MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

Consolidated Financial Report
June 30, 2017

C O N T E N T S

Arnett Carbis Toothman llp
CPAs & Advisors

actcpas.com

5700 Corporate Drive
Suite 650
Pittsburgh, PA 15237
412.635.6270 | 412.635.6278 fax
800.452.3003

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Monongalia Health System, Inc. and Subsidiaries
Morgantown, West Virginia

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Monongalia Health System, Inc. and Subsidiaries (collectively, Health System), which comprise the consolidated statements of financial position as of June 30, 2017 and 2016, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of June 30, 2017 and 2016, and the results of its operations, changes in net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information listed in the table of contents is presented for purposes of additional analyses 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 audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Arnett Carbis Toothman LLP

Pittsburgh, Pennsylvania
October 3, 2017

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
June 30, 2017 and 2016

ASSETS	**2017**	2016
CURRENT ASSETS		
Cash and cash equivalents	**$ 32,133,351**	$ 49,293,093
Assets whose use is limited	**16,537,133**	16,312,765
Patient accounts receivable, net of allowance for doubtful accounts 2017 $11,047,407; 2016 $9,168,571	**48,117,640**	46,261,374
Due from affiliated entities	**146,530**	162,932
Due from third-party payors	**2,838,567**	3,372,630
Other receivables	**4,828,573**	2,988,628
Inventories	**7,032,310**	7,386,013
Prepaid expenses and other assets	**3,155,929**	2,696,393
Total current assets	**114,790,033**	128,473,828
INVESTMENTS, AT FAIR VALUE, WHOSE USE IS LIMITED		
By Board for capital improvements	**120,598,269**	111,043,576
Professional liability self-insurance funding arrangement held by trustee	**5,193,578**	5,252,982
Tax increment financing bonds held by trustee	**2,786,955**	2,515,639
Under bond indenture agreements held by trustee	**8,600,945**	7,709,772
	137,179,747	126,521,969
Less current portion	**16,537,133**	16,312,765
Total investments, at fair value, whose use is limited	**120,642,614**	110,209,204
OTHER ASSETS		
Property and equipment, net	**246,123,689**	236,238,265
Long-term physician loans receivable	**1,030,580**	255,071
Goodwill	**3,416,779**	-
Other investments	**14,654,524**	13,044,356
Insurance recoveries receivable	**1,009,997**	1,212,694
Beneficial interest in assets held by others	**11,323,455**	12,573,123
Patient accounts receivable, special payment arrangements, net of allowance for doubtful accounts 2017 $350,000; 2016 $442,000	**346,817**	300,239
Total other assets	**277,905,841**	263,623,748
Total assets	**$ 513,338,488**	$ 502,306,780

See Notes to Consolidated Financial Statements

LIABILITIES AND NET ASSETS	2017	2016
CURRENT LIABILITIES		
Accounts payable and accrued expenses	**$ 28,745,525**	$ 28,009,795
Current portion of long-term debt	**4,016,294**	4,089,412
Due to third-party payors	**3,045,344**	1,777,366
Prospective resident and security deposits	**137,630**	81,600
Total current liabilities	**35,944,793**	33,958,173
LONG-TERM LIABILITIES		
Long-term debt, net of current portion	**197,619,285**	201,635,226
Other long-term liabilities	**66,922**	58,505
Rabbi Trust liability	**2,763,952**	2,151,667
Derivative obligation	**13,725,361**	20,110,932
Accrued pension obligation	**26,331,056**	46,822,622
Refundable fees	**12,922,056**	12,764,212
Deferred revenue for advance fees	**766,363**	809,335
Deferred revenue for advance rent	**1,007,598**	1,058,169
Estimated professional and general liability obligation	**6,522,122**	6,100,276
Total long-term liabilities	**261,724,715**	291,510,944
NET ASSETS		
Unrestricted	**207,303,204**	167,045,445
Temporarily restricted	**7,784,970**	9,215,477
Permanently restricted	**580,806**	576,741
Total net assets	**215,668,980**	176,837,663
Total liabilities and net assets	**$ 513,338,488**	$ 502,306,780

See Notes to Consolidated Financial Statements

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
Years Ended June 30, 2017 and 2016

	2017	2016
REVENUE		
Patient service revenue (net of contractual allowances and discounts)	**$ 344,264,232**	$ 317,193,794
Provision for bad debts	**(14,175,565)**	(12,904,102)
Net patient service revenue, less provision for bad debts	**330,088,667**	304,289,692
Rental income	**246,760**	96,079
Other revenue	**1,926,462**	3,535,152
Total revenue	**332,261,889**	307,920,923
EXPENSES		
Wages, salaries, and benefits	**169,529,802**	151,192,986
Supplies and other	**94,588,631**	92,943,203
Purchased services	**27,427,657**	25,130,529
Depreciation	**20,535,623**	18,802,689
Interest	**8,497,108**	7,940,427
Insurance	**3,230,230**	3,947,684
Total expenses	**323,809,051**	299,957,518
Operating income	**8,452,838**	7,963,405
NONOPERATING GAINS (LOSSES)		
Investment gains	**10,679,527**	2,463,403
Donations	**2,532,013**	3,163,812
Change in beneficial interest in assets held by others	**177,329**	(1,594,758)
Net (loss) from equity affiliates	**(200,211)**	(866,476)
Change in fair value of derivative obligation	**6,385,572**	(7,129,294)
Other gains (losses)	**(20,274)**	20,657
Total nonoperating gains (losses)	**19,553,956**	(3,942,656)
Excess of revenue and gains over expenses and losses	**28,006,794**	4,020,749
Change in minimum pension obligation	**12,250,965**	(24,783,257)
Increase (decrease) in unrestricted net assets	**$ 40,257,759**	$ (20,762,508)

See Notes to Consolidated Financial Statements

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
Years Ended June 30, 2017 and 2016

	2017	2016
UNRESTRICTED NET ASSETS		
Excess of revenue and gains over expenses and losses	**$ 28,006,794**	$ 4,020,749
Change in minimum pension obligation	**12,250,965**	(24,783,257)
Increase (decrease) in unrestricted net assets	**40,257,759**	(20,762,508)
TEMPORARILY RESTRICTED NET ASSETS		
Change in beneficial interest in assets held by others	**(1,430,507)**	2,656,148
PERMANENTLY RESTRICTED NET ASSETS		
Contributions for endowment funds	**4,065**	126,300
Change in net assets	**38,831,317**	(17,980,060)
Net assets, beginning of year	**176,837,663**	194,817,723
Net assets, end of year	**$ 215,668,980**	$ 176,837,663

See Notes to Consolidated Financial Statements

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
Years Ended June 30, 2017 and 2016

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	**$ 38,831,317**	$ (17,980,060)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Restricted contributions	**(4,065)**	(126,300)
Change in fair value of derivative obligation	**(6,385,571)**	7,129,294
Provision for bad debts	**14,175,565**	12,904,102
Depreciation	**20,535,623**	18,802,689
Bond premium and discount amortization	**(490,165)**	(500,430)
Amortization of bond issuance costs	**112,102**	125,913
(Gain) loss on disposal of property and equipment	**192,422**	(46,562)
Loss on equity method investments	**200,211**	866,476
Amortization of advance fees	**(189,281)**	(147,267)
Advance fees received	**2,351,789**	2,206,850
Change in minimum pension obligation	**(12,250,965)**	24,783,257
Change in beneficial interest in assets held by others	**1,249,668**	(1,187,690)
Changes in operating assets and liabilities:		
Patient accounts receivable	**(15,103,022)**	(13,995,452)
Due from affiliated entities	**16,402**	(44,446)
Due to/from third-party payors	**1,802,041**	(2,417,631)
Other receivables	**(2,615,454)**	(590,538)
Inventories	**353,703**	408,844
Insurance recoveries receivable	**202,697**	24,632
Prepaid expenses and other assets	**(459,536)**	42,484
Trading securities	**(9,382,778)**	(3,144,945)
Other investments	**(1,173,094)**	(1,805,017)
Accounts payable and accrued expenses	**241,288**	4,990,862
Deferred revenue for advance rent	**(50,571)**	(47,333)
Accrued pension obligation	**(8,240,601)**	(8,828,941)
Estimated professional and general liability obligation	**421,846**	762,506
Net cash provided by operating activities	**24,341,571**	22,185,297
CASH FLOWS FROM INVESTING ACTIVITIES		
Property and equipment acquisitions	**(30,236,117)**	(21,771,436)
Proceeds from sale of property and equipment	**31,379**	127,160
Acquisition of Wedgewood Physicians, Inc. (net of cash)	**(5,598,038)**	-
Net cash (used in) investing activities	**(35,802,776)**	(21,644,276)

See Notes to Consolidated Financial Statements

	2017	2016
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments on long-term debt	**$ (3,710,996)**	$ (2,303,002)
Proceeds from issuance of long-term debt	**-**	480,395
Refunds from issuance of deposits and refundable fees	**(1,991,606)**	(1,259,385)
Proceeds from restricted contributions	**4,065**	126,300
Net cash (used in) financing activities	**(5,698,537)**	(2,955,692)
Net (decrease) in cash and cash equivalents	**(17,159,742)**	(2,414,671)
Cash and cash equivalents:		
Beginning of year	**49,293,093**	51,707,764
End of year	**$ 32,133,351**	$ 49,293,093
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION		
Cash paid during the year for interest	**$ 8,458,911**	$ 7,133,320
Capital expenditures funded by capital lease borrowings	**$ -**	$ 49,311,473

See Notes to Consolidated Financial Statements

Note 1. Description of Organization

Nature of activities: Monongalia Health System, Inc. (MHS) is a not-for-profit corporation which sponsors and controls two hospitals and other health related corporations (collectively, Health System). The health related corporations (Subsidiaries) include Monongalia County General Hospital Company (MHMC), Mon Elder Services, Inc. (MES), Monongalia Emergency Medical Services, Inc. (MEMS), Preston Memorial Hospital (PMH), and Mon Health Care, Inc. (MHC). Each of these Subsidiaries' service area is primarily Monongalia and surrounding counties.

MHS is a not-for-profit organization incorporated for the purpose of providing management, planning, development, coordination, and other activities related to the promotion of health care within MHS's service area.

MHMC is a not-for-profit corporation that operates an acute care hospital facility in Morgantown, West Virginia.

MES, d/b/a The Village at Heritage Point, is a not-for-profit corporation which was established to develop, own, and operate a continuing care retirement village in the Morgantown, West Virginia, area consisting of 90 independent living apartments, 40 assisted living units, and common support areas on approximately 11 acres.

MEMS is a not-for-profit organization incorporated to provide emergency ambulance, rescue, neonatal, and transportation services to the Monongalia County community.

PMH is a not-for-profit, critical access hospital providing acute, medical, surgical, rehabilitative, and outpatient services. PMH is located in Kingwood, Preston County, West Virginia. MHS became the sole member of PMH effective February 28, 2014. PMH is the parent organization of Preston Memorial Medical Group, Inc. and Preston Memorial Foundation, which are now all consolidated and presented as an affiliate under MHS in these consolidated financial statements.

MHS owns all of the capital stock of MHC. MHC, which is a for-profit taxable entity, provides home respiratory care and has a retail operation of durable medical equipment.

MHS also owns all of the capital stock of Morgantown Medical Arts Building, Inc. (MMAB) which is a for-profit entity. MMAB owns and leases real estate in the Monongalia County community.

MHS also manages rental properties acquired for possible future expansion of health care services within the area.

Note 2. Summary of Significant Accounting Policies

Principles of consolidation: The consolidated financial statements include the accounts of MHS and its Subsidiaries. All significant intercompany accounts and transactions have been eliminated in consolidation.

Basis of accounting: The accompanying consolidated financial statements are presented in accordance with the accrual basis of accounting, whereby revenue is recognized when earned and expenses are recognized when incurred.

Basis of presentation: The consolidated financial statements presentation follows the recommendations of the Financial Accounting Standards Board (FASB) regarding guidance on *Financial Statements of Not-for-Profit Organizations* and of the American Institute of Certified Public Accountants (AICPA) in its *Audit and Accounting Guide for Health Care Organizations.* The Health System is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted, temporarily restricted, and permanently restricted net assets as follows:

Unrestricted net assets represent contributions, gifts, and grants which have no donor-imposed restrictions or which arise as a result of operations.

Temporarily restricted net assets represent contributions, gifts, and grants which have donor-imposed limitations on their use for a specified time period or purpose. The Health System recognizes its beneficial interest in the Foundation of Monongalia General Hospital, Inc. (Foundation), which has temporarily restricted net assets.

Permanently restricted net assets represent contributions, gifts, and grants that have been restricted by donors to be maintained by the Health System in perpetuity. The Health System recognizes its beneficial interest in the Foundation which has permanently endowed scholarship funds that comprise the entire balance of permanently restricted net assets.

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

Use of estimates: The preparation of consolidated financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and disclosures of contingent assets and liabilities at the date of the consolidated financial statements, and reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Cash and cash equivalents: The Health System considers all highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents. All debt instruments purchased with a maturity of more than three months are considered to be investments.

