WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Financial Statements and Supplementary Information

June 30, 2017 and 2016

(With Independent Auditors' Report Thereon)

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

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KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
Western Maryland Health System Corporation:

We have audited the accompanying consolidated financial statements of Western Maryland Health System Corporation and subsidiaries, which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Western Maryland Health System Corporation and subsidiaries as of June 30, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information in Schedules 1–3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

October 10, 2017

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	47,198	72,949
Investments		23,310	26,145
Funds on deposit with trustee		17,489	17,205
Accounts receivable, less allowance for doubtful accounts of $3,728 in 2017 and $3,439 in 2016		35,786	37,134
Pledge receivable, net		186	273
Other receivables, less allowance for uncollectible accounts of $1,430 in 2017 and $1,064 in 2016		5,561	5,147
Inventories and other current assets		10,093	9,886
Total current assets		139,623	168,739
Investments		83,919	51,134
Board designated investments		10,324	10,150
Other long-term investments		440	411
Investments restricted by donor or grantor		6,093	5,314
Beneficial interest in trustee held Foundation assets		1,836	1,971
Property and equipment, net		274,181	288,845
Investments in affiliates		31,647	24,994
Other assets		9,363	5,097
Total assets	$	557,426	556,655
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	12,234	11,472
Accounts payable and accrued liabilities		12,485	13,859
Accrued bond interest payable		5,694	5,975
Accrued salaries and benefits		11,563	10,800
Payable to third-party payors		6,645	7,623
Total current liabilities		48,621	49,729
Long-term debt, net of current portion		235,185	250,165
Pension benefits in excess of pension assets		74,394	112,152
Other liabilities		17,731	13,671
Total liabilities		375,931	425,717
Commitments and contingencies			
Net assets:			
Unrestricted:			
Unrestricted net assets		171,932	122,106
Noncontrolling interest in consolidated subsidiaries		1,455	1,292
Total unrestricted net assets		173,387	123,398
Temporarily restricted		5,991	5,313
Permanently restricted		2,117	2,227
Total net assets		181,495	130,938
Total liabilities and net assets	$	557,426	556,655

See accompanying notes to consolidated financial statements.

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Statements of Operations

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Unrestricted revenues and other support:		
Patient service revenue (net of contractual allowances and charity)	$ 330,257	319,910
Provision for bad debts	(6,921)	(7,363)
Net patient service revenue	323,336	312,547
Other revenue	6,171	7,046
Total revenues and other support	329,507	319,593
Expenses:		
Salaries and wages	109,581	105,284
Employee benefits	40,227	35,862
Professional fees	18,358	18,198
Purchased services	47,784	45,821
Supplies	53,628	53,595
Utilities	4,660	4,705
Insurance	2,497	3,123
Interest	11,388	11,949
Depreciation and amortization	25,116	25,483
Other	7,294	7,863
Total expenses	320,533	311,883
Operating income	8,974	7,710
Nonoperating income:		
Equity in income of affiliates	5,650	1,215
Investment income, including realized gains on trading portfolio	3,134	1,508
Unrealized gains on trading portfolio	5,532	761
Other	(64)	(1,634)
Total nonoperating income	14,252	1,850
Excess of revenues over expenses	$ 23,226	9,560

See accompanying notes to consolidated financial statements.

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total net assets
Balance at June 30, 2015	$ 161,844	4,980	2,293	169,117
Excess of revenues over expenses	9,560	—	—	9,560
Investment gain	—	25	—	25
Donations	—	1,388	—	1,388
Grants	—	72	—	72
Change in funded status of pension plan	(46,237)	—	—	(46,237)
Net assets released for operations	—	(595)	—	(595)
Net assets released for purchase of property and equipment	557	(557)	—	—
Change in beneficial interest of trustee-held Foundation assets	—	—	(66)	(66)
Distributions to noncontrolling interest in consolidated subsidiaries	(2,326)	—	—	(2,326)
Change in net assets	(38,446)	333	(66)	(38,179)
Balance at June 30, 2016	123,398	5,313	2,227	130,938
Excess of revenues over expenses	23,226	—	—	23,226
Investment gain	—	672	—	672
Donations	—	1,260	—	1,260
Grants	—	30	—	30
Change in funded status of pension plan	28,403	—	—	28,403
Net assets released for operations	—	(783)	—	(783)
Net assets released for purchase of property and equipment	501	(501)	—	—
Change in beneficial interest of trustee-held Foundation assets	—	—	(110)	(110)
Distributions to noncontrolling interest in consolidated subsidiaries	(2,141)	—	—	(2,141)
Change in net assets	49,989	678	(110)	50,557
Balance at June 30, 2017	$ 173,387	5,991	2,117	181,495

See accompanying notes to consolidated financial statements.

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Statements of Cash Flows

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Cash flows from operating activities:		
Change in net assets	$ 50,557	(38,179)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	25,116	25,483
Amortization of bond financing costs and premiums	(3,134)	(3,171)
Loss on extinguishment of debt	—	1,782
Change in funded status of pension plan	(28,403)	46,237
Provision for bad debts	6,921	7,363
Distributions to noncontrolling interest holder	2,141	2,326
Loss on sale of assets	32	173
Equity in income of affiliates	(5,650)	(1,215)
Realized and unrealized gains on investments	(7,003)	(333)
Change in beneficial interest in trustee held Foundation assets	110	66
Restricted contributions	(1,290)	(1,460)
Changes in assets and liabilities:		
Accounts receivable	(5,573)	(5,658)
Other receivables	(327)	(737)
Inventories and other current assets	(207)	191
Accounts payable and accrued liabilities, accrued bond interest payable and accrued salaries and benefits	(950)	(3,493)
Payable to third-party payors	(978)	979
Other assets, funded status of pension plan, and other liabilities	(9,561)	(3,497)
Net cash provided by operating activities	21,801	26,857
Cash flows from investing activities:		
Purchase of long-lived assets	(10,310)	(13,890)
Change in funds on deposit with trustee	(284)	(6,865)
Net change in investments	(24,797)	(2,814)
Net cash used in investing activities	(35,391)	(23,569)
Cash flows from financing activities:		
Repayments of long-term debt	(11,170)	(2,900)
Capital lease payments	(30)	(176)
Proceeds from restricted contributions	1,290	1,460
Restricted investment loss	(110)	(66)
Distributions to noncontrolling interest holder	(2,141)	(2,326)
Net cash used in financing activities	(12,161)	(4,008)
Net decrease in cash and cash equivalents	(25,751)	(720)
Cash and cash equivalents at beginning of year	72,949	73,669
Cash and cash equivalents at end of year	$ 47,198	72,949
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 11,669	7,440
Capital additions accrued but not paid	418	360

See accompanying notes to consolidated financial statements.

