MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

Consolidated Financial Report
June 30, 2019

C O N T E N T S

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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, 2019 and 2018, 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, 2019 and 2018, and the results of its operations, changes in net assets, and 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
September 25, 2019

Arnett Carbis Toothman llp
CPAs & Advisors

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
June 30, 2019 and 2018

ASSETS	**2019**	2018
CURRENT ASSETS		
Cash and cash equivalents	**$ 24,590,243**	$ 21,572,830
Assets whose use is limited	**17,862,913**	15,519,112
Patient accounts receivable, net	**50,925,373**	50,385,564
Due from affiliated entities	**144,487**	236,793
Due from third-party payors	**4,982,916**	5,817,703
Other receivables	**7,566,720**	6,525,952
Inventories	**9,586,437**	9,127,072
Prepaid expenses and other assets	**4,147,276**	5,365,688
Total current assets	**119,806,365**	114,550,714
INVESTMENTS, AT FAIR VALUE, WHOSE USE IS LIMITED		
By Board for capital improvements	**139,205,073**	143,555,591
Professional liability self-insurance funding arrangement held by trustee	**11,327,484**	14,165,561
Tax increment financing bonds held by trustee	**1,866,955**	2,306,955
By donor	**5,488,565**	-
Under bond indenture agreements held by trustee	**8,465,906**	8,450,643
	166,353,983	168,478,750
Less current portion	**17,862,913**	15,519,112
Total investments, at fair value, whose use is limited	**148,491,070**	152,959,638
OTHER ASSETS		
Property and equipment, net	**266,977,132**	266,506,757
Long-term physician loans receivable	**143,635**	394,062
Goodwill	**3,416,779**	3,416,779
Other investments	**15,555,087**	16,246,902
Other long-term assets	**2,339,864**	-
Insurance recoveries receivable	**1,585,642**	1,013,582
Beneficial interest in assets held by others	**1,163,441**	10,450,295
Patient accounts receivable, special payment arrangements, net	**221,199**	297,146
Total other assets	**291,402,779**	298,325,523
Total assets	**$ 559,700,214**	$ 565,835,875

See Notes to Consolidated Financial Statements

LIABILITIES AND NET ASSETS	2019	2018
CURRENT LIABILITIES		
Accounts payable and accrued expenses	**$ 35,678,108**	$ 40,168,689
Line of credit	**900,000**	1,000,000
Current portion of long-term debt	**4,785,679**	5,199,445
Due to third-party payors	**3,225,835**	2,892,828
Prospective resident and security deposits	**198,539**	128,191
Total current liabilities	**44,788,161**	49,389,153
LONG-TERM LIABILITIES		
Long-term debt, net of current portion	**189,988,752**	194,387,490
Other long-term liabilities	**196,715**	82,148
Rabbi Trust liability	**2,605,991**	3,376,863
Derivative obligation	**14,993,077**	10,493,117
Accrued pension obligation	**18,654,592**	15,864,395
Refundable fees	**13,943,424**	13,506,941
Deferred revenue for advance fees	**1,000,913**	708,830
Deferred revenue for advance rent	**909,694**	958,646
Estimated professional and general liability obligation	**10,161,071**	11,353,576
Total long-term liabilities	**252,454,229**	250,732,006
NET ASSETS		
Net assets without donor restrictions	**256,512,987**	258,250,189
Net assets with donor restrictions	**5,944,837**	7,464,527
Total net assets	**262,457,824**	265,714,716
Total liabilities and net assets	**$ 559,700,214**	$ 565,835,875

See Notes to Consolidated Financial Statements

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
Years Ended June 30, 2019 and 2018