Fair value measurements: The FASB has issued authoritative guidance regarding *Fair Value Measurements*, which defines fair value, establishes a framework for measuring fair value in generally accepted accounting principles, and expands disclosures about fair value measurements. Fair value as defined under generally accepted accounting principles is an exit price, representing the price 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. The Health System utilizes market data or assumptions that market participants would use in pricing the asset or liability. Generally accepted accounting principles establish a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: Level I, defined as observable inputs such as quoted prices in active markets; Level II, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level III, defined as unobservable inputs about which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Patient accounts receivable: Patient accounts receivable are carried at the original charge less an estimate made for doubtful or uncollectable accounts. The allowance is based upon a review of the outstanding balances aged by financial class. Management uses collection percentages based upon historical collection experience to determine collectability. Patient accounts receivable are written off when deemed uncollectable. For receivables associated with self-pay patients without insurance, MHMC and PMH record a provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. Recoveries of accounts previously written off are recorded as a reduction to the provision for bad debt expense when received. Interest is not charged on patient accounts receivable.

The Health System's allowance for doubtful accounts for self-pay patients decreased from 91.2% of self-pay accounts receivable as of June 30, 2016, to 86.7% of self-pay accounts receivable as of June 30, 2017. In addition, MHMC's self-pay write offs increased approximately $890,000 from approximately $11,407,000 for the fiscal year 2016 to $12,297,000 for fiscal year 2017. The Health System does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write offs from third-party payors.

Patient accounts receivable, special payment arrangements: MHMC and MEMS have made arrangements with certain patients for monthly payments over an extended period. Accordingly, this receivable is reflected as a long-term asset.

Inventories: Inventories, which consist primarily of pharmaceuticals and medical supplies, are valued at the lower of cost or market. Cost is determined using the first-in, first-out (FIFO) method.

Investments: Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value on the consolidated statements of financial position. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the excess of revenue and gains over expenses and losses unless the income or loss is restricted by donor or law. The Health System classifies their professionally managed investments as trading securities, thus the related unrealized gains and losses on these investments are included in the excess of revenue and gains over expenses and losses.

Investments whose use is limited: Investments whose use is limited consist of the following:

- Funds set aside by the Board of Directors (Board) for future capital improvements, over which the Board retains control and may, at its discretion, subsequently use for other purposes.
- Funds held by a trustee under a self-insurance trust arrangement.
- Funds invested in tax incremental financing bonds issued to construct an access road on and refurbish an existing road near the campus of MHMC.
- Funds held in escrow under bond indenture agreements.

Investment risk and uncertainties: The Health System invests in professionally managed portfolios that contain corporate bonds, United States government obligations, municipal obligations, asset-backed securities, international bonds, marketable equity securities, and money market funds. Such investments are exposed to various risks, such as interest rate, market, and credit. Due to the level of risk associated with such investments and the level of uncertainty related to changes in the value of such investments, it is at least reasonably possible that changes in risks in the near term would materially affect investment balances and the amounts reported in the consolidated financial statements.

Investments, equity method: Except for MHS's ownership of MMAB (Note 6), investments in affiliates in which the Health System has at least a 20%, but not more than 50%, stock or partnership ownership interest are recorded using the equity method, adjusted for the Health System's share of its undistributed earnings or losses. All other investments in these types of entities are recorded at cost.

Goodwill: The Health System recorded goodwill as the excess of purchase price over the fair value of the identifiable assets acquired for various acquisitions. Authoritative guidance related to goodwill and other intangible assets prescribes the application of a two-step process for impairment testing of goodwill if adverse qualitative factors exist indicating that it is more likely than not that goodwill is impaired. This is performed annually, as well as when an event triggering impairment may have occurred. Upon determination that goodwill is more than likely to be impaired, the two-step process would be applied. The first step tests for impairment while the second step, if necessary, measures impairment. The Health System has selected June 30 on which to perform its annual evaluation of goodwill for impairment. No indicators of impairment were identified as of June 30, 2017 or 2016.

Property and equipment: Property and equipment acquisitions are recorded at cost or, if donated, at fair value at the date of receipt. Depreciation is provided over the estimated useful life of each class of depreciable asset ranging from 5 to 39 years and is computed on the straight-line method.

Valuation of long-lived assets: The Health System accounts for the valuation of long-lived assets using FASB Accounting Standards Codification (ASC) Topic 410, *Asset Retirement and Environmental Obligations* (FASB ASC 410), which requires that long-lived assets and certain identifiable intangible assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of the long-lived asset is measured by a comparison of the carrying amount of the asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be 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. Assets to be disposed of are reportable at the lower of the carrying amount or fair value, less costs to sell.

Deferred costs: The underwriting discount, premium, and issuance costs on bond issues are being amortized on the interest method over the life of the bonds. These costs are presented as a direct deduction from the carrying amount of the related debt liability.

Beneficial interest in assets held by others: The Health System follows FASB guidance on the *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust that Raises or Holds Contributions for Others,* which establishes standards for transactions involving donors. MHMC, as beneficiary, and the Foundation, as the recipient organization, have an arrangement whereby the Foundation accepts contributions from donors and agrees to use those funds to benefit MHMC. Therefore, MHMC includes the net assets of the Foundation as a beneficial interest. MES has an arrangement with a local community foundation in which the foundation accepts contributions from donors and agrees to use them to benefit MES, and, accordingly, MES includes in net assets the amount donated to the community foundation on MES's behalf.

Prospective resident and security deposits and deferred revenue: MES collects 10% of the expected entrance fees from prospective residents once an independent living unit is identified for occupancy. These initial deposits are refundable to the prospective residents until their time of occupancy, less an administrative fee, which may be waived subject to provisions in the residency agreement. The remaining 90% of the expected entrance fees is collected at the residents' point of occupancy. MES may also collect deposits from prospective residents, designated as waiting list fees, which place those prospective residents at a priority level. These deposits are applied toward the prospective residents' 10% entrance fees. Finally, MES collects a security deposit on each of its assisted living units.

The residents of MES's independent living units are entitled to either a 95% or 90% refund of their entrance deposit fees depending upon whether the units occupied are for single occupancy (95%) or double occupancy (90%). Beginning in April 2003, new residents moving into the independent living units have the additional option of paying a reduced entrance deposit fee in exchange for receiving only a 75% or 60% refund.

Refunds are subject to a new resident paying the entrance deposit fees and other provisions as provided in the residency agreement. MES amortizes to revenue the nonrefundable entrance deposit fees received over the estimated remaining life expectancy of the resident and records the advance refundable fees as a liability. Refundable entrance deposit fees received from residents of MES are recorded as liabilities and are contingently refunded to the resident upon termination of the agreement and MES's ability to reoccupy the respective unit.

Self-insurance programs: MHS, MHMC, PMH, and MES self-insure their professional and general liability losses up to specified amounts per claim. In addition, the self-insurance plan has specified annual aggregate loss limits. Occurrence basis commercial insurance is maintained for losses in excess of the self-insured coverage.

In connection with the self-insurance program, a revocable trust fund was established and is maintained by an independent trustee, for the purpose of appropriating assets based on actuarial funding recommendations. Under the trust agreement, the trust assets can only be used for payment of professional and general liability losses, related expenses, and the cost of administering the trust. The trust assets, including contributions and earnings thereon, are included on the consolidated statements of financial position. Income from the trust assets and self-insurance expenses are reported on the consolidated statements of operations. MHS, MHMC, PMH, and MES provide for losses as they become reasonably estimable.

The Health System also has self-insurance programs for employee health and worker's compensation.

The provision for estimated self-insured obligations includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Bond premium and discount: The premium on the Series 2015 and discount on the Series 2011 and 2015 bond issues are being amortized over the life of the bonds using the interest method and offset the interest costs incurred on the bonds.

Income taxes: The Health System is generally exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code, with the exception of MHC and MMAB which are corporations subject to income tax. Additionally, the Health System qualifies for charitable contributions deductions under Section 170(b)(1)(A)(vi) and has been classified as an organization that is not a private foundation under Section 509(a)(1). Income which is not related to exempt purposes, less applicable deductions, is subject to federal and state corporate income taxes. The Health System had no significant unrelated business income for the years ended June 30, 2017 or 2016. Interest and penalties related to income tax assessments, if any, are reflected in income tax expense on the accompanying consolidated statements of operations.

The Health System follows the FASB's authoritative guidance on accounting for uncertainty in income taxes. The guidance clarifies the accounting for the recognition and measurement of the benefits of individual tax positions in the consolidated financial statements. Tax positions must meet a recognition threshold of more-likely-than-not in order for the benefit of those tax positions to be recognized in the consolidated financial statements. The Health System has determined that no material unrecognized tax benefits or obligations exist. Generally, tax returns for years ended June 30, 2014, and thereafter remain subject to examination by federal and state tax authorities.

Provider taxes: The State of West Virginia assesses a health care provider tax on net patient service revenue from acute care hospital services primarily at a rate of 2.5%. During 2017 and 2016, MHMC incurred provider taxes of $5,576,730 and $5,365,803, respectively, which are included in supplies and other expenses on the accompanying consolidated statements of operations. During 2017 and 2016, PMH incurred $660,501 and $649,615, respectively, which are recorded as provider tax and included in supplies and other expenses on the accompanying consolidated statements of operations.

Excess of revenue and gains over expenses and losses: For purposes of presentation, transactions deemed by management to be ongoing, major, or central to the provision of health care services are reported as operating revenue and expenses. Peripheral or incidental transactions are reported as non-operating gains and losses. Changes in unrestricted net assets, which are excluded from excess of revenue and gains over expenses and losses, include minimum pension obligation adjustments.

Net patient service revenue, less provision for bad debts: Net patient service revenue, less provision for bad debts is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

The Health System's revenue 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. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered.

Charity care: The Health System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Health System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Cost is used as the measurement basis for charity care disclosures and cost is identified as the direct and indirect cost of providing the charity care. The estimated costs of providing charity care services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing charity care to patients. The ratio of costs to charges is calculated based on the Health System’s total expenses (less bad debt expense) divided by gross patient service revenue.

The estimated cost of providing charity care amounted to $1,911,000 and $1,531,000 for the years ended June 30, 2017 and 2016, respectively.

Electronic health record incentive revenue: The American Recovery and Reinvestment Act of 2009 established the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act authorized the Centers for Medicare and Medicaid Services (CMS) to establish the Meaningful Use Program to achieve national health care goals through the use of electronic health records (EHR). Through the Meaningful Use Program, organizations and eligible providers will receive incentives for meeting steadily more challenging electronic health record use criteria from 2011 through 2016. To receive an EHR incentive payment, the organizations have to show that they are “meaningfully using” their EHR by meeting thresholds for a number of objectives. The CMS has established the objectives for “meaningful use” that eligible hospitals must meet in order to receive an incentive payment.

MHMC records EHR revenue under the grant accounting model ratably over the federal reporting period when management believes that reasonable assurance of compliance has been met with the program requirements. For the years ended June 30, 2017 and 2016, MHMC recognized $0 and $502,044, respectively, of EHR incentive revenue which is recorded in other revenue on the consolidated statements of operations. The amounts recorded are management’s best estimate and are subject to audit by the federal government or its designee. Changes to recorded estimates are recognized in the period known.

Obligation to provide future services: MES annually calculates the present value of the net cost of future services and the use of facilities to be provided to current residents and compares that amount with the balance of deferred revenue from entrance deposit fees. If the present value of the net cost of future services and the use of facilities exceeds the deferred revenue from advance fees, a liability is recorded (obligation to provide future services and use of facilities) with the corresponding charge to income. MES has determined that no accrual is required as of June 30, 2017 or 2016, as management has the ability to charge additional fees, if necessary, to meet such obligations.

Advertising costs: The Health System expenses the costs associated with advertising when incurred. Advertising expense amounted to approximately $1,160,000 and $1,222,000 for the years ended June 30, 2017 and 2016, respectively.

Subsequent events: The Health System evaluated the effect subsequent events would have on the consolidated financial statements through October 3, 2017, which is the date the consolidated financial statements were issued (Note 25).

