Consolidated Financial Statements and Supplementary Information

Western Maryland Health System Corporation
Years Ended June 30, 2019 and 2018
With Report of Independent Auditors

Ernst & Young LLP

Western Maryland Health System Corporation

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2019 and 2018

Contents

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Report of Independent Auditors

Board of Directors
Western Maryland Health System Corporation and subsidiaries

We have audited the accompanying consolidated financial statements of Western Maryland Hospital System Corporation and subsidiaries, which comprise the consolidated balance sheet as of June 30, 2019, and the related consolidated statements of operations, changes in net assets and cash flows for the year 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 audit. We did not audit the financial statements of Western Maryland Insurance Company, LTD, a wholly-owned subsidiary, which statements reflect total assets constituting 4.2% in 2019 and total revenues constituting 0.5% in 2019 of the related consolidated totals. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Western Maryland Insurance Company, LTD, is based solely on the report of the other auditors. We conducted our audit 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 entity'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. 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.

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Opinion

In our opinion, based on our audit and the report of the other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Western Maryland Health System Corporation and subsidiaries at June 30, 2019, and the consolidated results of their operations, changes in their net assets, and their cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Change in Accounting Principles

As discussed in Note 2 to the consolidated financial statements, Western Maryland Health System Corporation changed its method for revenue recognition as a result of the adoption of Accounting Standards (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, effective July 1, 2018, changed its method of financial statement presentation as a result of the adoption of ASU 2016-14, *Presentation of Financial Statements of Not-For-Profit Entities*, and changed the classification of certain pension expenses as a result of the adoption of ASU 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, in the year ended June 30, 2019. Our opinion is not modified with respect to these matters.

Report of Other Auditors on June 30, 2018 Financial Statements

The consolidated financial statements of Western Maryland Health System and subsidiaries for the year ended June 30, 2018, were audited by other auditors who expressed an unmodified opinion on those statements on October 3, 2018.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information 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. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

October 21, 2019

Western Maryland Health System Corporation

Consolidated Balance Sheets

	June 30 2019	2018
	(Dollars in Thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 37,205**	$ 42,833
Investments	**–**	21,612
Funds on deposit with trustee	**18,089**	17,784
Accounts receivable	**41,031**	37,452
Pledge receivable	**54**	95
Other receivables	**5,859**	4,618
Inventories and other current assets	**9,998**	11,301
Total current assets	**112,236**	135,695
Investments	**128,939**	93,505
Board designated investments	**7,858**	10,484
Other long-term investments	**225**	223
Investments restricted by donor or grantor	**6,821**	5,680
Beneficial interest in trustee held Foundation assets	**2,144**	2,144
Property and equipment, net	**246,598**	257,026
Investments in affiliates	**38,035**	35,175
Other assets	**6,038**	5,043
Total assets	**$ 548,894**	$ 544,975
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 13,263**	$ 12,722
Accounts payable and accrued liabilities	**10,588**	8,915
Accrued bond interest payable	**5,089**	5,399
Accrued salaries and benefits	**16,268**	13,989
Payable to third-party payors	**5,280**	6,295
Deferred Revenue	**239**	–
Total current liabilities	**50,727**	47,320
Long-term debt, net of current portion	**203,661**	219,608
Pension benefits in excess of pension assets	**71,960**	49,163
Other liabilities	**13,381**	12,497
Total liabilities	**339,729**	328,588
Net assets:		
Net assets without donor restrictions	**198,584**	207,005
Net assets with donor restrictions	**9,018**	7,908
Total parent net assets	**207,602**	214,913
Noncontrolling interest in consolidated subsidiaries	**1,563**	1,474
Total net assets	**209,165**	216,387
Total liabilities and net assets	**$ 548,894**	$ 544,975

See accompanying notes to consolidated financial statements.

Western Maryland Health System Corporation

Consolidated Statements of Operations

	Year Ended June 30	
	2019	**2018**
	(Dollars in Thousands)	
Unrestricted revenues and other support:		
Patient service revenue	**$ 332,461**	$ 334,534
Provision for bad debts	**–**	(7,310)
Net patient service revenue	**332,461**	327,224
Other revenue	**6,795**	6,255
Total revenues and other support	**339,256**	333,479
Expenses:		
Salaries and wages	**126,698**	116,519
Employee benefits	**38,539**	35,391
Professional fees	**22,512**	19,816
Purchased services	**36,741**	47,601
Supplies	**54,897**	52,718
Utilities	**4,302**	4,400
Insurance	**2,165**	1,907
Interest	**10,179**	10,798
Depreciation and amortization	**25,168**	24,558
Other	**7,153**	7,640
Total expenses	**328,354**	321,348
Operating income	**10,902**	12,131
Nonoperating income:		
Equity in income of affiliates	**1,533**	2,593
Investment income (loss), including realized gains on trading portfolio	**1,723**	4,473
Unrealized gains on trading portfolio	**8,634**	4,549
Other	**81**	(79)
Total nonoperating income	**11,971**	11,536
Excess of revenues over expenses	**$ 22,873**	$ 23,667

See accompanying notes to consolidated financial statements.

Western Maryland Health System Corporation

Consolidated Statements of Changes in Net Assets

Years Ended June 30, 2019 and 2018
(Dollars in Thousands)

	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions	Total Net Assets
Balance at June 30, 2017	$ 173,387	$ 8,108	$ 181,495
Excess of revenues over expenses	23,667	–	23,667
Investment gain	–	(46)	(46)
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
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	(200)	34,892
Balance at June 30, 2018	208,479	7,908	216,387
Excess of revenues over expenses	**22,873**	**–**	**22,873**
Investment gain	**–**	**111**	**111**
Donations	**–**	**1,344**	**1,344**
Grants	**–**	**237**	**237**
Change in funded status of pension plan	**(29,367)**	**–**	**(29,367)**
Net assets released for operations	**–**	**(510)**	**(510)**
Net assets released for purchase of property and equipment	**132**	**(137)**	**(5)**
Unrealized gains on investments	**–**	**65**	**65**
Distributions to noncontrolling interest in consolidated subsidiaries	**(1,970)**	**–**	**(1,970)**
Change in net assets	**(8,332)**	**1,110**	**(7,222)**
Balance at June 30, 2019	**$ 200,147**	**$ 9,018**	**$ 209,165**

See accompanying notes to consolidated financial statements.