	2019	2018
REVENUE		
Net patient service revenue	**$ 371,363,703**	$ 343,543,458
Rental income	**658,588**	534,085
Other revenue	**4,790,333**	3,360,392
Net assets released from restrictions used for operations	**2,450,979**	-
Total revenue	**379,263,603**	347,437,935
EXPENSES		
Wages, salaries, and benefits	**202,312,439**	201,208,960
Supplies and other	**107,408,706**	100,341,596
Purchased services	**36,445,766**	35,908,488
Depreciation	**25,403,185**	24,810,659
Interest	**8,564,495**	8,521,457
Insurance	**1,145,128**	3,517,504
Total expenses	**381,279,719**	374,308,664
Operating (loss)	**(2,016,116)**	(26,870,729)
NONOPERATING GAINS (LOSSES)		
Investment gains	**11,690,574**	8,296,059
Donations	**437,936**	2,415,308
Change in beneficial interest in assets held by others	**-**	28,089
Net (loss) from equity affiliates	**(460,420)**	(136,725)
Excess of unrestricted assets acquired over liabilities assumed in acquisition of Stonewall Jackson Memorial Hospital	**-**	59,394,634
Change in fair value of derivative obligation	**(4,499,960)**	3,232,244
Other (losses)	**(39,356)**	(6,525)
Total nonoperating gains	**7,128,774**	73,223,084
Excess of revenue and gains over expenses and losses	**5,112,658**	46,352,355
OTHER CHANGES IN NET ASSETS WITHOUT DONOR RESTRICTIONS		
Net assets released from restrictions for capital expenditures	**190,157**	-
Change in minimum pension obligation	**(7,040,017)**	4,594,630
Increase (decrease) in net assets without donor restrictions	**$ (1,737,202)**	$ 50,946,985

See Notes to Consolidated Financial Statements

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
Years Ended June 30, 2019 and 2018

	2019	2018
NET ASSETS WITHOUT DONOR RESTRICTIONS		
Excess of revenue and gains over expenses and losses	**$ 5,112,658**	$ 46,352,355
Net asset released from restrictions used for capital expenditures	**190,157**	-
Change in minimum pension obligation	**(7,040,017)**	4,594,630
Increase (decrease) in net assets without donor restrictions	**(1,737,202)**	50,946,985
NET ASSETS WITH DONOR RESTRICTIONS		
Change in beneficial interest in assets held by others	**364**	(1,357,157)
Change in net unrealized gains (losses) on investments	**192,564**	-
Net assets released from restrictions	**(2,641,136)**	-
Beneficial interest in assets held by others	**-**	455,908
Contributions	**928,518**	-
(Decrease) in net assets with donor restrictions	**(1,519,690)**	(901,249)
Change in net assets	**(3,256,892)**	50,045,736
Net assets:		
Beginning of year	**265,714,716**	215,668,980
End of year	**$ 262,457,824**	$ 265,714,716

See Notes to Consolidated Financial Statements

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
Years Ended June 30, 2019 and 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	**$ (3,256,892)**	$ 50,045,736
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Excess of unrestricted assets acquired over liabilities assumed in acquisition of Stonewall Jackson Memorial Hospital (net of cash and cash equivalents)	**-**	(57,970,420)
Consolidation of Foundation of Monongalia General Hospital (net of cash and cash equivalents)	**(9,638,517)**	-
Restricted contributions	**-**	(455,908)
Change in fair value of derivative obligation	**4,499,960**	(3,232,244)
Depreciation	**25,403,185**	24,810,659
Bond premium and discount amortization	**(430,009)**	(473,158)
Amortization of bond issuance costs	**110,334**	105,477
Gain on disposal of property and equipment	**(576,880)**	(249,541)
Loss on equity method investments	**460,420**	136,725
Amortization of advance fees	**(147,077)**	(193,111)
Advance fees received	**2,362,378**	1,874,716
Change in minimum pension obligation	**7,040,017**	(4,594,630)
Change in beneficial interest in assets held by others	**10,000,941**	1,329,068
Changes in operating assets and liabilities:		
Patient accounts receivable	**(463,862)**	4,634,515
Due from affiliated entities	**74,422**	1,166
Due to/from third-party payors	**1,167,794**	(1,943,527)
Other receivables	**(540,962)**	(189,961)
Inventories	**(441,725)**	(700,645)
Insurance recoveries receivable	**(572,060)**	(3,585)
Prepaid expenses and other assets	**1,307,518**	(2,031,617)
Trading securities	**10,683,607**	10,471,083
Other investments	**(539,477)**	(1,048,524)
Other long-term assets	**(2,147,430)**	-
Accounts payable and accrued expenses	**(4,530,473)**	4,779,595
Deferred revenue for advance rent	**(48,952)**	(48,952)
Accrued pension obligation	**(4,249,820)**	(5,872,031)
Estimated professional and general liability obligation	**(1,192,505)**	1,035,454
Net cash provided by operating activities	**34,333,935**	20,216,340
CASH FLOWS FROM INVESTING ACTIVITIES		
Property and equipment acquisitions	**(26,556,737)**	(28,298,914)
Proceeds from sale of property and equipment	**1,287,981**	1,487,499
Net cash (used in) investing activities	**(25,268,756)**	(26,811,415)

