WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Financial Statements and Supplementary Information

June 30, 2018 and 2017

(With Independent Auditors' Report Thereon)

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

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KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

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, 2018 and 2017, 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, 2018 and 2017, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audit was 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 3, 2018

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Balance Sheets

June 30, 2018 and 2017

(Dollars in thousands)

Assets		2018	2017
Current assets:			
Cash and cash equivalents	$	42,833	47,198
Investments		21,612	23,310
Funds on deposit with trustee		17,784	17,489
Accounts receivable, less allowance for doubtful accounts of $4,641 in 2018 and $3,728 in 2017		37,452	35,786
Pledge receivable, net		95	186
Other receivables, less allowance for uncollectible accounts of $1,351 in 2018 and $1,430 in 2017		4,618	5,561
Inventories and other current assets		11,301	10,093
Total current assets		135,695	139,623
Investments		93,505	83,919
Board designated investments		10,484	10,324
Other long-term investments		223	440
Investments restricted by donor or grantor		5,680	6,093
Beneficial interest in trustee held Foundation assets		2,144	1,836
Property and equipment, net		257,026	274,181
Investments in affiliates		35,175	31,647
Other assets		5,043	9,363
Total assets	$	544,975	557,426
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	12,722	12,234
Accounts payable and accrued liabilities		8,915	12,485
Accrued bond interest payable		5,399	5,694
Accrued salaries and benefits		13,989	11,563
Payable to third-party payors		6,295	6,645
Total current liabilities		47,320	48,621
Long-term debt, net of current portion and deferred financing costs		219,608	235,185
Pension benefits in excess of pension assets		49,163	74,394
Other liabilities		12,497	17,731
Total liabilities		328,588	375,931
Net assets:			
Unrestricted:			
Unrestricted net assets		207,005	171,932
Noncontrolling interest in consolidated subsidiaries		1,474	1,455
Total unrestricted net assets		208,479	173,387
Temporarily restricted		5,462	5,991
Permanently restricted		2,446	2,117
Total net assets		216,387	181,495
Total liabilities and net assets	$	544,975	557,426

See accompanying notes to consolidated financial statements.

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Statements of Operations

Years ended June 30, 2018 and 2017

(Dollars in thousands)

	2018	2017
Unrestricted revenues and other support:		
Patient service revenue (net of contractual allowances and charity)	$ 334,534	330,257
Provision for bad debts	(7,310)	(6,921)
Net patient service revenue	327,224	323,336
Other revenue	6,255	6,171
Total revenues and other support	333,479	329,507
Expenses:		
Salaries and wages	116,519	109,581
Employee benefits	35,391	40,227
Professional fees	19,816	18,358
Purchased services	47,601	47,784
Supplies	52,718	53,628
Utilities	4,400	4,660
Insurance	1,907	2,497
Interest	10,798	11,388
Depreciation and amortization	24,558	25,116
Other	7,640	7,294
Total expenses	321,348	320,533
Operating income	12,131	8,974
Nonoperating income:		
Equity in income of affiliates	2,593	5,650
Investment income, including realized gains on trading portfolio	4,473	3,134
Unrealized gains on trading portfolio	4,549	5,532
Other	(79)	(64)
Total nonoperating income	11,536	14,252
Excess of revenues over expenses	$ 23,667	23,226

See accompanying notes to consolidated financial statements.

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2018 and 2017

(Dollars in thousands)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total net assets
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
Excess of revenues over expenses	23,667	—	—	23,667
Investment gain	—	(67)	—	(67)
Donations	—	1,059	—	1,059
Grants	—	30	—	30
Change in funded status of pension plan	12,886	—	—	12,886
Net assets released for operations	—	(824)	—	(824)
Net assets released for purchase of property and equipment	729	(727)	—	2
Unrealized gains on investments	—	—	21	21
Change in beneficial interest of trustee-held Foundation assets	—	—	58	58
Transfers (to) from affiliates	—	—	250	250
Distributions to noncontrolling interest in consolidated subsidiaries	(2,190)	—	—	(2,190)
Change in net assets	35,092	(529)	329	34,892
Balance at June 30, 2018	$ 208,479	5,462	2,446	216,387

See accompanying notes to consolidated financial statements.