Western Maryland Health System Corporation

Consolidated Statements of Cash Flows

	Year Ended June 30	
	2019	**2018**
	(Dollars in Thousands)	
Operating activities		
Change in net assets	**$ (7,222)**	$ 34,892
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	**25,168**	24,558
Amortization of bond financing costs and premiums	**(2,801)**	(2,971)
Change in funded status of pension plan	**29,367**	(12,886)
Provision for bad debts	**–**	7,310
Distributions to noncontrolling interest holder	**1,970**	2,190
Equity in income of affiliates	**(1,533)**	(2,593)
Realized and unrealized gains on investments	**(11,076)**	(6,571)
Change in beneficial interest in trustee held Foundation assets	**–**	(58)
Restricted contributions	**(1,581)**	(1,089)
Changes in assets and liabilities:		
Accounts receivable	**(3,579)**	(8,976)
Other receivables	**(1,200)**	1,034
Inventories and other current assets	**1,303**	(1,208)
Accounts payable and accrued liabilities, accrued bond interest payable and accrued salaries and benefits	**3,642**	(1,497)
Payable to third-party payors	**(1,015)**	(350)
Deferred revenue	**239**	–
Other assets, funded status of pension plan, and other liabilities	**(7,703)**	(13,259)
Net cash provided by operating activities	**23,979**	18,526
Investing activities		
Purchase of long-lived assets	**(14,624)**	(7,229)
Change in funds on deposit with trustee	**(305)**	(295)
Net change in investments	**(1,568)**	(2,090)
Net cash used in investing activities	**(16,497)**	(9,614)
Financing activities		
Repayments of long-term debt	**(12,385)**	(11,795)
Capital lease payments	**(336)**	(439)
Proceeds from restricted contributions	**1,581**	1,089
Restricted investment loss	**–**	58
Distributions to noncontrolling interest holder	**(1,970)**	(2,190)
Net cash used in financing activities	**(13,110)**	(13,277)
Net decrease in cash and cash equivalents	**(5,628)**	(4,365)
Cash and cash equivalents at beginning of year	**42,833**	47,198
Cash and cash equivalents at end of year	**$ 37,205**	$ 42,833
Supplemental disclosure of cash flow information		
Cash paid for interest	**$ 10,488**	$ 11,093
Capital additions accrued but not paid	**636**	476

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 signed a Letter of Intent with University of Pittsburgh Medical Center (UPMC) on March 28, 2019 to establish a fully integrated health system and to achieve among other things, quality improvement, enhanced access to care, increased community benefits, better population health, improved patient experiences and cost/efficiency savings for the benefit of the patients and communities it serves. The Health System will be a wholly-owned subsidiary of UPMC via the affiliation.

The objective of the full affiliation includes the provision of enhanced clinical programs and coordinated health services to the communities in and around Western Maryland and promotion of financial and operational sustainability for the Health System in furtherance of its mission.

It is anticipated a Definitive Agreement will be signed in early December 2019 with an effective date in January 2020.

1. Mission and Organization (continued)

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

Acute Care Hospital

Western Maryland Regional Medical Center – a full service community hospital located in Cumberland, Maryland, licensed for 233 acute care beds, owned and operated by the Health System.

Long-Term Care

Frostburg Nursing and Rehabilitation Center (Frostburg)

Other

Western Maryland Health System Foundation, Inc. (Foundation)

Western Maryland Insurance Company, Ltd. (WMIC)

Haystack Consolidated Services, Inc. (Haystack)

Cumberland Properties, Inc. (Cumberland)

Memorial Medical Center Services, Inc. (MMCS)

Johnson Heights Medical Building Partnership (Johnson Heights)

Haystack Imaging Services, LLC (Haystack Imaging)

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

2. Summary of Significant Accounting Policies

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.

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.

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.

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.

Cost of Goods Sold

Cost of goods sold consists primarily of drugs, medical supplies, and surgical implants used in the care and treatment of patients.

2. Summary of Significant Accounting Policies (continued)

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.

The fair values of individual investments are based on quoted market prices of individual securities or investments or estimated amounts using quoted market prices of similar investments. Long-term investments represent investments without donor restrictions and income earned on investments with and without donor restrictions. The cost of securities sold is based on the specific-identification method. Investments are classified as either current or noncurrent based on the Health System's intent of use, maturity dates and availability for current operations. Substantially all of the Health System's investment portfolio (excluding certain assets limited as to use) is classified as trading, with unrealized gains and losses included in excess of revenue over expenses. Certain trusteed assets that are included in assets limited as to use are classified as other than trading. These assets primarily consist of funds held for payment of principal and interest on bonds and deferred compensation trusts.

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.

2. Summary of Significant Accounting Policies (continued)

Property and Equipment

Property and equipment are stated at historical cost or, if donated, at fair market value at date of gift. Depreciation of property and equipment is provided over the estimated useful lives of the related assets, using the straight-line method. Depreciation expense includes amortization of assets held under capital leases and amortization of internal-use software costs. Interest costs, net of interest income earned on borrowed funds during construction of capital assets, is capitalized as a component of the cost of acquiring the 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 net assets with donor restrictions. 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.

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.

2. Summary of Significant Accounting Policies (continued)

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, 2019 and 2018.