(1) Mission and Organization

Western Maryland Health System Corporation (the Health System or WMHS) is a not-for-profit community health system. The mission of the Health System is to improve the health status and quality of life of the individuals and the communities served, especially those in need. The Health System provides patient and family centered services through responsible management of human and fiscal resources. The Health System is a values-driven health system that respects and supports life, preserves the dignity of each individual, and promotes a healthy and just society through collaboration with others who share the Health System's values.

The Health System accepts patients regardless of their ability to pay. Those patients who meet certain criteria under its charity care policies receive services at no charge or at an amount less than full charges. Essentially, these policies define charity services as those services for which no payment is anticipated. In addition to providing charity care, the Health System provides other programs and services for the general community. The Health System offers over 90 community health programs that include programs that target health education programs and health screenings to patients. A wide variety of health screenings are offered throughout the year for the general community that are free of charge or offered for a nominal fee. The Health System provides free education programs on a variety of health topics. The Health System also sponsors community health screenings and community health fairs, which provide health screenings, education and activities targeted to health and safety.

The Health System comprises the following wholly or partially owned, and controlled, consolidated subsidiaries in Cumberland, Maryland:

(a) Acute Care Hospital

Western Maryland Regional Medical Center – a full service community hospital located in Cumberland, Maryland, licensed for 231 acute care beds, owned and operated by the Health System.

(b) Long-Term Care

Frostburg Nursing and Rehabilitation Center (Frostburg)

(c) Other

Western Maryland Health System Foundation, Inc. (Foundation)

Western Maryland Insurance Company, Ltd. (WMIC)

Haystack Consolidated Services, Inc. (Haystack)

Cumberland Properties, Inc. (Cumberland)

Memorial Medical Center Services, Inc. (MMCS)

Johnson Heights Medical Building Partnership (Johnson Heights)

Haystack Imaging Services, LLC (Haystack Imaging)

In addition, the Health System has investments in several unconsolidated affiliates, which are accounted for under the cost or equity methods of accounting, as appropriate (see note 6).

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles, and include the accounts of the Health System and its subsidiaries and controlled entities. Significant intercompany accounts and transactions have been eliminated in consolidation. The Health System's consolidated financial statements reflect the respective interests of the minority investors in the joint ventures' net assets and changes in net assets.

(b) Investments in Affiliates

Investments in certain joint ventures, which are not controlled by the Health System, are accounted for using the cost or equity method of accounting as appropriate (see note 6). These investments are included as investments in affiliates in the accompanying consolidated balance sheets. The Health System's proportionate share of income or loss of the unconsolidated joint ventures is included in nonoperating income in the accompanying consolidated statements of operations.

(c) Cash Equivalents

Cash equivalents consist primarily of temporary investments with maturities of three months or less when purchased and certain overnight repurchase agreements. Overnight repurchases are principally unsecured and are subject to normal credit risk.

(d) Accounts Receivable

Patient accounts receivable are stated at estimated net realizable amounts from patients, third-party payors and other insurers when services are provided. The Health System bills the insurer directly for services provided. Insurance coverage and credit information is obtained from patients when available. No collateral is obtained for accounts receivable.

(e) Inventories

Inventories primarily consist of medical supplies and drugs and are carried at lower of cost or market. Cost is determined principally using the average cost method, which approximates the first-in first-out (FIFO) method.

(f) Investments

The Health System's investment portfolio, including board designated investments and investments restricted by donor or grantor, is considered a trading portfolio and is classified as current or noncurrent assets based on management's intention as to use. Accordingly, realized and unrealized gains and losses are included in investment income in the accompanying consolidated statements of operations. Dividend and interest income, as well as realized gains on sales of securities, are included in investment income.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the balance sheet. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the excess of revenues over expenses.

The Health System maintains operating reserves in investments equivalent to twelve months of capital asset expenditures and interest payments on the Health System's Series 2014 Revenue Bonds. That balance is maintained in the current asset section of the accompanying consolidated balance sheets.

(g) Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at date of gift. Depreciation is determined using a straight-line basis over the estimated useful lives of the related assets. Repairs and maintenance are expensed as incurred.

Gifts of long-lived assets, such as land, building or equipment, or cash gifts to be used for purchase of long-lived assets, are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are reported are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as temporarily restricted net assets. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported as released from restrictions when the donated or acquired long-lived assets are placed in service.

The Health System opened a 275-bed capacity, state-of-the-art hospital on November 21, 2009. Adjacent to the hospital is a 120,000-square-foot medical office building (MOB) previously owned and operated by a third-party medical office building developer until the purchase of the MOB by WMHS on February 17, 2011. The MOB includes both hospital services and physicians' office space.

(h) Impairment of Long-Lived Assets

Management regularly evaluates whether events or changes in circumstances have occurred that could indicate an impairment in the value of long-lived assets. In accordance with the provisions of Accounting Standards Codification (ASC) Subtopic 360-10, *Accounting for the Impairment or Disposal of Long-Lived Assets*, if there is an indication that the carrying amount of an asset is not recoverable, the Health System projects undiscounted cash flows, excluding interest, to determine if an impairment loss should be recognized. The amount of impairment loss is determined by comparing the historical carrying value of the asset to its estimated fair value. Estimated fair value is determined through an evaluation of recent and projected financial performance using discounted cash flows.

In addition to consideration of impairment upon the events or changes in circumstances described above, management regularly evaluates the remaining lives of its long-lived assets. If estimates are changed, the carrying value of affected assets is allocated over the remaining lives.

In estimating the future cash flows for determining whether an asset is impaired and if expected future cash flows used in measuring assets are impaired, the Health System groups the assets at the lowest

level for which there are identifiable cash flows independent of other groups of assets. If such assets are impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the estimated fair value of the assets. Fair value is based upon market prices, where available, or discounted cash flows. Management believes that no revision to the remaining useful lives is required and there were no impairment of long lived assets during the years ended June 30, 2017 and 2016.

(i) Financing Costs

Financing costs incurred in issuing long-term debt have been deferred and are shown as a reduction to long term debt on the balance sheet. These costs are being amortized using the effective interest method over the term of the related debt. In November 2014, the Health System issued new debt and refunded the previous debt. The unamortized balances were $2,092 and $2,208 at June 30, 2017 and 2016, respectively.

(j) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are limited as to use by donors to a specific time period or purpose. Permanently restricted net assets are to be held in perpetuity at the instruction of the donor. Income from permanently restricted net assets is used as defined by the donor.

