridge. Main focus areas are communicable disease prevention and control, emergency preparedness, environmental health, epidemiology, population health, regulatory enforcement, and school health.

The Department has statutory obligations to prevent and control communicable disease in Cambridge. In fiscal year 2019, staff administered 847 flu vaccines at sites throughout the city and followed up on 214 communicable disease reports, including foodborne illness, norovirus, and mumps in the community. The Department operates a large regional tuberculosis ("TB") program at CHA Cambridge Hospital; and in fiscal year 2019, public health nursing staff managed 1,999 patient visits at the hospital for evaluation and treatment of latent and active TB, and made home visits to Cambridge residents with active or suspect TB. The Department operates the school health program in the Cambridge public schools, and nurses handled 49,294 student visits for illness, injury, medication administration, and medical procedures during the 2018-2019 school year. The Department also provided oversight and clinical guidance to three nonpublic schools, as well as city-managed preschools and camps.

In addition, the Department released a mini-documentary, *Prepare the Port!*, which was screened at a 2019 community forum and other events in the Port neighborhood; collaborated with the City's Birth to 3rd Grade Partnership to develop and pilot nutrition and physical activity guidelines for daycares and preschools; and supported fathers with the newly expanded Cambridge Dads program by offering events for fathers and children, launching a 13-week Nurturing Fathers workshop series, hosting a discussion group called Cambridge Dads Talk, and surveying fathers to better understand their needs.

The Department continued to promote healthy lifestyles and chronic disease prevention through its nutrition, men's health, violence and injury prevention, substance abuse, early literacy, and childhood asthma programs. With regard to the statewide opioid crisis, the Department's efforts included staffing the City Manager's Opioid Working Group, which released a formal report and recommendations in March 2019; producing the second comprehensive Cambridge opioid overdose data report; implementing a five-year, $425,000 federal grant to reduce prescription drug misuse among the city's public high school students; individually interviewing 742 seventh and ninth graders to assess their risk for substance abuse, as part of a state-mandated screening; offering overdose recognition and response training to Cambridge businesses and city leaders, in collaboration with AIDS Action Committee's Access: Drug User Health Program; sharing timely information about opioid prevention, intervention, and treatment through Overdose Prevention and Education Network ("OPEN"), a regional coalition led by the Department; and working closely with city and community partners on related initiatives.

The Department implemented Year 4 strategies of the city's five-year Community Health Improvement Plan ("CHIP"). The plan describes actionable goals, objectives, and strategies for making tangible progress in four health priority areas for the city: Mental health and substance abuse; violence; healthy, safe and affordable housing; and healthy eating and physical activity. Two additional topics—health access and health equity/social justice—are integrated across priority areas.

The Cambridge Public Health Department achieved national accreditation in August 2018, becoming one of the first health departments in Massachusetts to meet rigorous national standards for delivering quality programs and services to the community.

The Department of Community Health Improvement ("CHI") has the goal of improving the health of our community by providing a broad array of community health initiatives targeting populations at risk for health care disparities. These populations include individuals who are low-income, immigrants, of cultural or linguistic minorities, or otherwise at risk because of homelessness or mental illness. CHI works to inform these individuals of available services, reduces barriers to accessing care, creates links to appropriate health care services and provides culturally appropriate, accessible, and engaging education about preventive care and healthy lifestyles.

CHI also partners with various community groups, non-profit agencies, and public health departments to collaboratively work towards creating a culture of health, advocating for and improving health care access and reducing health disparities. Activities include identifying important community health issues, developing a collaborative work plan, and aligning this community work with CHA clinical services.

The Department also operates grant funded programs that address key areas, such as HIV/AIDS, homelessness, teen pregnancy prevention, elder depression and domestic violence to promote health and wellbeing. CHI is actively engaged in population health efforts including addressing social determinants of health.

The Institute for Community Health ("ICH") was founded in 2000 by the Alliance and two other health care systems as a collaborative effort to improve the health of Cambridge, Somerville, and surrounding cities and towns. The Alliance is now the sole member as BIDMC terminated their membership during the year.

ICH is a non-profit consulting organization working regionally and across New England. The organization provides participatory evaluation, applied research, planning, and data services to assist health care systems, government agencies, and community-based agencies measure and report their impact. Core to this approach is the development of long-term partnerships, a commitment to co-learning and capacity building, and a deep appreciation for the diverse experiences, perspectives, values, and resources that partners contribute to community health improvement.

**Build Academic Mission**
Through affiliations with Harvard Medical School, Harvard School of Public Health, Harvard School of Dental Medicine and the Tufts University School of Medicine, the Alliance has provided educational opportunities for over 30 years. The Alliance offers residency and training programs in a variety of disciplines, including internal medicine, family medicine, and adult and child psychiatry.

The Cambridge Integrated Clerkship, started in fiscal year 2005, continues to attract some of the brightest and most accomplished medical students from Harvard Medical School. This is an alternative experience for third year Harvard Medical students with a "continuity of care" curriculum.

The Alliance is a member of the Association of American Medical Colleges ("AAMC") and Council of Boston Teaching Hospitals ("COBTH").

**Strengthen Financial Position**
The Alliance reported an excess of revenue over expenses of $7.1 million and $10.4 million fiscal years 2019 and 2018, respectively.

The Alliance continues to move forward toward becoming an Accountable Care Organization ("ACO") and to leverage its ACO role in its relationships with payers and clinical partners to improve clinical outcomes and financial performance.

The Alliance received $1.3 million and $1.5 million of federal funds in 2019 and 2018 for meeting the electronic medical record meaningful use requirement, respectively. The Alliance continues to upgrade the electronic medical record with new releases from Epic. There is continuous improvement work for enhancements, and work flow changes as necessary. CHA has also worked to implement Epic billing, which went live July 1, 2019. These combined efforts keep CHA current with technologies and meeting the meaningful use requirements.

During fiscal years 2018 and 2019, the Alliance expanded primary care services and pharmaceutical services in several under-served communities within its service area. This expansion will improve access to care and will contribute to CHA's strategic goal of improving financial performance.

During fiscal year 2018 and 2019, the Alliance launched an employee prescription program and expanded its contract pharmacy relationships. This allowed us to realize reduced employee benefit expenses and increased volume and revenue.

In fiscal year 2018, the retail pharmacy at the Cambridge Hospital campus received full specialty pharmacy accreditation by URAC. The specialty pharmacists invest time in patient care plans monitoring many aspects of the patient's drug therapy ensuring quality of life is not compromised. This results in the pharmacy providing improved clinical services, patient care and increased prescription volume. Additionally, in fiscal year 2019, the Alliance's URAC accreditation for specialty pharmacy, and the outpatient pharmacy management's training on business analytics were key to manufacturers granting the Alliance access to their limited drug distribution ("LDD") channels.

The specialty pharmacy is working to integrate with the Alliance's ambulatory clinics. The pharmacy is approaching this by disease state, and started with Hepatitis C. HIV, oncology and neurological conditions will be the next focus.

During fiscal year 2019, the Alliance prepared for additional specialty pharmacy accreditations from Accreditation Commission for Health Care ("ACHC") and URAC mail order in preparation of the planned expansion to open a registered mail order facility in fiscal year 2020, and because many payers are requiring pharmacies to obtain at least two specialty pharmacy accreditations by 2020.

The specialty pharmacists also manage The Alliance's Elder Service Plan's ("ESP") Medication Therapy Management ("MTM") program. ESP receives funding per member from Medicare D for this program. The program focuses on medication adherence, polypharmacy and overall drug utilization with disease states to ensure optimization of drug therapy. ESP had favorable MTM Acumen scores this past year and according to ESP's pharmacy benefit manager we are the only ESP plan and pharmacy who has an MTM program in place.

The Elder Services Plan program expanded to Malden in fiscal year 2017, and membership has grown from 439 members as of June 2018 to 466 members as of June 2019.

During fiscal year 2018 the Alliance consolidated health insurance plans offered to employees to two options that encourage employees to receive their care at the Alliance and our affiliate BIDMC. The new coverage went into effect July 1, 2017 and is administered by Health Plans, Inc., a wholly owned subsidiary of Harvard Pilgrim Health Care.

CHA entered into a clinical affiliation with BIDMC in April 2013. In fiscal years 2015, CHA began participating in the Beth Israel Deaconess Care Organization ("BIDCO"). This participation allows CHA physicians and hospitals to join with other physician groups and hospitals in one overall structure to share risk and to invest in the infrastructure necessary to manage populations of patients and coordinate their care under global risk contracts, such as the Medicare Pioneer ACO. The Alliance recorded $1.7 million and $2.6 million in fiscal year 2019 and 2018, respectively, related to the risk share agreement with BIDCO.

CHA and BIDMC have implemented a shared medical record system which allows providers in both institutions to coordinate care and provide the very best treatment for each patient.

In March 2018, the Alliance partnered with Tufts Health Public Plans ("THPP") and launched the ACO product, Tufts Health Together with CHA. The plan was selected to participate in the MassHealth Accountable Care Organization program. The Alliance recorded a loss reserve of $5.2 million in fiscal year 2019, related to this risk share agreement.

**Leadership and Workforce**

**"**Caring for all and Caring Completely" is our focus. The Alliance continues to work to integrate patient and staff experience, patient safety, and provider and staff engagement.

The Alliance recognizes that the development of leadership and workforce is key to a successful organization. CHA employs approximately 4,400 individuals from diverse backgrounds, including approximately 800 nursing staff and approximately 500 active medical staff.

The Alliance continues to work to improve employee and provider engagement. During fiscal year 2018, the organization conducted its second, biennial Employee and Provider Engagement Surveys, and retained the Advisory Board to implement, analyze, and support follow-up improvement actions. Our

fiscal year 2018 results showed substantial improvement over fiscal year 2016. CHA has committed to exceeding The Advisory Board's external benchmark of the 50th percentile in fiscal year 2020 surveys. Managers completed action plans to improve employee engagement based on the fiscal year 2018 results, and developed action plans to continue the positive movement reflected in the fiscal year 2018 results. A very active Provider Engagement Steering Committee was chartered and has been working on systemic changes in communication with, and operational support for, providers. This group is working with Chiefs and Administrative leaders to create a more local focus on continuing to improve and making CHA a great place to practice.

Two CHA-wide improvement goals were selected by the senior leadership team to address areas identified on the fiscal year 2018 survey: customer service and staff recognition. Based on the recommendations of our frontline leaders to maintain and enhance our gains, we will continue to focus on these same areas for the upcoming improvement cycle. To provide a consistent approach to meeting patient and customer needs, Acknowledge, Introduce, Duration, Explanation, Thank-you ("AIDET") training was implemented across the organization. The AIDET Communications framework is an evidence-based Studer practice. AIDET will continue, with significant enhancements, and has become part of the organization's culture. Several recognition vehicles, including the Compassion, Integrity, Respect, Community, Learning, Excellence ("CIRCLE") Awards Program which celebrates employees who demonstrate our core values, and CHA CARES notes, an electronic peer-to-peer appreciation application have increased dramatically as a result of the organization's focus on enhancing staff recognition. The Alliance surveyed employees and providers in October 2019, and will work to revise leadership and workforce initiatives accordingly.

We are continuing to use High-Middle-Low ratings as a leadership tool for reinforcing positive behavior and responding to poor performance. This is a best practice developed by The Studer Group and used by health systems nationwide to improve patient experience of care. Studer High-Middle-Low ratings are now routinely correlated with regretted and unregretted turnover; managers rate staff twice a year and use these ratings to guide their interactions with staff regarding performance coaching and reinforcement.

Leadership development initiatives this year included "Respect in the Workplace" trainings for managers and Senior Leaders. Human Resource's presentations were focused on creating an overall culture of respect, along with a review of manager responsibilities related to harassment and bullying in the workplace.

The organization is in the process of implementing a new HRIS system that is expected to be ready July 1, 2020. This system is expected to provide a better experience for our employees by centralizing all human resource and payroll related information into one system.

CHA's Wellness Program continues to provide education, resources, and challenges for employees to develop healthier lifestyles. This program was cited frequently in our employee and provider engagement surveys as a positive aspect of employment at CHA.

**Growth and Investment**
The Alliance Board has approved a capital budget for fiscal year 2020 of $25 million including continued investments in Radiology and Information Technology, and upgrades to our facilities.

The Provider Network's focus is on transforming to an Accountable Care - Patient Centered Medical Home ("ACO – PCMH") where patients will receive excellent care managed by their physicians at the Alliance and by its clinical partners. All 12 CHA medical practices have been named Level 3 Medical Homes by the National Committee for Quality Assurance ("NCQA"), the highest national designation, and have received the Massachusetts Health Policy Commission's Patient Centered Medical Home PRIME Certification.

CHA is integrating primary care and behavioral health care within its primary care practices. The Alliance, also has developed a Behavioral Health Home called Health Integration Program ("HIP") for patients with intensive mental illness. HIP features primary care clinicians within an outpatient psychiatry site. The program offers recovery-oriented care to adults with schizophrenia or other psychotic disorders, aiming to improve their complete health – mental, physical, and social.

CHA actively collaborated with BIDMC physicians and practices to expand access to care in local communities. CHA and BIDMC share information, develop bi-directional referral relationships, and cross-promote services to patients. This included work between CHA and BIDMC specialty departments, the BID-Chelsea practice, and the BIDMC Extended Community Care Program, which serves older adults in Skilled Nursing Facilities across the Metro-Boston region.

In June 2018, the Alliance opened the Assembly Square Care Center, an advanced medical home model. With 15 exam rooms, including 12 for general primary care and one each for behavioral health integration, pharmacotherapy and nutrition, the site will be staffed by 9 providers and expects to accommodate 24,000 patient visits annually. The site is designed for maximum co-location and to put the patient at the center of care. This means the team moves around instead of the patient. A unique feature of the new site is that it will also offer Urgent Care to existing patients of the Alliance.

In fiscal year 2017, our Elder Service Plan expanded to better serve frail adults in CHA's service area. ESP delivers all-inclusive care and support to adults (55+) who are nursing home eligible but are able to live independently in their own home with proper support. Membership in the Elder Service Plan grew to 466 members as of June 30, 2019.

The Alliance has developed major performance improvement projects that are categorized by the state as Public Hospital Transformation Incentive Initiatives ("PHTII"). In fiscal year 2019, the Alliance reported on four major performance improvement projects: Integration of Behavioral Health and Primary Care, Comprehensive Systems for Treating Mental Health & Substance Use ("MHSU") Conditions, Referral Management and Integrated Care Management, and Evidence-Based Practices for Medical Management of Chronic Conditions. CHA reports to the state on a number of health outcomes measures related to these projects. The Alliance recognized $129.3 million in fiscal year 2019 and $146.7 million in fiscal year 2018 of federal and state support revenue related to these projects.

| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| Patient service revenue, net of provision for bad debts | $ 308,946,397 | $ 302,601,635 | $ 314,585,810 | $ 328,918,213 | $ 340,480,741 |
| Federal and state support | 174,000,004 | 167,015,298 | 164,269,750 | 200,068,339 | 234,261,993 |
| Operating expenses | 576,846,145 | 602,576,390 | 598,619,709 | 652,953,287 | 691,664,627 |
| Excess (deficiency) of revenues over expenses | 28,870,194 | 1,877,737 | 9,380,425 | 10,419,496 | 7,122,119 |
| Operating cash flows | (122,452,003) | 92,121,527 | 13,991,943 | 81,418,524 | 3,295,647 |
| Patient days | 58,818 | 56,068 | 57,952 | 56,280 | 56,374 |
| Discharges | 11,700 | 10,688 | 10,888 | 10,683 | 10,184 |
| Average length of stay (days) | 5 | 5 | 5 | 5 | 6 |
| Number of licensed beds | 494 | 494 | 475 | 351 | 351 |
| Outpatient clinic visits | 675,750 | 706,312 | 699,080 | 703,973 | 714,483 |
| Cash and cash equivalents | 132,815,246 | 244,106,125 | 254,009,241 | 318,022,676 | 217,105,986 |
| Total assets | 505,671,473 | 515,165,669 | 515,520,593 | 546,539,268 | 541,916,911 |
| Working capital | 246,960,455 | 259,180,229 | 269,472,134 | 284,828,481 | 184,086,813 |
| Short-term debt and current portion of capital lease obligations | 3,495,413 | 3,346,576 | 2,150,738 | 438,701 | 76,018 |
| Long-term debt and noncurrent portion of capital lease obligations | 5,092,300 | 2,861,012 | 708,423 | 305,929 | 148,553 |
| Net position | 307,584,662 | 307,758,786 | 314,988,714 | 241,763,744 | 249,628,518 |
| Capital spending | $ 16,064,786 | $ 21,418,492 | $ 15,193,590 | $ 28,242,432 | $ 38,062,268 |
| Current ratio | 3.67 | 3.45 | 3.62 | 3.58 | 2.72 |
| Debt to equity | 3 % | 2 % | 1 % | 0 % | 0 % |

### Overview of the Basic Financial Statements

The basic financial statements (statements of net position, statements of revenue, expenses, and changes in net position, and statements of cash flows) present the financial position of the Alliance at June 30, 2019 and 2018, and the result of its operations and its financial activities for the years then ended. The statements of net position include all of the Alliance's assets and liabilities. The statements of revenue, expenses, and changes in net position reflect the year's activities on the accrual basis of accounting, when services are provided or obligations are incurred, not when cash is received or paid. This statement also reports other changes in the Alliance's net position. The statements of cash flows provide relevant information about cash receipts and cash payments and classify them as to operating, investing, and capital and related financing activities. The basic financial statements include notes that explain information in the basic financial statements and provide more detailed data.