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 $1,860 and $1,976 at June 30, 2019 and 2018, respectively.

Net Assets with Donor Restrictions

Net assets are classified for reporting purposes in two categories as net assets with donor restrictions and net assets without donor restrictions according to the existence or absence of donor-imposed restrictions. Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as restricted support if they are received with donor stipulations that limit the use of the donated assets to a specific purpose or time period or restricted by donor to be maintained in perpetuity. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished the net asset with donor restrictions are reclassified as net assets without donor restrictions and reported as net assets released from restrictions.

Net assets with donor restrictions related for capital purposes are recorded as a change in net assets without donor restrictions, while net assets with donor restrictions released for operating purpose are recorded as other operating revenue or as a reduction of the related expense.

2. Summary of Significant Accounting Policies (continued)

Net Patient Service Revenue and Accounts Receivable

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.

2. Summary of Significant Accounting Policies (continued)

In January of 2019, the HSCRC negotiated a new waiver with CMS that makes Maryland hospitals responsible to reduce the Total Cost of Care of Medicare patients in their service area. In January 2019 the WMHS transitioned to the "Total Cost of Care Model" which builds upon the successes of the All-Payer Model which is designed to progressively transform care delivery across the health care system with the objective of improving health and quality of care. The goal is to achieve person-centered care, moderate the growth of costs through transformation of the care delivery system, focus beyond hospital care to address the other parts of the health care system that must be involved in charges to achieve meaningful system-wide transformation. The Total Cost of Care Model (TCOC) focuses on all providers, not just hospital care, on total cost of care regardless of the setting, hospital quality and population health metrics, care transformation in the community, and provider alignment and post-acute care programs.

Explicit price concessions, 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. These amounts also represent an explicit price concession. There are also implicit price concessions accrued for amounts expected to become bad debt.

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.

Patient receivable include charges for amounts due from all patients less price concessions relating to allowances for the excess of established charges over the payments to be received on behalf of patients covered by Medicare, Medicaid and other insurers. The provision for price concessions is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the price concessions based upon historical experience of self-pay accounts receivable, including those balances after insurance payments and not covered by insurance.

2. Summary of Significant Accounting Policies (continued)

The Health System's revenues generally relate to contracts with patients in which our performance obligations are to provide health care services to the patients. These revenues are based upon the estimated amounts that management expects to be entitled to receive from patients and third-party payors. Refer to Note 3 for additional information regarding the recognition of revenues in accordance with generally accepted accounting principles.

Excess of Revenues over Expenses

The consolidated statement of operations includes the performance indicator, excess of revenues over expenses. Changes in net assets without donor restrictions, 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).

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.

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 donor-imposed restricted net assets.

Expenditures of temporarily restricted net assets are transferred to net assets without donor restrictions if for capital additions or reported as other revenue if for operating purposes.

2. Summary of Significant Accounting Policies (continued)

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 Consolidated and MMCS are taxable for profit entities, which recognized an immaterial amount of taxable income during 2019 and 2018. 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, 2019 and 2018.

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.

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.

2. Summary of Significant Accounting Policies (continued)

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.

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. During 2018, the decision was made that the Health System would not be renewing its agreement with Trivergent that expired June 30, 2019. The decision was also made to transfer the Trivergent employees working at WMHS back to WMHS on January 1, 2019. Therefore the salary expense for these employees was recorded for half the fiscal year as a Purchased Service and as a Salary expense for the other half of fiscal year 2019. Therefore, the Health System incurred $13,285 and $23,809 in expenses related to Trivergent during the years ending June 30, 2019 and 2018, respectively. These amounts are what was recorded in the purchased services caption in the consolidated statement of operations. The decrease from year to year was due to the majority of the salaries moving from Purchased Services to the Salary expense line halfway through fiscal year 2019.

WMHS' investment in Trivergent will be determined after Trivergent's year-end audit is completed in October. At that time any monies due/owing WMHS will be settled. WMHS has agreed to continue to participate in a limited number of services with Trivergent through FY2020.

2. Summary of Significant Accounting Policies (continued)

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.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*, which replaced most existing revenue recognition guidance in the U.S. GAAP and converged with international standards the financial reporting requirements for revenue from contracts with customers. The core principle of ASU 2014-09 is that an entity should recognize revenue for the transfer of goods or services equal to the amount that it expects to be entitled to receive for those goods or services. ASU 2014-09 also requires additional disclosures about the nature, timing, and uncertainty of revenue and cash flows arising from customer contracts including significant judgments and changes in judgments.

2. Summary of Significant Accounting Policies (continued)

The standard allows for both retrospective and prospective methods of adoption. The Health System adopted ASU 2014-09 effective July 1, 2018, using the modified retrospective method of transition. The Health System reviewed revenue streams and transactions under ASU 2014-09. For net patient service revenue, the Health System evaluated the application of the portfolio approach as a practical expedient to group patient contracts with similar characteristics, such that revenue for a given portfolio would not be materially different than if it were evaluated on a contract-by-contract basis. Upon adoption, virtually all of what was previously classified as provision for bad debts and was presented as a reduction to net patient service revenue on the consolidated statements of operations and changes in net assets is now treated as a price concession reduction and incorporated into what is reported as net patient service revenue. The new standard also requires enhanced disclosures related to the disaggregation of revenue and significant judgments made in measurement and recognition. The adoption of this ASU did not materially impact the consolidated financial statements, refer to footnote 3 for additional information.

In February 2016, the FASB issued ASU 2016-02, Leases, which will require entities to record additional leases onto the balance sheet. The standard aims to increase transparency and comparability among organizations by recognizing lease assets and liabilities and increasing disclosure requirements about leasing arrangements. ASU 2016-02 will be effective for annual periods beginning after December 15, 2018, and interim periods therein. The primary effect of adopting the ASU will be to record right-of-use assets and obligations for current operating leases. The Health System is evaluating the impact the adoption of the new guidance will have on its consolidated financial statements and will adopt the provisions on the effective date of July 1, 2019.