(k) Net Patient Service Revenue

In 2011, the Health Services Cost Review Commission (HSCRC) adopted a voluntary alternative rate system known as the Total Patient Revenue (TPR) program, initially established as a demonstration project. Under TPR, a prospective, fixed revenue budget is established by the HSCRC for the upcoming year. This fixed revenue budget incorporates all payors and is not adjusted for changes in volume, casemix or mix of inpatient services that occur during the year. The TPR revenue budget is adjusted annually for inflation and for population in a hospital's service area.

Consistent with the objectives of healthcare reform, the TPR model eliminates "payment for volume" and is designed to encourage hospitals to operate efficiently by reducing utilization and managing patients in the most appropriate care delivery setting. TPR does not include physician services or other kinds of unregulated services (i.e. freestanding ambulatory centers) that fall outside of the jurisdiction of the HSCRC. The TPR agreement allows the Health System to adjust unit rates, within certain limits, to achieve the overall revenue budget for the Health System at year end. Any overcharge or undercharge versus the revenue budget is prospectively added to the subsequent year's budget. While the TPR cap does not adjust for changes in volume or service mix, the TPR cap is adjusted annually for inflation, and for changes in payor mix, market share and uncompensated care. The HSCRC also may impose various revenue adjustments that could be significant in the future.

WMHS operated under the TPR agreement for six years, under two three-year TPR contracts.

In 2014, most Maryland hospitals who were not under the TPR agreements were put on a Global Budget Revenue Agreement (GBR) that was modeled after the TPR agreement with some minor differences. Effective July 1, 2016, the HSCRC transitioned TPR hospitals away from the TPR agreement to the GBR agreement for consistency with all hospitals. There were a few components of

the TPR agreement that were important to TPR hospitals that were incorporated into WMHS's GBR agreement around market share and population growth. The agreement is a one year agreement with an automatic renewal each year unless either party terminates it with notice.

Contractual adjustments, which represent the difference between amounts billed as patient service revenue and amounts paid by third-party payors, are accrued in the period in which the related services are rendered. Because the Health System does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

The Maryland Medicaid program is administered primarily through independent licensed managed care organizations. The State of Maryland has contracts with these independent managed care organizations to manage the care to eligible participants. Amounts due from the Medicaid program in Maryland are primarily due from the independent managed care organizations.

Under certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), federal incentive payments are available to hospitals, physicians and certain other professionals (Providers) when they adopt, implement or upgrade (AIU) certified electronic health record (EHR) technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. The Health System satisfied the CMS AIU and/or meaningful use criteria. As a result, the Health System recognized $25 and $531 for the years ended June 30, 2017 and 2016, respectively, of Medicare and Medicaid EHR incentive payments in other operating revenues in the consolidated statement of operations.

(l) Excess of Revenues over Expenses

The consolidated statement of operations includes the performance indicator, excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, include unrealized gains and losses on other than trading securities, change in funded status of the pension plan, permanent transfers of assets to and from affiliates for other than goods and services, and contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets).

(m) Charity Care

The Health System, as an integral part of its mission, accepts and treats all patients without regard to their ability to pay. A patient is classified as a charity patient in accordance with established criteria. Charity care is the recognition of services rendered for which no payment is expected.

(n) Donations

Unconditional donations are included in income when pledged or received. Donations restricted as to use by the donor are reflected as additions to temporarily or permanently restricted net assets. Expenditures of temporarily restricted net assets are transferred to unrestricted net assets if for capital additions, or reported as other revenue if for operating purposes.

(o) Income Taxes

The Health System and substantially all of its affiliates are tax exempt organizations under Section 501(c)(3) of the Internal Revenue Code (IRC) and are not subject to income taxes except to the extent it has taxable income from activities that are not related to its exempt purpose. No provision for income taxes was required to be made in the consolidated financial statements for these entities.

Johnson Heights is a general partnership and Haystack Imaging is a limited liability company and both are not directly subject to income taxes. The results of their operations are included in the tax returns of their partners. Haystack and MMCS are taxable for profit entities, which recognized an immaterial amount of taxable losses during 2017 and 2016. There is a full valuation allowance against their deferred tax costs.

The Health System and affiliates account for tax provisions in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Subtopic 740-10, *Accounting for Uncertainty in Income Taxes*, which creates a single model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing the minimum recognition threshold a tax position is required to meet before being recognized in the financial statements. Under the requirements of ASC Subtopic 740-10, an entity could be required to record an obligation as the result of a tax position they have historically taken on various tax exposure items. The Health System and affiliates have determined that it did not have any uncertain tax positions as of June 30, 2017 and 2016.

(p) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

(q) Western Maryland Health System Foundation

The Foundation is controlled by the Health System and thus its assets, liabilities, net assets and results of operations are consolidated within the Health System’s financial statements.

(r) Beneficial Interest in Trustee Held Assets

The Health System records a beneficial interest in several trusts (the assets of which are to be held in perpetuity) for which a portion of the income is to be distributed to the Health System. These changes in the fair value of the trusts are recorded as unrealized gains/losses in permanently restricted net assets.

(s) Trivergent Health Alliance MSO

On July 6, 2014, Western Maryland Health System Corporation, Frederick Regional Health System, and Meritus Health, three regional nonprofit health systems, formed Trivergent Health Alliance, LLC. The three key objectives of the Alliance are to improve the health of the population served by the three hospitals, improve the quality of care rendered by the hospitals and to reduce the cost of healthcare provided as embodied in the Management Services Organization (MSO). A subsidiary, Trivergent Health Alliance MSO, LLC, was created to oversee six key service lines for the three hospitals: supply chain, revenue cycle, laboratory, pharmacy, information systems, and human resources. The Health System incurred $25,369 and $23,192 in expenses related to Trivergent during the years ending June 30, 2017 and 2016, respectively for these services. These amounts are currently recorded in the purchased services caption in the consolidated statement of operations.

(t) Pension Plan

For employees hired prior to July 1, 2011, the Health System has a noncontributory defined benefit pension plan covering substantially all of its employees upon their retirement. Since 2008, the benefits are based on age, years of service and career average pay. Grandfathered employees prior to 2008 are based on age, years of service and final average pay based on their five highest paid years of their last 10 years of service. Effective July 1, 2011, employees hired or rehired will not participate in the plan. These employees will participate in a defined contribution plan that has been developed.

For the defined benefit pension plan, the Health System records annual amounts relating to its pension plan based on calculations that incorporate various actuarial and other assumptions including, discount rates, mortality, assumed rates of return, compensation increases, turnover rates and healthcare cost trend rates. The Health System reviews its assumptions on an annual basis and makes modifications to the assumptions based on current rates and trends when it is appropriate to do so. The Health System believes that the assumptions utilized in recording its obligations under its plans are reasonable based on its experience and market conditions.

