Consolidated Financial Statements and Supplementary Information

Peninsula Regional Health System, Inc.
Years Ended June 30, 2013 and 2012
With Reports of Independent Auditors

Ernst & Young LLP

Ernst & Young

Peninsula Regional Health System, Inc.

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2013 and 2012

Contents

Ernst & Young LLP
621 East Pratt Street
Baltimore, MD 21202
Tel: + 1 410 539 7040
Fax: + 1 410 783 3832
www.ey.com

Report of Independent Auditors

The Board of Trustees
Peninsula Regional Health System, Inc.

We have audited the accompanying consolidated financial statements of Peninsula Regional Health System, Inc. (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related consolidated statements of operations and 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 financial statements in conformity 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 financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of certain subsidiaries and joint ventures of Peninsula Health Ventures, Inc. (Health Ventures), a wholly-owned subsidiary of the Heath System. Two of the entities, Delmarva Surgery Center, LLC, (Delmarva) and Peninsula Imaging, LLC (Imaging), reflect total assets and total revenues constituting 2.8% and 1.1% in 2013 of the related consolidated totals. Those statements were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for Delmarva and Imaging, is based solely on the reports of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of 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 the auditor's 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, the auditor considers internal control relevant to the Health System'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 entity's internal control.

Ernst & Young

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, based on our audits and the reports of other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Peninsula Regional Health System, Inc. at June 30, 2013 and 2012, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

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

Ernst + Young LLP

September 23, 2013

Peninsula Regional Health System, Inc.

Consolidated Balance Sheets
(In Thousands)

	June 30	
	2013	**2012**
Assets		
Current assets:		
Cash and cash equivalents	**$ 29,289**	$ 33,719
Short-term investments	**4,757**	8,503
Accounts receivable, less allowance for uncollectible accounts (2013 – $7,497; 2012 – $7,408)	**37,253**	39,992
Inventories and other	**13,903**	14,178
Total current assets	**85,202**	96,392
Long-term investments	**171,591**	152,080
Board-designated investments	**18,941**	16,745
Assets limited as to use:		
Debt service reserve fund	**9,245**	9,311
Donor-restricted fund	**26,045**	24,489
Self-insurance fund	**13,154**	12,479
	48,444	46,279
Property and equipment, net	**211,756**	204,229
Unamortized financing costs, net of accumulated amortization (2013 – $667; 2012 – $716)	**2,313**	2,417
Other assets	**10,162**	11,729
Total assets	**$ 548,409**	$ 529,871

	June 30	
	2013	**2012**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 3,124**	$ 2,997
Current portion of accrued self-insured liabilities	**2,395**	1,895
Accounts payable and accrued liabilities	**34,667**	33,284
Advances from third-party payors	**8,054**	9,958
Total current liabilities	**48,240**	48,134
Long-term debt, net	**126,903**	130,318
Other liabilities	**14,344**	20,826
Total liabilities	**189,487**	199,278
Net assets:		
Unrestricted	**330,740**	305,162
Temporarily restricted	**17,999**	15,254
Permanently restricted	**8,083**	8,071
Peninsula Regional Health System, Inc net assets	**356,822**	328,487
Minority interest	**2,100**	2,106
Total net assets	**358,922**	330,593
Total liabilities and net assets	**$ 548,409**	$ 529,871

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets

(In Thousands)

	Year Ended June 30	
	2013	2012
Unrestricted revenue and other support:		
Net patient service revenue	**$ 379,456**	$ 382,666
Provisions for bad debts	**(15,608)**	(16,651)
Net patient service revenue less provision for bad debts	**363,848**	366,015
Other operating revenue	**6,453**	2,355
Total unrestricted revenue and other support	**370,301**	368,370
Operating expenses:		
Salaries and wages	**149,254**	146,085
Supplies and other expenses	**156,767**	152,267
Employee benefits	**40,044**	36,207
Depreciation	**22,254**	22,147
Interest	**6,248**	6,432
Total operating expenses	**374,567**	363,138
(Loss) income from operations	**(4,266)**	5,232
Nonoperating income:		
Investment income	**15,708**	9,307
Basis swap income	**644**	2,629
	16,352	11,936
Excess of unrestricted revenue and other support over expenses	**12,086**	17,168
Minority interest in loss (earnings) of controlled subsidiaries	**6**	(55)
Excess of unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**12,092**	17,113

Peninsula Regional Health System, Inc.

Consolidated Statements of Operations and Changes in Net Assets (continued)

(In Thousands)

	Year Ended June 30	
	2013	**2012**
Unrestricted net assets:		
Excess of unrestricted revenue and other support over expenses attributable to Peninsula Regional Health System, Inc.	**$ 12,092**	$ 17,113
Net assets released from restrictions	**269**	40
Unrealized gains (loss) on investments	**8,145**	(516)
Pension adjustment	**5,145**	(14,093)
Other	**(73)**	333
Increase in unrestricted net assets	**25,578**	2,877
Temporarily restricted net assets:		
Donations	**1,264**	974
Net realized gains on investments	**1,002**	563
Unrealized gains (loss) on investments	**1,112**	(351)
Net assets released from restrictions	**(633)**	(267)
Increase in temporarily restricted net assets	**2,745**	919
Permanently restricted net assets:		
Net realized gains on investments	**9**	7
Unrealized gains (loss) on investments	**3**	(1)
Increase in permanently restricted net assets	**12**	6
Increase in net assets	**28,335**	3,802
Net assets at beginning of year	**328,487**	324,685
Net assets at end of year	**$ 356,822**	$ 328,487

See accompanying notes.

Peninsula Regional Health System, Inc.

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30	
	2013	**2012**
Operating activities		
Change in net assets	**$ 28,335**	$ 3,802
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation of property and equipment	**22,254**	22,147
Amortization of original issue premium	**(292)**	(290)
Amortization of intangible assets	**102**	98
(Gains) losses on sale of property and equipment	**(193)**	51
Net unrealized (gains) losses on investments	**(7,233)**	631
Net realized gains on investments	**(10,721)**	(4,529)
Non-cash change in donor-restricted fund	**1,406**	–
Proceeds from restricted contributions and realized losses on restricted investments	**998**	570
Minority interest in earnings of controlled subsidiaries	**(6)**	(373)
Changes in operating assets and liabilities:		
Accounts receivable	**2,959**	(2,781)
Inventories and other assets	**1,269**	(1,215)
Accounts payable and accrued liabilities	**1,384**	5,094
Other liabilities	**(5,984)**	8,580
Advances from third-party payors	**(1,903)**	1,497
Net cash provided by operating activities	**32,375**	33,282
Investing activities		
Purchase of investments	**(127,851)**	(97,328)
Proceeds from sales of investments	**127,362**	80,991
Purchases of property and equipment	**(29,588)**	(15,986)
Change in assets limited as to use	**(2,734)**	1,801
Net cash used in investing activities	**(32,811)**	(30,522)
Financing activities		
Proceeds from restricted contributions and realized losses on restricted investments	**(998)**	(570)
Proceeds from borrowings	**–**	2,053
Repayments of long-term debt	**(2,996)**	(4,978)
Net cash used in financing activities	**(3,994)**	(3,495)
Net decrease in cash and cash equivalents	**(4,430)**	(735)
Cash and cash equivalents at beginning of year	**33,719**	34,454
Cash and cash equivalents at end of year	**$ 29,289**	$ 33,719

See accompanying notes.