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:

- Reduce the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions

- Present expenses by their functional and their natural classifications in one location in the financial statements;

2. Summary of Significant Accounting Policies (continued)

- 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

- Retain 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 adoption of this ASU did not have a material impact on the Health System's financial position and results of operations.

The Health System adopted ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. This new guidance requires the disaggregation of the service cost component from the other components of the net benefit cost, with the service cost component of net benefit cost to be reported in the same line on the consolidated statement of operations as other compensation costs, while other components of net benefit cost are presented in the consolidated statement of operations separately, outside a subtotal of operating income. The amendments also provide explicit guidance to allow only the service cost component of net benefit cost to be eligible for capitalization. The change in presentation of net benefit cost in the consolidated statement of operations is to be applied retrospectively, however, the accounts impacted for the year ended June 30, 2018 were not reclassified given the immateriality of the cost component, and the change in capitalization for only service cost applied prospectively. The guidance allows a practical expedient that permits the use of amounts disclosed in the retirement benefits footnote for prior comparative periods as the estimation basis for applying the retrospective presentation requirements. The Health System adopted this accounting standard for the year ended June 30, 2019.

2. Summary of Significant Accounting Policies (continued)

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement, Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement*. This ASU clarifies and improves the effectiveness of disclosures in the footnotes to financial statements by modifying disclosure requirements of fair value measurements. The ASU is effective for annual reporting periods beginning after December 15, 2019, with early adoption permitted. The Health System is evaluating the impact the adoption of the new guidance will have on its consolidated financial statements and will adopt the provisions on the effective date.

In August 2018, the FASB issued ASU 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plan – Changes to the Disclosure Requirements for Defined Benefit Plans*. This ASU intends to improve the effectiveness of disclosures in the footnotes to financial statements by modifying disclosure requirements for employers who sponsor defined benefit pension or post retirement plans. The ASU is effective for annual reporting periods beginning after December 15, 2021, with early adoption permitted. The Health System is evaluating the impact the adoption of the new guidance will have on its consolidated financial statements and will adopt the provisions on the effective date.

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 21, 2020.

(Dollars in Thousands)

3. Net Patient Service Revenue, Accounts Receivable, Implicit and Explicit Price Concessions and Business Concentrations

During fiscal years 2019 and 2018, net patient service revenue was received from the following payors:

	2019	2018
Medicare	**56%**	57%
Medicaid	**17**	17
Blue Cross	**10**	9
Self-pay	**2**	2
Other	**15**	15
	100%	100%

Gross accounts receivable at June 30, 2019 and 2018, consisted of the following payors:

	2019	2018
Medicare	**41%**	43%
Medicaid	**17**	18
Blue Cross	**8**	7
Self-pay	**15**	15
Other	**19**	17
	100%	100%

In May 2014, the FASB issued a new standard related to revenue recognition. The Health System adopted the new standard effective July 1, 2018, using the modified retrospective method. The most significant change from the adoption of the new standard relates to the Health System's presentation of the provision for bad debts. Under the previous standards, the Health System's estimate for amounts not expected to be collected based upon historical experience, were reflected as provision for bad debts and deducted from net patient service revenue to arrive at net patient service revenue less provision for bad debts. Under the new standard, those amounts will continue to be recognized as a reduction to net patient service revenue, however, not reflected separately as provision for bad debts, and accordingly, the caption net patient service revenue less provision for bad debts will no longer be presented on the consolidated statements of operations and changes in

3. Net Patient Service Revenue, Accounts Receivable, Implicit and Explicit Price Concessions and Business Concentrations (continued)

net assets. Subsequent changes in the estimate of collectability due to a change in the financial status of a payor, for example a bankruptcy, will be recognized as bad debt expense in operating expenses. The adoption of the new standard did not have a material impact on the consolidated financial statements.

The Health System's revenues generally relate to contracts with patients in which our performance obligations are to provide health care services to the patients. Revenues are recorded during the period the obligations to provide health care services are satisfied. Performance obligations for revenues are recognized based on charges incurred in relation to total expected charges. The Health System has agreements with third-party payors that provide for payments to the Health System for patient services at amounts different from its established rates. Management continually reviews the contractual estimation process to incorporate updates to laws and regulations and any changes in managed care contractual terms resulting from contract renegotiations and renewals.

The Health System's revenues are based upon the estimated amounts that management expects to be entitled to receive from patients and third-party payors. Estimates of explicit price concessions, formerly contractual allowances, under state-run programs are based upon the payment terms specified therein for regulated revenue and those under managed care and commercial insurance plans are based upon the payment terms specified in the related contractual agreements for unregulated revenue. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). Management also records estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record self-pay revenues at the estimated amounts that it expects to collect.

Additionally, the Health System's revenues may be subject to adjustment as a result of examination by government agencies or contractors and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreements with the payor, correspondence from the payor and the Health System's historical settlement activity, including an assessment to ensure it is probable a significant reversal in the amount of cumulative revenue recognized will not occur when the

(Dollars in Thousands)

3. Net Patient Service Revenue, Accounts Receivable, Implicit and Explicit Price Concessions and Business Concentrations (continued)

uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews and investigations.

The Health System has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Health System's expectation that the period between the time the service is provided to a patient and the time that the patient or third-party payor pays for that service will be one year or less.

The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of the Health System's revenues and patient receivable as a primary source of information in estimating the collectability of patient receivable.