(u) New Accounting Pronouncements

In 2016, the Health System adopted Accounting Standards Update (ASU) 2015-03, *Simplifying the Presentation of Debt Issuance Costs*. The presentation of debt issuance costs on the balance sheet has been changed from an asset to a direct reduction of debt. As a result of this change, $2,092 and $2,208 of deferred financing costs were classified as a direct reduction of debt at June 30, 2017 and 2016. The related consolidated statements of operations and changes in net assets for the periods were not affected by the adoption of ASU 2015-03.

The Financial Accounting Standards Board (FASB) issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled for those goods or services. ASU 2014-09 is effective for fiscal year 2019. The Health System expects to record a decrease in net patient service

revenue related to self-pay patients and a corresponding decrease in bad debt expense upon the adoption of the standard.

The FASB issued ASU No. 2016-02, *Leases (ASU 2016-02)*, which will require lessees to recognize most leases on-balance sheet, which will increase their reported assets and liabilities. This update was developed to provide financial statement users with more information about an entity's leasing activities, and will require changes in processes and internal controls. The adoption of ASU 2016-02 is effective in fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The Health System is currently assessing the impact of the adoption of ASU 2016-02 which is not expected to have a material impact on its financial position and results of operations.

The FASB issued ASU No. 2016-14, *Not-for Profit Entities (ASU 2016-14)*, which amends the requirements for financial statements and notes Topic 958, Not-for Profit Entities (NFP), and requires a NFP to:

- Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions
- Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements;
- Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and
- Retains the option to present operating cash flows in the statement of cash flows using either the direct or indirect method.

The adoption of ASU 2016-14 is effective fiscal year 2019, and is applied retrospectively in the year of adoption. The Health System does not anticipate that the adoption of this ASU will have a material impact on its financial position and results of operations.

The FASB issued ASU 2015-07, *Fair Value Measurement (ASU 2015-07) Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share*. This ASU removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Rather, those disclosures are limited to investments for which the entity has elected to measure the fair value using that practical expedient. ASU 2015-07 is effective in fiscal year 2017. This ASU requires retrospective application to all prior periods presented.

The FASB issued ASU no. 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost.* The amendments in this ASU require that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost as defined in paragraphs 715-30-35-4 and

(Dollars in thousands)

715-60-35-9 are required to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations, if one is presented. The amendments also allow only the service cost component to be eligible for capitalization when applicable (for example, as a cost of internally manufactured inventory of a self-constructed asset). ASU No. 2017-07 is effective for fiscal year 2020. This ASU requires retrospective application to all prior periods presented. The Company does not anticipate that the adoption of this ASU will have a material impact on its financial position and results of operations.

(v) Management's Assessment and Plans

The Health System adopted Account Standards Update (ASU) 2014-05, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, (ASU 2014-15) during 2017. ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Health System's ability to continue as a going concern and the Health System will continue to meet its obligations through October 10, 2018.

(w) Reclassifications

Certain prior year amounts have been reclassified to conform to current year presentation due to the respective application of ASU 2015-03 described in note 2 (u).

(3) Accounts Receivable, Allowance for Doubtful Accounts and Business Concentrations

During fiscal years 2017 and 2016, net patient service revenue was received from the following payors:

	2017	2016
Medicare	57 %	55 %
Medicaid	18	18
Blue Cross	9	10
Self-pay	1	2
Other	15	15
	100 %	100 %

(Continued)

(Dollars in thousands)

Gross accounts receivable at June 30, 2017 and 2016 consisted of the following payors:

	2017	2016
Medicare	44 %	43 %
Medicaid	19	20
Blue Cross	7	8
Self-pay	12	11
Other	18	18
	100 %	100 %

Patient accounts receivable are reduced by allowances for bad debts. In evaluating the collectability of accounts receivable, the Health System analyzes historical collections and write-offs and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for bad debts and provision for uncollectible accounts. Management regularly reviews its estimate and evaluates the sufficiency of the allowance for bad debts. The Health System analyzes contractual amounts due from patients who have third-party coverage and provides an allowance for doubtful accounts and a provision for bad debts. For patient accounts receivable associated with self-pay patients, which includes those patients without insurance coverage for a portion of the bill, the Health System records a significant provision for bad debts for patients that are unable or unwilling to pay for the portion of the bill representing their financial responsibility. Account balances are charged off against the allowance for doubtful accounts after all means of collection has been exhausted.

The activity in the allowance for bad debts is summarized as follows for the years ended June 30:

		2017	2016
Beginning balance as of July 1	$	3,439	3,467
Provision for uncollectible accounts		6,921	7,363
Less write offs		(6,632)	(7,391)
Ending balance as of June 30	$	3,728	3,439

(Continued)

(Dollars in thousands)

(4) Investments

Investments, which include Funds on deposit with trustees, Board designated investments, Investments restricted by donor or grantor, and other long-term investments consist of the following as of June 30:

		2017	2016
U.S. government obligations	$	15,701	5,088
Money market funds		33,996	31,002
Corporate stocks and other		58,723	44,220
Fixed income securities		33,155	30,049
	$	141,575	110,359

Investments have been classified in the accompanying consolidated balance sheets as follows as of June 30:

		2017	2016
Investments	$	107,229	77,279
Funds on deposit with trustee		17,489	17,205
Board designated investments		10,324	10,150
Other long-term investments		440	411
Investments restricted by donor or grantor		6,093	5,314
	$	141,575	110,359

Investment income and gains for assets limited as to use, cash equivalents, and other investments comprise the following for the years ended June 30:

		2017	2016
Income:			
Investment income	$	2,335	1,961
Realized (losses) gains on trading investment portfolio		799	(453)
Unrealized gains on trading investment portfolio		5,532	761
Restricted investment income		672	25
	$	9,338	2,294

(Continued)

(Dollars in thousands)

(5) Property and Equipment

Property and equipment and estimated useful lives (in years) are summarized as follows as of June 30:

	2017	2016
Land and land improvements (2–25 years)	$ 15,027	14,851
Buildings and improvements (5–40 years)	331,280	331,997
Equipment (3–20 years)	206,884	198,800
Construction in progress	1,063	576
	554,254	546,224
Less accumulated depreciation	280,073	257,379
Property and equipment, net	$ 274,181	288,845

Depreciation expense for the year ended June 30, 2017 was $25,000. Depreciation expense for the year ended June 30, 2016 was $25,367.