1. Organization and Mission

Peninsula Regional Health System, Inc. (the Health System) serves as the parent company to Peninsula Regional Medical Center (the Hospital), Peninsula Regional Medical Center Foundation, Inc. (the Foundation) and Peninsula Health Ventures, Inc. (Health Ventures). The Health System is a not-for-profit Maryland membership corporation established to manage the integrated delivery of health care services to the community. The Health System is the sole corporate member of the Hospital and the Foundation. In its capacity as sole corporate member, the Health System will appoint trustees, approve major expenditures and approve long-term borrowings.

The Hospital is a not-for-profit, nonstock corporation founded in 1897 to serve the health care needs of its region. Primary service areas include the Maryland counties of Wicomico, Somerset and Worcester, southern Delaware and the northern Eastern Shore of Virginia. The Hospital's mission is to improve the health care of the community by providing exceptional quality primary, secondary, and selected tertiary health care services to patients in a competent and compassionate manner, designed to elicit a high degree of customer satisfaction. The Hospital provides services regardless of race, creed, sex, national origin, handicap, or age. In May 2013, Delmarva Peninsula Insurance Company (DPIC) was formed as a wholly owned subsidiary of the Hospital. DPIC was formed as a captive insurer to provide professional and general liability insurance.

The Foundation is a not-for-profit, nonstock corporation organized to raise contributions exclusively for the benefit of charitable, educational, medical, and scientific purposes for the Hospital.

Health Ventures is a for-profit corporation organized for the purpose of owning, developing, operating and investing in health care enterprises on the Delmarva Peninsula. The Health System owns all of the outstanding shares of common stock of Health Ventures.

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Health System and all wholly owned subsidiaries, principally the Hospital, the Foundation and Health Ventures. Additionally, the Health System has consolidated a 55%-owned affiliate, Delmarva Surgery Center, LLC, and recorded a minority interest liability equal to the remaining ownership interest.

2. Significant Accounting Policies (continued)

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States 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 and the reported amounts of revenues and expenses during the reporting period. Actual amounts could differ from those estimates.

Reclassifications

Certain amounts from the prior year financial statements have been reclassified in order to conform to the current year presentation.

Fair Value of Financial Instruments

The carrying amounts of financial instruments, including cash and cash equivalents, accounts receivable, accounts payable, and advances from third-party payors, approximate fair value given the short-term nature of these financial instruments.

Cash and Cash Equivalents

Cash and cash equivalents include surplus operating funds invested in money market funds and highly liquid corporate, U.S. government and agency obligations, all with maturities of less than three months when purchased.

Investments and Investment Income

Investments are carried at fair value. All such investments are considered available for sale and are classified as current or noncurrent assets based on management's intention as to use. Short-term investments represent investments with contractual maturities within one year and current investments in money market funds which have been designated for long-term investment purposes. Assets limited as to use by donor restriction are recorded at fair value at the date of donation and changes in fair value are recognized in the period in which the change occurs. Investment income from all unrestricted investments is reported as nonoperating income. Investment income on investments of restricted assets is added to or deducted from the appropriate restricted net assets when restricted as to use by the donor.

2. Significant Accounting Policies (continued)

The value of securities sold is based on the specific identification method.

The Health System periodically evaluates whether any declines in the fair value of investments are other than temporary. This evaluation consists of a review of several factors, including but not limited to: length of time and extent that a security has been in an unrealized loss position; the existence of an event that would impair the issuer's future earnings potential; the near-term prospects for recovery of the market value of a security; and the intent and ability of the Health System to hold the security until the market value recovers. Realized gains or losses are included in nonoperating (expense) income in the accompanying consolidated statements of operations and changes in net assets. Declines in fair value below cost that are deemed to be other than temporary would be recorded as realized losses within nonoperating (expense) income. Based on its evaluation, the Health System has recorded no other-than-temporary impairments for the years ended June 30, 2013 and 2012.

Derivative Instruments

The Hospital entered into a forward-starting interest rate exchange agreement on August 9, 2005, with Morgan Stanley Capital Services Inc. (the Counterparty) to reduce the risk of changing interest rates with a notional amount of $137,845. Under the agreement, the Hospital paid a fixed rate of approximately 3.5% and received a variable rate of 68% of three-month London Interbank Offered Rate (LIBOR). The Hospital unwound the agreement on January 24, 2006, and paid the Counterparty a termination payment of $1,575 on February 9, 2006, from proceeds of the 2006 Bond issue. The termination payment of $1,575 has been recognized as unamortized financing costs and is being amortized over the life of the 2006 Bond issue using the straight-line method, which approximates the effective interest method.

On January 26, 2006, the Hospital amended the August 9, 2005, agreement with the Counterparty and entered into an interest rate swap (the Basis Swap) on a notional amount of $142,910 under which the Hospital will pay the Counterparty floating rate payments based upon the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Index and will receive floating rate payments based upon 68% of three-month LIBOR, plus a fixed spread of 0.523%. Under Accounting Standards Codification No. 815, *Derivatives and Hedging*, the Hospital has recognized its derivative instruments in the balance sheets at fair value. As these derivative instruments are not designated as hedges, the changes in fair value have been recognized in the accompanying statements of operations and changes in net assets as mark-to-market adjustments, included within basis swap income.

2. Significant Accounting Policies (continued)

The fair market value of the swap agreement is included in other liabilities or other assets in the accompanying consolidated balance sheets. The fair market value calculation includes a credit valuation adjustment (CVA) as required by ASC No. 820, *Fair Value Measurements and Disclosures*.

Credit exposure associated with non-performance by the counterparty to the derivative instrument is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the balance sheets.

The Hospital's derivative agreement does not contain any credit support provisions that require it to post collateral if there are declines in the derivative value or its credit rating.

The Hospital unwound the agreement on December 12, 2012 and received $2,147 at termination from the Counterparty net of $615 in fees. These proceeds have been reported in 2013 non-operating income. At June 30, 2012, the value of this instrument was a $2,068 asset position, recorded in other assets.

Accounts Receivable and Contractual Allowances

The Health System, through its member companies, provides services to patients in the Eastern Shore area of Maryland, Delaware and Virginia, the majority of whom are covered by third-party health insurance. The Health System bills the insurer directly for services provided.

Insurance coverage and financial information is obtained from patients upon admission when available. The Health System's policy is to perform in-house collection procedures for approximately 85 days. A determination is made at that time as to what additional collection efforts to pursue. A provision for uncollectible accounts is recorded for amounts not yet written off, which are expected to become uncollectible.