See Notes to Consolidated Financial Statements

	2019	2018
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments on long-term debt	**$ (4,492,829)**	$ (3,749,336)
Net borrowings (payments) on line of credit	**(100,000)**	1,000,000
Refunds from issuance of deposits and refundable fees	**(1,454,937)**	(1,216,110)
Net cash (used in) financing activities	**(6,047,766)**	(3,965,446)
Net increase (decrease) in cash and cash equivalents	**3,017,413**	(10,560,521)
Cash and cash equivalents:		
Beginning of year	**21,572,830**	32,133,351
End of year	**$ 24,590,243**	$ 21,572,830
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for interest	**$ 8,598,424**	$ 8,524,341

See Notes to Consolidated Financial Statements

Note 1. Description of Organization, Summary of Significant Accounting Policies

Nature of activities: Monongalia Health System, Inc. (MHS) is a not-for-profit corporation which sponsors and controls three 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 Corporation (PMH), Stonewall Jackson Memorial Hospital Company (SJMH), Foundation of Monongalia General Hospital, Inc. (Foundation), and Mon Health Care, Inc. (MHC). Each of these Subsidiaries' service areas are primarily in 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. Effective July 1, 2019, Monongalia Health System, Inc., Monongalia Emergency Medical Services, Inc., and West Virginia University Hospitals, Inc. (WVUH) entered into a definitive agreement to jointly provide ambulance services, including 911 emergency as well as non-emergency ambulance transportation services, to the residents of Monongalia County and Preston County and to otherwise make available non-emergency ambulance transportation services to affiliates, as reasonably requested. MHS and WVUH, members, have equal board representation and MHS provides certain purchased services to MEMS.

PMH is a not-for-profit, Critical Access Hospital (CAH) providing acute, medical, surgical, rehabilitative, and outpatient services. PMH is located in Kingwood, Preston County, West Virginia. PMH is the parent organization of Preston Memorial Medical Group, Inc. and Preston Memorial Foundation, Inc., which are now all consolidated and presented as an affiliate under MHS in these consolidated financial statements.

SJMH is a not-for-profit organization located in Weston, West Virginia, which provides acute medical services and outpatient services to citizens of Weston and surrounding communities. MHS became the sole member of SJMH effective October 1, 2017.

Foundation is a not-for-profit corporation which was created to provide grants and contributions for new services and capital expenditures to the Health System.

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. MHC owns 50% of Fairmont Home Medical Equipment and Supply Company.

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. Effective August 27, 2019, MHS entered into an agreement for the potential sale of MMAB.

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

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: Net assets and revenue, gains, and losses are classified based on donor-imposed stipulations. Accordingly, net assets of the Health System and changes therein are classified and reported as follows:

Net assets without donor restrictions are net assets available for use in general operations and not subject to donor restrictions. All revenue not restricted by donors is accounted for in net assets without donor restrictions.

Net assets with donor restrictions result from contributions, grants, or other inflows of assets whose use by the Health System is limited by donor or grantor imposed stipulations that either expire by passage of time or can be fulfilled and removed by actions of the Health System pursuant to those stipulations, from other asset enhancements and diminishments subject to the same kinds of stipulations, or from reclassifications to or from other classes of net assets as a consequence of donor or grantor imposed stipulations, their expiration by passage of time, or their fulfillment and removal by actions of the Health System pursuant to those stipulations. Other donor-imposed restrictions may be perpetual in nature, where the donor stipulates that resources be maintained in perpetuity.