(6) Investments in Affiliates

Investments in affiliates and equity in income (loss) of affiliates are as follows as of and for the years ended June 30:

Name	Interest	Business	Investment 2017	Investment 2016	Equity in income (loss) 2017	Equity in income (loss) 2016
Maryland Physicians Care, Inc.	25.00 %	State of Maryland Medicaid managed care	$ 27,025	21,418	5,607	1,354
Other affiliates	0.14% to 33.33%	Supply purchasing and medical equipment	4,622	3,576	43	(139)
			$ 31,647	24,994	5,650	1,215

(Continued)

(Dollars in thousands)

Maryland Physician Care had the following summary financial information as of and for the years ended June 30, 2017 and 2016:

		2017	2016
Total assets	$	308,769	220,516
Total liabilities		200,671	134,844
Net assets	$	108,098	85,672
Total revenues	$	1,110,819	899,594
Total expenses		1,088,393	906,587
Net income (loss)	$	22,426	(6,993)

(7) Long-Term Debt

Long-term debt consists of the following as of June 30:

		2017	2016
Maryland Health and Higher Educational Facilities Authority (MHHEFA) Series 2014 Revenue Bonds, interest rate 4% to 5.25%	$	222,040	233,270
Capital leases		1,105	1,075
Net unamortized bond premium		26,366	29,500
Long-term debt		249,511	263,845
Less current portion of long-term debt		12,234	11,472
Less unamortized financing fees		2,092	2,208
Long-term debt less current portion	$	235,185	250,165

Scheduled principal repayments on long-term debt for the years ending June 30 are as follows:

2018	$	12,234
2019		12,721
2020		13,263
2021		13,717
2022		14,335
Thereafter		156,875

In November 2014, MHHEFA issued $236,170 in bonds (Series 2014 Bonds) on behalf of the System. As security for WMHS obligations, the Bond Authority has been granted a lien, claim on and a security interest in all of the Receipts of WMHS. The lien, claim and security interest continuously applies for the entire term

of the Agreement. The Series 2014 Bonds were issued as $171,035 serial bonds maturing 2015 through 2035 and $65,135 term bonds maturing 2034. The Series 2014 Bonds maturing on or after July 2025 are subject to redemption at the option of MHHEFA prior to maturity, beginning July 2024. The Series 2014 Bonds were issued at fixed rates.

Principal payments on the Series 2014 revenue bonds commenced on July 1, 2015, and are due annually through July 1, 2035. Interest payments are due semi-annually commencing July 1, 2015. Interest on the Series 2014 bonds accrues at a rate of 4.0% to 5.25% per annum. The financing document contains quantitative and qualitative covenants (measured quarterly). The quantitative covenants include a debt service coverage ratio, a day's cash on hand requirement, current ratio requirement, a net days in accounts receivable requirement, and restrictions on operating losses and revenue over expenses.

In 2009, the Health System amended their line of credit agreement with a bank that permits the Health System to borrow up to $1,000. There is no expiration date on the line of credit and the interest rate as of June 30, 2017 was 4.5%. The line of credit primarily supports a letter of credit agreement in the amount of $300. There was no outstanding balance as of June 30, 2017 and 2016.

(8) Charity Care

The Health System utilizes a cost to charge ratio methodology to convert charity care to cost. Costs incurred are estimated based on the ratio of total operating expenses to gross charges applied to charity care charges. The amount of charges foregone for services and supplies furnished under the Health System's Charity Care policy aggregated approximately $10,386 and $9,670 for the years ended June 30, 2017 and 2016, respectively. The total direct and indirect costs to provide the care amounted to approximately $8,153 and $7,156 for the years ended June 30, 2017 and 2016, respectively.

(9) Retirement Plans

The WMHS Retirement Plan (the Plan) is a noncontributory defined benefit plan, which covers substantially all full-time employees who meet certain age and service requirements. The Plan's funding policy is to contribute, annually, the pension costs as determined by the Plan's actuary, subject to adjustment for full funding limitations as defined by the IRC.

The Health System's investment policy, established by the Investment Committee of the Finance Committee and approved by the Health System's Board of Directors, is to ensure current and future benefit obligations are adequately funded in a cost effective manner. The investment guidelines are based on a time horizon of greater than five years. In establishing the risk tolerances, the ability to withstand short and intermediate term variability with some interim fluctuations in market value and rates of return may be tolerated in order to achieve the longer-term objectives.

The measurement date of the Plan is June 30.

(Dollars in thousands)

The component of the Plan's funded status, net periodic benefit costs and actuarial assumptions used in accounting for defined benefit plans for the years ended June 30, 2017 and 2016 are as follows:

		2017	2016
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	304,259	257,078
Service cost		6,389	5,747
Interest cost		10,448	11,195
Assumptions		(9,879)	36,197
Actuarial loss		(1,488)	3,622
Benefits paid		(10,180)	(9,580)
Projected benefit obligation at end of year		299,549	304,259
Change in plan assets:			
Plan assets at fair value at beginning of year		192,107	186,592
Actual return		21,228	95
Employer contributions		22,000	15,000
Benefits paid		(10,180)	(9,580)
Fair value of plan assets at end of year		225,155	192,107
Funded status at end of year	$	(74,394)	(112,152)

		2017	2016
Amounts recognized in unrestricted net assets:			
Net prior service costs	$	(3,655)	(4,320)
Net actuarial loss		110,479	139,547
Amounts recognized in unrestricted net assets	$	106,824	135,227

		2017	2016
Components of net periodic benefit costs:			
Service cost	$	6,389	5,747
Interest cost		10,448	11,195
Expected return on plan assets		(13,977)	(12,745)
Recognized prior service cost		(665)	(665)
Recognized net loss		10,450	6,898
Net periodic pension cost	$	12,645	10,430

(Continued)

(Dollars in thousands)

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $106,824 and $135,227 at June 30, 2017 and 2016, respectively. Deferred pension costs represents unrecognized actuarial losses or unexpected changes in the projected benefit obligation and plan assets over time primarily due to changes in assumed discount rates and investment experience, unrecognized prior service costs, which is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. The amount of deferred pension costs expected to be recognized as a component of net period pension costs during the year ending June 30, 2018 is $7,485.

	2017	2016
Weighted average assumptions – benefit obligations:		
Discount rate	3.71 %	3.51 %
Salary scale	2.50	3.50
Return on assets	7.00	7.00
Weighted average assumptions – net periodic expense:		
Discount rate	3.51 %	4.37 %
Salary scale	2.50	2.00
Return on assets	7.00	7.00

The accumulated benefit obligation for the defined benefit pension plan was $295,865 and $301,820 at June 30, 2017 and 2016, respectively.

The Health System's pension plan weighted average asset allocations at the measurement dates of June 30, 2017 and 2016, by asset category, are as follows:

	Percentage of plan assets		
	Target allocation	2017	2016
Asset class:			
Equities	60 %	67 %	56 %
Fixed income	40	33	44

The Health System expects to contribute $16,000 to the Plan for the fiscal year ending June 30, 2018.