2. Significant Accounting Policies (continued)

Discounts ranging from 2% to 6% of charges are given to Medicare, Medicaid and certain approved commercial health insurance and health maintenance organization programs for regulated services. Discounts in varying percentages are given for certain unregulated services. These major payors routinely review patient billings and deny payment for certain charges as medically unnecessary or as performed without appropriate preauthorization. Discounts and denials are recorded as reductions of net patient service revenue. Revenue and accounts receivable from these third-party payors have been adjusted to reflect the difference between charges and the estimated reimbursable amounts.

Approximately 38% and 37% of accounts receivable were due from the Medicare program as of June 30, 2013 and 2012, respectively.

The Medicare and Medicaid reimbursement programs represent a substantial portion of the Health System's revenues. The Health System's operations are subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare, and Medicaid fraud and abuse. Over the past several years, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of fines and penalties, as well as repayments for patient services previously billed. Compliance with fraud and abuse standards and other government regulations can be subject to future government review and interpretation. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on the Health System.

Inventories and Other

Inventories and other primarily includes inventories of supplies and prepaid expenses. Inventories of supplies are carried at lower of cost or market, using the first-in, first-out method.

2. Significant Accounting Policies (continued)

Other Assets

Other assets primarily include a consolidated 55%-owned affiliate, Delmarva Surgery Center, LLC. The Hospital also has a 50% non-controlling interest in each of the following entities, which are accounted for as equity method investments: Peninsula Imaging, LLC, AHP Delmarva, LLP, Genesis Healthcare, Peninsula-NRH Regional Rehabilitation, LLC, Peninsula Home Care, LLC, and Peninsula Home Care at Nanticoke.

Assets Limited as to Use

Assets limited as to use primarily include assets held by trustees under indenture agreements, assets held by trustees under irrevocable self-insurance trust agreements and assets, including pledges receivable, whose use has been limited by the donor of the underlying funds. Amounts required to meet current liabilities have been classified in the consolidated balance sheets as current assets.

Board-Designated Investments

Board-designated investments include assets set aside by the Board of Trustees for future capital improvements and expansion. The Board of Trustees retains control of these assets and may, at its discretion, subsequently use them for other purposes.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted donations. Absent explicit donor stipulations about how long those assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

2. Significant Accounting Policies (continued)

Unamortized Financing Costs

Financing costs incurred in issuing the Maryland Health and Higher Educational Facilities Authority Project and Refunding Revenue Bonds have been capitalized and are being amortized using the straight-line method over the life of the bonds, which approximates the effective interest method. The amount amortized is recorded as an operating expense.

Estimated Self-Insurance Liabilities and Workers' Compensation

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Pension Benefits

Pension benefits are recorded in accordance with ASC No. 715, *Compensation – Retirement Benefits*, which requires the recognition of the funded status of pension plans within the accompanying consolidated balance sheets. As of June 30, 2013 and 2012, the funded status of the pension plan has been recorded within other long-term liabilities.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period or purpose. Temporarily restricted net assets are to be used for capital purposes and other health care services.

Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors and others for services rendered. During 2013 and 2012, approximately 48% and 48% of net patient service revenue was received under the Medicare program, 13% and 14% from CareFirst Blue Cross Blue Shield, 31% and 30% from contracts with other third parties, and 8% and 8% from other sources, respectively.

(In Thousands)

2. Significant Accounting Policies (continued)

The following table sets forth the detail of net patient service revenue:

	Year Ended June 30 2013	2012
Gross patient service revenue	**$ 490,809**	$ 489,758
Revenue deductions:		
Charity care	**22,153**	18,575
Contractual and other allowances	**89,200**	88,517
Patient revenue, net of deductions	**379,456**	382,666
Less: Provision for bad debts	**15,608**	16,651
Net patient service revenue less bad debts	**$ 363,848**	$ 366,015

The Health System employs physicians in several hospital-based specialties. The Health System bills for the services provided by these physicians. Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts are recorded as a reduction in physician revenue when the services are provided. For the years ended June 30, 2013 and 2012, the Health System recorded $25,337 and $24,080 of net physician revenue, respectively. At June 30, 2013 and 2012, approximately $1,199 and $1,834, respectively, of net physician accounts receivable are included in accounts receivable in the accompanying consolidated balance sheets.

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Health System analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Health System analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Health

2. Significant Accounting Policies (continued)

System records a provision for bad debts in the period of service on the basis of its past experience. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. The Health System has not changed its charity care or uninsured discount policies during fiscal years 2013 or 2012.

Other Operating Revenue

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology. For Medicare and Medicaid EHR incentive payments, the Hospital uses a gain contingency accounting method to recognize the revenues. Under this accounting policy, EHR incentive payments are recognized as revenue upon the completion of the meaningful use period and completion of the related 12-month cost report. Accordingly, the Hospital recognized approximately $4,100 of EHR revenues for the year ended June 30, 2013. This is based on cost report data which is subject to audit by CMS or its intermediaries, and the amounts recognized are subject to change.

These amounts are included in other operating revenue in the consolidated statements of operations. The Hospital's attestation of compliance with the meaningful use criteria is subject to audit by the federal government or its designee. The recognition of revenues is based on management's best estimate. Any subsequent changes in the recognition of the revenue will impact the results of operations in the period in which they occur.

Charity Care

The Health System provided care to patients who met certain criteria under its charity care policy, without charge or at amounts less than its approved rates. Because the Health System did not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amounts written off as charity care for 2013 and 2012, were $17,833 and $14,577, respectively. These amounts represent direct and indirect charity care costs, which are calculated using the Health System's cost to charge ratio. The state of Maryland rate system includes components within the rates to partially compensate Health Systems for uncompensated care.

(In Thousands)

2. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Health System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted donations if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose of the restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Investment Income

Investment income primarily includes income from short-term and long-term investments, board-designated investments and investments within assets limited as to use. In addition, investment income is also recorded for certain equity method investments that are included within other assets.

The components of investment income are as follows:

	Year Ended June 30	
	2013	**2012**
Interest and dividend income	**$ 3,657**	$ 3,712
Realized gains, net	**8,084**	1,803
Income earned on equity method investments	**3,623**	3,695
Other	**344**	97
Total	**$ 15,708**	$ 9,307

2. Significant Accounting Policies (continued)

Income Taxes

The Health System is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

Performance Indicator

The performance indicator for the Health System is excess of unrestricted revenue and other support over expenses, which includes all changes in unrestricted net assets except for changes in unrealized gains and losses on investments, pension adjustments in accordance with ASC No. 958-715 – *Not for Profit Entities – Compensation – Retirement Benefits* and net assets released from restrictions for property acquisitions.