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:

	2019	2018
U.S. government obligations	**$ 25,548**	$ 5,852
Money market funds	**26,089**	34,113
Corporate stocks and other	**81,186**	64,593
Fixed income securities	**29,109**	44,730
	$ 161,932	$ 149,288

(Dollars in Thousands)

4. Investments (continued)

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

	2019	2018
Investments	**$ 128,939**	$ 115,117
Funds on deposit with trustee	**18,089**	17,784
Board designated investments	**7,858**	10,484
Other long-term investments	**225**	223
Investments restricted by donor or grantor	**6,821**	5,680
	$ 161,932	$ 149,288

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

	2019	2018
Income		
Investment income	**$ (543)**	$ 2,384
Realized (losses) gains on trading investment portfolio	**2,266**	2,089
Unrealized gains on trading investment portfolio	**8,634**	4,549
Restricted investment (loss) income	**–**	(67)
	$ 10,357	$ 8,955

(Dollars in Thousands)

5. Property and Equipment

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

	2019	2018
Land and land improvements (2–25 years)	**$ 15,046**	$ 15,036
Buildings and improvements (5–40 years)	**331,217**	330,688
Equipment (3–20 years)	**223,891**	213,448
Construction in progress	**2,202**	493
	572,356	559,665
Less accumulated depreciation	**325,758**	302,639
Property and equipment, net	**$ 246,598**	$ 257,026

Depreciation expense for the year ended June 30, 2019, was $25,052. Depreciation expense for the year ended June 30, 2018, was $24,442.

6. Investments in Affiliates

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

			Investment		Equity in Income (Loss)	
Name	**Interest**	**Business**	**2019**	**2018**	**2019**	**2018**
Maryland Physicians Care, Inc.	25.00%	State of Maryland Medicaid managed care	**$ 31,159**	$ 29,625	**$ 1,534**	$ 2,600
Other affiliates	0.14% to 33.33%	Supply purchasing & MSO	**6,876**	5,550	**(1)**	(7)
			$ 38,035	$ 35,175	**$ 1,533**	$ 2,593

(Dollars in Thousands)

6. Investments in Affiliates (continued)

Maryland Physician Care had the following unaudited summary financial information as of and for the years ended June 30, 2019 and 2018:

	2019	2018
Total assets	**$ 357,263**	$ 351,389
Total liabilities	**232,629**	232,889
Net assets	**$ 124,634**	$ 118,500
Total revenues	**$ 1,107,454**	$ 1,132,477
Total expenses, net	**1,100,804**	1,122,077
Net income	**$ 6,650**	$ 10,400

7. Long-Term Debt

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

	2019	2018
Maryland Health and Higher Educational Facilities Authority (MHHEFA) Series 2014 Revenue Bonds, interest rate 4% to 5.25%	**$ 197,860**	$ 210,245
Capital leases	**330**	666
Net unamortized bond premium	**20,594**	23,395
Long-term debt	**218,784**	234,306
Less current portion of long-term debt	**13,263**	12,722
Less unamortized financing fees	**1,860**	1,976
Long-term debt less current portion	**$ 203,661**	$ 219,608

(Dollars in Thousands)

7. Long-Term Debt (continued)

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

2020	$ 13,263
2021	13,717
2022	14,335
2023	11,675
2024	12,200
Thereafter	133,000
Total	$ 198,190

In November 2014, MHHEFA issued $236,170 in bonds (Series 2014 Bonds) on behalf of the Health System. As security for WMHS obligations, the Bond Authority has been granted a lien, claim on and a security interest in all of the receipts of WMHS. The lien, claim and security interest continuously applies for the entire term of the Agreement. The Series 2014 Bonds were issued as $171,035 serial bonds maturing 2015 through 2035 and $65,135 term bonds maturing 2034. The Series 2014 Bonds maturing on or after July 2025 are subject to redemption at the option of MHHEFA prior to maturity, beginning July 2024. The Series 2014 Bonds were issued at fixed rates.

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

In 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 was December 31, 2018, and the Health System decided not to renew it at that time. There was no outstanding balance as of June 30, 2019 and 2018.

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 $10,861 and $10,489 for the years ended June 30, 2019 and 2018, respectively. The total direct and indirect costs to provide the care amounted to approximately $8,558 and $8,171 for the years ended June 30, 2019 and 2018, respectively.

9. Retirement Plans

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

The Health System's investment policy, established by the Investment Committee of the Finance Committee and approved by the Health System's Board of Directors, is to ensure current and future benefit obligations are adequately funded in a cost effective manner. The investment guidelines are based on a time horizon of greater than five years. In establishing the risk tolerances, the ability to withstand short and intermediate term variability with some interim fluctuations in market value and rates of return may be tolerated in order to achieve the longer-term objectives. The measurement date of the Plan is June 30.

(Dollars in Thousands)

9. Retirement Plans (continued)

The component of the Plan's funded status, net periodic benefit costs and actuarial assumptions used in accounting for the defined benefit plan for the years ended June 30, 2019 and 2018, are as follows:

	2019	2018
Change in projected benefit obligation		
Projected benefit obligation at beginning of year	**$ 290,370**	$ 299,549
Service cost	**2,275**	4,302
Interest cost	**11,457**	10,673
Assumptions	**34,074**	(5,714)
Actuarial loss	**1,255**	(560)
Benefits paid	**(12,033)**	(17,880)
Projected benefit obligation at end of year	**$ 327,398**	$ 290,370

	2019	2018
Change in plan assets		
Plan assets at fair value at beginning of year	**$ 241,207**	$ 225,155
Actual return	**14,264**	17,932
Employer contributions	**12,000**	16,000
Benefits paid	**(12,033)**	(17,880)
Fair value of plan assets at end of year	**255,438**	241,207
Funded status at end of year	**$ (71,960)**	$ (49,163)

	2019	2018
Amounts recognized in unrestricted net assets		
Net prior service costs	**$ (216)**	$ (265)
Net actuarial loss	**123,521**	94,203
Amounts recognized in unrestricted net assets	**$ 123,305**	$ 93,938