### Capital Assets and Debt Administration

At June 30, 2019 and 2018, the Alliance had capital assets, net of accumulated depreciation, of $159.5 million and $140.6 million, respectively, as shown in the table below (in thousands):

| | 2019 | 2018 |
|---|---|---|
| Land | $ 12,001 | $ 12,001 |
| Land improvements | 3,127 | 2,982 |
| Buildings and improvements | 260,937 | 253,090 |
| Equipment | 264,514 | 252,971 |
| Construction in progress | 23,755 | 9,524 |
| Capital leases | 9,867 | 10,432 |
| Less: Accumulated depreciation | (414,661) | (400,438) |
| Total | $ 159,540 | $ 140,562 |

The Alliance has been focused on improving quality, safety and efficiency of our healthcare delivery system. A significant strategic investment in this multi-year organization wide system implementation of additional Epic software. ROAR, Radiant (Radiology), OpTime (OR and Anesthesia), ADT (Registration

and Patient Movement) and Resolute (Billing for Hospital and Professional Services), will provide staff and providers with tools to make it easier to provide patient-centered care. The implementation was completed on July 1, 2019.

In February 2009, Congress passed the American Recovery and Reinvestment Act of 2009 ("ARRA") which provides incentives through Medicare and Medicaid for physicians and hospitals to achieve "meaningful use" of an electronic medical record. The Alliance received $1.3 million and $1.5 million of federal funds in 2019 and 2018 for meeting the electronic medical record "meaningful use" requirement, respectively. The Alliance continues to upgrade the electronic medical record with new releases from Epic. There is continuous improvement work for enhancements and work flow changes as necessary.

These combined efforts keep the Alliance current with technologies and meeting the "meaningful use" requirements. The implementation of Epic Inpatient systems was completed in fiscal years 2015. The Alliance also successfully implemented medication bar-coding technology in fiscal years 2015 in order to meet the requirements of the meaningful use of the electronic medical record system.

More detailed information about the Alliance's capital assets is presented in Note 6 to the financial statements.

The Alliance's debt relates to financing the purchase of 237 Hampshire Street. Below is a schedule of the Alliance's debt as of June 30, 2019 and 2018 (in thousands):

| | 2019 | 2018 |
|---|---|---|
| Capital leases - property | $ - | $ 239 |
| Capital leases - medical equipment | - | 172 |
| 237 Hampshire Street note payable | 225 | 297 |
| Interest-free loan | - | 36 |
| | $ 225 | $ 744 |

At June 30, 2019 and 2018, the current portion of long-term debt is approximately $0.08 million and $0.4 million, respectively.

**Financial Statement Summary**
***Summary of Net Position (In thousands)***

| | 2019 | 2018 | 2017 |
|---|---|---|---|
| Current assets | $ 291,117 | $ 395,367 | $ 372,141 |
| Capital assets | 159,540 | 140,562 | 131,208 |
| Other noncurrent assets | 91,260 | 10,610 | 12,172 |
| Total assets | 541,917 | 546,539 | 515,521 |
| Deferred outflow of resources | 28,727 | 14,624 | 14,832 |
| Due to third parties | 33,750 | 41,697 | 40,054 |
| Postemployment benefits | 137,129 | 146,531 | 140,473 |
| Bonds payable | - | - | 1,495 |
| Capital leases | - | 447 | 997 |
| Other liabilities | 78,712 | 84,938 | 66,655 |
| Pension obligation | 59,136 | 32,159 | 41,818 |
| Total liabilities | 308,727 | 305,772 | 291,492 |
| Deferred inflow of resources | 12,288 | 13,627 | 7,813 |
| Net position | | | |
| Unrestricted | 85,859 | 97,878 | 98,510 |
| Invested in capital assets - net of related debt | 159,315 | 139,818 | 128,349 |
| Restricted | 4,455 | 4,068 | 4,189 |
| Total net position | $ 249,629 | $ 241,764 | $ 231,048 |

**Assets**
***Current Assets***
*Liquidity*
At June 30, 2019, cash and cash equivalents decreased $101 million or 32% from June 30, 2018. CHA invested $99.4 million in US Treasury Notes, Agencies, and Commercial paper. Additionally, CHA reported cash provided by operations of $3.3 million, purchased capital assets of $37.5 million, paid principal and interest on debt of $0.4 million, and received $7.25 million in tax support from the City. The cash ratio of unrestricted liquid assets to current liabilities as of June 30, 2019 and 2018 is 2 to 1 and 2.9 to 1, respectively.

The Alliance had a receivable due from the Commonwealth of Massachusetts at June 30, 2019 of $19.2 million and at June 30, 2018 of $24.0 million.

Prepaid expenses increased from $6.9 million at June 30, 2018 to $7.8 million at June 30, 2019 related to the timing of payments of service contracts.

*Noncurrent Assets*
Assets whose use is limited decreased from $6.8 million at June 30, 2018 to $5.7 million at June 30, 2019. This decrease primarily relates to a decrease in the amounts of two Standby Letters of Credit which reduced the related collateral requirement, and a release of funds that had been previously restricted by the board.

*Deferred Outflow of Resources*
Deferred outflows on pension increased $13.2 million from $9.5 million at June 30, 2018 to $22.8 million at June 30, 2019 primarily related to the difference between projected and actual investment earnings on pension plan investments.

Deferred outflows on other post-employment benefits ("OPEB") increased $0.9 million from $5.1 million at June 30, 2018 to $5.9 million at June 30, 2019.

*Current Liabilities*
Accounts payable and accrued expenses decreased $7.3 million from June 30, 2018 to June 30, 2019.

Accrued salaries and compensated absences increased $4.4 million in fiscal year 2019 to $46.9 million. The increase primarily relates to increased staffing, and an increase in accrued incentives.

Current settlements due to third-party payors increased from $11.9 million at June 30, 2018 to $15 million at June 30, 2019, mainly due to a loss reserve recorded on risk contracts of $5.5 million, and a decrease in current Medicare settlements of $1.9 million.

Current capital lease obligations decreased from $0.4 million at June 30, 2018 to $0 at June 30, 2019. CHA made principal payments of $0.4 million based on the amortization schedules.

Deferred revenue decreased $3.3 million in fiscal year 2019 primarily related to recognition of Delivery System Reform Incentive Payment ("DSRIP") revenue and the timing of the receipt of monthly capitated payment for the Elder Service plan at June 30.

*Other Liabilities*
Long-term settlements due to third-party payors decreased from $29.8 million at June 30, 2018 to $18.8 million at June 30, 2019, mainly due to recognition of the Public Health Transformation ("PHT") revenue of $7.8 million, and $3.3 million patient service revenue.

Noncurrent capital lease obligations decreased from $0.08 million at June 30, 2018 to $0 at June 30, 2019 due to payment of regularly scheduled lease payments.

Post employment benefits are an actuarially determined liability. The liability decreased from $146.5 million at June 30, 2018 to $137.1 million at June 30, 2019.

Pension Liability is an actuarially determined liability. The Alliance participates in the Cambridge Retirement System, a cost sharing multiemployer public employee retirement system. The Alliance's pension liability increased from $32.2 million as of June 30, 2018 to $59.1 million as of June 30, 2019. Additionally, the Alliance has a special funding situation with the City, where the City has recorded an additional liability related to the Alliance's pension of $21.2 million and $17.2 million as of June 30, 2019 and 2018, respectively.

*Deferred Inflow of Resources*
The Alliance's Deferred Inflows of Resources decreased $1.3 million from $13.6 million at June 30, 2018 to $12.3 million at June 30, 2019. Deferred inflows of pension decreased $8.6 million while Deferred inflows of OBEP increased $7.2 million.

*Net Position*
The Alliance's Net Position increased from $241,763,744 at June 30, 2018 to $249,628,518 at June 30, 2019, mainly due the purchase of capital assets and no additional debt obligations.

Certain prior year information has been restated in order to conform to current year presentation under GASB Statement No. 75.

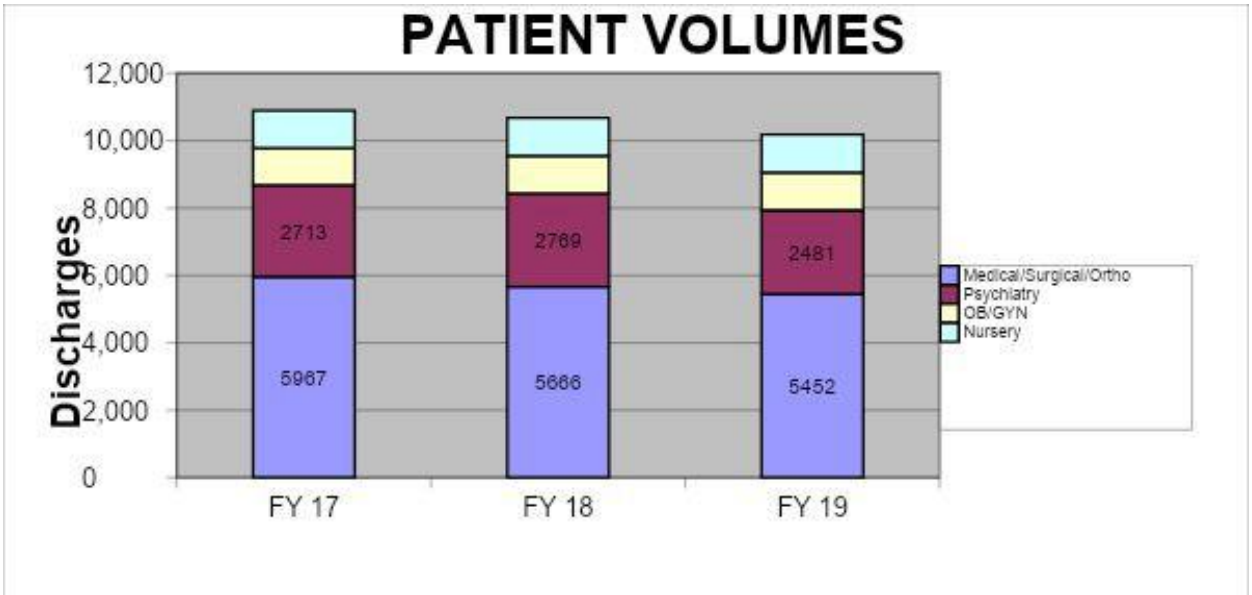
| *(in thousands)* | 2019 | 2018 | 2017 |
|---|---|---|---|
| **Operating revenue** | | | |
| Net patient service revenue | $ 340,481 | $ 328,918 | $ 314,586 |
| Federal and state support | 234,262 | 200,068 | 164,270 |
| Other operating revenue | 109,780 | 120,633 | 110,974 |
| Total operating revenue | 684,523 | 649,619 | 589,830 |
| **Operating expenses** | | | |
| Salary and benefits | 451,322 | 425,572 | 395,595 |
| Supplies | 72,092 | 73,380 | 59,096 |
| Service | 131,105 | 115,541 | 102,357 |
| Travel and training | 2,412 | 2,224 | 1,806 |
| Health Safety Net expense | 1,631 | 4,742 | 3,230 |
| Depreciation | 18,975 | 18,886 | 20,826 |
| Other expense | - | 537 | 302 |
| Pension expense | 14,128 | 12,071 | 15,408 |
| Total operating expenses | 691,665 | 652,953 | 598,620 |
| (Loss) from operations | (7,142) | (3,334) | (8,790) |
| **Nonoperating revenue (expenses)** | | | |
| Pension subsidy from City under special funding arrangement | 1,031 | 2,453 | 4,969 |
| Investment income | 6,433 | 3,717 | 1,695 |
| Interest expense | (19) | (71) | (180) |
| Tax support | 7,250 | 7,200 | 7,000 |
| Tax expense | (988) | - | - |
| Gain on disposal of fixed assets | 557 | 454 | 4,686 |
| Total nonoperating revenue - net | 14,264 | 13,753 | 18,170 |
| Excess of revenue over expenses | 7,122 | 10,419 | 9,380 |
| Other restricted donations | 744 | 296 | 169 |
| Increase in net position | 7,866 | 10,715 | 9,549 |
| **Net position** | | | |
| Beginning of year | 241,763 | 231,048 | 307,759 |
| Adjustment to adopt GASB 75 | - | - | (86,260) |
| End of year | $ 249,629 | $ 241,763 | $ 231,048 |

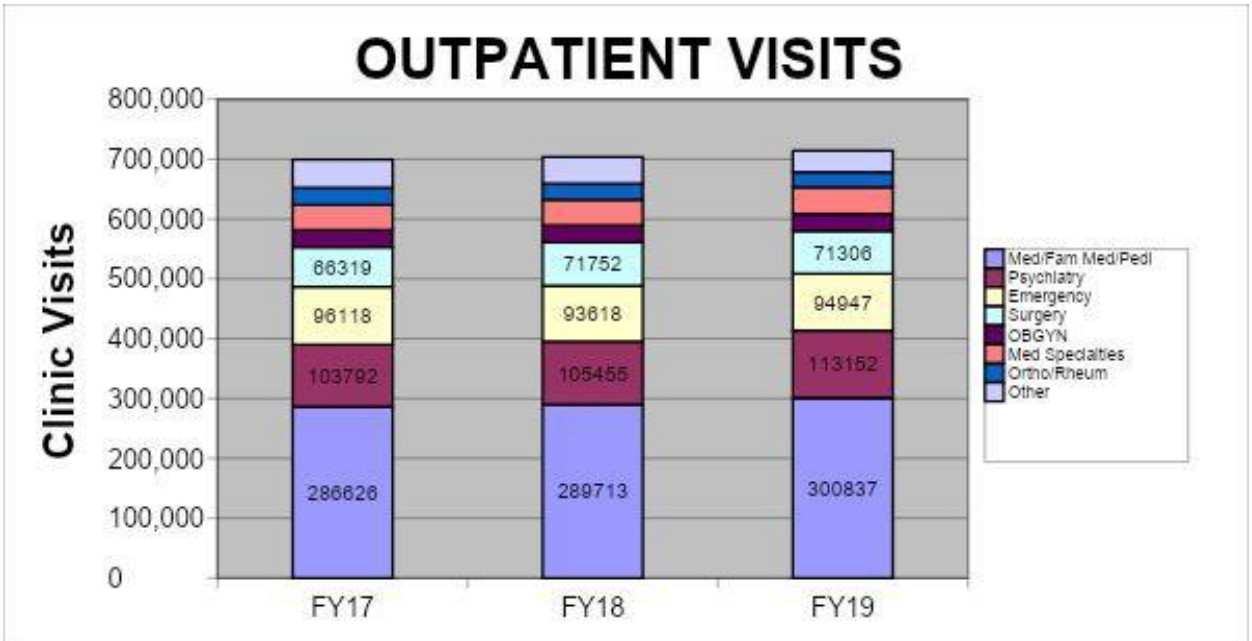
**Patient Volumes**
The Alliance's patient days increased about 94 or 0% in fiscal years 2019. The average length of stay increased from 5 to 6 days.

Discharges decreased about 499 or 5% in fiscal years 2019.

Clinic visits increased about 10,510 or 1% in fiscal years 2019.

The graphs below show actual volumes for fiscal year 2017, fiscal year 2018 and fiscal year 2019:




The organization reports a loss from operations of $7.1 million, $3.3 million, and $8.8 million in fiscal years 2019, 2018, and 2017, respectively.

***Operating Revenue***
The Alliance's operating revenue increased $34.9 million from fiscal year 2018 to fiscal year 2019.

Net patient service revenue increased $11.6 million, Federal and State Support increased $34.2 million, and Other Revenue decreased $10.9 million. The increase in net patient service revenue is attributable to an increase in outpatient volume and third party payer rate increases. For fiscal year 2019, Federal and State support revenue includes public hospital transformation incentives of $129.3 million, hospital quality incentives of $44.6 million, safety net funds of $21.8 million, DSRIP funds of $17.6 million, and integrated care incentives of $12.7 million. For fiscal year 2018, Federal and State support revenue includes public hospital transformation incentives of $146.7 million, hospital quality incentives of $17.3 million, safety net funds of $2.9 million, DSRIP funds of $15.4 million, and Health Safety Net funds of $11

The decrease of $10.9 million in other operating revenue primarily related to recording final DSTI revenue in fiscal year 2018 of $18 million, and an increase in retail pharmacy revenue and revenue related to capitated contracts.