Recent Accounting Pronouncements

In July 2011, the FASB issued ASU 2011-07 which provided guidance on the presentation and disclosure of patient service revenue, provisions for bad debts, and the allowance for doubtful accounts for certain health care entities. This guidance changes the presentation of the statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, the guidance requires enhanced disclosures about the policies for recognizing revenue and assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The adoption of this guidance resulted in a change in the presentation on the consolidated statement of operations and resulted in additional disclosures related to revenue recognition policies and the allowance for doubtful accounts.

(In Thousands)

3. Property and Equipment

A summary of property and equipment follows:

	Estimated Useful Lives	June 30 2013	2012
Land	–	**$ 11,385**	$ 11,385
Land improvements	20	**13,996**	13,996
Buildings and improvements	15 – 40	**207,096**	191,666
Fixed equipment	20	**34,115**	32,235
Movable equipment	7 – 10	**206,487**	192,397
		473,079	441,679
Less accumulated depreciation		**(270,004)**	(248,435)
		203,075	193,244
Construction in progress		**8,681**	10,985
Property and equipment, net		**$ 211,756**	$ 204,229

As of June 30, 2013, the Hospital was committed to building and equipment purchases totaling approximately $2,405.

4. Other Liabilities

The components of other liabilities are as follows:

	June 30 2013	2012
Long-term benefit obligation	**$ 2,986**	$ 9,112
Self insurance obligations	**10,921**	11,156
Other	**437**	558
Total	**$ 14,344**	$ 20,826

(In Thousands)

5. Long-Term Debt

Long-term debt consists of the following:

	June 30 2013	June 30 2012
Maryland Health and Higher Educational Facilities Authority Revenue Bonds Series 2006:		
Serial bonds with interest rates ranging from 3.50% to 5.00% and effective rates ranging from 3.49% to 4.67% due in various annual amounts on July 1 of each year from 2007 through 2021 and 2027	**$ 30,850**	$ 33,765
5.00% term bonds with effective rate of 4.44% due July 1, 2026	**24,635**	24,635
5.00% term bonds with effective rate of 4.63% due July 1, 2036	**69,505**	69,505
Property acquisition note:		
5.50% due March 1 of each year from 2007 to 2015	**30**	45
Building and equipment collateral loans:		
7.68% fixed rate due monthly from 2007 to 2012 and 4.40% fixed rate due monthly from 2012 to 2022	**1,987**	2,059
	127,007	130,009
Less: Current portion of Maryland Health and Higher Educational Facilities Authority Series 2006 serial bonds	**3,040**	2,915
Less: Property acquisition note	**15**	15
Less: Current portion of building and equipment collateral loans	**69**	67
	123,883	127,006
Original issue premium	**3,020**	3,312
Long-term debt, less current portion	**$ 126,903**	$ 130,318

5. Long-Term Debt (continued)

On February 9, 2006, the Maryland Health and Higher Educational Facilities Authority (MHHEFA) authorized the issuance of $142,910 aggregate principal amount of Revenue Bonds (Series 2006 Bonds) at a premium of $5,333. The proceeds of the issue, after payment of financing costs, were used primarily: (i) to finance and refinance a portion of the costs of construction, renovation, acquisition and equipping of the 2006 Project; (ii) to refund outstanding 1993 bonds; (iii) to pay a portion of the interest accruing on the Series 2006 Bonds for a period to extend to January 1, 2009; and (iv) to pay the Counterparty a termination payment of $1,575 in connection with a forward starting interest rate exchange agreement entered into on August 9, 2005, and unwound on January 24, 2006.

Under the terms of the 2006 project and refunding revenue bonds, the Hospital is required to maintain certain deposits with a trustee. Such deposits are included within assets limited as to use. The revenue note indenture also places limits on the incurrence of additional borrowings and requires that the Hospital satisfy certain measures of financial performance as long as the notes are outstanding.

The Hospital is required to make semiannual payments to the trustee sufficient to meet the annual debt service requirements of the refunding bond issue for the succeeding year. Annual sinking fund installments for the term bonds range from $3,690 on July 1, 2027, to $8,820 at maturity. The premium on the Series 2006 Bonds is being amortized over the life of the bonds using the effective interest method.

As security for the debt service requirements of the Series 2006 Bonds, the MHHEFA has a first lien and claim on all receipts of the Hospital. The terms of the indenture agreement restrict the Hospital’s ability to create additional indebtedness and its use of the facilities, and require the Hospital to maintain stipulated insurance coverage and a rate structure in each year sufficient to meet certain rate covenant requirements.

On March 1, 2006, the Hospital entered into a promissory note for the acquisition of property in the amount of $135 ($30 outstanding at June 30, 2013). The interest rate is 5.50% with principal and interest due annually through 2015.

(In Thousands)

5. Long-Term Debt (continued)

On June 1, 2012, Delmarva Surgery Center, LLC (the Company), a 55% owned subsidiary of Health Ventures, entered into a fixed rate loan agreement with BB&T Bank in the amount of $2,059 ($1,987 outstanding at June 30, 2013), with fixed monthly payments through June 1, 2022. Scheduled principal repayments on long-term debt for the years ending June 30 are as follows:

2014	$ 3,125
2015	3,258
2016	3,406
2017	3,574
2018	3,753
2019 and thereafter	109,891
	$ 127,007

Fair values of long-term debt are estimated using discounted cash flow analyses, based on current incremental borrowing rates for similar types of borrowing arrangements.

The fair value of the Health System's long-term debt outstanding as of June 30, 2013 and 2012, was $130,912 and $138,236, respectively.

Total interest paid for fiscal years 2013 and 2012, was $6,195 and $6,624, respectively.

6. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

	June 30	
	2013	**2012**
Health care services:		
Capital purposes	**$ 12,988**	$ 10,384
Patient services	**4,124**	3,973
Educational purposes	**887**	897
	$ 17,999	$ 15,254

(In Thousands)

6. Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets are restricted to:

	June 30 2013	June 30 2012
Investments to be held in perpetuity, the income from which is expendable to support health care services	**$ 8,083**	$ 8,071

The Foundation initiated a major fundraising campaign for capital funds during fiscal year 2005 to support the Hospital's capital plans that include expansion and modernization of facilities. The Foundation has raised approximately $14,629 as of June 30, 2013, which includes net pledges receivable present valued at approximately $1,349. There were two large donations that represent approximately 54% and 29%, respectively, of the net pledges receivable at year-end. The Foundation expects to receive payment on the majority of the pledges by 2014 and all payments by 2025. Additionally, during 2011, the Foundation launched a fundraising campaign to support the Operating Room expansion. This campaign has raised $2,486 as of June 30, 2013 which includes net pledges receivable present valued at $683. Pledges receivable are included in assets limited as to use in the accompanying balance sheets.