Note 3. Recent Accounting Pronouncements

In May 2014, the FASB issued guidance related to recognition of revenue from contracts with customers. This guidance requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers and requires certain qualitative and quantitative disclosures regarding revenue arising from contracts with customers. This Accounting Standards Update (ASU) will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The guidance permits the use of either a retrospective or modified retrospective (cumulative effect) transition method. In August 2015, the FASB issued an amendment to defer the effective dates for all entities by one year. During 2016, the FASB has issued varied guidance with the purpose of clarifying Topic 606: Revenue from Contracts with Customers. Such clarifications included: improving the operability and understandability of the implementation guidance on principal versus agent considerations; identifying performance obligations and also to improve the operability and understandability of the licensing implementation guidance; clarifying the objective of the collectability criterion for applying paragraph 606-10-25-7; permitting an entity to exclude amounts collected from customers for all sales (and other similar) taxes from the transaction price; specifying that the measurement date for noncash consideration is contract inception; providing a practical expedient that permits an entity to reflect the aggregate effect of all modifications that occur before the beginning of the earliest period presented when identifying the satisfied and unsatisfied performance obligations; determining the transaction price and allocating the transaction price to the satisfied and unsatisfied performance obligations; clarifying that a completed contract for purposes of transition is a contract for which all (or substantially all) of the revenue was recognized under legacy GAAP before the date of initial application; and clarifying that an entity that retrospectively applies the guidance in Topic 606 to each prior reporting period is not required to disclose the effect of the accounting change for the period of adoption. This guidance is effective with annual This guidance is effective for public entities with annual reporting periods beginning after December 15, 2017. Public entities include any of the following: (1) a public business entity, (2) a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market, or (3) an employee benefit plan that files or furnishes financial statements to the Securities Exchange Commission (SEC). Early application is not permitted. For all other entities (nonpublic entities), the amendments in these ASUs will be effective for annual reporting periods beginning after December 15, 2018. A nonpublic entity may elect to apply this guidance earlier, subject to certain limitations. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

In May 2015, the FASB issued guidance to eliminate diversity in practice related to how certain investments measured at net asset value with redemption dates in the future, including periodic redemption dates, are currently categorized within the fair value hierarchy. This guidance removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. This guidance also removes the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. This guidance is effective for public entities for fiscal years beginning after December 15, 2015, and for all other entities for fiscal years beginning after December 15, 2016. Public entities include any of the following: (1) a public business entity, (2) a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market, or (3) an employee benefit plan that files or furnishes financial statements to the Securities Exchange Commission (SEC). Early adoption is permitted. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

In July 2015, the FASB issued guidance with the purpose of simplifying that inventory currently be measured at the lower of cost or market. This guidance does not apply to inventory that is measured using last-in, first-out or the retail inventory method. This guidance does apply to other inventory, which includes inventory that is measured using first-in, first-out or average cost. This guidance states that an organization should measure inventory at the lower of cost or net realizable value. Net realizable value is the estimated selling price used in the ordinary course of business, less reasonably predictable costs of completion, disposal, and transportation. This guidance is effective for all entities for fiscal years beginning after December 15, 2016. Early adoption is permitted. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

In January 2016, the FASB issued guidance to address certain aspects of recognition, measurement, presentation, and disclosure of financial instruments for entities that hold financial assets or owe financial liabilities. The guidance will require: (a) certain equity investments to be measured at fair value with changes recognized in net income; (b) a qualitative assessment to identify impairment of equity investments without readily determinable fair value; (c) elimination of disclosures of the fair value of financial instruments measured at amortized costs and method(s) and significant assumptions used to estimate the fair value; (d) the exit price notion be used when measuring fair value; (e) separate presentation in other comprehensive income of the portion of the total change in the fair value of a liability; (f) separate presentation of financial assets and financial liabilities by measurement category and form of financial asset; and (g) clarification of how to evaluate the need for a valuation allowance on a deferred tax asset related to available-for-sale securities in combination with the entity's other deferred tax assets. This guidance is effective for public entities for fiscal years beginning after December 15, 2017, and for other entities, including not-for-profit entities and employee benefit plans within the scope of Topic 960 through 965 on plan accounting, for fiscal years beginning after December 15, 2018. Public entities include any of the following: (1) a public business entity, (2) a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market, or (3) an employee benefit plan that files or furnishes financial statements to the Securities Exchange Commission (SEC). Early adoption is not permitted except for certain exceptions for public entities. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

In February 2016, the FASB issued guidance related to recognition by a lessee of assets and liabilities on leases with terms of more than 12 months on the balance sheet. Consistent with U.S. GAAP, the recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee primarily will depend on its classification as a finance or operating lease; however, unlike current U.S. GAAP, which requires that only capital leases be recognized on the balance sheet, the ASU requires that both types of leases be recognized on the balance sheet. The ASU also requires disclosures to help financial statement users better understand the amount, timing, and uncertainty of cash flows arising from leases. These disclosures include qualitative and quantitative requirements, providing additional information about the amounts recorded in the financial statements. Lessor accounting remains largely unchanged from current U.S. GAAP, but the ASU contains some targeted improvements that are intended to align, where necessary, lessor accounting with the lessee accounting model and with the updated revenue recognition guidance issued in May 2014. Transition guidance is provided within the ASU and generally requires a retrospective approach. This guidance is effective for public entities with annual reporting periods beginning after December 15, 2018. Public entities include any of the following: (1) a public business entity, (2) a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market, or (3) an employee benefit plan that files or furnishes financial statements to the Securities Exchange Commission (SEC). For all other entities (nonpublic entities), the amendments in these ASUs will be effective for annual reporting periods beginning after December 15, 2019. Early application of the amendments in this guidance is permitted for all entities. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

In August 2016, the FASB issued guidance to improve certain current financial reporting for not-for-profits (NFPs). The main provisions of this ASU will require an NFP to present on the face of the statement of financial position amounts for two classes of net assets at the end of the period, rather than for the currently required three classes. NFPs will report amounts for net assets with donor restrictions and net

assets without donor restrictions, as well as the currently required amount for total net assets. This ASU will also require NFPs to present on the face of the statement of activities the amount of change in each of the two classes of net assets noted above. NFPs will continue to present on the face of the statement of cash flows the net amount for operating cash flows using either the direct or indirect method, but will no longer require indirect method reconciliation if using the direct method. NFPs will report investment return net of external and direct internal investment expenses and no longer be required to disclose these netted expenses. NFPs will also be required to use, in the absence of explicit donor stipulations, the placed-in-service approach for reporting expirations or restrictions on gifts of cash of other assets to be used to acquire or construct a long-lived asset and reclassify any amounts from net assets with donor restriction to net assets without donor restrictions for such long-lived assets that have been placed in service as of the beginning of the period of adoption (thus eliminating the current option to release the donor-imposed restriction over the estimated useful life of the acquired asset).

This ASU will further require an NFP to provide the following enhanced disclosures about: (a) amounts and purposes of governing board designations, appropriations, and similar actions as of the end of the period; (b) composition of net assets with donor restrictions at the end of the period and how the restrictions affect the use of resources; (c) qualitative information that communicates how an NFP manages its liquid resources available to meet cash needs for general expenditures within one year of the statement of financial position date; (d) quantitative information, either on the face the statement of financial position or in the notes, and additional qualitative information in the notes as necessary that communicates the availability of an NFP's financial assets at the statement of financial position date to meet cash needs for general expenditures within one year of the statement of financial position date; (e) amounts of expenses by both their natural classification and their functional classification; and (f) method used to allocate costs among program and support functions. This guidance is effective for NFPs with fiscal years beginning after December 15, 2017. Early adoption is permitted. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

In January 2017, the FASB issued guidance to simplify the subsequent measurement of goodwill. To address concerns over the cost and complexity of the two-step goodwill impairment test, the amendments in this ASU remove the second step of the test. An entity will apply a one-step quantitative test and record the amount of goodwill impairment as the excess of a reporting unit's carrying amount over its fair value, not to exceed the total amount of goodwill allocated to the reporting unit. The new guidance does not amend the optional qualitative assessment of goodwill impairment. This guidance is effective for public entities that are SEC filers for fiscal years beginning after December 15, 2019, public entities that are not SEC filers for fiscal years beginning after December 15, 2020, and for all other entities, including not-for-profit entities, for fiscal years beginning after December 15, 2021. Early adoption is permitted and amendments in this ASU should be applied on a prospective basis. The Health System is currently evaluating the impact, if any, that adoption will have on its consolidated financial statements.

Note 4. Net Patient Service Revenue, Less Provision for Bad Debts

MHMC, MHC, and MEMS have agreements with third-party payors that provide for payments at amounts different from their established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the established rates for services and actual amounts reimbursed by third-party payors. A summary of the payment arrangements with major third-party payors follows:

Medicare: Hospital inpatient and outpatient services rendered to Medicare program beneficiaries are generally paid based on a prospective payment system using diagnosis related groups or ambulatory payment classifications. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors.

Medicaid: Hospital inpatient services rendered to Medicaid program beneficiaries are paid based on a prospective payment system using diagnosis related groups while outpatient services are paid on the basis of a fee schedule.

PMH has agreements with third-party payors that provide for payments to them at amounts different from its established rates. PMH received designation as a Critical Access Hospital (CAH) under the Medicare and Medicaid programs on January 1, 2003. Accordingly, PMH receives payments on a reasonable and allowable cost basis for inpatient and most outpatient services provided to eligible Medicare and Medicaid patients.

Revenue from Medicare and Medicaid programs accounted for approximately 34% and 7%, respectively, of MHMC's and PMH's net patient service revenue for the year ended June 30, 2017, and 34% and 9%, respectively, of MHMC's and PMH's net patient service revenue for the year ended June 30, 2016.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Settlement of prior year cost reports and revisions to other prior year settlement estimates approximated $380,000 and $2,531,000 for the years ended June 30, 2017 and 2016, respectively, and were recorded in patient service revenue (net of contractual allowances and discounts) on the accompanying consolidated statements of operations.

Along with other similar hospitals nationwide, Monongalia County General Hospital Company, a consolidated member, received notice from the United States Department of Justice (USDOJ) in September 2010 that they were conducting an investigation to determine whether or not certain hospitals have submitted claims for payments for the implantation of Implantable Cardioverter Defibrillators (ICDs), which were not medically indicated and/or otherwise violated Medicare payment policy. In December 2015, MHMC recorded a settlement of $4,800,000 related to the investigation. This transaction was recorded as a contractual adjustment which resulted in a decrease in net patient service revenue for the year ended June 30, 2016.

Public Employees Insurance Agency (PEIA): Payments to MHMC for outpatient services rendered to PEIA program beneficiaries are based upon MHMC's current standard rates less a discount. Inpatient acute care services rendered to patients under this program are paid at prospectively determined rates per discharge. PEIA payments are made pursuant to legislative actions of the state of West Virginia.

Commercial insurance carriers: Patient services are rendered primarily on a fee-for-service basis. Hospital inpatient services for certain commercial carriers are paid based on a prospective payment system using diagnosis related groups.

Medicaid - Upper Payment Limit Program: In 2012, the West Virginia Medicaid Program received federal CMS approval to implement the Upper Payment Limit (UPL) program. The UPL program provides for supplemental Medicaid payments to MHMC. The payment is computed primarily on the following factors: hospital allowable total cost to charge ratio and what Medicaid paid for the fee for service segment of Medicaid. The West Virginia Department of Tax and Revenue has also implemented a tax on licensed general acute care hospitals as an expansion of the existing health care provider tax. In addition to the current tax of 2.5% currently imposed on providers of hospital services, there is an additional tax of .74% in 2017 and .72% in 2016 on gross revenue.

During 2017 and 2016, MHMC recorded $1,646,978 and $1,608,196, respectively, in taxes related to the UPL program, which has been included in supplies and other expenses on the consolidated statements of operations. The new revenue produced from this will be used as the State contribution toward drawing down additional federal matching dollars for Medicaid to enhance current hospital payment rates under the UPL program. The supplemental reimbursement for these services of $6,559,330 and $3,198,489 for 2017 and 2016, respectively, is included in net patient service revenue on the consolidated statements of operations. Included in the third-party payor settlements are amounts due from the program as of June 30, 2017 and 2016, of $2,033,350 and $0, respectively.

The Health System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Health System recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Health System's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Health System records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the years ended June 30 from these major payor sources, is as follows:

	June 30, 2017			
	Governmental Payors	**Non-Governmental Payors**	**Self-Pay**	**Total All Payors**
Patient service revenue (net of contractual allowances and discounts)	**$ 156,361,757**	**$ 177,595,491**	**$ 10,306,984**	**$ 344,264,232**

	June 30, 2016			
	Governmental Payors	**Non-Governmental Payors**	**Self-Pay**	**Total All Payors**
Patient service revenue (net of contractual allowances and discounts)	$ 151,334,164	$ 156,199,086	$ 9,660,544	$ 317,193,794

The composition of net patient service revenue for the years ended June 30 is as follows:

	2017	2016
Gross patient service charges	**$ 795,787,573**	$ 737,252,024
Less provisions for:		
Contractual adjustments under third-party reimbursement programs	**448,109,394**	417,195,946
Charity care	**3,337,538**	2,815,332
Resident credits	**76,409**	46,952
	451,523,341	420,058,230
Net patient service revenue	**344,264,232**	317,193,794
Less provision for bad debts	**(14,175,565)**	(12,904,102)
Net patient service revenue, less provision for bad debts	**$ 330,088,667**	$ 304,289,692

Note 5. Assets Whose Use is Limited

The composition of assets whose use is limited is set forth below. The following investments are stated at fair value as of June 30 on the consolidated statements of financial position:

	2017	2016
By Board for capital improvements:		
Equities		
Domestic	**$ 24,936,908**	$ 26,232,450
International	**17,770,427**	10,409,458
Real estate investment trust	**-**	7,110,911
Fixed income		
U.S. Treasury	**9,214,049**	9,005,593
Cash equivalent funds	**11,854,380**	15,988,164
Government agency bonds	**644,944**	1,975,200
Corporate bonds	**11,246,964**	11,357,394
Asset-backed securities	**13,168,267**	15,808,547
Alternative	**17,553,213**	837,569
International	**6,321,720**	3,941,044
Money market funds	**-**	70,977
Interest-bearing cash	**7,887,397**	8,306,269
	120,598,269	111,043,576
Under professional liability self-insurance funding arrangement held by trustee:		
Fixed income		
Government agency bonds	**4,129,271**	3,902,273
Corporate bonds	**1,015,516**	1,124,962
Interest-bearing cash	**48,791**	225,747
	5,193,578	5,252,982
Tax increment financing bonds and bond indenture agreements held by trustee:		
Fixed income		
Municipal bonds	**2,786,955**	2,515,639
Money market funds	**8,600,945**	7,709,772
	11,387,900	10,225,411
Total investments, at fair value, whose use is limited	**137,179,747**	126,521,969
Less: current portion of assets whose use is limited	**16,537,133**	16,312,765
Investments, at fair value, whose use is limited	**$ 120,642,614**	$ 110,209,204

The current portion of assets whose use is limited consists of cash and cash equivalents of the investments above of which a portion are funds available to pay the current portion of long-term debt and costs incurred on construction in progress which have not yet been paid. The Trustee of the Series 2008A, 2008B, 2011, and 2015 Revenue Bonds and tax increment financing bonds is holding proceeds of the bonds in the following funds as of June 30:

	2017	2016
Debt service fund - principal and interest	**$ 3,673,903**	$ 3,997,582
Project fund	**3,722,875**	3,712,190
Physician service fund	**1,204,167**	-
Tax increment financing funds	**2,786,955**	2,515,639
	$ 11,387,900	$ 10,225,411

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

	2017	2016
Interest and dividend income	**$ 154,839**	$ 1,331,499
Investment fees	**(582,357)**	(518,146)
Unrealized gains (loss) on change in fair value	**(3,801,959)**	1,576,259
Realized gains on sale of securities	**14,909,004**	73,791
	$ 10,679,527	$ 2,463,403

Note 6. Equity and Cost Investments

MHS has a 50% ownership interest in Care Partners, Inc. (Care Partners). Care Partners, a for-profit corporation, provides various in-home health services to patients residing in a six-county area in West Virginia.

MHS has an approximate 26% direct ownership interest in Mountaintop Limited Partnership (Mountaintop) and MTOP, LLC (MTOP), both of which are for-profit entities. MTOP is the general partner of Mountaintop, which is engaged in the business of acquiring, owning, improving, and leasing real estate and personal property to a freestanding surgical center that offers services to the general public.

MHS has a 35.3% ownership interest in Morgantown Physical Therapy Associates, Inc. (MPTA), a for-profit entity. MPTA provides outpatient physical therapy and rehabilitation medical services to residents of Monongalia County and surrounding counties. MHS received dividends of $0 and $81,436 during the years ended June 30, 2017 and 2016, respectively.

MHS has an approximate 30.8% ownership interest in Morgantown Accommodations, LLC (MAL), a for-profit entity. MAL was developed for the purpose of ownership, construction, and operation of a hotel and certain additional developments surrounding the hotel. Though considered a principal member, the Health System will not be the managing member and will not have control over the venture.

MHC owns 50% of Fairmont Home Equipment and Supply Company (Fairmont), a durable medical equipment retailer.

MHS obtained 100% of MMAB stock in the form of a donation, in December 2015. MMAB owns and leases real estate in the Monongalia County community. MHS is accounting for its ownership under the equity method of accounting. The amount recorded as of June 30, 2017 and 2016, was $2,194,954 and $2,294,894, respectively. MMAB's financial statements were not consolidated in the consolidated financial statements of the Health System due to immateriality and the nature of MMAB’s operation.

MHMC has a 51% ownership interest in MGH Surgery, LLC (OSC), a for-profit entity. OSC provides outpatient surgery services on the campus of MHMC. While MHMC is the majority owner, it maintains only 50% of the voting rights of the entity and, therefore, does not have control over the venture.

The Health System accounts for its investments in Care Partners, Mountaintop, MTOP, MPTA, MAL, Fairmont, MMAB, and OSC under the equity method of accounting. The unaudited combined results of operations and financial position of these equity basis affiliates as of and for the years ended June 30 are summarized below.

	2017	2016
Current assets	**$ 6,969,294**	$ 5,389,149
Property and equipment, net	**39,251,540**	33,400,662
Other assets	**1,996,058**	940,429
Total assets	**$ 48,216,892**	$ 39,730,240
Current liabilities	**$ 4,305,894**	$ 2,967,549
Long-term debt	**25,725,615**	19,981,563
Total liabilities	**30,031,509**	22,949,112
Stockholders' equity	**18,185,383**	16,781,128
Total liabilities and stockholders' equity	**$ 48,216,892**	$ 39,730,240
Total revenue	**$ 20,960,734**	$ 15,883,999
Net income (loss)	**$ 1,678,071**	$ (233,215)
Health System's share of net income (loss)	**$ (200,211)**	$ (866,476)

The Health System has an investment in a group purchasing organization, Premier, LP (Premier), which is recorded under the equity method and was $2,520,292 and $2,545,639 as of June 30, 2017 and 2016, respectively. On October 1, 2013, Premier finalized an initial public offering and reorganized from a private company to a public company, Premier, Inc. As a result of the reorganization, the Health System received 222,938 Class B common units in Premier Healthcare Alliance, LP (Premier LP). Per the terms of an exchange agreement with Premier, Premier LP and limited partners of Premier LP (the Exchange Agreement), the Health System may annually exchange up to one-seventh (1/7th) of its initial allocation of Class B common units and any additional Class B common units purchased by the Health System through exercise of the right of first refusal over Class B common units proposed to be exchanged by other member hospitals as described in the Exchange Agreement. If exercised, for Class B common units so exchanged, the Health System is entitled to receive either cash payments (from Premier or the other member owners under the right of first refusal), Class A common stock (one-to-one exchange ratio), or a combination of cash and Class A common stock. Cash payments will be determined per the terms of the Exchange Agreement, depending on whether the stock is traded on a national exchange, traded over-the-counter, or if there is no public market. During the year ended June 30, 2017, the Health System exchanged 26,757 of its Class B common units and received 21,288 shares of Class A common stock as well as a cash payment of $95,029. During the year ended June 30, 2016, the Health System exchanged 26,757 of its Class B common units and received 12,047 shares of Class A common stock as well as a cash payment of $692,466. The exchange provision of the Class B common units is accounted for as vendor incentive equity-based payments to non-employees and the estimated fair value of the related units is recognized as a reduction of supplies expense over the vesting period when it is considered probable the units will vest.

Supplies expense was reduced by $818,576 and $863,324 for the years ended June 30, 2017 and 2016, respectively. This reduction represents the recognized estimated value of such incentive. The estimated value of the Class B units involves significant assumptions, including that the Health System will remain a member of the Premier group purchasing organization (GPO). The actual amounts realized as a result of the exchange provision vesting could be materially different. Should the Health System terminate its relationship under the Premier GPO, the Health System must redeem its investment under the terms of its Exchange Agreement with Premier. The ultimate amount realized in the event of a termination could be materially different than the Health System's carrying value of its investment.

The Health System owns 10% of the stock of West Virginia Rehabilitation Hospital, Inc. (Rehab Hospital), which operates a rehabilitation hospital in Morgantown, West Virginia. The Health System accounts for its investment in the Rehab Hospital under the cost method of accounting. The Health System's investment at cost was $257,696 as of June 30, 2017 and 2016. The Rehab Hospital paid dividends of $432,819 and $180,096 during the years ended June 30, 2017 and 2016, respectively.

Rabbi Trust: The Health System provides supplemental retirement for certain key executives through the use of a nonstatutory mutual fund option plan (assets prior to May 8, 2002) and IRC §457(b) and §457(f) Plans. Other highly compensated employees have the opportunity to participate in the §457(b) plan through voluntary withholdings. A Rabbi Trust (Trust) is used to hold the assets of all three plans. The funding required for the employer provided supplemental retirement is recorded as additional salary expense. The actual funds are held by a bank, which is the trustee of the Trust. As of June 30, 2017 and 2016, the Trust totaled $2,763,952 and $2,151,667, respectively.

Other investments consist of the follow as of June 30:

	2017	2016
Investments		
Equity method	**$ 10,185,836**	$ 9,567,260
At cost	**1,704,736**	1,325,429
Rabbi Trust	**2,763,952**	2,151,667
	$ 14,654,524	$ 13,044,356

For the investments carried at cost, there were no identifiable events or changes in circumstances that may have led to an adverse effect on the fair value for the years ended June 30, 2017 or 2016.

Note 7. Acquisitions

On March 1, 2017, MHMC acquired the stock of Wedgewood Physicians, Inc. for $5,645,257. The following is a summary of the estimated fair value of the assets acquired and liabilities assumed:

Cash	$ 47,219
Net accounts receivable	975,387
Property, plant, and equipment	408,731
Real estate option	25,000
Service requirement fund	1,275,000
Goodwill	3,416,779
Accounts payable and other liabilities	(502,859)
Purchase price	$ 5,645,257

The balance of the service requirement fund is earned by the former owners of Wedgewood Physicians, Inc. as they complete a pre-established number of service years.

As a result of this acquisition, goodwill resulted from the excess purchase price over the net assets acquired in Wedgewood Physicians, Inc.

Note 8. Property and Equipment

Property and equipment, including property held for leasing, and property which is paid for by MHMC and MES but is owned by the Monongalia County Building Commission (Commission), a public corporation, and is managed and operated by MHMC and MES pursuant to lease agreements with the Commission, which expire July 1, 2055, consist of the following as of June 30:

	Estimated Useful Lives	**2017**	2016
Land and improvements	**N/A**	**$ 13,179,449**	$ 13,055,524
Road improvements	**8 years**	**1,148,705**	1,148,705
Buildings and improvements	**5 - 39 years**	**225,989,014**	214,580,540
Equipment	**5 - 10 years**	**147,724,872**	128,231,582
Furniture and fixtures	**5 - 10 years**	**3,017,297**	2,417,110
Vehicles	**5 years**	**3,238,206**	3,183,775
		394,297,543	362,617,236
Property held for leasing:			
Land		**12,483,267**	10,808,049
Buildings and improvements		**54,990,138**	52,382,730
Equipment		**1,324,224**	1,140,814
		68,797,629	64,331,593
		463,095,172	426,948,829
Less accumulated depreciation		**221,407,065**	201,771,402
		241,688,107	225,177,427
Construction in progress		**4,435,582**	11,060,838
Property and equipment, net		**$ 246,123,689**	$ 236,238,265

Depreciation expense was $20,535,623 and $18,802,689 for the years ended June 30, 2017 and 2016, respectively.

Capital lease assets included in property and equipment are as follows as of June 30:

	2017	2016
Capital lease assets	**$ 50,160,625**	$ 50,160,625
Less accumulated amortization	**2,548,340**	1,194,247
	$ 47,612,285	$ 48,966,378

Note 9. Beneficial Interest in Assets Held by Others

The Foundation was established as a Section 501(c)(3) organization within the meaning of the IRS solely for the purpose of providing grants and contributions for new services and capital expenditures to MHMC and its affiliated entities. MHMC's beneficial interests in the assets of the Foundation of $11,323,455 and $12,572,400 as of June 30, 2017 and 2016, respectively, are included in the accompanying consolidated financial statements. The Foundation does not guarantee any obligations of the Health System.