(Continued)

(Dollars in thousands)

The following benefit payments, which reflect expected future employee service, as appropriate, are expected to be paid in the following fiscal years ending June 30:

2018	$	10,862
2019		11,417
2020		12,053
2021		12,840
2022		13,802
2023–2027		82,492

The expected benefits to be paid are based on the same assumptions used to measure the Health System's benefit obligation as of June 30, 2017.

Effective July 1, 2011, employees hired or rehired will not participate in the Plan. These employees will participate in the Health System sponsored defined contributions plan whereby the Health System will make a contribution on behalf of the employee into a retirement account in the name of the employee. The contribution amount is based on several factors including years of service and salary levels. The Health System recorded expense related to these employees of $1,020 and $778 for the years ended June 30, 2017 and 2016, respectively. All Health System employees are eligible to contribute a portion of their compensation to the defined contribution plan.

The Health System will match the employee contribution of the employee compensation at some level based on several factors. The Health System's expense related to the matching component of the plan for the years ended June 30, 2017 and 2016 was $1,915 and $1,602, respectively, and is included in employee benefits in the accompanying consolidated statements of operations.

(10) Self-Insurance Programs

(a) General and Professional Liability (GLPL)

On December 14, 2004, the Health System formed a new wholly owned insurance subsidiary, Western Maryland Insurance Company, Ltd. (WMIC), an exempted company under the Companies Law of the Cayman Islands, to provide GLPL insurance to the Health System and certain affiliates. Effective January 1, 2005, this subsidiary insures the Health System for its GLPL risks under a claims-made policy. The current limit for WMIC for 2017 is $1,000 per claim and $4,000 in the aggregate. Claims in excess of $1,000 per claim and $4,000 in the aggregate, up to a limit of $30,000, have been reinsured with Zurich American Insurance Company as a primary layer for the first $25,000 and with CNA for a secondary layer of $5,000. Both firms are highly rated independent third-party insurance companies. In addition, the Health System's retained self-insurance risk under these policies is $1,000 per occurrence.

Management's estimate of the liability for GLPL claims, including incurred but not reported claims, is principally based on actuarial estimates performed by an independent third-party actuary. The Health System's estimated liability for GLPL claims, including incurred but not reported claims, totaled $16,679 and $12,763 as of June 30, 2017 and 2016, respectively. These amounts are included in other

(Dollars in thousands)

noncurrent liabilities in the accompanying consolidated financial statements. While management believes that this liability is adequate as of June 30, 2017, the ultimate liability may exceed the amount recorded. Additionally, the Health System has recorded an additional insurance recoveries receivable of $8,941 and $4,576 as of June 30, 2017 and 2016, respectively, included in other noncurrent assets.

(b) Workers' Compensation Insurance

In 2017 and 2016, the Health System participated in a self-insured plan for workers' compensation claims. Stop-loss coverage has been purchased through a commercial carrier for claims in excess of $500.

The Health System has accrued a liability recorded in accrued salaries and benefits of $2,399 and $2,105 as of June 30, 2017 and 2016, respectively, for known and incurred but not reported claims. Management believes this accrual is adequate to provide for all workers' compensation claims that have been incurred through June 30, 2017. Additionally, there are no significant insurance recoveries related to workers' compensation as of June 30, 2017 and 2016.

(c) Health Insurance

The Health System is self-insured for employee health claims. Under these self-insurance plans, the Health System has accrued a liability for salaries and benefits of $1,585 and $1,530 as of June 30, 2017 and 2016, respectively, for known claims and incurred but not reported claims. Management believes this accrual is adequate to provide for all employee health claims that may have been incurred through June 30, 2017. Additionally, there are no material insurance recoveries related to employee health claims as of June 30, 2017 and 2016.

(11) Lease Commitments

Future minimum payments under noncancelable operating leases and service contracts with terms in excess of one year or more for the years ending June 30 are as follows:

2018	$	3,526
2019		1,152
2020		259
2021		108
2022		—
Thereafter		—
Total	$	5,045

Rental expense under operating leases amounted to $2,085 and $2,409 for the years ended June 30, 2017 and 2016, respectively.

(Continued)

(Dollars in thousands)

(12) Temporarily and Permanently Restricted Net Assets

Temporarily and permanently restricted net assets as of June 30, 2017 and 2016 are available for the following purposes:

		2017	2016
Temporary restrictions:			
Specific support of healthcare services	$	5,991	5,313
Permanent restrictions:			
Trustee held assets to be held in perpetuity, the income from which primarily is expendable to support health care services	$	2,117	2,227

(13) Fair Value of Financial Instruments

(a) Fair Value of Financial Instruments

The following methods and assumptions were used by the Health System in estimating the fair value of their financial instruments:

Cash and cash equivalents, investments, funds on deposit with trustee, board designated investments, patient accounts receivable, other assets, accounts payable, and accrued liabilities, payable to third-party payors, and other long term liabilities – The carrying amounts reported in the consolidated balance sheets approximate the related fair values.

The fair value of a financial instrument is the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Those fair value measurements maximize the use of observable inputs. However, in situations where there is little, if any, market activity for the asset or liability at the measurement date, the fair value measurement reflects the Health System's own judgments about the assumptions that market participants would use in pricing the asset or liability. Those judgments are developed by the Health System based on the best information available in the circumstances.

The following methods and assumptions were used to estimate the fair value of each class of financial instruments:

Cash and cash equivalents, accounts receivable, due from affiliates, other assets, line of credit, accounts payable, advances from third-party payors, due to affiliates, and accrued expenses – The carrying amounts, at face value or cost plus accrued interest, approximate fair value because of the short maturity of these instruments.

Board designated and other investments – Equity and debt securities classified as trading are measured using quoted market prices at the reporting date multiplied by the quantity held.

(Continued)

(b) Long-Term Debt

The Series 2014 Bonds bear interest at fixed rates and, accordingly, had a carrying amount of $248,406 and $262,770 and a fair value of $248,146 and $260,865 as of June 30, 2017 and 2016 respectively.

The fair value of the Health System's long-term debt is measured using quoted offered-side prices when quoted market prices are available. If quoted market prices are not available, the fair value is determined by discounting the future cash flows of each instrument at rates that reflect, among other things, market interest rates and the Health System's credit standing. In determining an appropriate spread to reflect its credit standing, the Health System considers credit default swap spreads, bond yields of other long-term debt offered by the Health System, and interest rates currently offered for similar debt instruments of comparable maturities by the Health System's bankers as well as other banks that regularly compete to provide financing to the Health System.