Scheduled payments on pledges receivable for the years ending June 30 are as follows:

2014	$ 738
2015 – 2018	1,169
2019 and thereafter	600
	2,507
Less:	
Impact of discounting of pledges receivable to net present value	202
Allowance for uncollectible pledges	273
Net pledges receivable, capital campaign	2,032
Other pledges receivable	3
Total pledges receivable	$ 2,035

(In Thousands)

7. Functional Expenses

The Health System considers health care services and management and general to be its primary functional categories for purposes of expense classification. Depreciation and interest costs are included in health care services. The Health System's operating expenses by functional classification are as follows:

	Year Ended June 30	
	2013	**2012**
Health care services	**$ 339,353**	$ 329,237
Management and general	**35,214**	33,901
	$ 374,567	$ 363,138

8. Estimated Self-Insured Liability Claims and Workers' Compensation

The Hospital is self-insured for professional liability claims up to an annual limit of $2,000 per claim and $8,000 in aggregate. The Hospital carries an excess liability insurance policy for claims above these limits. There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted arising from services provided to patients. The Hospital has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. As of June 30, 2013 and 2012, the accrued self-insurance professional liability losses have been discounted at 0% and 2%, respectively, and in management's opinion provide an adequate reserve for loss contingencies. As of June 30, 2013 and 2012, respectively, $10,170 and $10,220 have been reserved for professional liability loss contingencies.

The Hospital established a trust for the purpose of setting aside assets based on actuarial funding recommendations. Under the trust agreement, the trust assets can only be used for payment of malpractice losses, related expenses and the cost of administering the trust. The assets of the trust are reported in assets limited as to use; income from trust assets, administrative costs and the Hospital's annual estimate of malpractice losses are reported in the consolidated statements of operations and changes in net assets.

The Hospital is self-insured for general liability claims beginning March 1, 2004, up to an annual limit of $1,000 per claim and $3,000 in aggregate. The Hospital carries an excess liability insurance policy for claims above these limits.

(In Thousands)

8. Estimated Self-Insured Liability Claims and Workers' Compensation (continued)

The Hospital is also self-insured for workers' compensation up to an annual limit of $500 per occurrence. The Hospital carries an excess liability insurance policy for workers' compensation claims above this limit. As of June 30, 2013 and 2012, respectively, $3,104 and $2,786 have been reserved for workers' compensation loss contingencies.

9. Investments

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

Fair values of all investments, including short-term investments, long-term investments, board-designated investments, and assets limited to use are based on quoted market prices and/or prices obtained from a third party using other market data for the same or comparable instruments and transactions in establishing the prices. Assets limited as to use also include the Foundation's temporarily restricted net assets which primarily consist of pledges receivable. Certain long-term pledges receivable have been discounted.

Fair value of investments and certain assets limited as to use held by the Health System is summarized as follows:

	June 30	
	2013	**2012**
Investments:		
Cash and cash equivalents	**$ 21,243**	$ 22,710
U.S. treasury securities	**9,637**	22,360
Corporate bonds	**44,463**	45,607
Equity securities	**142,649**	114,965
Government sponsored mortgage-backed securities	**31,849**	22,479
Other (including pledges receivable held at the Foundation)	**3,070**	5,721
Total	**$ 252,911**	$ 233,842

9. Investments (continued)

ASC No. 320, *Investments – Debt and Equity Securities,* provides guidance on the recognition and presentation of other-than-temporary impairments. In addition, additional disclosures are required related to other-than-temporary impairments. Under this revised guidance, if a debt security is in an unrealized loss position and the Health System has the intent to sell the debt security, or it is more likely than not that the Health System will have to sell the debt security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is recorded to other-than-temporary impairment losses recognized in the performance indicator in the consolidated statements of operations. For impaired debt securities that the Health System does not intend to sell or it is more likely than not that the Health System will not have to sell such securities, but the Health System expects that it will not fully recover the amortized cost basis, the credit component of the other-than-temporary impairment is recognized in other-than-temporary impairment losses recognized in income in the consolidated statements of operations and the non-credit component of the other-than-temporary impairment is recognized as a change in unrestricted net assets.

The credit component of other-than-temporary impairment is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the debt security. The net present value is calculated by discounting the best estimate of projected future cash flows at the effective interest rate implicit in the debt security at the date of acquisition. Cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default. Furthermore, unrealized losses entirely caused by non-credit-related factors related to debt securities for which the Health System expects to fully recover the amortized cost basis continue to be recognized as an unrealized loss on investments within the changes in unrestricted net assets.

(In Thousands)

9. Investments (continued)

The following table shows the gross unrealized losses and fair value of the Health System's investments with unrealized losses that are not deemed to be other than temporarily impaired, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at June 30, 2013 and 2012:

	Fair Value < 1 year	Unrealized Losses < 1 year	Fair Value > 1 year	Unrealized Losses > 1 year	Total Unrealized Losses
June 30, 2013					
Treasury securities	**$ 6,165**	**$ 112**	**$ 1,666**	**$ 35**	**$ 147**
Government sponsored mortgage backed securities	**12,405**	**303**	**3,788**	**161**	**464**
Corporate bonds	**21,863**	**679**	**1,675**	**91**	**770**
Equity securities	**15,176**	**1,047**	**1,680**	**112**	**1,159**
Total investments	**$ 55,609**	**$ 2,141**	**$ 8,809**	**$ 399**	**$ 2,540**

	Fair Value < 1 year	Unrealized Losses < 1 year	Fair Value > 1 year	Unrealized Losses > 1 year	Total Unrealized Losses
June 30, 2012					
Treasury securities	$ 10,471	$ 100	$ –	$ –	$ 100
Government sponsored mortgage backed securities	5,838	55	–	–	55
Corporate bonds	2,807	40	–	–	40
Equity securities	20,775	1,518	31	2	1,520
Total investments	$ 39,891	$ 1,713	$ 31	$ 2	$ 1,715

10. Fair Value Measurements

ASC No. 820, *Fair Value Measurements and Disclosures*, establishes a framework for measuring fair value. That framework provides 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 unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC No. 820 are described below:

- Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Health System has the ability to access.
- Level 2 – Inputs to the valuation methodology include:
  - Quoted prices for similar assets or liabilities in active markets;
  - Quoted prices for identical or similar assets or liabilities in inactive markets;
  - Inputs other than quoted prices that are observable for the asset or liability;
  - Inputs that are derived principally from or corroborated by observable market data by correlation or other means.
- Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

(In Thousands)

10. Fair Value Measurements (continued)

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the Health System's assets and liabilities measured at fair value, aggregated by level in the fair value hierarchy within which those measurements fall:

	Assets at Fair Value as of June 30, 2013			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	**$ 21,243**	**$ –**	**$ –**	**$ 21,243**
U.S. government securities	**9,637**	**–**	**–**	**9,637**
Corporate bonds	**–**	**44,463**	**–**	**44,463**
Government sponsored mortgage–backed securities	**–**	**31,849**	**–**	**31,849**
Equity securities	**142,649**	**–**	**–**	**142,649**
Other	**1,035**	**–**	**2,035**	**3,070**
Total assets	**$ 174,564**	**$ 76,312**	**$ 2,035**	**$ 252,911**

	Assets at Fair Value as of June 30, 2012			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	$ 22,710	$ –	$ –	$ 22,710
U.S. government securities	22,360	–	–	22,360
Corporate bonds	–	45,607	–	45,607
Government sponsored mortgage–backed securities	–	22,479	–	22,479
Equity securities	114,965	–	–	114,965
Other	928	2,467	2,326	5,721
Total assets	$ 160,963	$ 70,553	$ 2,326	$ 233,842

(In Thousands)

10. Fair Value Measurements (continued)

The fair values of securities are determined by third-party service providers utilizing various methods dependent upon the specific type of investment. Where quoted prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Where significant inputs, including benchmark yields, broker-dealer quotes, issuer spreads, bids, offers, the LIBOR curve and measures of volatility, are used by these third-party dealers or independent pricing services to determine fair values, the securities are classified within Level 2.