***Operating Expenses***
Operating expenses increased $38.7 million in fiscal year 2019.

Increases in expenses mainly related to the increase in Salary and Benefit expense of $25.7 million and Service expense increased $15.6 million. The increase in salaries is primarily due to increased market pressure on rates and increased staffing in critical areas needed for both patient satisfaction and growth. Additionally, the organization has seen an increase in employee health insurance expense over the prior year.

The Alliance recorded pension expense of $14.1 million, $12.1 million and $15.4 million in fiscal years 2019, 2018, and 2017 respectively. Additionally, because the Alliance is in a special funding situation with the City, the City has recorded pension expense related to the Alliance of $1.0 million, $2.5 million and $5.0 million in fiscal year 2019, 2018, and 2017 respectively. The Alliance has recorded this amount as pension subsidy from City under a special funding arrangement.

***Results From Operations***
The Alliance reported excess of revenue over expenses of $7.1 million, $10.4 million, and $9.4 million for fiscal years 2019, 2018 and 2017 respectively.

***2020 Outlook to the Future***
Everyone is welcome at CHA and treated with dignity. CHA has a special commitment to caring for the underserved, chronically ill, and others facing barriers to care. In support of this mission, the CHA Board Strategic Planning Committee developed a multiyear strategic plan in 2015 that charts its course through 2022. CHA's vision is to be the premier public health system in the nation and it aspires to be a valued and sustainable academic community health system that exceeds the expectations of its patients, purchasers and communities. Key components of the strategic plan include growth and continued transition to value-based models that align with the goals of improving health and quality while reducing costs.

CHA focuses on providing the services people need most every day – primary care, specialty care, behavioral health, emergency care, maternity and short hospital stays – in convenient locations near home, work, and the support of loved ones. CHA has reached key milestones in its strategic plan that include growing its primary care practices, integrating primary care and behavioral health, and the expansion of essential psychiatric services. A new primary care practice at Assembly Square (Somerville) opened in late FY18 and continued to hire providers, ramp up and accept new patients in

FY20. In addition, CHA expanded its Cambridge Family Health practice (in Porter Square, Cambridge) and opened a new specialty pharmacy program to serve a broad range of clients. To address access issues in mental health, new child and adult outpatient psychiatry services opened in Revere in FY19 and the CHA Everett Hospital Emergency Department Peer Recovery Coach Program expanded to include CHA Cambridge Hospital at the start of FY20. Comprehensive inpatient, specialty services and maternity planning is also underway.

When patients need more advanced care, CHA's clinical affiliation with Beth Israel Deaconess Medical Center (BIDMC) provides seamless and integrated access to tertiary/quaternary services. In 2019, BIDMC merged with Lahey Health and others to create the second largest health care delivery system in Massachusetts – Beth Israel Lahey Health (BILH). BILH is required to engage its affiliated safety net hospitals – including CHA, in regional planning. This effort is underway for CHA's service area and offers CHA opportunities to strengthen local services, improve access, grow, and reduce health care costs.

CHA also works with local agencies, community partners and post acute service providers to offer integrated care in community settings and at home when appropriate. All of these relationships mean CHA is able to get patients the right care at the right time in the right place, which helps build deep and lasting relationships with patients and contribute to a financially sustainable health system.

As care delivery models evolve and change, CHA evaluates its services to ensure they continue to serve patient and community needs and are financially sustainable. Across the country, urgent care is becoming a convenient and more affordable option to many emergency department visits. Based on data analysis and extensive work with a community task force, CHA plans to convert its Somerville Hospital Emergency Department to an Urgent Care Center in April 2020. The Somerville Urgent Care Center will benefit CHA patients through its integrated care model and fill a gap in the continuum for low-income, complex and/or linguistically/culturally diverse patients at a more affordable cost. CHA is pursuing additional service enhancements in Somerville to remain a leading provider of care to Somerville in the future.

Infrastructure investments also were made to improve both patient experience and operational efficiency. At the start of FY20, CHA rolled out a major expansion and improvement of its medical record system (Epic), including integration of additional modules to improve data collection, tracking and patient billing. This project, named ROAR – Radiant (Radiology), Op Time (OR and Anesthesia), ADT (registration and patient movement), and Resolute (hospital billing) – will support care coordination, an essential factor for success in a value-based/ACO environment. In addition to ROAR investments, an online appointment scheduling system (ZocDoc) was expanded to make it easier for patients to schedule primary care appointments and a text-based appointment reminder system was implemented to reduce no-show rates and improve productivity.

CHA has also made major investments in its safety and security protocols and technology. A systemwide emergency access improvement effort was launched in FY19 and is underway in FY20. Investments include improved wayfinding, signage, lighting, GPS locations, and other initiatives. CHA is sharing its learning with the Massachusetts Hospital and Health Association to improve safety across the state.

CHA recognizes that many factors influence health – physical, mental/behavioral, and environmental. CHA works closely with its communities and social service agencies to address the social determinants of health. For example, a free monthly mobile market is held at the CHA Revere Care Center to provide fresh produce for local residents facing food insecurity. CHA has been actively involved in supporting immigration and refugee issues through outreach and advocacy. To formalize this commitment to a broader definition of health, CHA established a board level committee (Board Committee on Population Health) dedicated to social determinants and public health issues across CHA and its communities, with a

focus on obesity and mental health/substance use. Responding to the growing public health crisis of obesity, and the detrimental effects of sugar on health, CHA eliminated sugar-sweetened beverages from its facilities in January 2019. These community and public health efforts strengthen CHA's ties to its local cities, creating new avenues to connect with patients and families, strengthen brand awareness and improve the health of populations.

In order to build awareness for the CHA system, a multiyear brand strategy is underway. A strong brand will help CHA attract new patients, staff, and supporters in order to grow and remain financially sustainable. Work to date includes a consistent naming convention and new signage to make it easier for patients to find care locations and to show CHA is a unified health system. In the fall of FY20, a multi-media brand marketing campaign will launch to create awareness for CHA and its commitment to inclusion, diversity and providing quality care for all. Additional initiatives, including a community engagement strategy, will follow in the spring of 2020.

CHA is also strengthening its academic mission. At the beginning of FY20, CHA opened a new Center for Health Equity & Advocacy to respond to the structural causes that result in healthcare inequities throughout the healthcare system. The center will provide curriculum and support needed to train an inter-professional audience of clinicians as they develop as agents for social changes for health equity. In addition, CHA welcomed Phil Philip Wang, MD, DrPH, as its new Chief of Psychiatry. Dr. Wang is a nationally renowned administrator, researcher and educator whose career has been dedicated to improving the lives of people with mental illnesses. Most recently, Dr. Wang served as the deputy medical director and director of research of the American Psychiatric Association. Preceding this position, Dr. Wang was the deputy director of the National Institute of Mental Health (NIMH). There, he assisted in overseeing 1,300 NIMH staff and approximately $1.5 billion spent annually on basic, translational and clinical research focused on prevention, recovery and cures.

All of the initiatives above are in place because of CHA's commitment to its patients, communities and staff. Through this value-focused approach, CHA strives to improve health outcomes while reducing individual and societal healthcare costs.

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Statements of Net Position
## June 30, 2019 and 2018

| | 2019 | 2018 |
|---|---|---|
| **Assets** | | |
| Current assets | | |
| Cash and cash equivalents | $ 217,105,986 | $ 318,022,676 |
| Patient accounts receivable - less allowance for doubtful accounts of $47,331,350 and $50,223,891 in 2019 and 2018, respectively | 33,750,042 | 34,108,970 |
| Inventories | 4,004,909 | 2,948,743 |
| Prepaid expenses | 7,759,535 | 6,908,527 |
| Due from third parties - current | 19,171,214 | 23,980,016 |
| Other current assets | 9,325,524 | 9,398,309 |
| Total current assets | 291,117,210 | 395,367,241 |
| Assets whose use is limited or restricted | | |
| Internally restricted by Board | 606,674 | 962,135 |
| Held for loan collateral | 2,619,883 | 3,124,766 |
| Held for malpractice claims | 2,369,000 | 2,655,000 |
| Held for trustee for insolvency fund | 100,000 | 100,000 |
| Total assets whose use is limited or restricted | 5,695,557 | 6,841,901 |
| Investments | 81,655,403 | - |
| Capital assets - net | 159,539,640 | 140,562,216 |
| Other assets | 3,909,101 | 3,767,910 |
| Total assets | $ 541,916,911 | $ 546,539,268 |
| **Deferred outflow of resources** | | |
| Deferred outflows on pension (Note 8) | $ 22,780,568 | $ 9,535,512 |
| Deferred outflows on OPEB (Note 9) | 5,946,366 | 5,088,139 |
| Total deferred outflow of resources | $ 28,726,934 | $ 14,623,651 |
| **Liabilities and Net Position** | | |
| Current liabilities | | |
| Accounts payable and accrued expenses | $ 28,714,414 | $ 36,012,445 |
| Accrued salaries and compensated absences | 46,923,767 | 42,486,248 |
| Deferred revenue | 2,849,500 | 6,141,900 |
| Due to third parties - current | 14,970,588 | 11,887,054 |
| Note payable - current | 76,018 | 72,680 |
| Capital lease obligations - current | - | 366,021 |
| Postemployment benefits - current | 5,459,434 | 5,635,127 |
| Pension obligation- current | 8,036,676 | 7,937,285 |
| Total current liabilities | 107,030,397 | 110,538,760 |
| Due to third parties - noncurrent | 18,778,931 | 29,809,887 |
| Post employment benefits - noncurrent | 131,670,031 | 140,895,926 |
| Note payable - noncurrent | 148,553 | 224,571 |
| Capital lease obligations - noncurrent | - | 81,358 |
| Pension obligation (Note 8) - noncurrent | 51,099,297 | 24,221,543 |
| Total liabilities | 308,727,209 | 305,772,045 |
| Deferred inflows of resources | | |
| Deferred inflows of pension (Note 8) | 3,013,040 | 11,584,814 |
| Deferred inflows of OPEB (Note 9) | 9,275,078 | 2,042,316 |
| Total deferred inflows of resources | 12,288,118 | 13,627,130 |
| Net position | | |
| Unrestricted | 85,858,489 | 97,878,392 |
| Invested in capital assets - net of related debt | 159,315,069 | 139,817,587 |
| Restricted | 4,454,960 | 4,067,765 |
| Total net position | 249,628,518 | 241,763,744 |
| Total liabilities, deferred inflows of resources, and net position | $ 570,643,845 | $ 561,162,919 |

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

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Statements of Revenue, Expenses, and Changes in Net Position
## Years Ended June 30, 2019 and 2018

| | 2019 | 2018 |
|---|---|---|
| **Operating revenue** | | |
| Net patient service revenue (net of provision for bad debts of $31,353,468 and $31,758,316 in 2019 and 2018, respectively) | $ 340,480,741 | $ 328,918,213 |
| Federal and state support (net of reserves of $0 and $7,800,000 in 2019 and 2018, respectively) | 234,261,993 | 200,068,339 |
| Other operating revenue | 109,780,339 | 120,632,545 |
| Total operating revenue | 684,523,073 | 649,619,097 |
| **Operating expenses** | | |
| Salary and benefits | 451,321,509 | 425,571,529 |
| Supplies | 72,092,010 | 73,380,245 |
| Service | 131,104,651 | 115,541,150 |
| Travel and training | 2,412,175 | 2,223,622 |
| Total service line expenses | 656,930,345 | 616,716,546 |
| **Other operating expenses** | | |
| Health Safety Net expense | 1,631,426 | 4,741,695 |
| Depreciation | 18,974,735 | 18,886,240 |
| Other expenses | - | 537,381 |
| Pension expense | 14,128,121 | 12,071,425 |
| Total operating expenses | 691,664,627 | 652,953,287 |
| (Loss) from operations | (7,141,554) | (3,334,190) |
| **Nonoperating revenue (expenses)** | | |
| Pension subsidy from City under special funding arrangement | 1,030,521 | 2,453,160 |
| Investment income | 6,432,850 | 3,717,158 |
| Interest expense | (19,078) | (70,961) |
| Tax support | 7,250,000 | 7,200,000 |
| Tax expense | (987,966) | - |
| Gain on disposal of fixed assets | 557,346 | 454,329 |
| Total nonoperating revenue - net | 14,263,673 | 13,753,686 |
| Excess of revenue over expenses | 7,122,119 | 10,419,496 |
| Other restricted donations | 742,655 | 295,963 |
| Increase in net position | 7,864,774 | 10,715,459 |
| **Net position** | | |
| Beginning of year | 241,763,744 | 231,048,285 |
| End of year | $ 249,628,518 | $ 241,763,744 |

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

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Statements of Cash Flows
## Years Ended June 30, 2019 and 2018

| | 2019 | 2018 |
|---|---|---|
| **Cash flows from operating activities** | | |
| Cash received from patients and third-party payors | $ 366,421,193 | $ 353,683,108 |
| Cash received from other governmental sources - net | 227,362,686 | 268,299,428 |
| Cash received from federal and state grants | 14,550,314 | 11,393,807 |
| Other receipts | 62,967,617 | 57,078,955 |
| Cash paid to employees for personnel services and fringe benefits | (444,202,153) | (417,536,578) |
| Cash paid for other than personnel services | (223,804,010) | (191,500,196) |
| Net cash provided by operating activities | 3,295,647 | 81,418,524 |
| **Cash flows from investing activities** | | |
| Cash provided by assets whose use is limited or restricted | 1,146,344 | 1,185,108 |
| Interest received | 5,545,142 | 3,717,158 |
| Purchase of long term investments | (99,432,567) | - |
| Redemption of long term investment | 18,389,882 | - |
| Net cash (used in) provided by investing activities | (74,351,199) | 4,902,266 |
| **Cash flows from capital and related financing activities** | | |
| Cash received for capital-net | | |
| Proceeds from the sale of fixed assets | 82,182 | 429,517 |
| Proceeds from insurance | 454,397 | - |
| Purchase of capital assets | (37,508,462) | (28,348,432) |
| Cash received for restricted gifts | 927,679 | 603,859 |
| Payments of tax expense | (658,674) | - |
| Payments on capital leases - principal | (316,502) | (523,101) |
| Payments on capital leases - interest | (7,188) | (22,130) |
| Payment of City of Cambridge bond - principal | - | (1,495,000) |
| Payment of City of Cambridge bond - interest | - | (67,500) |
| Payments on note payable of 237 Hampshire Street-principal | (72,680) | (69,487) |
| Payments on note payable of 237 Hampshire Street-interest | (11,890) | (15,081) |
| Net cash (used in) capital and related financing activities | (37,111,138) | (29,507,355) |
| **Cash flows from noncapital financing activities** | | |
| Cash appropriations received from City of Cambridge | 7,250,000 | 7,200,000 |
| Net cash provided by noncapital financing activities | 7,250,000 | 7,200,000 |
| Net increase in cash and cash equivalents | (100,916,690) | 64,013,435 |
| **Cash and cash equivalents** | | |
| Beginning of year | 318,022,676 | 254,009,241 |
| End of year | $ 217,105,986 | $ 318,022,676 |

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

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Statements of Cash Flows
## Years Ended June 30, 2019 and 2018

| | 2019 | 2018 |
|---|---|---|
| **Reconciliation of excess of revenue over expenses to net cash provided by operating activities** | | |
| (Loss) from operations | $ (7,141,554) | $ (3,334,190) |
| Adjustment to reconcile excess of revenue over expenses to net cash provided by operating activities | | |
| Release of restricted funds | (219,124) | (307,896) |
| Depreciation | 18,974,735 | 18,886,240 |
| Provision for bad debts | 31,353,468 | 31,758,316 |
| Change in assets and liabilities | | |
| (Increase) in patient accounts receivables | (30,994,539) | (35,692,169) |
| (Increase) in inventories | (1,056,166) | (361,684) |
| Decrease (increase) in other current assets | 381,872 | (2,608,301) |
| (Increase) in prepaid expenses | (851,008) | (1,376,076) |
| Decrease in due from third parties | 4,808,802 | 49,067,162 |
| (Increase) decrease in other assets | (141,191) | 376,465 |
| (Decrease) increase in accounts payable and accrued expenses | (8,181,128) | 8,633,132 |
| Increase in salaries and compensated absences | 4,437,519 | 6,086,313 |
| (Decrease) increase in due to third parties | (7,947,422) | 1,642,674 |
| (Decrease) increase in deferred revenue | (3,292,400) | 3,773,891 |
| Increase in net pension obligation | 6,190,836 | 4,974,336 |
| Increase in net OPEB obligation | (3,027,053) | (99,689) |
| Net cash provided by operating activities | $ 3,295,647 | $ 81,418,524 |
| Noncash financing activities-capital leases and financing | $ (130,877) | $ (26,943) |

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

## 1. Organization

The Cambridge Public Health Commission ("CPHC"), d/b/a Cambridge Health Alliance (the "Alliance" or "CHA"), is a public instrumentality. It was created effective July 1, 1996 (the "Effective Date") by Chapter 147 of the Acts of 1996 of the Commonwealth of Massachusetts (the "Enabling Act") as a public health care system comprising the operations and facilities of the City of Cambridge's Department of Health and Hospitals (the "Department") and Somerville Hospital.