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidated Statements of Cash Flows

Years ended June 30, 2018 and 2017

(Dollars in thousands)

	2018	2017
Cash flows from operating activities:		
Change in net assets	$ 34,892	50,557
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	24,558	25,116
Amortization of bond financing costs and premiums	(2,971)	(3,134)
Change in funded status of pension plan	(12,886)	(28,403)
Provision for bad debts	7,310	6,921
Distributions to noncontrolling interest holder	2,190	2,141
Loss on sale of assets	—	32
Equity in income of affiliates	(2,593)	(5,650)
Realized and unrealized gains on investments	(6,571)	(7,003)
Change in beneficial interest in trustee held Foundation assets	(58)	110
Restricted contributions	(1,089)	(1,290)
Changes in assets and liabilities:		
Accounts receivable	(8,976)	(5,573)
Other receivables	1,034	(327)
Inventories and other current assets	(1,208)	(207)
Accounts payable and accrued liabilities, accrued bond interest payable and accrued salaries and benefits	(1,497)	(950)
Payable to third-party payors	(350)	(978)
Other assets, funded status of pension plan, and other liabilities	(13,259)	(9,561)
Net cash provided by operating activities	18,526	21,801
Cash flows from investing activities:		
Purchase of long-lived assets	(7,229)	(10,310)
Change in funds on deposit with trustee	(295)	(284)
Net change in investments	(2,090)	(24,797)
Net cash used in investing activities	(9,614)	(35,391)
Cash flows from financing activities:		
Repayments of long-term debt	(11,795)	(11,170)
Capital lease payments	(439)	(30)
Proceeds from restricted contributions	1,089	1,290
Restricted investment loss	58	(110)
Distributions to noncontrolling interest holder	(2,190)	(2,141)
Net cash used in financing activities	(13,277)	(12,161)
Net decrease in cash and cash equivalents	(4,365)	(25,751)
Cash and cash equivalents at beginning of year	47,198	72,949
Cash and cash equivalents at end of year	$ 42,833	47,198
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 11,093	11,669
Capital additions accrued but not paid	476	418

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 213 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)
- Western Maryland Physician Network, LLC

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, 2018 and 2017.

(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 $1,976 and $2,092 at June 30, 2018 and 2017, 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 $6 and $25 for the years ended June 30, 2018 and 2017, 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 2018 and 2017. 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, 2018 and 2017.

On December 22, 2017, the President signed into law H.R. 1, originally known as the Tax Cuts and Jobs Act. The new law includes several provisions that result in substantial changes to the tax treatment of tax-exempt organizations and their donors. WMHS has reviewed these provisions and the potential impact and concluded the enactment of H.R. 1 will not have a material effect on the operations of the organization.

(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. Beginning in December 2017, oversight of the information systems service line was transferred from the MSO to WMHS. The Health System incurred $23,809 and $25,369 in expenses related to Trivergent during the years ending June 30, 2018 and 2017, 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. Effective January 1, 2018, a freeze was placed on benefit accruals in the Plan for all employees except those specified in the plan amendment with certain levels of years of service and/or age. Those employees whose benefits were frozen are now also participating in the defined contribution plan.

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

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 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 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, but early adoption will take place in fiscal year 2019. 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.

(Dollars in thousands)

(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 4, 2019.

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

During fiscal years 2018 and 2017, net patient service revenue was received from the following payors:

	2018	2017
Medicare	57 %	57 %
Medicaid	17	18
Blue Cross	9	9
Self-pay	2	1
Other	15	15
	100 %	100 %

Gross accounts receivable at June 30, 2018 and 2017 consisted of the following payors:

	2018	2017
Medicare	43 %	44 %
Medicaid	18	19
Blue Cross	7	7
Self-pay	15	12
Other	17	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

(Dollars in thousands)

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:

		2018	2017
Beginning balance as of July 1	$	3,728	3,439
Provision for uncollectible accounts		7,310	6,921
Less write offs		(6,397)	(6,632)
Ending balance as of June 30	$	4,641	3,728

(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:

		2018	2017
U.S. government obligations	$	5,852	15,701
Money market funds		34,113	33,996
Corporate stocks and other		64,593	58,723
Fixed income securities		44,730	33,155
	$	149,288	141,575

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

		2018	2017
Investments	$	115,117	107,229
Funds on deposit with trustee		17,784	17,489
Board designated investments		10,484	10,324
Other long-term investments		223	440
Investments restricted by donor or grantor		5,680	6,093
	$	149,288	141,575

(Continued)

(Dollars in thousands)

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

		2018	2017
Income:			
Investment income	$	2,384	2,335
Realized gains on trading investment portfolio		2,089	799
Unrealized gains on trading investment portfolio		4,549	5,532
Restricted investment (loss) income		(67)	672
	$	8,955	9,338

(5) Property and Equipment

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

		2018	2017
Land and land improvements (2–25 years)	$	15,036	15,027
Buildings and improvements (5–40 years)		330,688	331,280
Equipment (3–20 years)		213,448	206,884
Construction in progress		493	1,063
		559,665	554,254
Less accumulated depreciation		302,639	280,073
Property and equipment, net	$	257,026	274,181

Depreciation expense for the year ended June 30, 2018 was $24,442. Depreciation expense for the year ended June 30, 2017 was $25,000.

(Continued)

(Dollars in thousands)

(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		Equity in income (loss)	
			2018	2017	2018	2017
Maryland Physicians Care[1]	25.00 %	State of Maryland Medicaid managed care	$ 29,625	27,025	2,600	5,607
Other affiliates	0.14% to 33.33%	Supply purchasing and medical equipment	5,550	4,622	(7)	43
			$ 35,175	31,647	2,593	5,650

[1]Maryland Physicians Care is inclusive of Maryland Care, Inc. and Subsidiary and Maryland Care Management, Inc.

Maryland Physicians Care had the following summary financial information as of and for the years ended June 30, 2018 and 2017:

		2018	2017
Total assets	$	351,389	308,769
Total liabilities		232,889	200,671
Net assets	$	118,500	108,098
Total revenues	$	1,132,477	1,110,819
Total expenses		1,122,077	1,088,393
Net income	$	10,400	22,426

(Continued)

(Dollars in thousands)

(7) Long-Term Debt

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

		2018	2017
Maryland Health and Higher Educational Facilities Authority (MHHEFA) Series 2014 Revenue Bonds, interest rate 4% to 5.25%	$	210,245	222,040
Capital leases		666	1,105
Net unamortized bond premium		23,395	26,366
Long-term debt		234,306	249,511
Less current portion of long-term debt		12,722	12,234
Less unamortized financing fees		1,976	2,092
Long-term debt less current portion	$	219,608	235,185

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

2019	$	12,722
2020		13,263
2021		13,717
2022		14,335
2023		11,675
Thereafter		145,199

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.

(Continued)

(Dollars in thousands)

In 2017, the Health System amended their line of credit agreement with a bank that permits the Health System to borrow up to $1,000. The expiration date on the line of credit is December 31, 2018 and the interest rate as of June 30, 2018 was 5.00%. 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, 2018 and 2017.

(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 $10,489 and $10,386 for the years ended June 30, 2018 and 2017, respectively. The total direct and indirect costs to provide the care amounted to approximately $8,171 and $8,153 for the years ended June 30, 2018 and 2017, respectively.

(9) Retirement Plans

The WMHS Retirement Plan (the Plan) is a noncontributory defined benefit plan, which covers substantially all full-time employees who were employed prior to 2011 and 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.

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, 2018 and 2017 are as follows:

		2018	2017
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	299,549	304,259
Service cost		4,302	6,389
Interest cost		10,673	10,448
Assumptions		(5,714)	(9,879)
Actuarial loss		(560)	(1,488)
Benefits paid		(17,880)	(10,180)
Projected benefit obligation at end of year		290,370	299,549

(Continued)

(Dollars in thousands)

		2018	2017
Change in plan assets:			
Plan assets at fair value at beginning of year	$	225,155	192,107
Actual return		17,932	21,228
Employer contributions		16,000	22,000
Benefits paid		(17,880)	(10,180)
Fair value of plan assets at end of year		241,207	225,155
Funded status at end of year	$	(49,163)	(74,394)