Long-term pledges receivable, which are measured at fair value on a non-recurring basis, are discounted to net present value upon receipt using an appropriate risk-free discount rate based on the term of the receivable. Pledges receivable are recorded net of an allowance for uncollectible pledges. The following table provides a reconciliation of the beginning and ending balances of pledges receivable at fair value that used significant unobservable inputs (Level 3):

	Year Ended June 30	
	2013	**2012**
Pledges receivable		
Balance at July 1	**$ 2,326**	$ 2,939
New pledges	**337**	275
Collections on pledges	**(682)**	(815)
Write-off of pledges	**(16)**	(197)
Changes in reserves	**70**	124
Balance at June 30	**$ 2,035**	$ 2,326

11. Pension Plan

The Health System has a cash balance-type defined benefit pension plan covering substantially all of its employees. The Plan benefits are based on years of service and the employees' compensation during the last five years of covered employment. The Health System's funding policy is to make sufficient contributions to the Plan to comply with the minimum funding provisions of the Employee Retirement Income Security Act. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

11. Pension Plan (continued)

The Peninsula Regional Medical Center Pension Plus Plan (the Plan) provides annual allocations to a participant's hypothetical account. When a participant retires, the participant has the choice to receive a lump-sum distribution equal to the value of the hypothetical account or to receive an annuity based on the value of the hypothetical account.

Prior to January 1, 2009, the Plan provided three different allocations: (i) a service-related allocation, (ii) an age-related allocation, and (iii) a matching allocation. Both the service-related allocation and the age-related allocation were determined by multiplying a participant's annual compensation by a certain percentage. The matching allocation operated to provide an annual allocation in the Plan based on the participant's contribution to the Health System's 403(b) Plan.

The IRS issued new regulations that were effective as of January 1, 2009. The new regulations prohibited a pension plan from providing a matching allocation based on a participant's contributions to a different plan. The Plan provided a matching allocation based on a participant's contribution to a 403(b) Plan. In order to comply with the new tax law requirements, the Plan was amended effective as of December 31, 2008, to eliminate future matching allocations in the Plan. At the same time, the Health System adopted a 403(b) plan effective as of January 1, 2009, and provided a replacement matching contribution in the 403(b) plan.

The assets of the Plan are available to pay the benefits of eligible employees of all participating entities. The Plan had an unfunded liability of $2,986 and $9,112 as of June 30, 2013 and 2012, respectively. During 2013, an error was identified in the calculation of the discount rate which resulted in an understatement of the unfunded liability in the prior year financial statements. The impact to the prior year was determined to be immaterial and the correction was recorded in the current year as an actuarial loss.

(In Thousands)

11. Pension Plan (continued)

The following provides a reconciliation of the changes in fair value of the Plans' assets and projected benefit obligations, and the Plans' funded status:

	2013	2012
Accumulated benefit obligation	**$ 97,810**	$ 94,241
Projected benefit obligation, beginning of year	**$ 101,641**	$ 85,231
Service cost	**4,846**	3,926
Interest cost	**4,006**	5,024
Actuarial loss	**1,599**	11,094
Benefits paid	**(4,352)**	(3,634)
Projected benefit obligation, end of year	**107,740**	101,641
Fair value of plan assets, beginning of year	**92,529**	87,247
Actual gain on plan assets	**10,577**	1,816
Employer contributions	**6,000**	7,100
Benefits paid	**(4,352)**	(3,634)
Fair value of plan assets, end of year	**104,754**	92,529
Fair value of plan assets less than the projected benefit obligation	**$ (2,986)**	$ (9,112)
Accrued pension cost recorded in the consolidated balance sheets	**$ (2,986)**	$ (9,112)

(In Thousands)

11. Pension Plan (continued)

Components of net periodic benefit cost are as follows:

	Year Ended June 30	
	2013	**2012**
Service cost	**$ 4,844**	$ 3,926
Interest cost	**4,006**	5,025
Expected return on plan assets	**(7,051)**	(6,796)
Amortization of prior service credit	**(126)**	(126)
Recognized net actuarial loss	**3,343**	2,106
Net periodic benefit cost	**$ 5,016**	$ 4,135

Net amount recognized in unrestricted net assets that have not been recognized in net periodic benefit cost are as follows:

	2013	**2012**
Net actuarial loss	**$ 39,038**	$ 44,308
Prior service credit	**(441)**	(566)
Total recognized in unrestricted net assets	**$ 38,597**	$ 43,742

The estimated net actuarial loss and prior service credit for the Plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year are $3,300 and ($126), respectively.

(In Thousands)

11. Pension Plan (continued)

Weighted average assumptions used to determine projected benefit obligations and net periodic benefit costs at June 30 were as follows:

	2013	2012
Projected benefit obligation		
Discount rate	**4.15%**	4.00%
Rates of increase in compensation levels:		
Age:		
<30	**5.00%**	5.00%
30<44	**4.00%**	4.00%
45=<	**3.00%**	3.00%
Net periodic benefit cost		
Discount rate	**4.00%**	6.00%
Expected long-term return on plan assets	**7.25%**	7.50%
Rate of increase in compensation levels:		
Age:		
<30	**5.00%**	5.00%
30<44	**4.00%**	4.00%
45=<	**3.00%**	3.00%

The defined benefit pension plan asset allocation as of the measurement date and the target asset allocation, presented as a percentage of total plan assets, were as follows:

	2013	2012	Target Allocation
Debt securities	**29%**	33%	25% – 40%
Equity securities	**68**	64	45% –75%
Cash and cash equivalents	**3**	3	1% – 10%
Total	**100%**	100%	

(In Thousands)

11. Pension Plan (continued)

The Health System's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in U.S. equity securities and fixed income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. This is performed through forecasting and assessing ranges of investment outcomes over short-term and long-term horizons, and by assessing the Health System's financial condition and its future potential obligations from both the pension and general operational requirements. Complementary investment styles, such as growth and value equity investing techniques, are utilized by the Health System's investment advisors to further improve portfolio and operational risk characteristics. Equity investments, both active and passively managed, are used primarily to increase overall plan returns. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

Asset allocations and investment performance are formally reviewed at regularly scheduled meetings of the Health System's Financial Resources Committee.