On the Effective Date, all of the Department's cash, accounts receivable, inventory, and other personal property were transferred to the Alliance, and the Alliance assumed all of the debt and other obligations of the Department, except that bonds and notes issued by the City of Cambridge (the "City") remained general obligations of the City. The transfer of real property from the City to CPHC was effected by a 50-year lease dated as of the Effective Date. The Department was abolished on the Effective Date.

As provided in the Enabling Act, the Alliance also acquired Somerville Hospital on the Effective Date and subsequently consolidated the operations of Somerville Hospital into those of the Alliance. On July 1, 2001, CPHC acquired Whidden Memorial Hospital ("Whidden") in Everett, Massachusetts, and related assets and subsequently consolidated the operations of Whidden into those of the Alliance.

CPHC is governed by a 19-member board of trustees (the "Board"). The members of the Board are CPHC's chief executive officer who serves ex-officio and the following members who are appointed by the City Manager upon nomination by the Board: two officers or employees of the City, one member of the CPHC medical staff, and 15 members of the general public.

Although CPHC is a distinct and separate legal entity from the City, it is included as a discretely presented component unit in the basic financial statements of the City.

CPHC has the following subsidiaries:

- Somerville Hospital
- Whidden Memorial Hospital, Inc.
- Cambridge Health Alliance Physicians Organizations, Inc. ("CHAPO")
- CHA Management Services, Inc. (formerly Network Health, Inc. (formerly Cambridge Health Alliance Network Services Corporation))
- Institute for Community Health, Inc. ("ICH")
- Cambridge Health Alliance Foundation, Inc. (formerly Alliance Foundation for Community Health, Inc. changed on March 2, 2012)

The Alliance is the sole member of each of these subsidiaries as of June 30, 2019. The Alliance was one of two members of ICH until April 23, 2019 when BIDMC terminated its membership. The Alliance is a public instrumentality and all its subsidiaries are non-profit Corporations that have qualified as a tax-exempt organizations under Section 501(c)(3) of the Internal Revenue Code (the "Code").

## 2. Summary of Significant Accounting Policies

### Basis of Presentation

The financial statements of the Alliance have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America ("GAAP") as applied to government entities. The Governmental Accounting Standards Board ("GASB") is the accepted standard setting body for establishing governmental accounting and financial reporting principles. Under these standards, the Alliance is defined as a component entity.

The Alliance has adopted GASB statement No. 62*, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, which establishes guidance for applying standards included in Financial Accounting Standards Board ("FASB") and interpretations to the preparation of financial statements for proprietary fund activities. In accordance with GASB Statement No. 62, the Alliance complies with and observes all FASB statements and interpretations that were issued on or before November 30, 1989, unless they conflict with GASB pronouncements.

The Alliance has adopted Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*, effective for the year beginning after June 15, 2015, which supersedes Statement No. 55, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments* and amends Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, paragraphs 64, 74, and 82. The Statement reduces the GAAP hierarchy to two categories of authoritative GAAP and address the use of authoritative and nonauthoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP, to improve usefulness and comparability of financial statement information among state and local governments.

### Use of Estimates

The preparation of the accompanying financial statements in accordance with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates are made in the area of patient accounts receivable and accruals for settlements with third-party payors, pension expense and liability, other post employment benefits.

### Statements of Revenue, Expenses, and Changes in Net Position

In the accompanying statements of revenue, expenses, and changes in net position, transactions deemed by management to be ongoing to the provision of health care services are reported as revenue and expenses. Peripheral or incidental transactions are reported as nonoperating revenue and expenses.

### Revenue Recognition

***Fee for Service revenue***

*Governmental payers including Medicare and Medicaid:* Certain inpatient acute care services are paid at prospectively determined rates per discharge and patient day based on clinical, diagnostic or other factors. Outpatient services are paid using prospectively determined rates. Certain services are paid based on a cost reimbursement methodologies subject to certain limits.

*Other payers:* Payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Under the terms of various agreements, regulations, and statutes, certain elements of third-party reimbursement are subject to negotiation, audit, and/or final determination by third-party payors. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Variances between preliminary estimates of net patient service revenue and final third-party settlements are included in net patient service revenue in the year in which the settlement or change in estimate occurs. A portion of the amounts due to third-parties has been classified as noncurrent because such amounts, by their nature or by virtue of regulation or legislation, will not be assessed within one year. During 2019 and 2018, changes in prior-year estimates increased net patient service revenue approximately $10,807,524 and $7,867,510, respectively.

***Risk Based Revenue***
Certain patient care services are paid by governmental and commercial insurers on a risk basis. The risk payment method includes fixed capitation, medical or other services budgets, patient care delivery metrics and activities, premiums or a combination. The risk amounts are often adjusted based upon patient's health status, age, sex and other variables. Fee for service or other interim payments are paid to the Alliance until sufficient time when risk settlements can be estimated and made. The Alliance allows for these settlements by establishing reserves until final risk settlements are made. These risk reserves are estimated and establish in advance of settlements in order to allow for expected payment. Exact settlement amounts cannot be predicted and will vary from estimates.

Certain Delivery System Reform Incentive Payments ("DSRIP") Startup Funds are dedicated for primary care investment. ACOs are required to spend these funds on state-approved investments that support the ACO's primary care providers such as capital investments in primary care practices, trainings for primary care providers and support staff in population health management protocols, administrative staff to support front-line providers with clinical quality initiatives. Other DSRIP Startup Funds may be used by the ACO for other discrete state approved investments. Some examples of investment opportunities for ACOs include, but are not limited to: health information technology, contracting/network development, project management, and care coordination/management investment, assessments for members with identified long term service and support needs, workforce capacity development and new or expanded telemedicine capability. The Alliance accounts for its DSRIP funding as Federal and State support revenue on the statements of revenue, expenses and changes in net position.

DSRIP DSTI Glide Path funding for safety net hospital systems are made to make safety net providers more sustainable and aligned with value-based care delivery and payment incentives as they transition from traditional safety net funding. The Alliance accounts for its Glide Path funding as Federal and State Support revenue on the statements of revenue, expenses and changes in net position.

***Other Revenue***
The Alliance records revenue from capitated contracts, retail pharmacy operations, 340B contracted pharmacy arrangements, grants and other service contracts as other revenue.

***Capitation Contracts***
The Alliance has various capitation contracts with Medicaid, Medicare and other Commercial payers with various reimbursement arrangements including reimbursement based on a per-member-per month basis, shared risk, and limited risk, which are presented in other operating revenues. The Alliance recognized revenue related to the Elder Service Programs which includes both Medicare and Medicaid capitation contracts of $40,545,181 and $35,730,658 in 2019 and 2018, respectively.

**Functional Expenses**
Substantially, all expenses in the accompanying statements of revenue, expenses, and changes in net position are related to the delivery of health care services.

**Tax Support**
The Alliance receives tax support from the City whereby the Alliance provides specified health services under an agreement which extended until fiscal year 2024. The annual payment amount is subject to appropriation by the City Council.

**Cash and Cash Equivalents**
Cash and cash equivalents include unrestricted investments in highly liquid debt instruments with a remaining maturity of three months or less at the date of purchase.

**Inventories**
Inventories are stated at the lower of cost or market using the first-in, first-out method.

**Other Current Assets**
Other current assets consist of miscellaneous receivables and grant receivables and interest receivable.

**Assets Whose Use is Limited or Restricted**
Assets whose use is limited or restricted include assets set aside by the Board for future use by the psychiatry department, over which the Board retains control and may, at its discretion, subsequently use for other purposes. Assets whose use is limited or restricted also include collateral for letters of credit, malpractice claims, and the Elder Services Program insolvency fund which is restricted by the Commonwealth of Massachusetts (“Commonwealth”).

**Investments and Investment Income**
Investments are recorded at fair value in the accompanying statements of net position. Fair value is based on quoted market prices. Realized gains and losses on the sales of investments are determined by use of average cost. Declines in fair value that are judged to be other than temporary are reported as realized losses. There are no realized losses in fiscal year 2019. Investment income is recorded as earned.

**Capital Assets**
Capital assets are stated at cost, less accumulated depreciation. Donated capital assets are recorded at fair market value at date of donation, which is then treated as cost. Assets are depreciated on a straight-line basis over their estimated useful lives.

Capital lease assets and any related leasehold improvements are depreciated on a straight-line basis over the estimated useful life of the leased property or equipment if ownership of the property or equipment transfers by the end of the lease term, or the lease contains a bargain purchase option. Otherwise, they are depreciated over the shorter of the remaining lease term or estimated useful life of the leased property or equipment.

Leasehold improvements for property under operating leases are depreciated on a straight-line basis over the shorter of the remaining lease term or the estimated useful life of the assets.

The Alliance's policy is to capitalize assets with a cost of at least $2,500, and a useful life of at least two years.

Estimated useful lives of capital assets are determined based upon guidelines established by the American Hospital Association. The estimated useful lives of capital assets are as follows:

| | **Years** |
|---|---|
| Land improvements | 2 - 25 |
| Building and improvements | 5 - 40 |
| Major movable equipment | 3 - 20 |
| Fixed equipment | 5 - 25 |

The Alliance has adopted GASB No. 89, Accounting for Interest Costs Incurred before the end of a Construction Period in fiscal year 2018. The Alliance expenses interest costs as incurred.

**Income Taxes**
The Alliance is exempt from taxation pursuant to the Enabling Act and from federal taxation because it is a public instrumentality performing an essential governmental function.

The Internal Revenue Service ("IRS") has determined that Somerville Hospital, Whidden, CHAPO, CHA Management Services, Inc., ICH, and Cambridge Health Alliance Foundation, Inc. are exempt from federal income taxation because they are organizations described in Section 501(c)(3) of the Code. The IRS has further determined that none of these entities is a private foundation because each is a supporting organization described in Section 509(a)(3) of the Code. Somerville Hospital was an organization described in Section 509(a)(1) of the Code until July 25, 2013 when the IRS issued an updated determination letter classifying Somerville Hospital as a supporting organization described in Section 509(a)(3) of the Code.

The Tax Cuts and Jobs Act of 2017 ("TCJA") extended Unrelated Business Income Tax ("UBIT") to certain employee fringe benefits. The Alliance has recorded an expense of $987,966 for fiscal year 2019.

**Recent Accounting Pronouncements**

***New Accounting Pronouncements***

In January 2016, the GASB issued Statement No. 80, *Blending Requirements for Certain Component Units—an amendment of GASB Statement No. 14*. The objective of this Statement is to improve financial reporting by clarifying the financial statement presentation requirements for certain component units. This Statement amends the blending requirements established in paragraph 53 of Statement No. 14, The Financial Reporting Entity, as amended. for blending The application of this statement is effective for reporting periods beginning after June 15, 2016. The Alliance has adopted the statement in fiscal year 2018, and meets the requirement for blending under the earlier guidance. There was no impact to the financial statements or footnotes.

In March 2016, the GASB issued Statement No. 82, *Pension Issues*. The objective of this Statement is to address issues that have been raised with respect to Statements No. 67, Financial Reporting for Pensions and No. 73 Accounting and Financial Reporting for Pensions and Related Assets that are not within the Scope of GASB Statement 68, and Amendments to Certain Provision of GASB Statements 67 and 68. This statement amends Statements 67 and 68 to instead require the presentation of covered payroll, defined as the payroll on which contributions to a pension plan are based, and ratios that use that measure. The application of this statement is effective reporting periods beginning after June 15, 2016. The Alliance has adopted the statement in fiscal year 2018, and there was no impact to the financial statements or footnotes.

In June 2015, the GASB issued GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. GASB No. 75 addresses accounting and financial reporting for other postemployment plans that are provided to the employees of state and local governmental employers. This Statement establishes standards for recognizing and measuring liabilities, deferred outflows of resources, deferred inflows of resources, and expense. GASB No. 75 is effective for fiscal years beginning after June 15, 2017. The Alliance has adopted the statement in fiscal year 2018.

In March 2016, the GASB issued Statement No. 81, *Irrevocable Split-Interest Agreements*. The objective of this Statement is to improve accounting and financial reporting for irrevocable splitinterest agreements by providing recognition and measurement guidance for situations in which a government is a beneficiary of the agreement. The application of this statement is effective reporting periods beginning after December 15, 2016. The Alliance has evaluated this statement in fiscal year 2018 and there is no impact to the financial statements.

In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities*. The objective of this Statement is to clarify when a government has a fiduciary responsibility and is required to present fiduciary fund financial statements. The application of this statement is effective reporting periods beginning after December 15, 2018. The Alliance is currently evaluating the impact GASB No. 84 will have on its basic financial statements.

In March 2017, the GASB issued Statement No. 85, *Omnibus*. The objective of this Statement is to clarify multiple pronouncements. The application of this statement is effective reporting periods beginning after June 15, 2017. The Alliance has adopted the statement in fiscal year 2018, and there was no impact to the financial statements or footnotes.

In June 2017, the GASB issued Statement No. 87, *Leases.* The objective of this Statement is to require all leases to be accounted for as a liability and right to use lease asset. The application of this statement is effective reporting periods beginning after December 15, 2019. The Alliance is currently evaluating the impact GASB No. 87 will have on its basic financial statements.

In April 2018, the GASB issued Statement No. 88, *Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements*. The objective of this Statement is to improve consistency and provide additional disclosures in notes to financial statements related to debt, including direct borrowings and direct placements. The applications of this statement is effective for reporting periods beginning after June 15, 2018. The Alliance has adopted the statement in fiscal year 2019, and included related disclosures in Note 7.

In June 2018, the GASB issued Statement No. 89, *Accounting for Interest costs incurred before the end of a construction period*. This Statement simplifies the accounting for interest costs related to construction, and improves the comparability of information related to capital assets and costs of borrowing for a reporting period. The Alliance has adopted GASB No. 89 in fiscal year 2018, and there was no impact to the financial statements.

In August 2018, the GASB issued Statement No. 90, *Majority Equity Interests* – (Amendment of GASB Statement No. 14 and GASB Statement No. 61. This Statement aims to improve the consistency and comparability of reporting a government's majority equity interest in a legally separate organization and related financial statement information of component units. This Statement is effective for periods beginning after December 15, 2018. The Alliance is currently evaluating the impact GASB No. 90 will have on its financial statements and footnotes.

In May 2019, the GASB issued Statement No.91, *Conduit Debt Obligations*. This statement provides for a single method of reporting conduit debt obligations by issuers and eliminates diversity in practice associated with (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures. This Statement is effective for periods beginning after December 15, 2020. The Alliance has adopted the statement in fiscal year 2019, and there was no impact to the financial statements or footnotes.

## 3. Deposits and Investments

Investments are composed primarily of Massachusetts Municipal Depository Trust funds ("MMDT"), and money market funds.

The Treasurer of the Commonwealth of Massachusetts overseas the financial management of MMDT, a local investment pool for cities, towns, and other state and local agencies. The Cash Portfolio adheres to GASB Statement No. 79 (GASB 79), "*Certain External Investment Pools and Pool Participants*," which amends Statement No. 31 and establishes accounting and financial reporting standards for state and local governments that participate in a qualifying external investment pool that measures for financial reporting purposes all of its investments at amortized cost. MMDT is reported at amortized cost which approximates the net asset value of $1.00 per share. MMDT has a maturity of less than 1 year and is not rated. The Alliance's balance at MMDT as of June 30, 2019 and 2018 was $156,577,575 and $192,613,796, respectively. Amounts held at MMDT Cash Portfolio have no limitations or restrictions on withdrawal.

The Alliance categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation of inputs used to measure the fair value of the asset. Level 1 inputs are quoted prices in active markets for identical assets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs.

The Alliance has Level 1 inputs of money market funds valued at the daily closing price as reported by the fund. The Alliance held balances in a Commercial Money Market of $44,162,779 and $126,209,767 at June 30, 2019 and 2018, respectively. The Alliance's balance in a separate Money Market Fund at June 30, 2019 and 2018 is $1,430,942 and $1,390,832, respectively.

In 2019 The Alliance entered into an agreement with the investment management. The Alliance maintains investment balances as of June 30, 2019 in the amount of $101,012,222, of which, $19,356,618 is reported in Cash and cash equivalents and $81,655,403 is reported in Investments on the Statements of Net Position. Investments consist of US Treasury Notes, Agencies, Commercial Paper, and Money Markets. The primary objective of the Alliance's investment portfolio shall be the preservation of the real value of capital, liquidity that meets our needs, and as good a total return on investments as is consistent with the level of risk assumed.