Note 10. Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations consist of the following as of June 30:

		2017		2016
Variable Rate Hospital Refunding and Improvement Revenue Bonds, Series 2008A, dated February 6, 2008, with variable interest rates (1.73% and 1.27% as of June 30, 2017 and 2016, respectively) and varying maturities (final maturity on July 1, 2040, with varying annual principal payments ranging from $15,000 to $6,890,000), principal paid annually and interest paid monthly, collateralized by a Deed of Trust lien on MHMC facilities and a promissory note (Series 2008A Note) entered into by MHS, MES, and MHMC (collectively, Obligated Group). The Series 2008A Note is collateralized by the gross revenue of the Obligated Group and other security as defined in the Master Indenture. Approximately $11,600,000 of the bonds were refunded with the issuance of the Series 2011 bonds on April 20, 2011.	**$**	**34,440,000**	$	34,475,000
Taxable Variable Rate Hospital Bonds, Series 2008B, dated February 6, 2008, with adjustable interest rates (2.03% and 1.41% as of June 30, 2017 and 2016, respectively) and varying maturities (final maturity on July 1, 2040, with varying annual principal payments ranging from $240,000 to $870,000), principal paid annually and interest paid monthly, collateralized by a Deed of Trust lien on MHMC facilities.		**12,470,000**		12,735,000
Refunding Revenue Bonds, Series 2011, dated April 20, 2011, with fixed interest rates ranging from 2.00% to 6.50%, and varying maturities (final maturity on July 1, 2041, with varying annual principal payments ranging from $465,000 to $8,940,000), principal paid annually and interest paid semi-annually, collateralized by a Deed of Trust lien on MHMC facilities and a promissory note (Series 2011 Note) entered into by the Obligated Group. The Series 2011 Note is collateralized by the gross revenue of the Obligated Group and other security as defined in the Master Indenture. The balances include unamortized discount of approximately $435,000 and $452,000 as of June 30, 2017 and 2016, respectively.				
Hospital		**7,648,800**		8,040,293
MES		**10,010,709**		10,523,093

	2017	2016
Note payable to seller of real estate, interest rate at 8.00%, with monthly principal and interest payments of $3,669 through April 2019, collateralized by real estate.	**$ 74,846**	$ 111,286
Note payable to bank, with adjustable interest rates (5.5% as of June 30, 2017), with monthly principal and interest payments of $1,471 through April 2027, collateralized by real estate.	**132,831**	142,856
Hospital Revenue Bonds, Series 2015, dated April 28, 2015, with fixed interest rates ranging from 3.00% to 5.00%, and varying maturities (final maturity on July 1, 2035, with varying annual principal payments ranging from $990,000 to $4,125,000), principal paid annually and interest paid semi-annually, collateralized by a Deed of Trust lien on MHMC facilities and a promissory note (Series 2015 Note) entered into by the Obligated Group. The Series 2015 Note is collateralized by the gross revenue of the Obligated Group and other security as defined in the Master Indenture. The balances include unamortized premium of approximately $3,404,000 and $3,921,000 as of June 30, 2017 and 2016, and unamortized discount of approximately $239,000 and $250,000 as of June 30, 2017 and 2016, respectively.	**53,624,845**	55,120,930
USDA direct loan, with a fixed interest rate of 3.5%. Monthly principal and interest payments beginning in August 2015 in the amount of $107,640, through July 2051, collateralized by all personal property and revenue of PMH.	**25,245,927**	25,646,083
Note payable to bank, with adjustable interest rates (3.71% as of June 30, 2017). Monthly principal and interest payments beginning in August 2015 through July 2040, collateralized by all personal property and revenue of PMH.	**11,065,323**	11,363,439
Capital lease obligation for chemistry analyzer equipment entered into in August 2012, imputed interest rate of 4.29%, with monthly principal and interest payments of $15,953 through July 2017, collateralized by leased equipment.	**15,890**	201,715
Capital lease obligation for medical office park with imputed interest rate of 3.76% and monthly principal and interest payments of $198,160 through November 2055, collateralized by the buildings.	**48,445,841**	49,020,669
	203,175,012	207,380,364
Less: unamortized deferred financing costs	**1,539,433**	1,655,726
	201,635,579	205,724,638
Less: current portion of long-term debt	**4,016,294**	4,089,412
Long-term debt, net of current portion	**$ 197,619,285**	$ 201,635,226

The future maturities, including bond premium and discount amortization, under the assumption that the Series 2008A and 2008B Bonds are not called, are as follows as of June 30, 2017:

Years Ending June 30:		
2018	$	3,426,579
2019		3,512,442
2020		3,577,707
2021		3,696,570
2022		3,819,158
Thereafter		136,680,825
	$	154,713,281

As of June 30, 2017, future minimum lease payments for assets acquired under capital leases, which are included in the maturities of long-term debt and the capital leases above, are as follows:

Years Ending June 30:		
2018	$	2,393,862
2019		2,377,909
2020		2,377,909
2021		2,377,909
2022		2,377,909
Thereafter		79,461,792
		91,367,290
Less: amounts representing interest at a rate of 3.76%		42,905,559
Net present value of future minimum capital lease payments		48,461,731
Less: current portion		589,715
Capital lease obligations	$	47,872,016

In February 2008, the Commission issued Variable Rate Hospital Refunding and Improvement Revenue Bonds Series 2008A with a par value of $48,145,000. Proceeds of the Series 2008A Bonds were used to pay a portion of the cost of completion of construction projects, as well as refunding the Series 2005B Variable Rate Hospital Refunding Bonds and to finance a portion of the interest accruing on the Series 2008A Bonds from the date of their delivery to February 1, 2011.

In February 2008, the Commission issued Taxable Variable Rate Hospital Bonds Series 2008B with a par value of $14,250,000. Proceeds of the Series 2008B Bonds are being used to reimburse MHMC for certain payments made by it with respect to the pension liabilities of the Health System.

In April 2011, the Commission issued Refunding Revenue Bonds Series 2011 (Monongalia Health System Obligated Group) with a par value of $22,505,000 and discount of $534,974. Proceeds of the Series 2011 Bonds are being used to refund a portion of the Variable Rate Hospital Refunding and Improvement Revenue Bonds Series 2008A and to refund the Refunding Revenue Bonds Series 2005C.

In February 2014, Preston Memorial Hospital entered into a Commercial Real Estate Construction Non-Revolving Line of Credit / Term Loan (Construction Loan) in the principal amount not to exceed $38,500,000. Proceeds from the Construction Loan were used for the design, development, and construction of a new critical access hospital facility, medical office facilities, related site improvements, and equipment on real property located in Kingwood, Preston County, West Virginia. The Construction Loan was unconditionally guaranteed by the Obligated Group on a joint and several basis. Construction was completed in May 2015. In July 2015, PMH entered a loan agreement with the United States Department of Agriculture (USDA) in the principal amount of $26,000,000. The residual balance of the Construction Loan amounted to approximately $11,640,000 and was converted to a term loan in July 2015.

In April 2015, the Commission issued Refunding and Improvement Revenue Bonds Series 2015 (Monongalia Health System Obligated Group) with a par value of $51,450,000, premium of $4,536,905, and discount of $261,411. Proceeds from the Series 2015 Bonds were used to refund the Hospital Revenue Bonds Series 2005A, and to finance certain capital improvement projects of MHMC.

MHMC and MES have entered into 50-year lease agreements with the Commission for the lease of their facilities. Annual lease payments are equal to the annual debt service requirements for the Series 2008A, 2008B, 2011, and 2015 Bonds as stipulated by the Bond Trust Indentures. The leases have been accounted for as capital lease obligations in accordance with the FASB guidance on the topic of leases.

In January 2014, MHS entered into a sublease agreement to master lease office space from a third-party developer. A significant portion of the leased space will be sublet by MHMC and the balance will be non-related entities. The overall square footage is approximately 120,000 square feet. Sublease payments commenced in December 2015 when the buildings were available for occupancy, and tenants began occupancy during calendar year 2016.

As provided in the Bond Indentures, the Series 2008A, 2008B, 2011, and 2015 Bonds are subject to redemption prior to maturity. The Bond Indentures also place limits on the incurrence of additional borrowings and require that the Obligated Group satisfy certain measures of financial performance as long as the Bonds are outstanding.

PMH also has two lines of credit for $150,000 and $180,000 to support operations if needed. As of June 30, 2017, PMH has not drawn on these lines of credit.

Note 11. Deferred Revenue for Advance Rent

Deferred revenue for advance rent represents the unamortized portion of rent earned for the $850,000 rent advance for property formerly occupied by Morgantown Health Care Corp (MHCC) and rent paid in advance on apartments owned by MHS. When MHS sold MHCC, the buyer paid advance rent for a 30 year lease, and revenue is being recognized over the life of the lease. During fiscal year 2014, an additional portion of the property outlined above was leased by the original buyer in the same manner for $500,000.

Deferred revenue for advance rent consists of the following as of June 30:

	2017	2016
Advance rent	**$ 1,058,169**	$ 1,105,502
Rent revenue recognized	**(50,571)**	(47,333)
Deferred revenue for advance rent	**$ 1,007,598**	$ 1,058,169

Note 12. Pension Plan

Monongalia Health System, Inc. Retirement Plan: The Monongalia Health System, Inc. Retirement Plan (MHS Plan) is a noncontributory defined benefit plan for all eligible employees of MHMC, MHS, MEMS, and MHC. Effective March 1, 2005, the MHS Plan was amended to add a cash balance option. Employees hired before January 1, 2005, were given the option to choose between having his or her benefits determined under the new "cash balance formula" or under the existing "final average pay formula." New employees who qualified for participation in the MHS Plan on or after January 1, 2005, were automatically covered under the cash balance option. The MHS Plan was frozen, effective August 31, 2007, by way of an amendment approved on June 27, 2007.

On August 4, 2015, the Board of Directors of MHS approved a resolution to amend the MHS Plan to permit the election of a single sum distribution by certain terminated vested participants and surviving spouses where the actuarial equivalent of the accrued benefit does not exceed $250,000 provided that certain conditions are satisfied. The participants had a window from September 14, 2015, through October 30, 2015, to make the election to receive the lump sum. The impact in connection with this amendment was a decrease in the accrued pension obligation amounting to approximately $6,754,000.

All of the contributions necessary to fund the retirement benefits provided under the MHS Plan are placed in a trust fund. These assets consist primarily of common collective trusts with underlying investments in common stock, obligations of the United States government and its instrumentalities, and corporate bonds. Contributions required to fund plan benefits under the "final average pay formula" and "cash balance formula" are determined according to the projected unit credit funding method.

Early retirement, deferred retirement, termination, disability, and pre-retirement death benefits are also provided under the MHS Plan.

The Health System recognizes the overfunded or underfunded status of a defined benefit postretirement plan as an asset or liability on the consolidated statements of financial position and recognizes changes in that funded status in the year in which the changes occur. Funded status is measured as the difference between plan assets at fair value and the benefit obligation.

The Health System uses a June 30 measurement date for its defined benefit plan. In accordance with FASB ASC 715, *Compensation – Retirement Benefits* (FASB ASC 715), the Health System is required to recognize a minimum liability relating to the underfunded status of the MHS Plan. An underfunding results whenever the accumulated benefit obligation exceeds the fair value of the MHS Plan assets. The minimum pension liability adjustment is reflected as a component of other changes in unrestricted net assets on the consolidated statements of operations.

Obligation and funded status: The following table sets forth the changes in benefit obligations, changes in plan assets, and components of net periodic benefit cost for the defined benefit plan as of and for the years ended June 30:

	2017	2016
Change in benefit obligation		
Benefit obligation at beginning of year	**$ 233,731,895**	$ 218,537,889
Service cost	**1,250,000**	1,170,000
Interest cost	**7,141,657**	8,086,252
Actuarial (gain) loss	**(5,012,791)**	21,510,521
Benefits paid	**(9,202,339)**	(15,572,767)
Benefit obligation at end of year	**227,908,422**	233,731,895
Change in plan assets		
Fair value of plan assets at beginning of year	**188,804,091**	189,500,827
Actual return on plan assets	**16,870,432**	6,876,031
Employer contributions	**7,000,000**	8,000,000
Benefits paid	**(9,202,339)**	(15,572,767)
Fair value of plan assets at end of year	**203,472,184**	188,804,091
Unfunded status	**$ (24,436,238)**	$ (44,927,804)
Amounts recognized on the consolidated statements of financial position:		
Noncurrent liabilities	**$ (24,436,238)**	$ (44,927,804)

	2017	2016
Amounts recognized on the consolidated statements of financial position consist of:		
Prior service cost	**$ 1,308,051**	$ 1,359,287
Net loss	**(105,026,630)**	(117,231,227)
	(103,718,579)	(115,871,940)
Accumulated contributions in excess of net periodic benefit cost	**79,282,341**	70,944,136
Required minimum liability (unfunded accumulated benefit obligation)	**$ (24,436,238)**	$ (44,927,804)
Components of net periodic (benefit) cost:		
Service cost	**$ 1,250,000**	$ 1,170,000
Interest cost	**7,141,657**	8,086,252
Expected return on plan assets	**(12,819,927)**	(12,472,583)
Amortization of prior service cost	**(51,236)**	(51,236)
Recognized actuarial loss	**3,141,301**	2,438,626
Net periodic (benefit)	**$ (1,338,205)**	$ (828,941)

Other changes in plan assets and benefit obligations recognized in unfunded accumulated benefit obligation:

	2017	2016
Net gain (loss) arising during the period	**$ 9,160,900**	$ (27,107,072)
Prior service credit	**(51,236)**	(51,236)
Amortization and curtailment recognition accumulated loss	**3,141,301**	2,438,626
Total changes recognized in other changes in unrestricted net assets	**$ 12,250,965**	$ (24,719,682)

The estimated net loss and prior service credit for the defined benefit pension plan that will be amortized into net periodic benefit cost over the next fiscal year are $(3,141,301) and $51,236, respectively.

Amounts recognized in the consolidated financial statements consist of the following as of and for the years ended June 30:

	2017	2016
Accrued benefit cost	**$ 24,436,238**	$ 44,927,804
Additional minimum pension income adjustment	**12,250,965**	(24,719,682)
Net periodic benefit cost	**(1,338,205)**	(828,941)

Assumptions: Weighted-average assumptions used to determine benefit obligations as of June 30:

	2017	2016
Discount rate	**3.94%**	3.79%

Weighted-average assumptions used to determine net periodic benefit cost for the years ended June 30:

	2017	2016
Discount rate	**3.79%**	4.55%
Expected long-term return on plan assets	**6.75%**	6.75%

Various factors are considered in estimating the expected long-term rate of return on plan assets. Among the factors considered include the historical long-term returns on plan assets, the current and expected allocation of plan assets, input from actuaries and investment consultants, and long-term inflation assumptions.