(c) Fair Value Hierarchy

The Health System adopted ASC Topic 820, *Fair Value Measurement*, on July 1, 2008 for fair value measurements of financial assets and financial liabilities and for fair value measurements of nonfinancial items that are recognized or disclosed at fair value in the consolidated financial statements on a recurring basis. ASC Topic 820 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3 inputs are unobservable inputs for the asset or liability.

The level in the fair value hierarchy within which a fair measurement in its entirety falls is based on the lowest level input that is significant to the fair value measurement in its entirety.

(Continued)

(Dollars in thousands)

The table below presents assets that are measured at fair value as of June 30, 2017 aggregated by the three level valuation hierarchy:

	2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets:				
U.S. government obligations	$ 15,701	—	—	15,701
Money market funds	33,996	—	—	33,996
Corporate stocks and other	58,723	—	—	58,723
Fixed income securities	—	33,155	—	33,155
Total assets	$ 108,420	33,155	—	141,575

The table below presents assets that are measured at fair value as of June 30, 2016 aggregated by the three level valuation hierarchy:

	2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets:				
U.S. government obligations	$ 5,088	—	—	5,088
Money market funds	31,002	—	—	31,002
Corporate stocks and other	44,220	—	—	44,220
Fixed income securities	—	30,049	—	30,049
Total assets	$ 80,310	30,049	—	110,359

There were no significant transfers of investment assets between levels during the years ended June 30, 2017 and 2016.

The table below presents the pension plan's investable assets as of June 30, 2017 aggregated by the three level valuation hierarchy:

	2017			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets:				
Mutual funds	$ 58,992	—	—	58,992
Fixed income securities	—	39,048	—	39,048
Other funds	—	121,567	5,548	127,115
Total assets	$ 58,992	160,615	5,548	225,155

(Continued)

(Dollars in thousands)

The table below presents the pension plan's investable assets as of June 30, 2016 aggregated by the three level valuation hierarchy:

	2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets:				
Mutual funds	$ 39,109	—	—	39,109
Fixed income securities	—	40,915	—	40,915
Other funds	—	106,186	5,897	112,083
Total assets	$ 39,109	147,101	5,897	192,107

There were no significant transfers of the pension plan's investable assets between levels during the years ended June 30, 2017 and 2016.

The change in the fair value of the pension assets valued using significant unobservable inputs (Level 3) was due to the following:

	Level 3 investment
Ending balance June 30, 2016	$ 5,897
Disbursements	(597)
Variable interest	290
Other adjustments	(42)
Ending balance June 30, 2017	$ 5,548

(14) Commitments and Contingencies

(a) Litigation

From time to time, the Health System and its subsidiaries are involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management believes that these matters will be resolved without a significant adverse effect on the Health System's future financial position or results from operations. During 2017, WMHS become aware of a matter surrounding the provision of its Home Health Care services in West Virginia. As a result of that matter, WMHS was asked to pay back approximately $2.4 million related to provided home care services. WMHS has appealed that request and is currently in the first stage of the appeal. No payment is required until the first two phases of the appeal is exhausted. WMHS believes that it is not probable that the requested repayment will have to be paid. Accordingly, no reserve has been recorded as of June 30, 2017.

(b) Other Matters

The Health System has contracts with various physician groups to provide certain emergency, anesthesia and hospitalists services. Those contracts include certain income guarantee levels, which eliminate as volumes related to services provided increase. The Health System paid $3,403 and $4,168 related to the guarantee provisions of the contracts in 2017 and 2016, respectively.

(15) Regulation and Reimbursement

The Health System provides health care services primarily through one general acute care hospital. The Health System and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs;
- Regulation of hospital rates by the HSCRC;
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

Such inherent risks require the use of certain management estimates in the preparation of the Health System's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Health System's revenues and the Health System's operations are subject to a variety of other federal, state and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Health System.

Change in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Health System.

The current rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on an agreement between the Center for Medicaid and Medicare Services (CMS) and the HSCRC. This agreement is based upon a waiver from Medicare prospective pay system reimbursement principles granted to the State of Maryland under Section 1814(b) of the Social Security Act and will continue as long as all third-party payors elect to be reimbursed in Maryland under this program and the rate of increase for costs per hospital inpatient admission in Maryland is below the national average.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver ties hospital per capital revenue growth to the state's economic growth of 3.58%. CMS can require the state to submit a corrective action plan if targets for a given performance year are not met. The new waiver also imposes quality measures and encourages population health.

Under GBR, a prospective, fixed revenue budget is established by the HSCRC for the upcoming year. This fixed revenue budget incorporates all payors and is not adjusted for changes in volume, casemix or mix of inpatient services that occur during the year. The GBR revenue budget is adjusted annually for inflation and for population in a hospital's service area.

Consistent with the objectives of healthcare reform, the GBR model eliminates "payment for volume" and is designed to encourage hospitals to operate efficiently by reducing utilization and managing patients in the most appropriate care delivery setting. GBR does not include physician services or other kinds of unregulated services (i.e. freestanding ambulatory centers) that fall outside of the jurisdiction of the HSCRC. The GBR agreement allows the Health System to adjust unit rates, within certain limits, to achieve the overall revenue budget for the Health System at year end. Any overcharge or undercharge versus the revenue budget is prospectively added to the subsequent year's budget.

Effective July 1, 2013, the Health System and the HSCRC agreed to a three-year TPR contract. Effective July 1, 2016, the TPR agreement was converted to a GBR agreement that is for one year with an automatic renewal each year unless either party terminates it with notice.

(16) Noncontrolling Interest

Effective June 30, 2012, the Health System adopted accounting guidance that requires a not-for-profit reporting entity to account for and present noncontrolling interests in a consolidated subsidiary as separate

(Dollars in thousands)

component of the appropriate class of consolidated net assets (equity). The reconciliation of noncontrolling interest reported in unrestricted net assets is as follows:

	WMHS Corporation	Noncontrolling interest	Unrestricted net assets
Balance at June 30, 2015	$ 160,550	1,294	161,844
Operating income	5,386	2,324	7,710
Nonoperating income	1,850	—	1,850
Excess of revenues over expenses	7,236	2,324	9,560
Change in funded status of pension plan	(46,237)	—	(46,237)
Net assets released for purchase of property and equipment	557	—	557
Distributions to noncontrolling interest in consolidated subsidiaries	—	(2,326)	(2,326)
Change in net assets	(38,444)	(2)	(38,446)
Balance at June 30, 2016	122,106	1,292	123,398
Operating income	6,670	2,304	8,974
Nonoperating income	14,252	—	14,252
Excess of revenues over expenses	20,922	2,304	23,226
Change in funded status of pension plan	28,403	—	28,403
Net assets released for purchase of property and equipment	501	—	501
Distributions to noncontrolling interest in consolidated subsidiaries	$ —	(2,141)	(2,141)
Change in net assets	49,826	163	49,989
Balance at June 30, 2017	$ 171,932	1,455	173,387

(Continued)

(Dollars in thousands)

(17) Functional Expenses

The Health System considers healthcare services and general and administrative to be its primary functional categories for purposes of expense classification. The Health System's operating expenses by functional classification are as follows for the years ended June 30:

		2017	2016
Healthcare services	$	288,480	278,512
General and administrative		32,053	33,371
	$	320,533	311,883

(18) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2017 and through October 10, 2017. The Health System did not have any material recognizable subsequent events during this period.