As of June 30, 2019 and 2018, the carrying amount of the Alliance's bank deposits were $204,013,499 and $324,864,577, respectively, and the bank balances totaled $211,677,779 and $327,107,106, respectively. The amount insured through the Federal Depository Insurance Corporation as of June 30, 2019 and 2018 amounted to $839,754 and $1,097,401, respectively. Outstanding checks largely account for the difference between the bank balance and the carrying amount of deposits.

The Alliance's operating cash balances at June 30, 2019 and 2018 was $8,847,952 and $6,381,665, respectively. The Alliance monitors the credit worthiness of this institution and has not experienced any losses associated with deposits.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is 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 financial statements.

Custodial credit risk is the risk that in the event of bank failure, the Alliance's deposits may not be returned to the Alliance. The Alliance does not have a deposit policy for custodial credit risk.

Fixed income securities are subject to credit risk, which is the chance that a bond issuer will fail to pay interest or principal in a timely manner, or that negative perceptions of the issuer's ability to make these payments will cause security prices to decline. These circumstances may arise due to a variety of factors such as financial weakness, bankruptcy, litigation, and/or adverse political developments. Certain fixed income securities, primarily obligations of the U.S. government or those explicitly guaranteed by the U.S. government, are not considered to have significant credit risk.

The Alliance's investment policy, which in management's belief is in compliance with the Commonwealth statutes, authorizes the Alliance's treasurer to invest in the following:

| Investment Type | Moody's or Standard and Poor's Rating | Maximum Maturity |
|---|---|---|
| Money market mutual funds, | AA or better | |
| U.S. Treasury obligations, | | |
| Federal agencies and U.S. government-sponsored enterprises | | |
| Commonwealth of Massachusetts obligations | A or better | |
| Certificates of deposit | AA or better | 1 year |
| Repurchase agreements | A or better | |
| Bankers' acceptances eligible for purchase by the Federal Reserve | A or better | |
| Commercial paper | A1 or better | 270 days |
| Debt instruments, including corporate bonds | AA or better | 1 year |
| Asset-backed securities | AAA | 18 months |

It is the Alliance's policy to limit its investments in corporate bonds and commercial paper to the ratings noted above. As of June 30, 2019 and 2018, all investments met these requirements. The Alliance has no limit on the amount that they may invest in any one issuer.

As of June 30, 2019 and 2018, the Alliance had the following cash and investments:

| | | Fair Value | |
|---|---|---|---|
| | Maturities | 2019 | 2018 |
| Operating cash | Current | $ 1,273,429 | $ 4,650,182 |
| U.S. Agencies | July 2020 - June 2021 | 13,433,752 | - |
| U.S. Agencies | July 2021 - June 2022 | 1,671,327 | - |
| U.S. Agencies | July 2022 - June 2023 | 4,094,809 | - |
| U.S. Treasury Notes | July 2019 - June 2020 | 20,034,800 | - |
| U.S. Treasury Notes | July 2020 - April 2021 | 42,383,860 | - |
| Corporate Fixed Income | July 2019 - Feb 2020 | 18,824,900 | - |
| Investment in money market funds | Current | 46,162,494 | 127,600,599 |
| Investment in Massachusetts Municipal Depository Trust | Current | 156,577,575 | 192,613,796 |
| Total operating cash, cash equivalents, assets whose use is limited or restricted, and investments | | $ 304,456,946 | $ 324,864,577 |

These investments are recorded in the statements of net position as of June 30, 2019 and 2018, under the following captions:

| | 2019 | 2018 |
|---|---|---|
| Cash and cash equivalents | $ 217,105,986 | $ 318,022,676 |
| Investments | 81,655,403 | - |
| Assets whose use is limited or restricted | | |
| Internally by board | 606,674 | 962,135 |
| Held for loan collateral | | |
| Sentry letter of credit | 1,370,000 | 1,500,000 |
| 350 Main lease letter of credit | 875,000 | 875,000 |
| Assembly Square lease letter of credit | 374,883 | 749,766 |
| Total Assets whose use is limited or restricted | 3,226,557 | 4,086,901 |
| Held for malpractice claims | 2,369,000 | 2,655,000 |
| Held by trustee for insolvency fund | 100,000 | 100,000 |
| Total operating cash, cash equivalents, assets whose use is limited or restricted, and investments | $ 304,456,946 | $ 324,864,577 |

Fixed income investments as of June 20, 2019 were rated by Standard and Poor's and/or an equivalent national rating organization. These ratings are presented below using Standard and Poor's rating scale:

| | 2019 | 2018 |
|---|---|---|
| Operating cash | $ 1,273,429 | $ 4,650,182 |
| U.S. Agencies | 19,199,888 | - |
| U.S. Treasury Notes | 62,418,660 | - |
| Corporate Fixed Income | 18,824,900 | - |
| Investment in money market funds | 46,162,494 | 127,600,599 |
| Investment in Massachusetts Municipal Depository Trust | 156,577,575 | 192,613,796 |
| | $ 304,456,946 | $ 324,864,577 |

## 4. Charity Care

The Alliance provides charity care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Alliance does not pursue collections of amounts determined to qualify as charity care, they are not reported as revenue. The amount of foregone charges was $27,448,072 and $36,480,469 for the years ended June 30, 2019 and 2018, respectively. The equivalent percentage of charity care to all patients served was approximately 3.0% and 4.2% of total patient service charges for the years ended June 30, 2019 and 2018, respectively. The Alliance has recognized revenues of approximately $0 and $11,000,000 in fiscal years 2019 and 2018, for reimbursement from the Commonwealth related to Health Safety Net ("HSN"), respectively. This amount is included as federal and state support in the statements of revenue, expenses, and changes in net position. The Alliance made payments to HSN in 2019 and 2018 in the amount of $1,631,426 and $4,741,695, respectively, which is

included in other operating expenses in the accompanying statements of revenue, expenses, and changes in net position.

Services rendered to Medicaid patients are reimbursed at less than cost, which the Alliance considers partial charity care. These charity care amounts were approximately $32,497,094 and $49,953,415 for the years ended June 30, 2019 and 2018, respectively.

## 5. Patient Service Revenue and Related Reimbursement and Accounts Receivable

Patient service revenue is reported net of allowances for contractual adjustments and bad debts for the years ended June 30, 2019 and 2018, as follows:

| | 2019 | 2018 |
|---|---|---|
| Gross patient service revenue (excluding charity care of $27,448,072 and $36,480,469 in 2019 and 2018, respectively) | $ 875,593,133 | $ 834,335,855 |
| Less: Allowances for | | |
| Contractual adjustments | 503,758,924 | 473,659,326 |
| Bad debts | 31,353,468 | 31,758,316 |
| Net patient service revenue | $ 340,480,741 | $ 328,918,213 |

The Alliance's net patient accounts receivable and gross patient revenue from patients and third party payors as of and for the years ended June 30, 2019 and 2018, were as follows:

| | 2019 | | 2018 | |
|---|---|---|---|---|
| | Net Patient Receivables | Gross Patient Revenue | Net Patient Receivables | Gross Patient Revenue |
| Medicare | 18 % | 24 % | 17 % | 25 % |
| Medicaid | 41 | 40 | 50 | 37 |
| Blue cross | 8 | 10 | 8 | 9 |
| Commercial insurance | 6 | 7 | 5 | 4 |
| Patients (self-pay and HSN) | 7 | 5 | 3 | 5 |
| Other | 20 | 14 | 17 | 20 |
| | 100 % | 100 % | 100 % | 100 % |

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with laws and regulations can be subject to future government review and interpretation as well as significant regulatory action. Failure to comply with such laws and regulations can result in fines, penalties, and exclusion from the Medicare and Medicaid programs. The Alliance believes it is in compliance with all applicable laws and regulations.

The Alliance grants credit to patients, substantially all of whom are local residents. The Alliance generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, health maintenance organizations, and commercial insurance policies). As of June 30, 2019 and 2018, the Alliance had receivables from the Commonwealth (Medicaid) of $3,335,543 and $5,172,012, respectively.

## 6. Capital Assets

Capital assets as of June 30, 2019 and 2018, are composed of the following:

| | June 30, 2018 | Additions | Transfer | Disposals | June 30, 2019 |
|---|---|---|---|---|---|
| **Capital assets not being depreciated** | | | | | |
| Land | $ 12,000,965 | $ - | $ - | $ - | $ 12,000,965 |
| Construction in progress | 9,523,833 | 38,062,268 | (23,830,645) | | 23,755,456 |
| Total capital assets-not being depreciated | 21,524,798 | 38,062,268 | (23,830,645) | - | 35,756,421 |
| **Capital assets-being depreciated** | | | | | |
| Land improvements | 2,982,078 | - | 144,988 | - | 3,127,066 |
| Building and improvements | 253,090,045 | - | 7,846,768 | - | 260,936,813 |
| Major moveable equipment | 143,114,221 | - | 11,375,572 | (4,295,871) | 150,193,922 |
| Fixed equipment | 109,856,902 | - | 4,463,317 | - | 114,320,219 |
| Property under capital leases | 4,109,946 | - | - | (566,429) | 3,543,517 |
| Equipments under capital leases | 6,322,500 | - | - | - | 6,322,500 |
| Total capital assets-being depreciated | 519,475,692 | - | 23,830,645 | (4,862,300) | 538,444,037 |
| Less: Accumulated depreciation for | | | | | |
| Land improvements | 1,698,258 | 143,847 | - | - | 1,842,105 |
| Building and improvements | 174,580,031 | 9,455,678 | - | - | 184,035,709 |
| Major moveable equipment | 125,505,771 | 6,015,825 | - | (4,280,431) | 127,241,165 |
| Fixed equipment | 89,022,810 | 2,931,216 | - | - | 91,954,026 |
| Property under capital leases | 5,145,731 | 115,533 | (1,245,987) | (471,760) | 3,543,517 |
| Equipment under capital leases | 4,485,673 | 312,636 | 1,245,987 | - | 6,044,296 |
| Total accumulated depreciation | 400,438,274 | 18,974,735 | - | (4,752,191) | 414,660,818 |
| Total capital assets-being depreciated - net | 119,037,418 | (18,974,735) | 23,830,645 | (110,109) | 123,783,219 |
| Capital assets - net | $ 140,562,216 | $ 19,087,533 | $ - | $ (110,109) | $ 159,539,640 |

| | June 30, 2017 | Additions | Transfer | Disposals | June 30, 2018 |
|---|---|---|---|---|---|
| **Capital assets not being depreciated** | | | | | |
| Land | $ 7,199,945 | $ 4,801,020 | $ - | $ - | $ 12,000,965 |
| Construction in progress | 4,765,737 | 23,441,412 | (18,683,316) | - | 9,523,833 |
| Total capital assets-not being depreciated | 11,965,682 | 28,242,432 | (18,683,316) | - | 21,524,798 |
| **Capital assets-being depreciated** | | | | | |
| Land improvements | 2,848,689 | - | 133,389 | - | 2,982,078 |
| Building and improvements | 244,602,328 | - | 9,066,330 | (578,613) | 253,090,045 |
| Major moveable equipment | 137,817,183 | - | 6,387,141 | (1,090,103) | 143,114,221 |
| Fixed equipment | 106,760,446 | - | 3,096,456 | - | 109,856,902 |
| Property under capital leases | 4,109,946 | - | - | - | 4,109,946 |
| Equipments under capital leases | 6,573,861 | - | - | (251,361) | 6,322,500 |
| Total capital assets-being depreciated | 502,712,453 | - | 18,683,316 | (1,920,077) | 519,475,692 |
| Less: Accumulated depreciation for | | | | | |
| Land improvements | 1,559,943 | 138,315 | - | - | 1,698,258 |
| Building and improvements | 165,595,494 | 9,563,150 | - | (578,613) | 174,580,031 |
| Major moveable equipment | 120,768,149 | 5,825,594 | - | (1,087,972) | 125,505,771 |
| Fixed equipment | 86,267,425 | 2,755,385 | - | - | 89,022,810 |
| Property under capital leases | 4,793,296 | 603,796 | - | (251,361) | 5,145,731 |
| Equipment under capital leases | 4,485,673 | - | - | - | 4,485,673 |
| Total accumulated depreciation | 383,469,980 | 18,886,240 | - | (1,917,946) | 400,438,274 |
| Total capital assets-being depreciated - net | 119,242,473 | (18,886,240) | 18,683,316 | (2,131) | 119,037,418 |
| Capital assets - net | $ 131,208,155 | $ 9,356,192 | $ - | $ (2,131) | $ 140,562,216 |

Depreciation expense relating to capital assets amounted to $18,974,735 and $18,886,240 for the years ended June 30, 2019 and 2018, respectively.

## 7. Long-Term Debt

### Note Payable

The Alliance's outstanding notes form direct borrowings related to business-type activities of $224,571 at June 30, 2019 are related to the purchase of a condominium at 237 Hampshire Street in Cambridge, the location of the Cambridge Family Health practice. The condominium was purchased in 2012 for $850,000 with $680,000 financed through a note payable to the seller. The note is amortized over 10 years through May 2022 with monthly payments of $7,047 and an interest rate of 4.5%. The Note includes a provision that in an event of default, the entire unpaid balance of the note and any unpaid interest will become due immediately.

Financing as of June 30, 2019 and 2018 consists of the following:

| | 2019 | 2018 |
|---|---|---|
| Note payable for 237 Hampshire Street Purchase | $ 224,571 | $ 297,251 |
| Less: Current portion | 76,018 | 72,680 |
| Noncurrent portion | $ 148,553 | $ 224,571 |

**Maturities of Notes Payable**

| Years Ending June 30, 2019 | Principal Payments | Interest Payments | Total Payments |
|---|---|---|---|
| 2020 | $ 76,018 | $ 8,551 | $ 84,569 |
| 2021 | 79,511 | 5,058 | 84,569 |
| 2022 | 69,042 | 1,432 | 70,474 |
| | | | - |
| **Balance at June 30, 2019** | $ 224,571 | $ 15,041 | $ 239,612 |

Financing activity for the years ended June 30, 2019 and 2018 were as follows:

| | Beginning Balance | Increases | Decreases | Ending Balance | Due Within One Year |
|---|---|---|---|---|---|
| **2019** | | | | | |
| Note payable - 237 Hampshire Street | $ 297,251 | $ - | $ (72,680) | $ 224,571 | $ 76,018 |

| | Beginning Balance | Increases | Decreases | Ending Balance | Due Within One Year |
|---|---|---|---|---|---|
| **2018** | | | | | |
| Note payable - 237 Hampshire Street | $ 366,738 | $ - | $ (69,487) | $ 297,251 | $ 72,680 |

**Leases**

The Alliance currently has no capital lease obligations. A schedule of future minimum lease payments, including interest, as of June 30, 2019, under capital and operating lease obligations is as follows:

| Years Ending June 30, 2019 | Operating Leases |
|---|---|
| 2020 | $ 8,467,516 |
| 2021 | 7,592,682 |
| 2022 | 7,810,077 |
| 2023 | 7,470,724 |
| 2024 | 5,295,067 |
| 2025 | 4,550,756 |
| 2026 | 2,806,181 |
| 2027 | 1,628,411 |
| 2028 | 145,178 |
| 2029 | - |
| | $ 45,766,592 |

Capital lease activity, excluding interest, for the years ended June 30, 2019 and 2018, were as follows:

| | Beginning Balance | Increases | Decreases | Ending Balance | Due Within One Year |
|---|---|---|---|---|---|
| **2019** | | | | | |
| Capital lease obligations | $ 447,379 | $ - | $ (447,379) | $ - | $ - |

| | Beginning Balance | Increases | Decreases | Ending Balance | Due Within One Year |
|---|---|---|---|---|---|
| **2018** | | | | | |
| Capital lease obligations | $ 997,423 | $ - | $ (550,044) | $ 447,379 | $ 366,021 |

Leases that do not meet the criteria for capitalization are classified as operating leases with rentals expensed straight line over the term of the lease. The Alliance leases office space under several operating lease arrangements. Rent expense amounted to $9,330,116 and $8,333,493 for the years ended June 30, 2019 and 2018, respectively.