The overall rate of expected return on assets assumption was based on historical returns, with adjustments made to reflect expectations of future returns. The extent to which the future expectations were recognized included the target rates of return for the future which have not historically changed.

The fair value of the Health System's pension plan assets as of June 30, 2013 and 2012, by asset category (see Note 10, *Fair Value Measurements* for a description of the asset categories) are as follows:

	June 30, 2013			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	**$ 3,318**	**$ –**	**$ –**	**$ 3,318**
U.S. Treasuries	**5,069**	**–**	**–**	**5,069**
Government sponsored mortgage-backed securities	**–**	**7,161**	**–**	**7,161**
Corporate debt securities	**–**	**17,829**	**–**	**17,829**
Publically traded equity securities	**70,591**	**417**	**–**	**71,008**
Other	**369**	**–**	**–**	**369**
Total investments	**$ 79,347**	**$ 25,407**	**$ –**	**$ 104,754**

(In Thousands)

11. Pension Plan (continued)

	June 30, 2012			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Investments at fair value:				
Cash and cash equivalents	$ 3,114	$ –	$ –	$ 3,114
U.S. Treasuries	7,499	–	–	7,499
Government sponsored mortgage-backed securities	–	5,102	–	5,102
Corporate debt securities	–	24,251	–	24,251
Publically traded equity securities	52,155	–	–	52,155
Other	408	–	–	408
Total investments	$ 63,176	$ 29,353	$ –	$ 92,529

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

U.S. Treasuries: the fair value is determined by an active price for an identical security in an observable market.

Corporate debt securities and government sponsored mortgage-backed securities: the fair value is estimated using quoted prices for similar assets in active markets or quoted prices for identical or similar assets in non-active markets (few transactions, limited information, non-current prices, and high variability over time).

Money market funds: the carrying value of these money market funds approximates fair value as the maturities are less than three months.

Publically traded equity securities: the fair value is determined by market quotes for an identical security in an observable market.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

(In Thousands)

11. Pension Plan (continued)

Cash Flows

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

2014	$ 9,928
2015	9,966
2016	9,466
2017	9,157
2018	9,305
2019 – 2023	42,754

The Health System intends to make voluntary contributions to the defined benefit pension plan of $6 million for the year ending June 30, 2014. This funding level exceeds any regulatory requirements for 2013.

12. Commitments and Contingencies

Agreement with the Office of Inspector General

The Health System received several subpoenas from the Office of Inspector General of the U.S. Department of Health and Human Services (OIG), requiring the production of certain documents related to claims for physician health care services provided by a former Medical Staff Member. These subpoenas were issued in connection with a civil investigation being conducted by the U.S. Attorney's Office for the District of Maryland. In January 2011, the Health System reached a tentative "Agreement in Principle", which was ultimately approved by the U.S. Department of Justice, the OIG, the Office of Personnel Management (OPM), and the state of Maryland in August 2011, to resolve all remaining potential civil claims arising out of the Health System's medical services to patients of the physician. The Health System reached this agreement without admitting liability in order to avoid the expense and uncertainty of litigation and to allow the Health System to move forward. In this regard and consistent with the settlement, an amount of $1.8 million was paid in June 2011. The settlement also includes a five year Corporate Integrity Agreement that will require the Health System to establish and/or enhance various compliance processes and also have several independent peer review reports completed on an annual basis.

12. Commitments and Contingencies (continued)

Other

The Health System has been named as a defendant in various lawsuits arising from the performance of its normal activities. In the opinion of the Health System's management, after discussion with legal counsel, the amount, if any, of the Health System's ultimate liability under these lawsuits will not have a material adverse effect on the financial position of the Health System.

A portion of the Health System's revenues is received from health maintenance organizations and other managed care payors. Managed care payors generally use case management activities to control utilization. These payors also have the ability to select providers offering the most cost-effective care. Management does not believe that the organization has undue exposure to any one managed care payor.

The Health System's revenues may be subject to adjustment as a result of examination by government agencies or contractors based upon differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered. Section 302 of the Tax Relief and Health Care Act of 2006 authorized a permanent program involving the use of third-party recovery audit contractors (RACs) to identify Medicare overpayments and underpayments made to providers. We have established protocols to respond to RAC requests and payment denials. Payment recoveries resulting from RAC reviews are appealable through administrative and judicial processes, and we intend to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. As of June 30, 2013 and 2012, the Health System has recorded an estimated reserve regarding the Medicare overpayments. In the opinion of the Health System's management, the ultimate settlement of this matter will not have a material adverse effect on the financial position of the Health System.

As part of a national investigation, the Health System is working on a data request by the Department of Justice (DOJ) regarding the Medicare programs coverage guidelines for the implantation of implantable cardioverter defibrillators (ICD's). As of June 30, 2013, no case or demand for payment has been initiated by DOJ or Centers for Medicare and Medicaid Services (CMS).

12. Commitments and Contingencies (continued)

On June 22, 2012, the Health System filed a self disclosure to CMS, reporting technical violations of the self referral regulations (referred to as Stark). As of June 30, 2013, the Health System does not believe the settlement of this issue will have a material adverse effect on the entity's financial statements.

13. Maryland Health Services Cost Review Commission

Certain Hospital charges are subject to review and approval by the Maryland Health Services Cost Review Commission (HSCRC). Hospital management has filed the required forms with the Commission and believes the Hospital to be in compliance with Commission requirements.

The current rate of reimbursement for principally all inpatient services and certain other services to patients under the Medicare and Medicaid programs is based on an agreement between the Centers for Medicare and Medicaid Services and the Commission. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the State of Maryland under Section 1814(b) of the Social Security Act and will continue as long as the rate of increase for costs per hospital inpatient admission in Maryland is below the national average. Management expects this agreement will remain in effect at least through June 30, 2014.

Under the HSCRC rate-setting system, the Hospital's inpatient charges are subject to an inpatient charge per case target (the Charge Per Case Target). Under the charge per case target methodology, the Hospital monitors its average charge per case compared to HSCRC case mix adjusted targets on a monthly basis. The Charge Per Case (CPC) Target is adjusted annually for inflation, case mix changes, and other factors.

Beginning in fiscal year 2011, the HSCRC adjusted its Charge Per Case policy and removed one-day stay (ODS) cases from the Hospital's case mix and charge per case revenue. ODS cases are now reimbursed on approved HSCRC charges rather than under the case mix adjusted CPC target.

Beginning in fiscal year 2012, the Hospital entered into a three-year agreement with the HSCRC to participate in the Admission Readmission Revenue (ARR) program. The ARR arrangement is a voluntary revenue constraint program to incentivize hospitals to coordinate care and reduce unnecessary readmissions. The ARR agreement imposes a case mix adjusted Charge per Episode

13. Maryland Health Services Cost Review Commission (continued)

(CPE) target to inpatient admissions and any subsequent readmission within 30 days of the discharge of the initial admission of the same patient. The CPE target is adjusted annually for inflation, case mix charges, and other factors.