MHS Plan assets: Allocation of plan assets is based on a diversified portfolio consisting of common collective trusts with underlying investments in fixed income as well as domestic and international equity securities. The investment policy for the defined benefit plan is to balance risk and return using a diversified portfolio consisting primarily of high quality equity and fixed income securities. To accomplish this goal, the MHS Plan's assets are actively managed by outside investment managers with the objective of optimizing long-term return while maintaining a high standard of portfolio quality and proper diversification. The maturities of fixed income securities are monitored so there is sufficient liquidity to meet current benefit payment obligations. The Pension and Investment Committee provides oversight of the MHS Plan investments and the performance of the investment managers.

The composition of the MHS Plan assets and targeted allocation percentages are as follows as of June 30:

	2017	2016	Target Range
Asset category			
Equity securities	**40%**	40%	40 - 50%
Debt securities	**60%**	60%	50 - 60%
Other	**0%**	0%	0 - 20%
	100%	100%	

The following are descriptions of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used as of June 30, 2017 or 2016:

Money market funds: These investments are public investment vehicles valued using $1 for the Net Asset Value (NAV). The money market fund is classified within Level I of the valuation hierarchy.

Common collective trusts: These investments are public investment vehicles valued using the NAV provided by the administrator of the fund. The NAV is based on the value of the underlying assets owned by the fund, minus its liabilities, and then divided by the number of shares outstanding. The NAV is classified within Level II of the valuation hierarchy because the NAV's unit price is quoted on a private market that is not active; however, the unit price is based on underlying investments which are traded on an active market.

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

The following tables present the fair values of the Health System's pension plan assets at fair value as of June 30 by asset category:

	June 30, 2017			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market fund *	**$ 2,340,209**	**$ 2,340,209**	**$ -**	**$ -**
Common collective trusts *				
Equity				
Large cap	**24,301,737**	**-**	**24,301,737**	**-**
Small/mid cap	**8,228,118**	**-**	**8,228,118**	**-**
International	**49,263,120**	**-**	**49,263,120**	**-**
Fixed income				
Long duration	**110,287,286**	**-**	**110,287,286**	**-**
Opportunistic	**9,051,714**	**-**	**9,051,714**	**-**
Total assets at fair value	**$ 203,472,184**	**$ 2,340,209**	**$ 201,131,975**	**$ -**

	June 30, 2016			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market fund *	$ 739,606	$ 739,606	$ -	$ -
Common collective trusts *				
Equity				
Large cap	17,066,657	-	17,066,657	-
Small/mid cap	10,236,581	-	10,236,581	-
International	47,042,242	-	47,042,242	-
Fixed income				
Long duration	105,163,795	-	105,163,795	-
Opportunistic	8,555,210	-	8,555,210	-
Total assets at fair value	$ 188,804,091	$ 739,606	$ 188,064,485	$ -

* There are no unfunded commitments, redemption frequency restrictions, or other redemption restrictions.

Contributions and estimated future benefits: The Health System made contributions totaling $7,000,000 and $8,000,000 to the MHS Plan for the plan years ended June 30, 2017 and 2016, respectively. The Health System expects to contribute $6,000,000 during fiscal year 2018.

Expected pension benefits to be paid in future years are as follows as of June 30, 2017:

Years Ending June 30:	
2018	$ 10,060,338
2019	10,663,443
2020	11,244,588
2021	11,700,598
2022	12,175,757
2023 to 2027	65,677,314

The Preston Memorial Hospital Corporation Retirement Plan (PMH Plan) for the employees of PMH is a single-employer defined benefit pension plan administered by PMH. The PMH Plan provides retirement benefits to PMH Plan members and beneficiaries. There were no required contributions for the years ended June 30, 2017 or 2016. The most recent actuarial valuation was performed as of December 31, 2015, with a mid-year update for reporting purposes which showed plan assets of $3,104,525 and actuarial accrued liability of $4,999,343. The resulting unfunded status of the PMH Plan in the amount of $1,894,818 for each of the years ended June 30, 2017 and 2016, is recorded as part of the consolidated accrued pension obligation on the accompanying consolidated statements of financial position. The change in minimum pension obligation amounted to $0 and $63,575 for the years ended June 30, 2017 and 2016, respectively, which is recorded as part of the change in minimum pension obligation on the accompanying consolidated statements of operations.

	2017	2016
Reconciliation of Accrued Pension:		
Unfunded status at end of year - MHS Plan	**$ 24,436,238**	$ 44,927,804
Unfunded status at end of year - PMH Plan	**1,894,818**	1,894,818
Accrued Pension Obligation	**$ 26,331,056**	$ 46,822,622

Note 13. Temporarily Restricted Net Assets

Various donations have been made to the Health System for specific purposes. The unexpended balances of these special donations are as follows as of June 30:

	2017	2016
Constuction costs of facility expansion and renovation project	**$ 1,088,704**	$ 3,471,822
Hospice	**752,693**	700,026
Cancer awareness	**4,720,030**	3,900,517
Charitable remainder trusts	**543,855**	500,708
Scholarships	**209,613**	189,634
Health fair	**30,196**	26,720
Wellness program	**125,000**	125,000
Other restricted purposes	**314,879**	301,050
	$ 7,784,970	$ 9,215,477

Current accounting standards require certain disclosures for donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act of 2006 (UPMIFA). The State of West Virginia has adopted UPMIFA. In management's opinion, the adoption of UPMIFA had no impact on the accounting of the Health System's endowments.

Note 14. Related Party Transactions

Morgantown Physical Therapy Associates, Inc.: MHS charged MPTA $23,148 and $23,191 for rent during the years ended June 30, 2017 and 2016, respectively.

A summary of amounts due from affiliated entities is as follows as of June 30:

	2017	2016
Care Partners, Inc.	**$ 89**	$ 96
Fairmont Home Equipment and Supply Company	**48,421**	109,917
MGH Surgery, LLC	**6,960**	-
Mountaintop Limited Partnership	**21,492**	9,346
The Auxiliary of Monongalia General Hospital	**12,609**	10,935
The Foundation of Monongalia General Hospital	**47,603**	22,481
Other affiliated entities	**9,356**	10,157
Due from affiliated entities	**$ 146,530**	$ 162,932

Note 15. Estimated Costs of Professional and General Liability Coverage

MHS, MHMC, PMH, and MES are self-insured for the purpose of providing professional and general liability coverage up to specified amounts per claim. In addition, the self-insurance plan has specified annual aggregate loss limits. Professional actuarial consultants have been retained to determine funding requirements.

The amounts funded have been placed in a self-insurance trust account that is being administered by a trustee. MHMC was not required to make contributions to the self-insurance trust during the years ended June 30, 2017 or 2016. Investment income on self-insurance trust investments totaled approximately $102,000 and $88,500 for the years ended June 30, 2017 and 2016, respectively, and is included in investment gains on the consolidated statements of operations. The self-insurance trust account is included in investments whose use is limited on the consolidated statements of financial position. Excess umbrella coverage with a commercial carrier is maintained in the amount of $10,000,000 for each occurrence and one-year aggregate. This funded amount in the self-insurance trust is intended to provide a contingency fund for unexpected significant professional and general liability losses that may occur.

The Health System has recorded a receivable for estimated insurance recoveries of approximately $1,010,000 and $1,213,000 as of June 30, 2017 and 2016, respectively, with a corresponding gross up in the estimated professional and general liability obligation.

Losses from asserted claims and from unasserted claims identified under the Health System's risk management system are accrued based on actuarial estimates that incorporate past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. As of June 30, 2017 and 2016, the Health System has recorded approximately $7,445,000 and $7,078,000, respectively, as the liability for professional and general liability claims. The estimated current portion of approximately $923,000 in 2017 and $977,000 in 2016 is included in accounts payable and accrued expenses on the accompanying consolidated statements of financial position. The estimated liability for such professional and general liability claims has been discounted using a discount rate of 3% in 2017 and 2016. While the ultimate amount of costs incurred under the Health System’s self-insured programs is dependent on future developments, in management’s opinion, recorded reserves are adequate to cover the future settlement of claims. However, it is reasonably possible that recorded reserves may not be adequate to cover the future settlement of claims. Adjustments, if any, to estimates recorded resulting from ultimate claim payments will be reflected in operations in the periods in which such adjustments are known.

Note 16. Self-Insurance Program for Employee Health Benefits

The Health System maintains a self-insurance program for employee health benefits. The program covers substantially all employees. Contributions to the Plan are made by both the Health System and employees in amounts based on historical experience. Stop-loss coverage is also maintained through a commercial carrier with an annual deductible of $100,000, which limits the Health System's liability to $1,000,000 per individual annually. The cost to the Health System was approximately $25,945,000 and $19,298,000 for the years ended June 30, 2017 and 2016, respectively. The Health System has provided a reserve of $2,426,000 and $2,040,000 as of June 30, 2017 and 2016, respectively, to cover the employer portion of any claims incurred but not yet reported or reported but not paid as of June 30, 2017 and 2016, respectively. This reserve is included with accounts payable and accrued expenses on the accompanying consolidated statements of financial position.

Note 17. Commitments and Contingencies

Derivative obligation: MHMC entered into interest rate swap agreements to alter the interest rate characteristics of its variable rate bond obligations. MHMC uses these interest rate swap agreements to effectively convert its floating rate debt to an approximate fixed rate, thus reducing the impact of interest rate changes on future income. These agreements involve the payment of fixed rate amounts in exchange for floating rate interest receipts over the life of the agreement without an exchange of the underlying principal amount. The differential to be paid or received is accrued as interest rates change and recognized as an adjustment to interest expense related to the debt.

As of June 30, 2017, MHMC has three interest rate swap agreements outstanding with notional amounts and maturity dates as follows:

		Notional Amounts	
	Maturity	**2017**	2016
2002 Series	July 1, 2017	**$ 785,000**	$ 918,913
2008A Series	July 1, 2040	**34,440,000**	34,475,000
2008B Series	July 1, 2040	**12,470,000**	12,735,000

2002 Series SWAP Agreement - The agreement originally pertained to Series 2002 Bonds of the Obligated Group which were subsequently refunded by part of the Series 2005C Bonds. The agreement effectively adjusted the interest rate on approximately 44% of the outstanding Series 2005C Bonds, prior to the refunding of these bonds with Series 2011, to a fixed rate of 3.96% as of April 20, 2011. The agreement now functions as a stand-alone instrument. The fair value of the interest rate swap agreement as of June 30, 2017 and 2016, was a liability of approximately $1,000 and $31,000, respectively.

2008A Series SWAP Agreement - The agreement effectively adjusts the interest rate on approximately 100% of the outstanding Series 2008A Bonds as of June 30, 2014, to a fixed rate of 3.68% as of June 30, 2017 and 2016. The fair value of the interest rate swap agreement as of June 30, 2017 and 2016, was a liability of approximately $3,359,000 and $5,110,000, respectively.

2008B Series SWAP Agreement - The agreement effectively adjusts the interest rate on approximately 100% of the outstanding Series 2008B Bonds as of June 30, 2015, to a fixed rate of 4.77% as of June 30, 2017 and 2016. The fair value of the interest rate swap agreement as of June 30, 2017 and 2016, was a liability of approximately $10,365,000 and $14,970,000, respectively.

The following table summarizes the location and approximate amounts of the values for MHMC's interest rate swap agreements:

	Liability Derivatives			
	June 30, 2017		June 30, 2016	
Derivatives not designated as hedging instruments	**Consolidated Statement of Financial Position Location**	**Fair Value**	Consolidated Statement of Financial Position Location	Fair Value
Derivative obligation	**Long-term liabilities**	**$ 13,725,000**	Long-term liabilities	$ 20,111,000

The following table summarizes the location and approximate amounts of derivative gains (losses) on MHMC's interest rate swap agreements:

Derivatives not designated as hedging instruments	**Location of gain (loss) recognized**	**Years Ended June 30, 2017**	2016
Change in fair value of derivative obligation	Nonoperating gains (losses)	**$ 6,386,000**	$ (7,129,000)

Management obtained a valuation of the interest rate swap agreements from an independent analyst, who values derivatives, such as MHMC's interest rate swaps, by adjusting the mid-market valuation for a theoretical non-performance or credit risk of MHMC. MHMC is posting no collateral. Therefore, the entire swap value is subject to the fair value measurement adjustment. The mid-market valuation for the liability associated with the swap agreements as of June 30, 2017 and 2016, was determined to be approximately $14,748,000 and $21,383,000, respectively, and the fair value measurement valuation resulted in a reduction of this amount by $1,023,000 and $1,272,000, respectively.

Litigation: The Health System is involved in litigation arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Health System's future financial position. However, the ultimate outcome of these matters is not determinable.

Note 18. Concentrations of Credit Risk

MHMC, MHC, MEMS, and PMH grant credit without collateral to its patients and customers, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors is as follows as of June 30:

	2017	2016
Other third-party payors (none over 10%)	**39%**	37%
Medicare and Medicaid	**34**	33
Blue Cross	**23**	27
Patients	**4**	3
	100%	100%

The Health System routinely invests its surplus operating funds and its board-designated capital improvement funds in repurchase agreements with financial institutions. The Health System's policy requires these investments to be secured by pledged United States government and related agency obligations. The Health System has also invested its board-designated capital improvement funds in various corporate bonds and in a bank short-term money market fund. Management believes that the credit risk related to these investments is minimal.