		2018	2017
Amounts recognized in unrestricted net assets:			
Net prior service costs	$	(265)	(3,655)
Net actuarial loss		94,203	110,479
Amounts recognized in unrestricted net assets	$	93,938	106,824

		2018	2017
Components of net periodic benefit costs:			
Service cost	$	4,302	6,389
Interest cost		10,673	10,448
Expected return on plan assets		(16,012)	(13,977)
Recognized prior service cost		(3,391)	(665)
Recognized net loss		8,083	10,450
Net periodic pension cost	$	3,655	12,645

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $93,938 and $106,824 at June 30, 2018 and 2017, 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

(Continued)

(Dollars in thousands)

to be recognized as a component of net period pension costs during the year ending June 30, 2018 is $6,662.

	2018	2017
Weighted average assumptions – benefit obligations:		
Discount rate	4.01 %	3.71 %
Salary scale	2.50	2.50
Return on assets	7.00	7.00
Weighted average assumptions – net periodic expense:		
Discount rate	3.71 %	3.51 %
Salary scale	2.50	2.50
Return on assets	7.00	7.00

The accumulated benefit obligation for the defined benefit pension plan was $287,741 and $295,865 at June 30, 2018 and 2017, respectively.

The Health System's pension plan weighted average asset allocations at the measurement dates of June 30, 2018 and 2017, by asset category, are as follows:

	Percentage of plan assets		
	Target allocation	2018	2017
Asset class:			
Equities	60 %	72 %	67 %
Fixed income	40	28	33

The Health System expects to contribute $12,000 to the Plan for the fiscal year ending June 30, 2019.

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:

2019	$ 11,422
2020	12,200
2021	13,172
2022	14,244
2023	15,225
2024–2028	87,601

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, 2018.

(Continued)

In the second quarter of fiscal year 2018, lump sum payments of a participant's accrued benefits were offered to terminated vested participants with balances of $75 or less. This resulted in a payout of $6,832 and a net decrease in the pension benefits in excess of pension assets.

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. Effective January 1, 2018, a freeze was placed on benefit accruals in the Plan for all participants except those specified in the plan amendment with certain levels of years of service and/or age. Those participants whose benefits were frozen are now also participating in the defined contribution plan. The Health System recorded expense related to the employees in the defined contribution plan of $2,865 and $1,020 for the years ended June 30, 2018 and 2017, 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, 2018 and 2017 was $2,123 and $1,915, 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 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 $11,291 and $16,679 as of June 30, 2018 and 2017, respectively. These amounts are included in other noncurrent liabilities in the accompanying consolidated financial statements. While management believes that this liability is adequate as of June 30, 2018, the ultimate liability may exceed the amount recorded. Additionally, the Health System has recorded an additional insurance recoveries receivable of $4,631 and $8,941 as of June 30, 2018 and 2017, respectively, included in other noncurrent assets.

(Dollars in thousands)

(b) Workers' Compensation Insurance

In 2018 and 2017, 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 $2,228 and $2,399 as of June 30, 2018 and 2017, 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, 2018. Additionally, there are no significant insurance recoveries related to workers' compensation as of June 30, 2018 and 2017.

(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 $1,735 and $1,585 as of June 30, 2018 and 2017, 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, 2018. Additionally, there are no material insurance recoveries related to employee health claims as of June 30, 2018 and 2017.

(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:

2019	$	1,882
2020		935
2021		591
2022		419
2023		332
Thereafter		24
Total	$	4,183

Rental expense under operating leases amounted to $2,119 and $2,085 for the years ended June 30, 2018 and 2017, respectively.

(Continued)

(Dollars in thousands)

(12) Temporarily and Permanently Restricted Net Assets

Temporarily and permanently restricted net assets as of June 30, 2018 and 2017 are available for the following purposes:

		2018	2017
Temporary restrictions:			
Specific support of healthcare services	$	5,462	5,991
Permanent restrictions:			
Trustee held assets to be held in perpetuity, the income from which primarily is expendable to support health care services	$	2,446	2,117

(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 $233,640 and $248,406 and a fair value of $228,954 and $248,146 as of June 30, 2018 and 2017 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.