## 8. Retirement Plans

The Cambridge Hospital participates in the City of Cambridge Retirement System, a defined benefit contributory pension plan.The Alliance reported under GASB 68 for the years ending June 30, 2019 and 2018. GASB 68 establishes standards for measuring and recognizing liabilities, deferred outflows of resources, deferred inflows of resources, and expense. For defined benefit pensions, GASB 68 identifies the methods and assumptions that should be used to project benefit payments, discount projected benefit payments to their actuarial present value, and attribute that present value to periods of employee service. GASB 68 requires the liability of employers to employees for defined benefit plans (Net Pension Liability ("NPL") or Net Pension Asset ("NPA")) to be measured as the portion of the present value of projected benefit payments to be provided through the pension plan to current active and inactive employees that is attributed to those employees' past periods of service (Total Pension Liability ("TPL")), less the amount of the pension plan's fiduciary net position. Prior to implementing GASB 68, employers participating in cost-sharing plans with a special funding arrangement recognized annual pension expense equal to their contractually required contribution to the plan. Upon the adoption of GASB 68, employers participating in cost-sharing plans with a special funding arrangement recognize their proportionate share of the collective pension amounts for all benefits provided through the plan based on an allocation methodology. In addition, pension expense and revenues are adjusted to reflect amounts recognized by nonemployer contributing entities for pensions provided through the pension plan.

### Plan Description

The City contributes to the Cambridge Retirement System ("System"), a cost sharing, multiple-employer public employee retirement system that acts as the investment and administrative agent for the City, the Alliance, Cambridge Redevelopment Authority and Cambridge Housing Authority. The System provides retirement, disability, and death benefits to plan members and beneficiaries.

Pursuant to Section 6(g) of Chapter 147 of the Acts of Massachusetts and the Administrative Service Agreement between the City and CHA dated May 6, 1997, the City is statutorily and contractually required to fund a portion of CHA's employer contribution to the System. Fiscal year 1997 pension expense serves as the base annual amount due from the Alliance, and increases or

decreases in an amount equal to the percentage increase or decrease in the Cambridge Retirement System funding schedule approved by the Commonwealth of Massachusetts' Public Employee Retirement Administration Commission.

Accordingly, a special funding situation as defined by GASB Statement No. 68 exists and the City is treated as a nonemployer contributing entity relative to the portion of the contribution it makes on behalf of CHA. As such, the City records in its financial statements the net pension liability and deferred outflows and inflows of resources related to this nonemployer contribution, and the Alliance has disclosed these amounts in the footnote.

The System is a member of the Massachusetts Contributory System which is governed by Chapter 32 of the Massachusetts General Laws.

Employees covered by the Contributory Retirement Law are classified into one of four groups depending on job classification.

**Benefits Provided**
For employees hired prior to April 2, 2012, the annual amount of retirement allowance is based on the member's final three-year average salary multiplied by the number of years and full months of creditable service at the time of retirement and multiplied by a percentage according to the age of the member at retirement.

*A* member's final three-year average salary is defined as the greater of the highest consecutive three-year average annual rate of regular compensation and the average annual rate of regular compensation received during the last three years of creditable service prior to retirement.

For employees hired on April 2, 2012 or later, the annual amount of the retirement allowance is based on the member's final five-year average salary multiplied by the number of years and full months of creditable service at the time of retirement and multiplied by a percentage according to the age and years of creditable service of the member at retirement.

A member's final five-year average salary is defined as the greater of the highest consecutive five-year average annual rate of regular compensation and the average annual rate of regular compensation received during the last five years of creditable service prior to retirement.

The maximum annual amount of retirement allowance is 80 percent of the member's final average salary. Any member who is a veteran also receives an additional yearly retirement allowance of $15 per year of creditable service, not exceeding $300. The veteran allowance is paid in addition to the 80 percent maximum.

Employees are eligible for service-related disability benefits regardless of length of service. Ten years of creditable service is required for nonservice related disability benefits. The death benefit is the amount of the employee's contributions or if the employee was eligible to retire, the surviving spouse benefit is based on retirement at the date of death.

**Plan Membership**
At December 31, 2018, plan membership consisted of:

| | |
|---|---|
| Retired participants and beneficiaries receiving benefits | 2,019 |
| Inactive participants entitled to a return of their employee contributions | 728 |
| Inactive participants with a vested right to a deferred or immediate benefit | 126 |
| Active plan members | 3,019 |
| Total | 5,892 |

**Contributions**
Plan members are required to contribute a percentage of their regular gross compensation to the System, depending on their employment date.

| Date of Hire | Contribution Rate |
|---|---|
| Prior to January 1, 1975 | 5 % |
| January 1, 1975 - December 31, 1983 | 7 % |
| January 1, 1984 - June 30, 1996 | 8 % |
| July 1, 1996 onward | 9 % |

In addition, employees hired after December 31, 1978 contribute an additional 2 percent of salary in excess of $30,000.

For fiscal years 2019 and 2018, the City made contributions to the plan on behalf of CHA in the amount of $2,849,585 and $3,827,252, respectively.

The Commonwealth reimburses the System for a portion of the benefit payments for cost-of-living increases granted before July 1998. The contributions of plan members and the participating employers are governed by Chapter 32 of the Massachusetts General Laws.

**Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions**
At June 30, 2019 and 2018, the Alliance reported a liability for its proportionate share of the net pension liability. The City also subsidizes a share of the net pension liability for the Alliance.

| | 2019 | 2018 |
|---|---|---|
| Alliance's proportionate share of the net pension liability | $ 59,135,973 | $ 32,158,828 |
| City's proportionate share of the net pension liability associated with the Alliance | 21,230,557 | 17,158,570 |
| | $ 80,366,530 | $ 49,317,398 |

| | 2019 | 2018 |
|---|---|---|
| Current and noncurrent liabilities as of June 30, 2019 and 2018 | | |
| Current liabilities | $ 8,036,676 | $ 7,937,285 |
| Noncurrent liabilities | 51,099,297 | 24,221,543 |
| Alliance's proportionate share of the net pension liability | $ 59,135,973 | $ 32,158,828 |

Proportionate Share of Net Pension Liabilities, Pension Expense and Deferred Outflows of Resources Related to Pensions

At June 30, 2019, the Alliance reported a liability of $59,135,973 for its proportionate share of the System's net pension liability measured as of December 31, 2018, and based on an actuarial valuation as of January 1, 2018. The proportion of the System's net pension liability was based on required contributions to the System relative to the required contributions of all participating employers. Additionally, the City reported a proportionate share of the net pension liability related to the special funding situation with the Alliance in an amount of $21,230,557.

To determine employers' proportionate share of the net pension liability, allocations of net pension liability were performed. At December 31, 2018, the Alliance was allocated 18.51% (17.70% in the prior year) of the net pension liability. Additionally, the City was allocated 6.65% (9.44% in the prior year) related to the special funding situation with the Alliance based on the proportion of the required employer contributions.

For the years ended June 30, 2019 and 2018, the Alliance recognized pension expense of $14,128,121 and $12,071,425, respectively. At June 30, 2019 and 2018, the Alliance reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

| | 2019 | |
|---|---|---|
| | Deferred Outflows of Resources | Deferred Inflows of Resources |
| Difference between expected and actual experience | $ 847,373 | $ 2,706,398 |
| Changes of assumptions | 6,933,321 | - |
| Changes in proportion and differences between employer contributions and proportionate share of contribution | 1,373,652 | 306,642 |
| Net difference between projected and actual investment earnings on pension plan investments | 13,626,222 | - |
| | $ 22,780,568 | $ 3,013,040 |

| | 2018 | |
|---|---|---|
| | **Deferred Outflows of Resources** | **Deferred Inflows of Resources** |
| Difference between expected and actual experience | $ - | $ 3,449,476 |
| Changes of assumptions | 9,400,473 | - |
| Changes in proportion and differences between employer contributions and proportionate share of contribution | 135,039 | 351,370 |
| Net difference between projected and actual investment earnings on pension plan investments | - | 7,783,968 |
| | $ 9,535,512 | $ 11,584,814 |

Deferred outflows (inflows) net will be recognized in pension expense as follows:

| **Year Ended June 30,** | |
|---|---|
| 2020 | $ 7,330,136 |
| 2021 | 2,269,857 |
| 2022 | 2,519,497 |
| 2023 | 7,226,590 |
| 2024 | 421,448 |
| | $ 19,767,528 |

For fiscal years 2019 and 2018, the City recognized pension expense on behalf of CHA in the amount of $1,030,521 and $2,453,160, respectively. At June 30, 2019 and 2018, the City reported deferred outflows of resources and deferred inflows of resources related to CHA's pension from the following sources:

| | 2019 | |
|---|---|---|
| | **Deferred Outflows of Resources** | **Deferred Inflows of Resources** |
| Difference between expected and actual experience | $ 304,218 | $ 971,630 |
| Changes of assumptions | 2,489,149 | - |
| Changes in proportion and differences between employer contributions and proportionate share of contribution | - | 8,836,112 |
| Net difference between projected and actual investment earnings on pension plan investments | 4,891,985 | - |
| | $ 7,685,352 | $ 9,807,742 |

| | 2018 | |
|---|---|---|
| | Deferred Outflows of Resources | Deferred Inflows of Resources |
| Difference between expected and actual experience | $ - | $ 1,840,492 |
| Changes of assumptions | 5,015,689 | - |
| Changes in proportion and differences between employer contributions and proportionate share of contribution | - | 7,035,447 |
| Net difference between projected and actual investment earnings on pension plan investments | - | 4,153,191 |
| | $ 5,015,689 | $ 13,029,130 |

The City will recognize the deferred inflows in pension expense as follows:

| Year Ended June 30, | |
|---|---|
| 2020 | $ (194,507) |
| 2021 | (1,044,081) |
| 2022 | (954,453) |
| 2023 | 908,196 |
| 2024 | (837,545) |
| | $ (2,122,390) |

**Actuarial Assumptions**

The total pension liability as of December 31, 2019 and 2018 was based on actuarial valuation as of January 1, 2018, using the following actuarial assumptions, applied to all periods included in the measurement period:

| | 2019 | 2018 |
|---|---|---|
| Investment rate of return | 7.50 % | 7.50 % |
| Discount rate | 7.50 % | 7.50 % |
| Inflation rate | 3.50 % | 3.50 % |
| Projected salary increases | 4.50 % | 4.50 % |
| Cost of living adjustments | 3.00% of first $16,000 of retirement income | 3.00% of first $16,000 of retirement income |
| Pre-retirement | RP-2014 Blue Collar Employee Mortality Table set forward one year for females projected generationally with scale MP-2017 | RP-2014 Blue Collar Employee Mortality Table set forward one year for females projected generationally with scale MP-2017 |
| Healthy retiree | RP-2014 Blue Collar Healthy Annuitant Mortality Table set forward one year for females projected generationally with scale MP-2017 | RP-2014 Blue Collar Healthy Annuitant Mortality Table set forward one year for females projected generationally with scale MP-2017 |
| Disabled retiree | RP-2014 Blue Collar Healthy Annuitant Mortality Table set forward one year projected generationally with scale MP-2017 | RP-2014 Blue Collar Healthy Annuitant Mortality Table set forward one year projected generationally with scale MP-2017 |

The long-term expected rate of return on pension plan investments was determined using the building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. Best estimates of arithmetic real rates of return for each major asset class included in the pension plan's target asset allocation as of December 31, 2018 and 2017 are summarized in the following table:

| | December 31, 2018 | | December 31, 2017 | |
|---|---|---|---|---|
| **Asset Class** | **Target Asset Allocations** | **Long Term Expected Real Rate of Return** | **Target Asset Allocations** | **Long Term Expected Real Rate of Return** |
| Cash | 0.0 % | 0.0 % | 0.0 % | 1.06 % |
| Domestic equity | 25.0 % | 6.16 % | 26.0 % | 6.15 % |
| International developed markets equity | 9.0 % | 6.69 % | 9.0 % | 7.11 % |
| International emerging markets equity | 10.0 % | 9.47 % | 10.0 % | 9.41 % |
| Core fixed income | 15.0 % | 1.89 % | 10.0 % | 1.68 % |
| High-yield fixed income | 8.0 % | 4.00 % | 13.0 % | 4.13 % |
| Real estate | 10.0 % | 4.58 % | 10.0 % | 4.90 % |
| Commodities | 2.5 % | 4.77 % | 5.0 % | 4.71 % |
| Hedge fund, GTAA, Risk parity | 9.0 % | 3.68 % | 9.0 % | 3.94 % |
| Private equity | 11.5 % | 10.00 % | 8.0 % | 10.28 % |

**Discount Rate**

The discount rate used to measure the total pension liability was 7.50% as of December 31, 2018 and 2017. The projection of cash flows used to determine the discount rate assumed plan member contributions will be made at the current contribution rate and that the System contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

*Sensitivity of the Alliance's proportionate share of the net pension liability to changes in the discount rate.*

The following presents the Alliance's proportionate share of the net pension liability calculated using the discount rate of 7.50% as of December 31, 2019 and 2018, as well as what the Alliance's share of the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate:

| **June 30, 2019** | **1% Decrease 6.50%** | **Discount Rate 7.50%** | **1% Increase 8.50%** |
|---|---|---|---|
| Alliance's proportionate share of the net pension liability | $ 92,571,572 | $ 59,135,973 | $ 31,018,472 |

| **June 30, 2018** | **1% Decrease 6.50%** | **Discount Rate 7.50%** | **1% Increase 8.50%** |
|---|---|---|---|
| Alliance's proportionate share of the net pension liability | $ 62,746,380 | $ 32,158,829 | $ 6,467,256 |

**Pension Plan Fiduciary Net Position**

The System is on a calendar fiscal year, and therefore financial information of the System is as of and for the year ended December 31, 2018. The System issues stand alone financal statements, and is also included in the City's fiduciary fund financial statements. Complete financial statements for the System for its year ended December 31, 2018 are available from its offices on 100 Cambridgepark Drive, Suite 101, Cambridge, MA 02140.

**Basis of Accounting**
The System's financial statements are prepared using the full accrual basis of accounting. Plan member contributions are recognized in the period in which the contributions are due. Employer contributions to the plan are recognized when due and the employer has made a legal commitment to provide the contributions. Benefits and refunds are recognized when due and payable in accordance with the terms of each plan.

Cash and cash equivalents are considered to be cash on deposit, and highly liquid short-term investments with original maturities of three months or less from the date of acquisition.

Investments of the System are stated at fair value determined as follows:

(i) Fixed income securities are stated at quoted market value.

(ii) Equity securities are stated at quoted market value.

(iii) Real estate funds are stated at net asset value.

(iv) Venture capital funds are stated at net asset value.

(v) International investments are stated at quoted market value and are included in equities and fixed income categories.

(vi) Alternative investments are stated at net asset value.

**Somerville Hospital and Whidden Memorial Hospital**
***Plan Description***
Effective January 1, 1987, Somerville Hospital established the Partnership Plan (the "Plan"), a defined contribution plan qualified under Section 403(b) of the IRS code. On July 1, 2001, the Alliance purchased Whidden Memorial Hospital and these employees became eligible to participate in the Plan. The Plan is a deferred salary savings plan available to employees of Somerville Hospital and Whidden Memorial Hospitals. The Plan was amended and restated effective January 1, 2009 and then amended effective July 1, 2009, January 1, 2010, October 1, 2011, November 11, 2011, December 4, 2011, January 1, 2013, and further amended effective November 1, 2013.

***Contributions***
Under the Plan, Participants may contribute up to 85% of gross salary to the Plan, not to exceed annual limitations set by the IRS. The Alliance does make contributions to the Plan for employees with two or more years of service and who are in a position with weekly budgeted and scheduled hours of 20 or more or who are in a position with weekly budgeted and scheduled hours of less than 20 hours who work more than a 1,000 hours for each of those two years. The Alliance may make two types of contributions, a matching and a nonelective ("core") contribution. These employer contributions are calculated on a bi-weekly basis for Participants eligible to receive the Employer contributions. The Alliance makes matching contributions equal to 1% of the Participant's gross compensation for every 1% voluntarily contributed up to 2% of gross compensation unless otherwise specified in a collective bargaining agreement. The Alliance makes a 2% nonelective ("core") contribution of the Participant's gross compensation whether or not the employee makes a voluntary contribution. All contributions to the Plan are fully vested at the time of contribution. The Alliance contributed approximately $5,681,078 and $5,261,337 for the

years ended June 30, 2019 and 2018, respectively. Plan members contributed approximately $12,326,770 and $11,236,710 for the years ended June 30, 2019 and 2018, respectively.

**The Cambridge Health Alliance Physicians Organization, Inc.**

***Plan Description***

CHAPO sponsors the CHAPO 403(b) Plan, a tax-sheltered annuity plan effective January 1, 1996, and amended the Plan effective October 1, 2007 All employees are eligible to participate in the Plan.

***Contributions***

Employees may elect to defer a portion of their compensation to the Plan, not to exceed annual limitations set by the IRS. For employees who make voluntary contributions to the Plan CHAPO makes matching contributions of 1/3 of 1% of the participant's annual compensation for every 1% voluntarily contributed up to 6% of annual compensation for any participant actively employed during the Plan year for a maximum of 2% matching contribution. In addition, CHAPO will make a Core Contribution of 2% of employees' annual salary (subject to federal tax limits) whether or not employees choose to voluntarily contribute to the Plan. Employees are 100% vested in the employer match and core contribution after two years of service. For vesting purposes employees must work a minimum of 1,000 hours in the plan calendar year. The Alliance contributed $3,159,709 and $3,054,895 to the CHAPO 403(b) plan for the years ended June 30, 2019 and 2018, respectively. Plan members contributed $6,309,999 and $6,273,334 to the CHAPO 403(b) plan for the years ended June 30, 2019 and 2018, respectively.