Credit risk: The Health System has deposits in financial institutions in excess of amounts insured by the Federal Deposit Insurance Corporation (FDIC). Management believes it is not exposed to any significant credit risk on cash and cash equivalents.

Note 19. 403(b) Savings Plan

MHS, MHMC, and MEMS participate in the Monongalia Health System 403(b) Retirement and Savings Plan. MHS, MHMC, and MEMS match 50% of each employee's contribution up to 4% of compensation provided that they have attained 1,000 service hours during the plan year. MHS, MHMC, and MEMS matching contributions are made annually in March for those employees who participated in the plan and were employed as of December 31 of the previous year. MHS, MHMC, and MEMS contributions totaled approximately $1,459,000 and $1,397,000 during the years ended June 30, 2017 and 2016, respectively.

In addition to the employer matching contribution, the employer also makes a retirement security contribution (RSC) for each employee that participated in the 403(b) Plan for MHS, MHMC, and MEMS. The RSC is based upon an age and service formula and is paid on a calendar year basis. For the calendar year ended December 31, 2016, the RSC contribution to the 403(b) Plan was approximately $3,222,000. As of June 30, 2017 and 2016, the RSC accrual was approximately $1,858,000 and $1,606,000, respectively.

Note 20. 401(k) Savings Plan

MES and MHC participate in the Monongalia Health System 401(k) Savings Plan. Participation in the plan is restricted to employees at least 21 years of age that have a minimum of one year of service. MES matches 50% of each employee's contribution up to 4% of compensation. MHC matches 50% of each participant's contributions up to 2% of the employee's compensation provided that they are participants in the Monongalia Health System, Inc. Retirement Plan, have attained 1,000 service hours during the plan year, and have their pension plan benefits determined based upon the cash balance provisions of the plan. MHC and MES matching contributions are made annually in January for those employees who participated in the plan and were employed as of December 31 of the previous year. MES and MHC contributions totaled approximately $70,200 and $61,200 during the years ended June 30, 2017 and 2016, respectively.

In addition to the employer matching contribution, the employer also makes a retirement security contribution (RSC) for each employee that participated in the 401(k) Plan for MHC. The RSC is based upon an age and service formula and is paid on a calendar year basis. For the calendar year ended December 31, 2016, the RSC contribution to the 401(k) Plan was approximately $47,300. As of June 30, 2017 and 2016, the RSC accrual was approximately $29,600 and $26,400, respectively.

PMH employees are eligible to participate in a defined contribution plan if they are over 21 years of age and have completed ninety days of service. PMH contributed approximately $286,700 and $202,000 during the years ended June 30, 2017 and 2016, respectively. Contributions made by PMH vest over a five year period at 20% per year.

Note 21. Certain Significant Risks and Uncertainties

The Health System and others in the health care business are subject to certain inherent risks, including substantial dependence on revenue derived from reimbursement by the federal Medicare and state Medicaid programs which have been drastically cut in recent years and which entail exposure to various health care fraud statutes, government regulations, government budgetary constraints, and proposed legislative and regulatory changes, as well as lawsuits alleging malpractice and related claims. Such inherent risks require the use of certain management estimates in the preparation of the Health System's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Health System's operations are subject to a variety of federal, state, and local legal and regulatory risks, including, without limitation, the federal Anti-Kickback statute and the federal Ethics in Patient Referral Act (so-called Stark Law), many of which apply to virtually all companies engaged in the health care services industry. The Anti-Kickback statute prohibits, among other things, the offer, payment, solicitation, or receipt of any form of remuneration in return for the referral of Medicare and Medicaid patients. The Stark Law prohibits, with limited exceptions, financial relationships between ancillary service providers and referring physicians.

The Medicare and Medicaid programs are highly regulated. Compliance with laws and regulations governing the Medicare and Medicaid programs is subject to government review and interpretation, as well as significant regulatory action, including fines, penalties, and possible exclusion from the Medicare and Medicaid programs. The failure of the Health System to comply with applicable reimbursement regulations could adversely affect the Health System's business. It is not possible to quantify fully the effect of potential legislative or regulatory changes, the administration of such legislation, or any other governmental initiatives on the Health System's business. Accordingly, there can be no assurance that the impact of these changes or any future health care legislation will not adversely affect the Health System's business. There can be no assurance that payments under governmental and private third-party payor programs will be timely, will remain at levels comparable to present levels, or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. The Health System's financial condition and results of operations may be materially and adversely affected by the reimbursement process, which in the health care industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled. In addition, under the Medicare program, if the federal government makes a formal demand for reimbursement, even related to contested items, payment must be made for those items before the provider is given an opportunity to appeal and resolve the case.

Note 22. Fair Value of Financial Assets and Liabilities

The Health System follows the provisions set forth by FASB ASC 820 for its financial assets and liabilities. This guidance clarifies that fair value is an exit price, representing the price 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. The Health System utilizes market data or assumptions that market participants would use in pricing the asset or liability. This guidance also establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: Level I, defined as observable inputs such as quoted prices in active markets; Level II, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level III, defined as unobservable inputs about which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The following are descriptions of the valuation methodologies used for assets and liabilities measured at fair value. There have been no changes in the methodologies used as of June 30, 2017 or 2016:

Money market funds: These investments are public investment vehicles valued using $1 for the net asset value (NAV). The money market fund is classified within Level I of the valuation hierarchy.

Institutional funds: These investments are private investment vehicles valued using the NAV provided by the administrator of the fund. The NAV is based on the value of the underlying assets owned by the fund, minus its liabilities, and then divided by the number of shares outstanding. The NAV is classified within Level II of the valuation hierarchy because the NAV's unit price is quoted on a private market that is not active; however, the unit price is based on underlying investments which are traded on an active market.

Interest rate swap: The fair value is based on estimates of the related London Interbank Offered Rate (LIBOR) swap rates during the term of the swap agreements.

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

There were no changes during the years ended June 30, 2017 and 2016, to the Health System's valuation techniques used to measure asset and liability fair values on a recurring basis.

As required by FASB ASC 820, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The Health System's assessment of the significance of a particular input to the fair value measurement requires judgment, and may affect the valuation of fair value assets and liabilities and their placement within the fair value hierarchy levels.

The following tables present the financial instruments carried at fair value as of June 30, 2017 and 2016, by caption, on the consolidated statements of financial position by the guidance valuation hierarchy defined above.

	June 30, 2017			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market funds *	**$ 8,600,945**	**$ 8,600,945**	**$ -**	**$ -**
Institutional funds:				
Equities:				
Domestic	**24,936,908**	**-**	**24,936,908**	**-**
International	**17,770,427**	**-**	**17,770,427**	**-**
Fixed income:				
U.S. Treasury	**9,214,049**	**-**	**9,214,049**	**-**
Cash equivalent funds	**11,854,380**	**-**	**11,854,380**	**-**
Government bonds	**4,774,215**	**-**	**4,774,215**	**-**
Municipal bonds	**2,786,955**	**-**	**2,786,955**	**-**
Corporate bonds	**16,037,487**	**-**	**16,037,487**	**-**
Asset-backed securities	**13,168,267**	**-**	**13,168,267**	**-**
Alternative	**4,934,472**	**-**	**4,934,472**	**-**
International	**15,165,454**	**-**	**15,165,454**	**-**
Total assets at fair value	**$ 129,243,559**	**$ 8,600,945**	**$ 120,642,614**	**$ -**
Liabilities:				
Interest rate swaps at fair value	**$ 13,725,361**	**$ -**	**$ 13,725,361**	**$ -**

	June 30, 2016			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market funds *	$ 7,780,749	$ 7,780,749	$ -	$ -
Institutional funds:				
Equities:				
Domestic	26,232,450	-	26,232,450	-
International	10,409,458	-	10,409,458	-
Real estate investment trust	7,110,911	-	7,110,911	-
Fixed income:				
U.S. Treasury	9,005,593	-	9,005,593	-
Cash equivalent funds	15,988,164	-	15,988,164	-
Government bonds	5,877,473	-	5,877,473	-
Municipal bonds	2,515,639	-	2,515,639	-
Corporate bonds	12,482,356	-	12,482,356	-
Asset-backed securities	15,808,547	-	15,808,547	-
Alternative	837,569	-	837,569	-
International	3,941,044	-	3,941,044	-
Total assets at fair value	$ 117,989,953	$ 7,780,749	$ 110,209,204	$ -
Liabilities:				
Interest rate swaps at fair value	$ 20,110,932	$ -	$ 20,110,932	$ -

* There were no unfunded commitments or redemption restrictions associated with these funds.

There were no transfers between Level I, Level II, or Level III during the years ended June 30, 2017 or 2016. Transfers are recognized at the end of the reporting period.

The Health System has approximately $40,069,000 and $57,825,000 of cash as of June 30, 2017 and 2016, respectively, which was not classified as a Level as prescribed within the topic on FASB ASC 820. As of June 30, 2017 and 2016, approximately $7,936,000 and $8,532,000, respectively, of cash was included in assets whose use is limited on the consolidated statements of financial position.

The determination of fair value above incorporates various factors required under FASB ASC 820. These factors include not only the credit standing of the counterparties involved and the impact of credit enhancements, but also the impact of the Health System's nonperformance risk on its liabilities.

Note 23. Fair Value of Financial Instruments

The carrying amounts of the Health System's financial instruments, excluding long-term obligations, approximate their fair values. The Health System's long-term obligations are recorded at amortized cost. The Series 2011 and Series 2015 bonds have inseparable third-party credit enhancements. The fair values below, which have been estimated using pricing models that utilize available market information, exclude the effect of the inseparable third-party credit enhancement. The long-term obligations are categorized as Level II within the fair value hierarchy. There were no changes during the years ended June 30, 2017 and 2016, to the Health System's valuation techniques used to measure or disclose fair value of long-term obligations.

	June 30, 2017		June 30, 2016	
	Fair Value	**Carrying Value**	Fair Value	Carrying Value
Series 2011 Revenue Bonds	**$ 20,580,353**	**$ 17,659,509**	$ 22,501,919	$ 18,563,386
Series 2015 Revenue Bonds	**55,351,763**	**53,624,845**	59,011,300	55,120,930

Note 24. Functional Expenses

The Health System provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows for the years ended June 30:

	2017	2016
Health care services	**$ 269,238,460**	$ 239,684,802
General and administrative	**50,532,092**	56,601,426
Total functional expenses	**319,770,552**	296,286,228
Mon Health Care, Inc. expenses	**4,038,499**	3,671,290
Total expenses	**$ 323,809,051**	$ 299,957,518

Note 25. Subsequent Event - Acquisition

On September 1, 2017, a certificate of need was approved that allowed the Health System to become the sole member of Stonewall Jackson Memorial Hospital Company (SJMH). SJMH is a nonprofit corporation. SJMH operates a 70 licensed bed acute care hospital and related facilities, consisting of 56 medical/surgical beds, 6 intensive care/critical care unit beds, and 8 obstetrical beds and is located in and around Weston, West Virginia. Under the acquisition, SJMH will continue to operate and provide existing services at its various locations.