(Dollars in thousands)

The table below presents assets that are measured at fair value as of June 30, 2018 aggregated by the three level valuation hierarchy:

	2018			
	Level 1	Level 2	Level 3	Total
Assets:				
U.S. government obligations	$ 18,770	—	—	18,770
Money market funds	34,112	—	—	34,112
Corporate stocks and other	64,594	—	—	64,594
Fixed income securities	—	31,812	—	31,812
Total assets	$ 117,476	31,812	—	149,288

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

There were no transfers of investment assets between levels during the years ended June 30, 2018 and 2017.

The table below presents the pension plan's investable assets as of June 30, 2018 aggregated by the three level valuation hierarchy:

	2018			
	Level 1	Level 2	Level 3	Total
Assets:				
Mutual funds	$ 63,546	—	—	63,546
Fixed income securities	—	39,281	—	39,281
Other funds	—	133,185	5,195	138,380
Total assets	$ 63,546	172,466	5,195	241,207

(Continued)

(Dollars in thousands)

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

There were no significant transfers of the pension plan's investable assets between levels during the years ended June 30, 2018 and 2017.

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, 2017	$ 5,548
Disbursements	(522)
Variable interest	(43)
Other adjustments	212
Ending balance June 30, 2018	$ 5,195

(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 fiscal 2018, WMHS became aware of a matter surrounding compliance with Medicare billing rules in connection with its Home Health Care services. As a result of that matter, WMHS was asked to pay back amounts related to services provided during the period January 1, 2015 through November 21, 2016. WMHS has appealed that request and the matter is currently pending before an Administrative Law Judge. WMHS has recorded a reserve related to this matter of $1,035 within accounts payable and accrued liabilities as of June 30, 2018.

(Continued)

(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 $2,110 and $3,403 related to the guarantee provisions of the contracts in 2018 and 2017, 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, 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
Operating income		9,923	2,208	12,131
Nonoperating income		11,536	—	11,536
Excess of revenues over expenses		21,459	2,208	23,667
Change in funded status of pension plan		12,886	—	12,886
Net assets released for purchase of property and equipment		729	—	729
Distributions to noncontrolling interest in consolidated subsidiaries		—	(2,190)	(2,190)
Change in net assets		35,074	18	35,092
Balance at June 30, 2018	$	207,006	1,473	208,479

(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:

		2018	2017
Healthcare services	$	288,891	288,480
General and administrative		32,457	32,053
	$	321,348	320,533

(18) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2018 and through October 3, 2018. 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, 2018

(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	$ 36,229	5,974	277	353	—	42,833
Investments	15,381	—	868	5,363	—	21,612
Funds on deposit with trustee	17,784	—	—	—	—	17,784
Accounts receivable, net	36,541	911	—	—	—	37,452
Pledge receivable, net	—	—	—	95	—	95
Other receivables, net	5,882	(6)	2	27	(1,287)	4,618
Inventories and other current assets	16,048	5	—	1	(4,753)	11,301
Total current assets	127,865	6,884	1,147	5,839	(6,040)	135,695
Investments	93,505	—	—	—	—	93,505
Board designated investments	10,484	—	—	—	—	10,484
Other long-term investments	75	—	—	148	—	223
Investments restricted by donor or grantor	504	—	—	5,176	—	5,680
Beneficial interest in trustee held and Foundation assets	—	—	—	2,144	—	2,144
Property and equipment, net	256,318	708	—	—	—	257,026
Investments in affiliates	35,175	—	—	—	—	35,175
Other assets	5,043	—	—	—	—	5,043
Total assets	$ 528,969	7,592	1,147	13,307	(6,040)	544,975

(Continued)