Schedule 1

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

Assets	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Eliminations	Consolidated
Current assets:						
Cash and cash equivalents	$ 40,667	6,040	161	330	—	47,198
Investments	17,369	—	988	4,953	—	23,310
Funds on deposit with trustee	17,489	—	—	—	—	17,489
Accounts receivable, net	35,015	771	—	—	—	35,786
Pledge receivable, net	—	—	—	186	—	186
Other receivables, net	6,287	(11)	2	23	(740)	5,561
Inventories and other current assets	13,682	6	—	—	(3,595)	10,093
Total current assets	130,509	6,806	1,151	5,492	(4,335)	139,623
Investments	83,919	—	—	—	—	83,919
Board designated investments	10,324	—	—	—	—	10,324
Other long-term investments	75	—	—	365	—	440
Investments restricted by donor or grantor	507	—	—	5,586	—	6,093
Beneficial interest in trustee held and Foundation assets	—	—	—	1,836	—	1,836
Property and equipment, net	273,472	709	—	—	—	274,181
Investments in affiliates	31,647	—	—	—	—	31,647
Other assets	9,363	—	—	—	—	9,363
Total assets	$ 539,816	7,515	1,151	13,279	(4,335)	557,426

See accompanying independent auditors' report.

(Continued)

Schedule 1

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

Liabilities and Net Assets	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Eliminations	Consolidated
Current liabilities:						
Current portion of long-term debt	$ 12,234	—	—	—	—	12,234
Accounts payable and accrued liabilities	12,198	3,882	—	740	(4,335)	12,485
Accrued bond interest payable	5,694	—	—	—	—	5,694
Accrued salaries and benefits	11,292	271	—	—	—	11,563
Payable to third-party payors	6,645	—	—	—	—	6,645
Total current liabilities	48,063	4,153	—	740	(4,335)	48,621
Long-term debt, net of current portion	235,185	—	—	—	—	235,185
Pension benefits in excess of pension assets	74,394	—	—	—	—	74,394
Other liabilities	17,731	—	—	—	—	17,731
Total liabilities	375,373	4,153	—	740	(4,335)	375,931
Net assets:						
Unrestricted:						
Unrestricted net assets	162,481	3,362	1,151	4,938	—	171,932
Noncontrolling interest in consolidated subsidiaries	1,455	—	—	—	—	1,455
Total unrestricted net assets	163,936	3,362	1,151	4,938	—	173,387
Temporarily restricted	226	—	—	5,765	—	5,991
Permanently restricted	281	—	—	1,836	—	2,117
Total net assets	164,443	3,362	1,151	12,539	—	181,495
Total liabilities and net assets	$ 539,816	7,515	1,151	13,279	(4,335)	557,426

Schedule 2

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Statement of Operations Information

Year ended June 30, 2017

(Dollars in thousands)

	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Eliminations	Consolidated
Unrestricted revenues and other support:						
Patient service revenue (net of contractual allowances and charity)	$ 323,207	7,050	—	—	—	330,257
Provision for bad debts	(6,807)	(114)	—	—	—	(6,921)
Net patient service revenue	316,400	6,936	—	—	—	323,336
Other revenue	6,557	100	—	—	(486)	6,171
Total revenues and other support	322,957	7,036	—	—	(486)	329,507
Expenses:						
Salaries and wages	105,405	4,176	—	—	—	109,581
Employee benefits	38,846	1,381	—	—	—	40,227
Professional fees	18,281	77	—	—	—	18,358
Purchased services	46,986	782	—	452	(436)	47,784
Supplies	53,019	609	—	25	(25)	53,628
Utilities	4,447	212	—	1	—	4,660
Insurance	2,492	3	—	2	—	2,497
Interest	11,388	—	—	—	—	11,388
Depreciation and amortization	24,971	145	—	—	—	25,116
Other	6,485	825	—	9	(25)	7,294
Total expenses	312,320	8,210	—	489	(486)	320,533
Operating income (loss)	10,637	(1,174)	—	(489)	—	8,974

See accompanying independent auditors' report.

(Continued)

Schedule 2

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Statement of Operations Information

Year ended June 30, 2017

(Dollars in thousands)

	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Eliminations	Consolidated
Nonoperating income:						
Equity in income of affiliates	$ 5,599	—	51	—	—	5,650
Investment income	2,552	10	22	550	—	3,134
Unrealized gains (loss) on trading portfolio	5,154	—	(17)	395	—	5,532
Other	(19)	—	—	(45)	—	(64)
Total nonoperating income	13,286	10	56	900	—	14,252
Excess (deficiency) of revenues over (under) expenses	$ 23,923	(1,164)	56	411	—	23,226

Schedule 3

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2017

(Dollars in thousands)

	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Consolidated
Unrestricted net assets:					
Balance at June 30, 2016	$ 113,250	4,526	1,095	4,527	123,398
Excess of revenues over expenses	23,923	(1,164)	56	411	23,226
Change in funded status of pension plan	28,403	—	—	—	28,403
Net assets released for purchase of property and equipment	501	—	—	—	501
Distributions to noncontrolling interest in consolidated interest	(2,141)	—	—	—	(2,141)
Balance at June 30, 2017	163,936	3,362	1,151	4,938	173,387
Temporarily restricted net assets:					
Balance at June 30, 2016	245	—	—	5,068	5,313
Investment gain	—	—	—	672	672
Donations	508	—	—	752	1,260
Grants	30	—	—	—	30
Net assets released for operations	(56)	—	—	(727)	(783)
Net assets released for purchase of property and equipment	(501)	—	—	—	(501)
Balance at June 30, 2017	226	—	—	5,765	5,991
Permanently restricted net assets:					
Balance at June 30, 2016	255	—	—	1,972	2,227
Change in beneficial interest of trustee-held Foundation assets	26	—	—	(136)	(110)
Balance at June 30, 2017	281	—	—	1,836	2,117
Net assets at June 30, 2017	$ 164,443	3,362	1,151	12,539	181,495

See accompanying independent auditors' report.