(Dollars in Thousands)

9. Retirement Plans (continued)

	2019	2018
Components of net periodic benefit costs		
Service cost	**$ 2,275**	$ 4,302
Interest cost	**11,457**	10,673
Expected return on plan assets	**(15,081)**	(16,012)
Recognized prior service cost	**(49)**	(3,391)
Recognized net loss	**6,828**	8,083
Net periodic pension cost	**$ 5,430**	$ 3,655

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $123,305 and $93,938 at June 30, 2019 and 2018, respectively. Deferred pension costs represents unrecognized actuarial losses or unexpected changes in the projected benefit obligation and plan assets over time primarily due to changes in assumed discount rates and investment experience, unrecognized prior service costs, which is the impact of changes in plan benefits applied retrospectively to employee service previously rendered. The amount of deferred pension costs expected to be recognized as a component of net period pension costs during the year ending June 30, 2020, is $9,629.

	2019	2018
Weighted average assumptions – benefit obligations:		
Discount rate	**3.29%**	4.01%
Salary scale	**2.50**	2.50
Return on assets	**6.25**	7.00
Weighted average assumptions – net periodic expense:		
Discount rate	**4.01%**	3.71%
Salary scale	**2.50**	2.50
Return on assets	**6.25**	7.00

The accumulated benefit obligation for the defined benefit pension plan was $324,002 and $287,741 at June 30, 2019 and 2018, respectively.

(Dollars in Thousands)

9. Retirement Plans (continued)

The Health System's pension plan weighted average asset allocations at the measurement dates of June 30, 2019 and 2018, by asset category, are as follows:

	Percentage of Plan Assets		
	Target Allocation	**2019**	**2018**
Asset class:			
Equities	60%	**72%**	72%
Fixed income	40	**28**	28

The Health System expects to contribute $12,000 to the Plan for the fiscal year ending June 30, 2020.

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:

2020	$ 13,215
2021	13,852
2022	14,653
2023	15,379
2024	16,025
2025–2029	87,005

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, 2019.

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.

9. Retirement Plans (continued)

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 $4,881 and $2,865 for the years ended June 30, 2019 and 2018, 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, 2019 and 2018, was $2,364 and $2,123, respectively, and is included in employee benefits in the accompanying consolidated statements of operations.

10. Self-Insurance Programs

General and Professional Liability (GLPL)

On December 14, 2004, the Health System formed a new wholly owned insurance subsidiary, Western Maryland Insurance Company, Ltd. (WMIC), an exempted company under the Companies Law of the Cayman Islands, to provide GLPL insurance to the Health System and certain affiliates. Effective January 1, 2005, this subsidiary insures the Health System for its GLPL risks under a claims-made policy with $1,000 per claim and a $4,000 annual policy aggregate with up to a limit of $30,000, have been reinsured with CNA as a primary layer for the first $15,000 and with Sompo for a secondary layer of $15,000. 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 claim.

10. Self-Insurance Programs (continued)

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 $12,009 and $11,291 as of June 30, 2019 and 2018, 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, 2019, the ultimate liability may exceed the amount recorded. Additionally, the Health System has recorded an additional insurance recoveries receivable of $5,076 and $4,631 as of June 30, 2019 and 2018, respectively, included in other noncurrent assets.

Workers' Compensation Insurance

In 2019 and 2018, 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 $2,429 and $2,228 as of June 30, 2019 and 2018, 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, 2019. Additionally, there are no significant insurance recoveries related to workers' compensation as of June 30, 2019 and 2018.

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 $1,965 and $1,735 as of June 30, 2019 and 2018, 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, 2019. There were no material insurance recoveries related to employee health claims as of June 30, 2018. However, in the fiscal year ending June 30, 2019, there was approximately $933 in insurance recoveries related to one very large employee health insurance claims.

(Dollars in Thousands)

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:

2020	$	1,560
2021		1,240
2022		828
2023		440
2024		169
Thereafter		24
Total	$	4,261

Rental expense under operating leases amounted to $1,686 and $2,119 for the years ended June 30, 2019 and 2018, respectively.

12. Net Assets With Donor Restrictions

Temporarily and permanently restricted net assets as of June 30, 2019 and 2018, are available for the following purposes:

	2019		**2018**
Temporary restrictions:			
Specific support of healthcare services	**$ 6,561**	$	5,462
Permanent restrictions:			
Trustee held assets to be held in perpetuity, the income from which primarily is expendable to support health care services	**2,457**		2,446
Total net assets with donor restrictions	**$ 9,018**	$	7,908

13. Fair Value of Financial Instruments

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.

13. Fair Value of Financial Instruments (continued)

Long-Term Debt

The Series 2014 Bonds bear interest at fixed rates and, accordingly, had a carrying amount of $218,454 and $233,640 and a fair value of $219,881 and $228,954 as of June 30, 2019 and 2018, 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.

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.

(Dollars in Thousands)

13. Fair Value of Financial Instruments (continued)

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.

The table below presents assets that are measured at fair value as of June 30, 2019, aggregated by the three level valuation hierarchy:

	2019			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
U.S. government obligations	**$ 25,086**	**$ 462**	**$ –**	**$ 25,548**
Money market funds	**26,089**	**–**	**–**	**26,089**
Corporate stocks and other	**81,186**	**–**	**–**	**81,186**
Fixed income securities	**1,019**	**28,090**	**–**	**29,109**
Total assets	**$ 133,380**	**$ 28,552**	**$ –**	**$ 161,932**

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

There were no transfers of investment assets between levels during the years ended June 30, 2019 and 2018.