Schedule 1

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Balance Sheet Information

June 30, 2018

(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	$ 12,722	—	—	—	—	12,722
Accounts payable and accrued liabilities	8,664	5,003	1	1,287	(6,040)	8,915
Accrued bond interest payable	5,399	—	—	—	—	5,399
Accrued salaries and benefits	13,691	298	—	—	—	13,989
Payable to third-party payors	6,295	—	—	—	—	6,295
Total current liabilities	46,771	5,301	1	1,287	(6,040)	47,320
Long-term debt, net of current portion	219,608	—	—	—	—	219,608
Pension benefits in excess of pension assets	49,163	—	—	—	—	49,163
Other liabilities	12,497	—	—	—	—	12,497
Total liabilities	328,039	5,301	1	1,287	(6,040)	328,588
Net assets:						
Unrestricted:						
Unrestricted net assets	198,952	2,291	1,146	4,616	—	207,005
Noncontrolling interest in consolidated subsidiaries	1,474	—	—	—	—	1,474
Total unrestricted net assets	200,426	2,291	1,146	4,616	—	208,479
Temporarily restricted	202	—	—	5,260	—	5,462
Permanently restricted	302	—	—	2,144	—	2,446
Total net assets	200,930	2,291	1,146	12,020	—	216,387
Total liabilities and net assets	$ 528,969	7,592	1,147	13,307	(6,040)	544,975

See accompanying independent auditors' report.

Schedule 2

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Statement of Operations Information

Year ended June 30, 2018

(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)	$ 327,604	6,930	—	—	—	334,534
Provision for bad debts	(7,118)	(192)	—	—	—	(7,310)
Net patient service revenue	320,486	6,738	—	—	—	327,224
Other revenue	6,643	116	—	—	(504)	6,255
Total revenues and other support	327,129	6,854	—	—	(504)	333,479
Expenses:						
Salaries and wages	112,111	4,408	—	—	—	116,519
Employee benefits	34,388	1,003	—	—	—	35,391
Professional fees	19,753	63	—	—	—	19,816
Purchased services	46,826	733	—	467	(425)	47,601
Supplies	52,150	568	—	23	(23)	52,718
Utilities	4,199	201	—	1	(1)	4,400
Insurance	1,901	6	—	2	(2)	1,907
Interest	10,798	—	—	—	—	10,798
Depreciation and amortization	24,414	144	—	—	—	24,558
Other	6,643	813	—	237	(53)	7,640
Total expenses	313,183	7,939	—	730	(504)	321,348
Operating income (loss)	13,946	(1,085)	—	(730)	—	12,131

(Continued)

Schedule 2

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Statement of Operations Information

Year ended June 30, 2018

(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	$ 2,593		—	—	—	2,593
Investment income	4,006	12	25	430	—	4,473
Unrealized gains (loss) on trading portfolio	4,458		(30)	121	—	4,549
Other	62	2	—	(143)	—	(79)
Total nonoperating income	11,119	14	(5)	408	—	11,536
Excess (deficiency) of revenues over (under) expenses	$ 25,065	(1,071)	(5)	(322)	—	23,667

See accompanying independent auditors' report.

Schedule 3

WESTERN MARYLAND HEALTH SYSTEM CORPORATION

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2018

(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, 2017	$ 163,936	3,362	1,151	4,938	173,387
Excess of revenues over expenses	25,065	(1,071)	(5)	(322)	23,667
Change in funded status of pension plan	12,886	—	—	—	12,886
Net assets released for purchase of property and equipment	729	—	—	—	729
Distributions to noncontrolling interest in consolidated interest	(2,190)	—	—	—	(2,190)
Balance at June 30, 2018	200,426	2,291	1,146	4,616	208,479
Temporarily restricted net assets:					
Balance at June 30, 2017	226	—	—	5,765	5,991
Investment gain		—	—	(67)	(67)
Donations	671	—	—	388	1,059
Grants	30	—	—	—	30
Net assets released for operations	2	—	—	(826)	(824)
Net assets released for purchase of property and equipment	(727)	—	—	—	(727)
Balance at June 30, 2018	202	—	—	5,260	5,462
Permanently restricted net assets:					
Balance at June 30, 2017	281	—	—	1,836	2,117
Unrealized gains on investments	21	—	—	—	21
Change in beneficial interest of trustee-held Foundation assets	—	—	—	58	58
Transfers (to) from affiliates	—	—	—	250	250
Balance at June 30, 2018	302	—	—	2,144	2,446
Net assets at June 30, 2018	$ 200,930	2,291	1,146	12,020	216,387

See accompanying independent auditors' report.