Also beginning in fiscal year 2011, the Commission implemented the Charge Per Visit (CPV) methodology for certain outpatient services. Using fiscal year 2010 as the base period, the actual average 2011 CPV is compared with the base period target. Similar to the CPC target, the CPV target is adjusted annually for inflation, case mix changes, and other factors. The outpatient services that are excluded from the CPV methodology are reimbursed on approved HSCRC charges. In March 2012, the HSCRC suspended the outpatient CPV methodology retroactive to July 1, 2011. Until further notice, all outpatient services are reimbursed on approved HSCRC unit rate charge.

Under these methodologies, a target average charge is established for the Hospital based on past actual charges and case mix indices. The actual average charge is compared with the target average charge, and to the extent that the actual average exceeds or is less than the target, the difference adjusted for applicable penalties will reduce or increase the approved target for future rate years. For the year ended June 30, 2013 the Hospital's charges exceeded the target by $4,460 and for the year ended June 30, 2012 charges were less than the target by $124.

The timing of the HSCRC's rate adjustments for the Hospital could result in an increase or reduction in rates due to the variances and penalties described above in a year subsequent to the year in which such items occur, and there is at least a possibility that the amounts may be material. The Hospital's policy is to record revenue based on actual charges for services to patients in the year in which the services are performed. The Hospital recognizes unbilled revenue for in-house patients.

14. Subsequent Events

Effective May 16, 2013, Delmarva Peninsula Insurance Company (DPIC) was formed as a captive insurer to provide professional and general liability insurance. DPIC is a wholly owned subsidiary of the Medical Center, which was formed in the Cayman Islands and began operations in July 2013. Effective July 1, 2013, the primary layer of professional and general liability insurance and the excess umbrella liability coverage is insured through DPIC. DPIC obtains 100% reinsurance for the excess umbrella liability coverage through commercial insurance carriers.

The Health System has evaluated subsequent events through September 23, 2013, the date the financial statements were issued.

Supplementary Information

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet
(In Thousands)

June 30, 2013

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 19,121	$ 1,021	$ 9,132	$ 15	$ –	$ 29,289
Short-term investments	4,757	–	–	–	–	4,757
Accounts receivable, less allowance for uncollectible accounts	36,728	–	525	–	–	37,253
Inventories and other	13,518	–	385	–	–	13,903
Total current assets	74,124	1,021	10,042	15	–	85,202
Long-term investments	171,591	–	–	–	–	171,591
Investment in subsidiaries		–	–	362,736	(362,736)	–
Board-designated investments	18,941	–	–	–	–	18,941
Assets limited as to use:						
Debt service reserve fund	9,245	–	–	–	–	9,245
Donor-restricted fund	26,045	5,931	–	–	(5,931)	26,045
Self-insurance fund	13,154	–	–	–	–	13,154
Total assets limited as to use	48,444	5,931	–	–	(5,931)	48,444
Property and equipment, net	207,843	–	3,913	–	–	211,756
Unamortized financing costs, net of accumulated amortization	2,254	–	59	–	–	2,313
Other assets	2,317	–	7,845	–	–	10,162
Total assets	$ 525,514	$ 6,952	$ 21,859	$ 362,751	$ (368,667)	$ 548,409

Peninsula Regional Health System, Inc.

Consolidating Balance Sheet (continued)

(In Thousands)

June 30, 2013

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Current portion of long-term debt	$ 3,055	$ –	$ 69	$ –	$ –	$ 3,124
Current portion of accrued self-insured liabilities	2,395	–	–	–	–	2,395
Accounts payable and accrued liabilities	34,418	–	249	–	–	34,667
Advances from third-party payors	8,054	–	–	–	–	8,054
Total current liabilities	47,922	–	318	–	–	48,240
Long-term debt, net	124,985	–	1,918	–	–	126,903
Other liabilities	14,344	–	–	–	–	14,344
Total liabilities	187,251	–	2,236	–	–	189,487
Net assets:						
Unrestricted	312,181	1,021	17,523	330,737	(330,722)	330,740
Temporarily restricted	17,999	5,931	–	23,930	(29,861)	17,999
Permanently restricted	8,083	–	–	8,083	(8,083)	8,083
Peninsula Regional Health System, Inc net assets	338,263	6,952	17,523	362,750	(368,666)	356,822
Minority interest	–	–	2,100	–	–	2,100
Total net assets	338,263	6,952	19,623	362,750	(368,666)	358,922
Total liabilities and net assets	$ 525,514	$ 6,952	$ 21,859	$ 362,750	$ (368,666)	$ 548,409

Peninsula Regional Health System, Inc.

Consolidating Statement of Operations

(In Thousands)

Year Ended June 30, 2013

	Peninsula Regional Medical Center	Peninsula Regional Medical Center Foundation, Inc.	Peninsula Health Ventures, Inc.	Peninsula Regional Health System, Inc.	Eliminations	Consolidated
Unrestricted revenue and other support:						
Net patient service revenue	$ 375,278	$ –	$ 4,178	$ –	$ –	$ 379,456
Provision for bad debts	(15,598)	–	(10)	–	–	(15,608)
Net patient service revenue less provision for bad debts	359,680	–	4,168	–	–	363,848
Other operating revenue	6,444	–	9	–	–	6,453
Net assets released from restrictions	–	395	–	–	(395)	–
Total unrestricted revenue and other support	366,124	395	4,177	–	(395)	370,301
Operating expenses:						
Salaries and wages	149,254	–	–	–	–	149,254
Supplies and other expenses	151,802	–	4,965	–	–	156,767
Employee benefits	40,044	–	–	–	–	40,044
Depreciation	22,008	–	246	–	–	22,254
Interest	6,151	–	97	–	–	6,248
Contributions to Hospital	–	395	–	–	(395)	–
Total operating expenses	369,259	395	5,308	–	(395)	374,567
Income (loss) from operations	(3,135)	–	(1,131)	–	–	(4,266)
Nonoperating income:						
Nonoperating income	13,210	1	2,497	–	–	15,708
Basis swap income	644	–	–	–	–	644
	13,854	1	2,497	–	–	16,352
Excess of unrestricted revenue and other support over expenses	10,719	1	1,366	–	–	12,086
Minority interest in earnings of controlled subsidiaries	–	–	6	–	–	6
Excess of unrestricted revenue and other support over expenses attributable to PRHS	$ 10,719	$ 1	$ 1,372	$ –	$ –	$ 12,092

Ernst & Young LLP

Assurance | Tax | Transactions | Advisory

About Ernst & Young
Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, our 167,000 people are united by our shared values and an unwavering commitment to quality. We make a difference by helping our people, our clients and our wider communities achieve their potential.

For more information, please visit www.ey.com

Ernst & Young refers to the global organization of member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. This Report has been prepared by Ernst & Young LLP, a client serving member firm located in the United States.