(Dollars in Thousands)

13. Fair Value of Financial Instruments (continued)

The table below presents the pension plan's investable assets as of June 30, 2019, aggregated by the three level valuation hierarchy:

	2019			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Mutual funds	**$ 67,111**	**$ –**	**$ –**	**$ 67,111**
Fixed income securities	**–**	**40,432**	**–**	**40,432**
Other funds	**6,548**	**141,347**	**–**	**147,895**
Total assets	**$ 73,549**	**$ 181,779**	**$ –**	**$ 255,438**

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

There were no significant transfers of the pension plan's investable assets between levels during the years ended June 30, 2019 and 2018.

14. Commitments and Contingencies

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.

14. Commitments and Contingencies (continued)

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 had recorded a reserve related to this matter of $1,035 within accounts payable and accrued liabilities as of June 30, 2018. However, during fiscal year 2019, an analysis was performed to determine a more accurate amount of this liability by looking at the actual claims affected in a three year period for which Medicare had not already withdrawn the payments. At that time, it was determined that the liability be decreased to $387. That amount is what remains in the reserve as of June 30, 2019.

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 incurred $2,907 and $2,110, related to the guarantee provisions of the contracts in 2019 and 2018, 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.

15. Regulation and Reimbursement (continued)

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.

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.

15. Regulation and Reimbursement (continued)

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.

In January 2014, CMS approved a new waiver for Maryland for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new All-Payer 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.

In January 2019, Medicare approved a new 10-year wavier for Maryland under a "Total Cost of Care All Payer Model. The Model began in January 2019 and builds upon the successes of the All-Payer Model. Maryland Hospitals must progressively transform care delivery across the heath system to improve health and quality of care. The Model remains in place as long as Maryland meets the Model performance requirements which includes the state's growth in Medicare spending must remain lower than the national growth rate and no more than 3.58% per year.

The Total Cost of Care Model encourages continued care redesign, focuses on improving chronic care and population health and includes aggressive quality of care goals and range of population health goals.

The HSCRC will utilize a Medicare Performance Adjustment (MPA) which incorporates attribution, episode and/or geographic measures with TCOC for Medicare into hospital value-based payments to provide a level of direct hospital accountability within the All Payer Model. For CY 2018 and 2019 the revenue at risk is 0.5% and 1% of Medicare Hospital revenue respectively.

(Dollars in Thousands)

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 component of the appropriate class of consolidated net assets (equity). The reconciliation of noncontrolling interest reported in net assets without donor restrictions is as follows:

	WMHS Corporation	Non-controlling Interest	Net Assets Without Donor Restrictions
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
Operating income	**8,843**	**2,059**	**10,902**
Nonoperating income	**11,971**	**–**	**11,971**
Excess of revenues over expenses	**20,814**	**2,059**	**22,873**
Change in funded status of pension plan	**(29,367)**	**–**	**(29,367)**
Net assets released for purchase of property and equipment	**132**	**–**	**132**
Distributions to noncontrolling interest in consolidated subsidiaries	**–**	**(1,970)**	**(1,970)**
Change in net assets	**(8,421)**	**89**	**(8,332)**
Balance at June 30, 2019	**$ 198,584**	**$ 1,563**	**$ 200,147**

(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:

	2019	2018
Healthcare services:		
Salaries and wages	**$ 113,141**	$ 104,750
Employee benefits	**34,415**	31,817
Professional fees	**20,103**	17,815
Purchased services	**32,810**	42,793
Supplies	**49,023**	47,393
Utilities	**3,842**	3,956
Insurance	**1,933**	1,714
Interest	**9,090**	9,707
Depreciation and amortization	**22,475**	22,078
Other	**6,213**	6,868
Total healthcare services	**293,045**	288,891
General and administrative:		
Salaries and wages	**13,557**	11,769
Employee benefits	**4,124**	3,574
Professional fees	**2,409**	2,001
Purchased services	**3,931**	4,808
Supplies	**5,874**	5,325
Utilities	**460**	444
Insurance	**232**	193
Interest	**1,089**	1,091
Depreciation and amortization	**2,693**	2,480
Other	**940**	772
Total general and administrative	**35,309**	32,457
Total expenses	**$ 328,354**	$ 321,348

(Dollars in Thousands)

18. Liquidity and Availability

As part of its liquidity management, the Health System structures its financial assets to be available to satisfy general operating expenses, current liabilities, and other obligations as they come due. Financial assets available for general expenditures within one year of June 30, 2019, include the following:

	2019
Cash and cash equivalents	$ 37,205
Patient receivables	41,031
Total available within one year	$ 78,236

The Health System has assets whose use is limited and held by trustees and assets held for donor-restricted purposes. These assets are not included in the amounts above.

The Health System invests in accordance with the investment policy. The asset allocation of the investment portfolio is broadly diversified in domestic and global equities and fixed income investment strategies to maximize the Health System's ability to meet long-term investment objectives at established risk levels while maintaining liquidity levels designed to meet portfolio management.

The Health System's most restrictive bond covenant requires the obligated group to maintain unrestricted cash and marketable securities on hand to meet 45 days of normal operating expenses, which would be $35,325 as of June 30, 2019.

19. Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2019, and through October 21, 2019. The Health System did not have any material recognizable subsequent events during this period that impacted the financial statements, except for the item identified below.

In August 2019, the Health System purchased a 40.7% interest in SurgCenter of Western Maryland, an Ambulatory Surgery Center (ASC). It purchased an existing partner's interest. The ASC will provide an opportunity for the Health System's employed physicians to provide surgery in a freestanding ASC as a lower cost alternative to hospital- based surgeries. The ASC complements the goals under the Total Cost of Care Model.