## 9. Post Employment Benefit Plan

The Cambridge Health Alliance administers the OPEB plan, a single-employer OPEB plan that is used to provide postemployment benefits other than pension for all eligible employees. Management of the OPEB plan is governed by Cambridge Health Alliance. No assets are accumulated in a trust that meets the criteria in paragraph 4 of Statement 75.

All retired employees of The Cambridge Hospital are eligible for pension benefits and receive certain postretirement benefits, including healthcare, dental, and life insurance under Chapter 32 of the Massachusetts General Laws. These benefits are administered by the Cambridge Public Health Commission. Standalone financial statements are not issued for this program.

**Benefits Provided**

The Alliance funds a portion of health insurance costs and life insurance premiums, with the remainder paid by the retirees.

For employees that retired prior to August 31, 2010, health insurance premiums are 90% paid by the Alliance, Medex III insurance premiums are 96% paid by the Alliance, and Medicare Part B premiums are 99% reimbursed by the Alliance. The schedule below shows the monthly retiree contributions for health insurance:

| Monthly Retiree Contribution | Retirement prior to September 1, 2010 | Retirement after September 1, 2010 |
|---|---|---|
| CHA Choice plans | | |
| Individual | 88.33 | 441.66 |
| Family | 231.43 | 1,157.15 |
| CHA Option plans | | |
| Individual | 62.27 | 311.36 |
| Family | 163.26 | 816.29 |
| Medicare advantage plans | 31.70 | 158.50 |
| Medicare supplemental plans | | |
| Medex3 | 7.50 | Not Applicable |
| Managed blue for seniors | 46.57 | Not Applicable |

Changes to the Plan were made and adopted as of June 30, 2010 and were effective for employees that retired after August 31, 2010. The changes included: increasing retiree contributions to 50% of the premium for health benefits, eliminating Medex III; and eliminating reimbursement of Medicare Part B premiums. These changes resulted in an overall reduction of the Alliance's post-employment benefit liability.

Effective July 1, 2017, Cambridge Health Alliance consolidated its nonMedicare medical plans to two options administered by Harvard Pilgrim. Projected costs have been adjusted to reflect this change. Unions notified prior to December 31, 2016 had this plan change reflected in the 2017 fiscal year expense while all participants had this plan change reflected in the 2018 fiscal year expense.

**Plan Membership**
At December 31, 2018, plan membership consisted of:

| | |
|---|---|
| Inactive plan members and beneficiaries receiving benefits | 682 |
| Active plan members | 549 |
| | 1,231 |

**Total OPEB Liability**
The Alliance's total OPEB liability as of June 30, 2019 of $137,129,465 was measured as of December 31, 2018. The Alliance's total OPEB liability as of June 30, 2018 of $146,531,053 was measured as of December 31, 2016. The actuarial valuation as of December 31, 2018 was used for both measurement dates.

**Actuarial Assumptions**

The total OPEB liability as of June 30, 2019 and 2018 were determined using the following actuarial assumptions and other inputs.

| | |
|---|---|
| Discount rate | 3.78% as of December 31, 2016<br>3.44% as of December 31, 2017<br>4.10% as of December 31, 2018 |
| Inflation rate | 3.5% |
| Health care trend rates | 7.0% decreasing by 0.25% for 10 years to an ultimate level of 4.5% per year |
| Mortality rates | |
| Pre-retirement | RP-2014 Blue Collar Employee Mortality Table set forward one year for female participants projected generationally using Scale MP-2017 |
| Healthy retiree | RP-2014 Blue Collar Healthy Annuitant Employee Mortality Table set forward one year for female participants projected generationally using Scale MP-2017 |
| Disabled retiree | RP-2014 Blue Collar Healthy Annuitant Employee Mortality Table set forward one year projected generationally using Scale MP-2017 |

The discount rate is based on the 20-year tax exempt General Obligation Municipal bond index rates.

Effective July 1, 2017 the Alliance consolidated the nonMedicare medical plans to two options administered by Harvard Pilgrim. Projected costs were adjusted to reflect this change. Unions notified prior to December 31, 2016 had this plan change reflected in the 2018 fiscal year expense while all participants had this plan change reflected in the 2018 fiscal year expense. The 2017 expense reflects changes that were agreed with collective bargaining units prior to December 31, 2016. The 2018 expense reflects the changes for all participants.

**Changes in the Total OPEB Liability**

| | 2019 | 2018 |
|---|---|---|
| **Total OPEB liability at beginning of the year** | $ 146,531,053 | $ 140,473,327 |
| Changes for the year | | |
| Service cost | 2,407,237 | 2,359,058 |
| Interest | 5,029,613 | 5,297,437 |
| Differences between expected and actual experience | (7,558,286) | - |
| Changes of assumptions | (3,795,972) | 6,836,640 |
| Changes of benefit terms | - | (3,058,295) |
| Benefit payments | (5,484,180) | (5,377,114) |
| Net change in total OPEB liability | (9,401,588) | 6,057,726 |
| **Total OPEB liability at end of year** | $ 137,129,465 | $ 146,531,053 |

Changes of assumptions reflect the change in discount rate, current health cost experience, medical and prescription drug trend assumptions, excise tax on high health plans, enrollment for current retirees, and mortality assumptions.

*Sensitivity of the total OPEB liability to changes in the discount rate.* The following presents the total OPEB liability of the Alliance, and the total OPEB liability if it had been calculated using a discount rate that is 1 percent higher or 1 percent lower than the current rate of 4.10% at December 31, 2018 and 3.44% at December 31, 2017.

| | 1% Decrease | Discount Rate | 1% Increase |
|---|---|---|---|
| **December 31, 2018** | | | |
| Total OPEB liability | $ 157,195,091 | $ 137,129,465 | $ 120,712,612 |
| Discount rate | 3.10 % | 4.10 % | 5.10 % |
| **December 31, 2017** | | | |
| Total OPEB liability | $ 169,417,440 | $ 146,531,053 | $ 128,027,999 |
| Discount rate | 2.44 % | 3.44 % | 4.44 % |

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rate. The following presents the total OPEB liability of the Alliance, and the total OPEB liability if it had been calculated using a health care cost trend rate that is 1 percent higher or 1 percent lower than the current rates.

| | 1% Decrease | Health care cost trend rate | 1% Increase |
|---|---|---|---|
| **December 31, 2018** | | | |
| Total OPEB liability | $ 120,025,961 | $ 137,129,465 | $ 158,175,930 |
| **December 31, 2017** | | | |
| Total OPEB liability | $ 126,038,426 | $ 146,531,053 | $ 172,229,310 |

The Alliance recognized OPEB expense of $5,063,855 for the year ended June 30, 2019 and OPEB expense of $5,277,425 for the year ended June 30, 2018.

The Alliance reported Deferred Outflows of Resources and Deferred Inflows of Resources related to OPEB as follows:

| | 2019 | |
|---|---|---|
| | Deferred Outflows of Resources | Deferred Inflows of Resources |
| Changes of assumptions | $ 3,339,638 | $ 3,748,589 |
| Differences between expected and actual experience | - | 5,526,489 |
| Employer contributions after measurement date | 2,606,728 | - |
| | $ 5,946,366 | $ 9,275,078 |

| | 2018 | |
|---|---|---|
| | Deferred Outflows of Resources | Deferred Inflows of Resources |
| Changes of assumptions | $ 5,088,139 | $ 2,042,316 |

Amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

| Year Ended June 30, | |
|---|---|
| 2020 | $ 329,969 |
| 2021 | (1,461,083) |
| 2022 | (2,197,598) |
| 2023 | - |
| 2024 | - |
| | $ (3,328,712) |

## 10. Risk Management

**Malpractice Insurance**
The Alliance and its employees have malpractice insurance coverage through a claims-made basis insurance policy with per-claim limits of $5 million. As of June 30, 2019 and 2018, management believes there are no asserted or unasserted claims that would have a material adverse effect on the Alliance's financial position.

The Alliance is protected as a public employer as defined in Section 1 of Chapter 258 of the Massachusetts General Laws, which limits liability to a maximum of $100,000 per claim in all matters except actions relating to federal/civil rights, eminent domain, and breach of contract.

**Litigation**
Various claims, generally and reasonably expected from normal business, are known or not yet known but reasonably expected to be asserted against the Alliance and its interests, employees, and volunteers. The Alliance will defend vigorously claims that it believes have no merit. While the ultimate financial impact of such liability, if any, arising from any such claim is presently indeterminable, it is management's opinion that the ultimate resolution of known claims or reasonably expected claims will not have a material adverse impact on the financial statements of the Alliance.

In addition, the health care industry, as a whole, is subject to numerous laws, regulations, and standards and expectations of federal, state, and local governments. Compliance with these can be subject to future governmental review and interpretation, as well as regulatory actions unknown or unasserted at this time. Such compliance in the health care industry has recently come under increased governmental scrutiny which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenue from patient services. Management does not believe that these matters will have a material adverse effect on Alliance's financial statements. Furthermore, Alliance's management realizes that such fines and penalties would not be covered by commercial insurance.

**Workers' Compensation Insurance**

The Alliance is insured for workers' compensation in a shared risk plan administered by Sentry Insurance. The insurance is structured to share the risk, so that the Alliance directly incurs and funds the cost of each claim, subject to a per-claim stop-loss limit of $350,000, and an annual $4,530,000 aggregate stop-loss for claims in the year ended June 30, 2019. This aggregate annual stop loss will be $4,826,100 for the year ending June 30, 2020. This stop-loss is provided by Sentry Insurance, and the Alliance has pledged $1.5 million of its investments as collateral to a letter of credit related to this policy as of June 30, 2019 and 2018. As of June 30, 2019, management believes there are no asserted or unasserted claims that would have a material adverse effect on the Alliance's financial statements. The Alliance's cost of workers' compensation benefits for fiscal 2019 and 2018 was $1,632,208 and $1,265,726 and is included in salary and benefits expenses in the accompanying statements of revenue, expenses, and changes in net position, respectively.

## 11. Subsequent Events

Subsequent events have been evaluated through October 31, 2019, the date the financial statements were available to be issued. No additional events have been identified which would require adjustment to the financial statements or disclosure in the notes to the financial statements.

# Required Supplementary Information

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Required Supplementary Information
## Schedules of the Alliance's Proportionate Share of the Net Pension Liability
## (Unaudited)
## June 30, 2019 and 2018

| *(Dollar amounts in thousands)* | 2019 | 2018 | 2017 | 2016 |
|---|---|---|---|---|
| Alliance's proportion of the net pension liability | 18.51 % | 17.70 % | 17.70 % | 17.93 % |
| Alliance's proportionate share of the net pension liability | $ 59,136 | $ 32,159 | $ 41,894 | $ 48,849 |
| City's proportionate share of the net pension liability associated with the alliance | 21,231 | 17,159 | 27,892 | 34,767 |
| | $ 80,367 | $ 49,318 | $ 69,786 | $ 83,616 |
| Alliance's covered-employee payroll | $ 58,263 | $ 62,068 | $ 65,140 | $ 69,046 |
| Alliance's proportionate share of the net pension liability as a percentage of its covered-employee payroll | 101.50 % | 51.81 % | 64.31 % | 72.20 % |
| Plan fiduciary net position as a percentage of the total pension liability | 79.89 % | 88.02 % | 83.08 % | 79.60 % |

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Required Supplementary Information
## Schedule of the Alliance's Contributions (Unaudited)
## June 30, 2019 and 2018

| *(Dollar amounts in thousands)* | 2019 | 2018 | 2017 | 2016 |
|---|---|---|---|---|
| Contractually required contribution | $ 7,937 | $ 7,173 | $ 7,034 | $ 6,734 |
| Contribution in relation to the contractually required contribution | (7,937) | (7,173) | (7,034) | (6,734) |
| Contribution deficiency (excess) | $ - | $ - | $ - | $ - |
| Alliance's covered-employee payroll | $ 58,263 | $ 62,068 | $ 65,140 | $ 69,046 |
| Contributions as a percentage of covered-employee payroll | 13.62% | 11.56% | 10.80% | 9.75% |

# Cambridge Health Alliance
**(A component unit of the City of Cambridge, Massachusetts)**
## Required Supplementary Information
## Schedule of Changes in the Alliance's Total OPEB Liability and Related Ratios
## (Unaudited)
## Year Ended June 30, 2019 and 2018

| *(Dollar amounts in thousands)* | 2019 | 2018 | 2017 |
|---|---|---|---|
| **Total OPEB Liability** | | | |
| Service cost | $ 2,407 | $ 2,359 | $ 2,394 |
| Interest | 5,030 | 5,297 | 5,081 |
| Differences between expected and actual experience | (7,558) | | |
| Changes of assumptions | (3,796) | 6,837 | (4,180) |
| Changes of benefit terms | - | (3,058) | (217) |
| Benefit payments | (5,484) | (5,377) | (5,083) |
| Net change in total OPEB liability | (9,401) | 6,058 | (2,005) |
| Total OPEB liability - beginning | 146,531 | 140,473 | 142,478 |
| Total OPEB liability - ending | $ 137,130 | $ 146,531 | $ 140,473 |
| Covered-employee payroll | $ 59,070 | $ 60,880 | $ 65,220 |
| Total OPEB liability as a percent of covered-employee payroll | 232.15% | 240.69% | 215.38% |

**Notes to Schedule:**

| | | |
|---|---|---|
| Changes of assumption. | Changes of asumptions reflets the effects of changes in the discount rate each period. | |
| | The following are the discount rates used each period: | |
| | 2019 (Measurement date 12/31/2018) | 4.10 % |
| | 2018 (Measurement date 12/31/2017) | 3.44 % |

# Schedule of Expenditures of Federal Awards

# Cambridge Health Alliance
## (A Component Unit of the City of Cambridge, Massachusetts)
## Schedule of Expenditures of Federal Awards
## Year Ended June 30, 2019

| Federal Grantor/Pass-Through Grantor/Program or Cluster title | CFDA Number | Direct | Pass-Through | Pass-Through Awards Entity | Pass-Through Entity Award Number | Total Expenditures | Passed to Sub-Recipients |
|---|---|---|---|---|---|---|---|
| **Research and Development Cluster** | | | | | | | |
| **Direct Programs** | | | | | | | |
| **U.S. Department of Health and Human Services ("HHS")** | | | | | | | |
| National Institutes of Health | | | | | | | |
| Research and Training in Complementary and Integrative Health | 93.213 | $ 196,170 | $ - | | | $ 196,170 | $ - |
| Minority Health and Health Disparities Research | 93.307 | 74,099 | - | | | 74,099 | - |
| Cancer Cause and Prevention Research | 93.393 | 12,723 | - | | | 12,723 | - |
| Substance Abuse and Mental Health Services Administration | | | | | | | |
| Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances ("SED") | 93.104 | 728,536 | - | | | 728,536 | - |
| Total HHS Direct Research Programs | | 1,011,528 | - | | | 1,011,528 | - |
| **Pass-Through Programs** | | | | | | | |
| **HHS** | | | | | | | |
| Agency for Healthcare Research and Quality | | | | | | | |
| Research on Healthcare Costs, Quality and Outcomes | 93.226 | - | 23,164 | The General Hospital Corporation | R01HS024725 | 23,164 | - |
| Research on Healthcare Costs, Quality and Outcomes | 93.226 | - | 2,927 | University of Southern California | 111075441 | 2,927 | - |
| 93.226 Total | | | 26,091 | | | 26,091 | |
| Centers for Disease Control and Prevention | | | | | | | |
| Injury Prevention and Control Research and State and Community Based Programs | 93.136 | - | 129,059 | The University of South Florida Board of Trustees | 5820-1303-00-A | 129,059 | - |
| Health Program for Toxic Substances and Disease Registry | 93.161 | - | 37,052 | Boston Children's Hospital | 5U61TS000237-05 | 37,052 | - |
| Health Resources and Services Administration | | | | | | | |
| National Research Service Award in Primary Care Medicine | 93.186 | - | 67,816 | Beth Israel Deaconess | 4T32HP327150101 | 67,816 | - |
| Indian Health Service | | | | | | | |
| Demonstration Projects for Indian Health | 93.933 | - | 94,890 | The Healing Lodge of the Seven Nations | U261IHS0090-03-01 | 94,890 | - |
| National Institutes of Health | | | | | | | |
| Research and Training in Complementary and Integrative Health | 93.213 | - | 247,347 | Brown University | 5UH2AT009145-03 | 247,347 | - |
| Research and Training in Complementary and Integrative Health | 93.213 | - | 105,623 | Massachusetts General Hospital | 1P01AT009965-01 | 105,623 | - |
| 93.213 Total | | - | 352,970 | | | 352,970 | - |
| Drug Abuse and Addiction Research Programs | 93.279 | - | 66,175 | Dartmouth College | R34DA040086-C3 | 66,175 | - |
| Minority Health and Health Disparities Research | 93.307 | - | 30,992 | Boston Medical Center | 1R01MD010527-01 | 30,992 | - |
| Minority Health and Health Disparities Research | 93.307 | - | 134,634 | Massachusetts General Hospital | 1R01MD010456-01A1 | 134,634 | - |
| 93.307 Total | | - | 165,626 | | | 165,626 | - |
| National Center for Advancing Translational Sciences | 93.350 | - | 16,550 | Harvard University | UL1TR001102 | 16,550 | - |
| Biomedical Research and Research Training | 93.859 | - | 174,591 | The Healing Lodge of the Seven Nations | 1S06GM128015.01 | 174,591 | - |
| Child Health and Human Development Extramural Research | 93.865 | - | 409,592 | Partners Mclean Hospital Corp | 5R01HD79484-02 | 409,592 | - |
| Total HHS Pass-Through Research Programs | | - | 1,540,412 | | | 1,540,412 | - |
| **U.S. Department of Homeland Security** | | | | | | | |
| Federal Emergency Management Agency | | | | | | | |
| Assistant To Firefighters Grant | 97.044 | - | 58,649 | Skidmore College | EMW-2017-FP-00445 | 58,649 | - |
| Total Research and Development Cluster | | $ 1,011,528 | $ 1,599,061 | | | $ 2,610,589 | $ - |

The accompanying notes are an integral part of this schedule of federal awards.