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF FINANCIAL POSITION
June 30, 2017 (with comparative totals for 2016)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2017 Consolidated**	2016 Consolidated
CURRENT ASSETS											
Cash and cash equivalents	$ 18,371,458	$ 10,739,779	$ 176,293	$ -	$ 29,287,530	$ 2,448,371	$ 316,357	$ 81,093	$ -	**$ 32,133,351**	$ 49,293,093
Assets whose use is limited	-	8,749,725	2,577,993	-	11,327,718	5,209,415	-	-	-	**16,537,133**	16,312,765
Patient accounts receivable, net	-	43,474,696	8,396	-	43,483,092	3,201,892	755,306	677,350	-	**48,117,640**	46,261,374
Due from affiliated entities	918,306	809,671	47,531	(709,004)	1,066,504	-	-	-	(919,974)	**146,530**	162,932
Due from third-party payors	-	2,178,111	-	-	2,178,111	660,456	-	-	-	**2,838,567**	3,372,630
Other receivables	311,277	2,736,770	2,399	-	3,050,446	70,389	106,803	1,600,935	-	**4,828,573**	2,988,628
Inventories	-	6,305,842	19,422	-	6,325,264	553,325	-	153,721	-	**7,032,310**	7,386,013
Prepaid expenses and other assets	156,343	2,671,004	72,402	-	2,899,749	198,572	8,352	49,256	-	**3,155,929**	2,696,393
Total current assets	19,757,384	77,665,598	2,904,436	(709,004)	99,618,414	12,342,420	1,186,818	2,562,355	(919,974)	**114,790,033**	128,473,828
INVESTMENTS, AT FAIR VALUE, WHOSE USE IS LIMITED											
By Board for capital improvements	-	94,905,980	18,285,554	-	113,191,534	7,406,735	-	-	-	**120,598,269**	111,043,576
Professional liability self-insurance funding arrangement held by trustee	-	5,193,578	-	-	5,193,578	-	-	-	-	**5,193,578**	5,252,982
Tax increment financing bonds held by trustee	-	2,786,955	-	-	2,786,955	-	-	-	-	**2,786,955**	2,515,639
Under bond indenture agreements held by trustee	-	8,600,945	-	-	8,600,945	-	-	-	-	**8,600,945**	7,709,772
	-	111,487,458	18,285,554	-	129,773,012	7,406,735	-	-	-	**137,179,747**	126,521,969
Less current portion	-	8,749,725	2,577,993	-	11,327,718	5,209,415	-	-	-	**16,537,133**	16,312,765
Total investments, at fair value, whose use is limited	-	102,737,733	15,707,561	-	118,445,294	2,197,320	-	-	-	**120,642,614**	110,209,204
OTHER ASSETS											
Property and equipment, net	63,955,034	132,304,053	12,206,275	-	208,465,362	35,608,850	1,079,369	970,108	-	**246,123,689**	236,238,265
Long-term physician loans receivable	-	1,030,580	-	-	1,030,580	-	-	-	-	**1,030,580**	255,071
Goodwill	-	3,416,779	-	-	3,416,779	-	-	-	-	**3,416,779**	-
Other investments	14,324,101	3,076,779	-	-	17,400,880	-	-	47,915	(2,794,271)	**14,654,524**	13,044,356
Insurance recoveries receivable	-	888,443	13,964	-	902,407	107,590	-	-	-	**1,009,997**	1,212,694
Beneficial interest in assets held by others	-	11,323,455	-	-	11,323,455	-	-	-	-	**11,323,455**	12,573,123
Patient accounts receivable, special payment arrangements, net of allowance for doubtful accounts	-	320,412	-	-	320,412	-	26,405	-	-	**346,817**	300,239
Total other assets	78,279,135	152,360,501	12,220,239	-	242,859,875	35,716,440	1,105,774	1,018,023	(2,794,271)	**277,905,841**	263,623,748
Total assets	$ 98,036,519	$ 332,763,832	$ 30,832,236	$ (709,004)	$ 460,923,583	$ 50,256,180	$ 2,292,592	$ 3,580,378	$ (3,714,245)	**$ 513,338,488**	$ 502,306,780

See Independent Auditor's Report

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF FINANCIAL POSITION (CONTINUED)
June 30, 2017 (with comparative totals for 2016)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2017 Consolidated**	2016 Consolidated
CURRENT LIABILITIES											
Accounts payable and accrued expenses	$ 1,396,589	$ 23,578,163	$ 1,090,824	$ -	$ 26,065,576	$ 1,960,463	$ 298,401	$ 421,085	$ -	**$ 28,745,525**	$ 28,009,795
Current portion of long-term debt	613,289	2,161,718	504,097	-	3,279,104	737,190	-	-	-	**4,016,294**	4,089,412
Due to third-party payors	-	1,105,796	-	-	1,105,796	1,939,548	-	-	-	**3,045,344**	1,777,366
Due to affiliates	177,387	507,228	24,389	(709,004)	-	154,150	400,802	365,022	(919,974)	**-**	-
Prospective resident and security deposits	1,830	-	135,800	-	137,630	-	-	-	-	**137,630**	81,600
Total current liabilities	2,189,095	27,352,905	1,755,110	(709,004)	30,588,106	4,791,351	699,203	786,107	(919,974)	**35,944,793**	33,958,173
LONG-TERM LIABILITIES											
Long-term debt, net of current portion	47,907,398	104,748,484	9,256,512	-	161,912,394	35,706,891	-	-	-	**197,619,285**	201,635,226
Other long-term liabilities	66,922	-	-	-	66,922	-	-	-	-	**66,922**	58,505
Rabbi Trust liability	2,322,624	441,328	-	-	2,763,952	-	-	-	-	**2,763,952**	2,151,667
Derivative obligation	-	13,725,361	-	-	13,725,361	-	-	-	-	**13,725,361**	20,110,932
Accrued pension obligation	-	24,436,238	-	-	24,436,238	1,894,818	-	-	-	**26,331,056**	46,822,622
Refundable fees	-	-	12,922,056	-	12,922,056	-	-	-	-	**12,922,056**	12,764,212
Deferred revenue for advance fees	-	-	766,363	-	766,363	-	-	-	-	**766,363**	809,335
Deferred revenue for advance rent	1,007,598	-	-	-	1,007,598	-	-	-	-	**1,007,598**	1,058,169
Estimated professional and general liability obligation	-	5,207,568	88,964	-	5,296,532	1,225,590	-	-	-	**6,522,122**	6,100,276
Total long-term liabilities	51,304,542	148,558,979	23,033,895	-	222,897,416	38,827,299	-	-	-	**261,724,715**	291,510,944
NET ASSETS											
Unrestricted	44,417,882	148,763,068	6,042,092	-	199,223,042	6,486,773	1,593,389	2,794,271	(2,794,271)	**207,303,204**	167,045,445
Temporarily restricted	125,000	7,508,074	1,139	-	7,634,213	150,757	-	-	-	**7,784,970**	9,215,477
Permanently restricted	-	580,806	-	-	580,806	-	-	-	-	**580,806**	576,741
Total net assets	44,542,882	156,851,948	6,043,231	-	207,438,061	6,637,530	1,593,389	2,794,271	(2,794,271)	**215,668,980**	176,837,663
Total liabilities and net assets	$ 98,036,519	$ 332,763,832	$ 30,832,236	$ (709,004)	$ 460,923,583	$ 50,256,180	$ 2,292,592	$ 3,580,378	$ (3,714,245)	**$ 513,338,488**	$ 502,306,780

See Independent Auditor's Report

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF OPERATIONS
Year Ended June 30, 2017 (with comparative totals for 2016)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2017 Consolidated**	2016 Consolidated
REVENUE											
Patient service revenue (net of contractual allowances and discounts)	$ -	$ 294,414,272	$ 5,529,423	$ -	$ 299,943,695	$ 36,529,563	$ 4,166,273	$ 3,661,629	$ (36,928)	**$ 344,264,232**	$ 317,193,794
Provision for bad debts	-	(11,035,264)	-	-	(11,035,264)	(1,872,311)	(937,245)	(330,745)	-	**(14,175,565)**	(12,904,102)
Net patient service revenue, less provision for bad debts	-	283,379,008	5,529,423	-	288,908,431	34,657,252	3,229,028	3,330,884	(36,928)	**330,088,667**	304,289,692
Rental income	1,344,537	-	-	(892,496)	452,041	-	-	-	(205,281)	**246,760**	96,079
Other revenue	4,923,796	808,265	121,606	(4,290,605)	1,563,062	1,020,399	121,057	(176,115)	(601,941)	**1,926,462**	3,535,152
Total revenue	6,268,333	284,187,273	5,651,029	(5,183,101)	290,923,534	35,677,651	3,350,085	3,154,769	(844,150)	**332,261,889**	307,920,923
EXPENSES											
Wages, salaries, and benefits	4,549,258	137,028,990	2,986,001	-	144,564,249	21,178,377	2,389,776	1,397,400	-	**169,529,802**	151,192,986
Supplies and other	(252,653)	85,588,883	971,877	(892,496)	85,415,611	6,721,743	502,743	2,190,743	(242,209)	**94,588,631**	92,943,203
Purchased services	78,730	23,612,244	211,833	-	23,902,807	3,259,920	255,572	9,358	-	**27,427,657**	25,130,529
Depreciation	1,467,148	14,755,940	762,112	-	16,985,200	3,043,051	251,748	255,624	-	**20,535,623**	18,802,689
Management fees	-	4,234,543	56,062	(4,290,605)	-	535,129	33,501	33,311	(601,941)	**-**	-
Interest	1,832,810	4,726,654	642,743	-	7,202,207	1,294,901	-	-	-	**8,497,108**	7,940,427
Insurance	42,768	2,414,529	40,199	-	2,497,496	498,030	192,628	42,076	-	**3,230,230**	3,947,684
Total expenses	7,718,061	272,361,783	5,670,827	(5,183,101)	280,567,570	36,531,151	3,625,968	3,928,512	(844,150)	**323,809,051**	299,957,518
Operating income (loss)	(1,449,728)	11,825,490	(19,798)	-	10,355,964	(853,500)	(275,883)	(773,743)	-	**8,452,838**	7,963,405
NONOPERATING GAINS (LOSSES)											
Investment gains	1,333,449	7,984,362	1,278,619	-	10,596,430	82,986	84	27	-	**10,679,527**	2,463,403
Donations	-	2,477,141	1,500	-	2,478,641	75,585	150	(22,363)	-	**2,532,013**	3,163,812
Change in beneficial interest in assets held by others	-	177,413	(84)	-	177,329	-	-	-	-	**177,329**	(1,594,758)
Net (loss) from equity affiliates	(43,574)	-	-	-	(43,574)	-	-	(156,637)	-	**(200,211)**	(866,476)
Change in fair value of derivative obligation	-	6,385,572	-	-	6,385,572	-	-	-	-	**6,385,572**	(7,129,294)
Other gains (losses)	-	(40,000)	-	-	(40,000)	19,346	380	-	-	**(20,274)**	20,657
Total nonoperating gains (losses)	1,289,875	16,984,488	1,280,035	-	19,554,398	177,917	614	(178,973)	-	**19,553,956**	(3,942,656)
Excess (deficiency) of revenue and gains over expenses and losses	(159,853)	28,809,978	1,260,237	-	29,910,362	(675,583)	(275,269)	(952,716)	-	**28,006,794**	4,020,749
Change in net assets from Mon Health Care, Inc., excluding dividends	(952,716)	-	-	-	(952,716)	-	-	-	952,716	**-**	-
Other changes in unrestricted net assets	-	-	-	-	-	-	-	999,948	(999,948)	**-**	-
Change in minimum pension obligation	-	12,250,965	-	-	12,250,965	-	-	-	-	**12,250,965**	(24,783,257)
Increase (decrease) in unrestricted net assets	$ (1,112,569)	$ 41,060,943	$ 1,260,237	$ -	$ 41,208,611	$ (675,583)	$ (275,269)	$ 47,232	$ (47,232)	**$ 40,257,759**	$ (20,762,508)

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MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULES OF CHANGES IN NET ASSETS
Years Ended June 30, 2017 and 2016

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**Consolidated Totals**
Net assets, June 30, 2015	$ 44,312,239	$ 135,900,543	$ 4,646,355	$ -	$ 184,859,137	$ 8,033,191	$ 1,925,395	$ 1,749,257	$ (1,749,257)	**$ 194,817,723**
Excess (deficiency) of revenue and gains over expenses and losses	2,000,309	3,254,137	136,640	-	5,391,086	(656,503)	(161,387)	(552,447)	-	**4,020,749**
OTHER CHANGES IN NET ASSETS										
Change in minimum pension obligation	-	(24,719,682)	-	-	(24,719,682)	(63,575)	-	-	-	**(24,783,257)**
Transfer of net assets	(104,650)	-	-	-	(104,650)	-	104,650	1,550,229	(1,550,229)	**-**
Change in net assets from Mon Health Care, Inc., excluding dividends	(552,447)	-	-	-	(552,447)	-	-	-	552,447	**-**
Change in beneficial interest in assets held by others	-	2,656,065	83	-	2,656,148	-	-	-	-	**2,656,148**
Contributions for endowment funds	-	126,300	-	-	126,300	-	-	-	-	**126,300**
Total other changes in net assets	(657,097)	(21,937,317)	83	-	(22,594,331)	(63,575)	104,650	1,550,229	(997,782)	**(22,000,809)**
Change in net assets	1,343,212	(18,683,180)	136,723	-	(17,203,245)	(720,078)	(56,737)	997,782	(997,782)	**(17,980,060)**
Net assets, June 30, 2016	45,655,451	117,217,363	4,783,078	-	167,655,892	7,313,113	1,868,658	2,747,039	(2,747,039)	**176,837,663**
Excess (deficiency) of revenue and gains over expenses and losses	(159,853)	28,809,978	1,260,237	-	29,910,362	(675,583)	(275,269)	(952,716)	-	**28,006,794**
OTHER CHANGES IN NET ASSETS										
Change in minimum pension obligation	-	12,250,965	-	-	12,250,965	-	-	-	-	**12,250,965**
Transfer of net assets	-	-	-	-	-	-	-	999,948	(999,948)	**-**
Change in net assets from Mon Health Care, Inc., excluding dividends	(952,716)	-	-	-	(952,716)	-	-	-	952,716	**-**
Change in beneficial interest in assets held by others	-	(1,430,423)	(84)	-	(1,430,507)	-	-	-	-	**(1,430,507)**
Contributions for endowment funds	-	4,065	-	-	4,065	-	-	-	-	**4,065**
Total other changes in net assets	(952,716)	10,824,607	(84)	-	9,871,807	-	-	999,948	(47,232)	**10,824,523**
Change in net assets	(1,112,569)	39,634,585	1,260,153	-	39,782,169	(675,583)	(275,269)	47,232	(47,232)	**38,831,317**
Net assets, June 30, 2017	$ 44,542,882	$ 156,851,948	$ 6,043,231	$ -	$ 207,438,061	$ 6,637,530	$ 1,593,389	$ 2,794,271	$ (2,794,271)	**$ 215,668,980**

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