Supplementary Information

Western Maryland Health System Corporation

Consolidating Balance Sheet

June 30, 2019
(Dollars in Thousands)

	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 35,645	$ 853	$ (1)	$ 708	$ –	$ 37,205
Investments		–			–	–
Funds on deposit with trustee	18,089	–	–	–	–	18,089
Accounts receivable, net	39,674	1,357	–	–	–	41,031
Pledge receivable, net	–	–	–	54	–	54
Other receivables, net	7,713	–	2	19	(1,875)	5,859
Inventories and other current assets	11,395	6	–	–	(1,403)	9,998
Total current assets	112,516	2,216	1	781	(3,278)	112,236
Investments	121,822	–	1,212	5,905	–	128,939
Board designated investments	7,858	–	–	–	–	7,858
Other long-term investments	74	–	–	151	–	225
Investments restricted by donor or grantor	595	–	–	6,226	–	6,821
Beneficial interest in trustee held and foundation assets	–	–	–	2,144	–	2,144
Property and equipment, net	245,952	646	–	–	–	246,598
Investments in affiliates	38,035	–	–	–	–	38,035
Other assets	6,038	–	–	–	–	6,038
Total assets	$ 532,890	$ 2,862	$ 1,213	$ 15,207	$ (3,278)	$ 548,894

Western Maryland Health System Corporation

Consolidating Balance Sheet (continued)

June 30, 2019
(Dollars in Thousands)

	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Current portion of long-term debt	$ 13,263	$ –	$ –	$ –	$ –	$ 13,263
Accounts payable and accrued liabilities	10,332	1,658	1	1,875	(3,278)	10,588
Accrued bond interest payable	5,089	–	–	–	–	5,089
Accrued salaries and benefits	15,975	293	–	–	–	16,268
Payable to third-party payors	5,219	61	–	–	–	5,280
Deferred revenue	239	–	–	–	–	239
Total current liabilities	50,117	2,012	1	1,875	(3,278)	50,727
Long-term debt, net of current portion	203,661	–	–	–	–	203,661
Pension benefits in excess of pension assets	71,960	–	–	–	–	71,960
Other liabilities	13,381	–	–	–	–	13,381
Total liabilities	339,119	2,012	1	1,875	(3,278)	339,729
Net assets:						
Net assets without donor restrictions	191,613	850	1,212	4,909	–	198,584
Net assets with donor restrictions	595	–	–	8,423	–	9,018
Total Parent net assets	192,208	850	1,212	13,332	–	207,602
Noncontrolling interest in consolidated subsidiaries	1,563	–	–	–	–	1,563
Total net assets	193,771	850	1,212	13,332	–	209,165
Total liabilities and net assets	$ 532,890	$ 2,862	$ 1,213	$ 15,207	$ (3,278)	$ 548,894

See accompanying report of independent auditors.

Western Maryland Health System Corporation

Consolidating Statement of Operations

Year Ended June 30, 2019
(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	$ 326,119	$ 6,342	$ –	$ –	$ –	$ 332,461
Other revenue	7,223	104	–	–	(532)	6,795
Total revenues and other support	333,342	6,446	–	–	(532)	339,256
Expenses:						
Salaries and wages	122,408	4,290	–	–	–	126,698
Employee benefits	37,428	1,111	–	–	–	38,539
Professional fees	22,459	53	–	–	–	22,512
Purchased services	35,973	771	–	484	(487)	36,741
Supplies	54,377	520	–	26	(26)	54,897
Utilities	4,097	205	–	–	–	4,302
Insurance	2,160	5	–	2	(2)	2,165
Interest	10,179	–	–	–	–	10,179
Depreciation and amortization	25,050	118	–	–	–	25,168
Other	6,383	720	–	67	(17)	7,153
Total expenses	320,514	7,793	–	579	(532)	328,354
Operating income (loss)	12,828	(1,347)	–	(579)	–	10,902
Nonoperating income:						
Equity in income of affiliates	1,533	–	–	–	–	1,533
Investment income	1,089	(92)	23	703	–	1,723
Unrealized gains (loss) on trading portfolio	8,443	–	43	148	–	8,634
Other	60	–	–	21	–	81
Total nonoperating income	11,125	(92)	66	872	–	11,971
Excess (deficiency) of revenues over (under) expenses	$ 23,953	$ (1,439)	$ 66	$ 293	$ –	$ 22,873

See accompanying report of independent auditors.

Western Maryland Health System Corporation

Consolidating Statement of Changes in Net Assets

Year Ended June 30, 2019
(Dollars in Thousands)

	Western Maryland Health System Corporation	Frostburg Nursing & Rehabilitation Center	Haystack Consolidated Services, Inc.	Western Maryland Health System Foundation Inc.	Consolidated
Net assets without donor restrictions					
Balance at June 30, 2018	$ 200,425	$ 2,291	$ 1,146	$ 4,617	$ 208,479
Excess of revenues over expenses	23,953	(1,439)	66	293	22,873
Change in funded status of pension plan	(29,367)	–	–	–	(29,367)
Net assets released for purchase of property and equipment	132	–	–	–	132
Distributions to noncontrolling interest in consolidated interest	(1,970)	–	–	–	(1,970)
Balance at June 30, 2019	193,173	852	1,212	4,910	200,147
Net assets with donor restrictions					
Balance at June 30, 2018	504	–	–	7,404	7,908
Investment gain	–	–	–	111	111
Donations	26	–	–	1,318	1,344
Grants	237	–	–	–	237
Net assets released for operations	(47)	–	–	(463)	(510)
Net assets released for purchase of property and equipment	(137)	–	–	–	(137)
Unrealized gains on investments	11	–	–	54	65
Change in beneficial interest of trustee-held Foundation assets	–	–	–	–	–
Transfers (to) from affiliates	–	–	–	–	–
Balance at June 30, 2019	594	–	–	8,424	9,018
Net assets at June 30, 2019	$ 193,767	$ 852	$ 1,212	$ 13,334	$ 209,165

See accompanying report of independent auditors.

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