# Cambridge Health Alliance
## (A Component Unit of the City of Cambridge, Massachusetts)
## Schedule of Expenditures of Federal Awards
## Year Ended June 30, 2019

| Federal Grantor/Pass-Through Grantor/Program or Cluster title | CFDA Number | Direct | Pass-Through | Pass-Through Awards Entity | Pass-Through Entity Award Number | Total Expenditures | Passed to Sub-Recipients |
|---|---|---|---|---|---|---|---|
| **Other Programs** | | | | | | | |
| **Direct Programs** | | | | | | | |
| **HHS** | | | | | | | |
| Health Resources and Services Administration | | | | | | | |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | $ 69,366 | $ - | | | $ 69,366 | $ - |
| Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease | 93.918 | 506,156 | - | | | 506,156 | - |
| Mental and Behavioral Health Education and Training Grants | 93.732 | 139,383 | - | | | 139,383 | - |
| **Pass-Through Programs** | | | | | | | |
| **HHS** | | | | | | | |
| Administration for Children and Families | | | | | | | |
| Affordable Care Act (ACA) Personal Responsibility Education Program | 93.092 | - | 108,000 | Massachusetts Department of Public Health | INTF3212M03170722018 | 108,000 | - |
| Refugee and Entrant Assistance State Administered Programs | 93.566 | - | 10,109 | Massachusetts Department of Public Health | INTF5189MM3501623086111 | 10,109 | - |
| Centers for Disease Control and Prevention | | | | | | | |
| Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs | 93.919 | - | 156,000 | Institute for Health and Recovery | ASTWH170062-01-00 | 156,000 | - |
| Public Health Emergency Preparedness | 93.069 | - | 551,859 | Massachusetts Department of Public Health | INTF6208PP1171226155 | 551,859 | 151,849 |
| Hospital Preparedness Program and Public Health Emergency Preparedness Aligned Cooperative Agreement | 93.074 | - | 766 | Massachusetts Department of Public Health | INTF6208PP1171226155 | 766 | - |
| Prevention Health And Health Services Block Grant Funded Solely With Prevention And Public Health Funds | 93.758 | - | 60,000 | Massachusetts Department of Public Health | INTF4200PP1502925081 | 60,000 | - |
| HIV Prevention Activities Health Department Based | 93.940 | - | 90,527 | Massachusetts Department of Public Health | INTF4944MM3181926011 | 90,527 | - |
| Harnessing Electronic Health Records to Enhance Reporting to the Vaccine Adverse Event Reporting System (VAERS) | 93.U01 | - | 26,642 | Harvard Pilgrim Health Care, Inc. | 200-2016-91779/75D30118F00001 | 26,642 | - |
| Health Resources and Services Administration | | | | | | | |
| Coordinated Services and Access to Research for Women, Infants, Children, and Youth | 93.153 | - | 120,017 | Dimock Community Health Center, Inc. | BQ1958 | 120,017 | - |
| HIV Emergency Relief Project Grants | 93.914 | - | 308,866 | Boston Public Health Commission | FY19016034A | 308,866 | - |
| Immed Office of the Secretary of Health and Human Services | | | | | | | |
| Advancing System Improvements for Key Issues in Women's Health | 93.088 | - | 15,000 | Institute for Health and Recovery | ASTWH170062-01-00 | 15,000 | - |
| Teenage Pregnancy Prevention Program | 93.297 | - | 1,900 | Massachusetts Alliance on Teen Pregnancy | 1TP1AH000085-01-00 | 1,900 | - |
| National Bioterrorism Hospital Preparedness Program | 93.069 | - | 207,290 | Massachusetts Department of Public Health | INTF6206PP1171226155 | 207,290 | - |
| National Bioterrorism Hospital Preparedness Program | 93.889 | - | 304,910 | Massachusetts Department of Public Health | INTF6208PP1171226155 | 304,910 | - |
| Office of Population Affairs | | | | | | | |
| Family Planning-Services | 93.217 | - | 221,662 | Action for Boston Community Development | 68120 | 221,662 | - |
| Substance Abuse and Mental Health Services Administration | | | | | | | |
| Opioid STR | 93.788 | - | 144,675 | Massachusetts Department of Public Health | INTF4944MM3181926011 | 144,675 | - |
| Block Grants for Prevention and Treatment of Substance Abuse | 93.959 | - | 20,000 | City of Somerville | 160189 | 20,000 | - |
| Block Grants for Prevention and Treatment of Substance Abuse | 93.959 | - | 20,000 | City of Somerville | INTF2354M04160222078 | 20,000 | - |
| Block Grants for Prevention and Treatment of Substance Abuse | 93.959 | - | 100,000 | Department of Public Health | INTF2354M04301822070 | 100,000 | 18,500 |
| Block Grants for Prevention and Treatment of Substance Abuse | 93.959 | - | 8,164 | Massachusetts Department of Public Health | INTF2351M03183626035 | 8,164 | - |
| 93.959 Total | | $ - | $ 148,164 | | | $ 148,164 | $ 18,500 |

The accompanying notes are an integral part of this schedule of federal awards.

# Cambridge Health Alliance
## (A Component Unit of the City of Cambridge, Massachusetts)
## Schedule of Expenditures of Federal Awards
## Year Ended June 30, 2019

| Federal Grantor/Pass-Through Grantor/Program or Cluster title | CFDA Number | Direct | Pass-Through | Pass-Through Awards Entity | Pass-Through Entity Award Number | Total Expenditures | Passed to Sub-Recipients |
|---|---|---|---|---|---|---|---|
| **Other Programs** | | | | | | | |
| **Pass-Through Programs** | | | | | | | |
| **HHS** | | | | | | | |
| Substance Abuse and Mental Health Services Administration | | | | | | | |
| Block Grants for Community Mental Service | 93.958 | $ - | $ 101,424 | Massachusetts Department of Public Health | SCDMH622001863920001111 | $ 101,424 | $ - |
| Grants for Primary Care Training & Enhancement | 93.884 | - | 15,000 | Center for Primary Care Harvard Medical School | 152688.5107867.0216 | 15,000 | - |
| Grants for Primary Care Training & Enhancement | 93.884 | - | 18,836 | Harvard University | 152688.5110810.0323 | 18,836 | - |
| Grants for Primary Care Training & Enhancement | 93.884 | - | 11,623 | Harvard University | 152688.5112142.0314 | 11,623 | - |
| 93.884 Total | | - | 45,459 | | | 45,459 | - |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | - | 17,859 | Gavin Foundation Inc. | TI-16-008 | 17,859 | - |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | - | 45,910 | Institute for Health and Recovery | 1H79SP021130-01 | 45,910 | - |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | - | 54,432 | Institute for Health and Recovery | 3H79 SP021130-04 | 54,432 | - |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | - | 24,895 | Justice Resources Institute, INC | 1U79SM063179-01 | 24,895 | - |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | - | 85,000 | Massahusetts Department of Public Health | INTF2354M04W50091131 | 85,000 | - |
| Substance Abuse and Mental Health Services Projects of Regional and National Significance | 93.243 | - | 26,846 | Wayside Youth & Family Support Network | Not Available | 26,846 | - |
| 93.243 Total | | - | 254,942 | | | 254,942 | - |
| Total HHS Other Programs | | 714,905 | 2,878,212 | | | 3,593,117 | 170,349 |
| **U.S. Department of Justice** | | | | | | | |
| **Pass-Through Programs** | | | | | | | |
| Office of Justice Programs | | | | | | | |
| Criminal and Juvenile Justice and Mental Health and Collaboration Program | 16.745 | - | 32,200 | City of Cambridge | 7903 | 32,200 | - |
| Crime Victim Assistance | 16.575 | - | 177,413 | Massahusetts Office for Victim Assistance | VOCA2019CAMBVRC00000 | 177,413 | - |
| Crime Victim Assistance | 16.575 | - | 271,631 | Massahusetts Office for Victim Assistance | VOCA2019CAMBHB000000 | 271,631 | - |
| 16.575 Total | | - | 449,044 | | | 449,044 | - |
| Total U.S. Department of Justice | | - | 481,244 | | | 481,244 | - |
| **U.S. Department of Agriculture** | | | | | | | |
| **Pass-Through Programs** | | | | | | | |
| Food and Nutrition Services | | | | | | | |
| WIC Special Supplemental Nutrition Program for Women, Infants, and Children | 10.557 | - | 537,065 | Massachusetts Department of Public Health | INTF3502M03162726127 | 537,065 | - |
| WIC Grants To States (WGS) | 10.578 | - | 1,179 | Massachusetts Department of Public Health | INTF3502M03162726127 | 1,179 | - |
| Total U.S. Department of Agriculture | | - | 538,244 | | | 538,244 | - |
| **U.S. Department of Homeland Security** | | | | | | | |
| **Pass-Through Programs** | | | | | | | |
| Federal Emergency Management Agency | | | | | | | |
| Disaster Grants - Public Assistance (Presidentially Declared Disasters) | 97.036 | - | 184,453 | Massachusetts Emergency Management Agency | CTFEMA4379CMBHA00231 | 184,453 | - |
| Total U.S. Department of Homeland Security | | - | 184,453 | | | 184,453 | - |
| **Health Center Cluster** | | | | | | | |
| **Pass-Through Programs** | | | | | | | |
| **U.S. Department of Health and Human Services** | | | | | | | |
| Health Resources and Services Administration | | | | | | | |
| Health Center Program | 93.224 | - | 123,644 | Boston Healthcare for the Homeless | CSH100901-02-1 | 123,644 | - |
| Total Health Center Cluster | | - | 123,644 | | | 123,644 | - |
| **CDBG - Entitlement Grants Cluster** | | | | | | | |
| **Pass-Through Programs** | | | | | | | |
| **U.S. Department of Housing and Urban Development** | | | | | | | |
| Assistant Secretary for Community Planning and Development | | | | | | | |
| Community Development Block Grant/Entitlement Grants | 14.218 | - | 4,000 | City of Somerville | 160183 | 4,000 | - |
| Total CDBG-Entitlement Grants Cluster | | - | 4,000 | | | 4,000 | - |
| Total Federal Expenditures | | $ 1,726,433 | $ 5,808,858 | | | $ 7,535,291 | $ 170,349 |

The accompanying notes are an integral part of this schedule of federal awards.

# Cambridge Health Alliance
**(A Component Unit of the City of Cambridge, Massachusetts)**
## Notes to Schedule of Expenditures of Federal Awards
## Year Ended June 30, 2019

### 1. Basis of Presentation

The accompanying Schedule of Expenditures of Federal Awards (the "Schedule") includes the expenditures of Cambridge Health Commission d/b/a Cambridge Health Alliance (the "Alliance") under programs of the federal government for the year ended June 30, 2019. Expenditures reported in the Schedule are reported on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of the Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic combined financial statements of the Alliance. CFDA numbers and pass-through numbers are provided when available. The Schedule includes adjustments made to amounts reported in prior years in the normal course of business.

For purposes of the Schedule, federal awards include all grants, contracts and similar agreements entered into directly by the Alliance with agencies and departments of the federal government and all subawards to the Alliance by nonfederal organizations pursuant to federal grants, contracts and similar agreements.

### 2. Indirect Cost Rate

The Alliance applies its predetermined approved facilities and administrative rate when charging indirect costs to federal awards rather than the 10% de minimis cost rate as described in Section 200.414 of the Uniform Guidance.

### 3. Women, Infants and Children (CFDA Number 10.557)

The food vouchers for which the Alliance was awarded amounted to $1,244,350 for the year ended June 30, 2019. Of this amount, the Alliance determines participant eligibility for receipt of food vouchers and presented $537,065 in the schedule of expenditures of federal awards for the Special Supplemental Nutrition Program for Women, Infants and Children grant as of June 30, 2019.

# Part II
# Reports on Internal Control and Compliance

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

To the Board of Trustees of
The Cambridge Public Health Commission d/b/a Cambridge Health Alliance

We have audited, 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, the financial statements of Cambridge Public Health Commission d/b/a Cambridge Health Alliance (the "Alliance"), a component unit of the City of Cambridge, Massachusetts, which comprise the statement of net position as of June 30, 2019 and the related statements of revenue, expenses and changes in net position and of cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated October 31, 2019.

**Internal Control Over Financial Reporting**

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

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

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

**Compliance and Other Matters**

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

**Purpose of this Report**

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
October 31, 2019

**Report of Independent Auditors on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance with the Uniform Guidance**

To the Board of Trustees of
The Cambridge Public Health Commission d/b/a Cambridge Health Alliance

**Report on Compliance for Each Major Federal Program**

We have audited Cambridge Public Health Commission's d/b/a Cambridge Health Alliance (the "Alliance"), a component unit of the City of Cambridge, Massachusetts compliance with the types of compliance requirements described in the OMB *Compliance Supplement* that could have a direct and material effect on each of the Alliance's major federal programs for the year ended June 30, 2019. The Alliance's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

***Management's Responsibility***

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

***Auditors' Responsibility***

Our responsibility is to express an opinion on compliance for each of the Alliance's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Alliance's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the Alliance's compliance.

***Opinion on Each Major Federal Program***

In our opinion, Cambridge Public Health Commission d/b/a Cambridge Health Alliance complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2019.

**Report on Internal Control Over Compliance**

Management of the Alliance is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Alliance's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Alliance's internal control over compliance.

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

Our consideration of internal control over compliance 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 compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

PricewaterhouseCoopers LLP

Boston, Massachusetts
October 31, 2019

# Part III
# Audit Findings and Questioned Costs

# Cambridge Health Alliance
**(A Component Unit of the City of Cambridge, Massachusetts)**
## Schedule of Findings and Questioned Costs
## Year Ended June 30, 2019

### I. Summary of Auditors' Results

**Financial Statements**

| | | |
|---|---|---|
| Type of auditor's report issued: | Unmodified | |
| Internal Control over Financial Reporting: | | |
| Material weakness identified? | ___ Yes | ✓ No |
| Significant deficiency(ies) identified that are not considered to be material weaknesses? | ___ Yes | ✓ None Reported |
| Noncompliance which is material to financial statements. | ___ Yes | ✓ No |

**Federal Awards**

| | | |
|---|---|---|
| Internal control over major programs: | | |
| Material weakness(es) identified? | ___ Yes | ✓ No |
| Significant deficiency(ies) identified that are not considered to be material weaknesses? | ___ Yes | ✓ None Reported |
| Type of auditors report issued on compliance for major programs: | Unmodified | |
| Any audit findings disclosed that are required to be reported in compliance with 2 CFR 200.516(a)? | ___ Yes | ✓ No |

**Identification of Major Programs**

| CFDA Number | Name of Federal Program or Cluster |
|---|---|
| Various | Research and Development Cluster |
| 93.919 | Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs |
| 93.959 | Block Grants for Prevention and Treatment of Substance Abuse |

| | | |
|---|---|---|
| Dollar threshold for Type A and Type B programs: | $750,000 | |
| Audit qualifies as low-risk auditee? | ✓ Yes | ___ No |

### II. Financial Statement Findings

None noted.

### III. Federal Award Findings

None noted.

# Cambridge Health Alliance
**(A Component Unit of the City of Cambridge, Massachusetts)**
## Summary Schedule of Status of Prior Audit Findings
## Year Ended June 30, 2019

There are no findings from prior years that require an update in this report.