Functional expense allocation: The costs of program and supporting service activities have been summarized on a functional basis in Note 22. The tables of functional expenses present the natural classification detail of expenses by function. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

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 an original 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 Financial Account Standards Board (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 reported at estimated net realizable value taking into account estimated implicit and explicit price concessions. The estimated implicit price concessions are based upon management's judgmental assessment of historical and expected net collections considering business and general economic conditions in its service area, trends in health care coverage, and other collection indicators. Throughout the year, management assesses the adequacy of the implicit price concession based upon its review of accounts receivable payor composition and aging, taking into consideration recent experience by payor category, payor agreement rate changes, and other factors. The results of these assessments are used to make modifications to patient service revenue and to establish an appropriate estimate for implicit price concessions. The Health System follows established guidelines for placing certain past-due patient balances with external collection agencies.

For receivables associated with services provided to patients who have third-party coverage (which includes patients with deductible and payment balances for which third-party coverage exists for part of the bill), the Health System analyzes contractually due amounts and provides an allowance for explicit price concessions, if necessary. The provision is based on an analysis of past experience related to the recent historical collection rate of uninsured patient balances.

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 net realizable value. Cost is determined using the first-in, first-out (FIFO) method. Net realizable value is the estimated selling price used in the ordinary course of business, less reasonable predictable cost of completion, disposal, and transportation.

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
- Donor restricted funds and receivables

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 4), 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, 2019 or 2018.

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 3 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. Effective July 1, 2018, the Foundation was consolidated into the Health System.

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. SJMH has an arrangement with a trust in which the trust accepts contributions from the donors and agrees to use them to benefit SJMH. SJMH includes the net assets of the trust as a beneficial interest.

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 had 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, SJMH, 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, SJMH, 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. These unamortized premiums and cost are netted against the carrying amount of the related debt liability.

Income taxes: The Health System is generally exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC), 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, 2019 or 2018. 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, 2016, 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 at a rate of 2.5%. During 2019 and 2018, MHMC incurred provider taxes of $5,796,003 and $5,573,731, respectively, which are included in supplies and other expenses on the accompanying consolidated statements of operations. During 2019 and 2018, PMH incurred $809,729 and $727,032, respectively, which are recorded as provider tax and included in supplies and other expenses on the accompanying consolidated statements of operations. During 2019 and 2018, SJMH incurred $684,729 and $381,906, 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 net assets without donor restriction, which are excluded from excess of revenue and gains over expenses and losses, include minimum pension obligation adjustments and net assets released from restrictions used for capital expenditures.

Net patient service revenue: On July 1, 2018, the Health System adopted the new revenue recognition accounting standard issued by the FASB using the full retrospective method. The adoption of the new standard did not have an impact on the recognition of new revenue for any periods prior to adoption. As a result, provision for bad debts is no longer presented as a separate line item on the consolidated statements of operations but included in net patient service revenue as an estimated implicit price concession deduction. Because all of its performance obligations relate to contracts with a duration of less than one year, the Health System has elected to apply the optional exemption provided in the authoritative guidance and, therefore, is not required to disclose the aggregate amount of the transaction prices allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period. The Health System has applied the practical expedient and all incremental customer contract acquisition costs are expensed as they are incurred, as the amortization period of the asset that the Health System otherwise would have recognized is one year or less in duration.

Patient service revenue is reported at the amount that reflects the consideration to which the Health System expects to be entitled to in exchange for providing patient care and is recognized as performance obligations are satisfied. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Health System bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as the performance obligations are satisfied.

Performance obligations associated with inpatient services are satisfied over time and are recognized based on actual charges incurred in relation to total expected charges. The Health System measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided and the Health System does not believe it is required to provide additional goods or services to the patient. Performance obligations associated with outpatient services are satisfied at the time services are rendered.

The Health System determines the transaction price based on standard charges for goods and services provided, reduced by explicit prior concessions (contractual adjustments) provided to third-party payors, discounts provided to uninsured patients in accordance with the Health System's policy, and implicit price concessions provided to uninsured patients. The Health System determines its estimates of explicit concessions and discounts based on contractual agreements, its discount policies, and historical experience. The Health System determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

The Health System has agreements with third-party payors that provide for reimbursement to the Health System at amounts different from its established rates. Explicit concessions under third-party reimbursement programs represent the difference between the Health System billings at established rates for services and 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 is designated as a Critical Access Hospital under the Medicare and Medicaid programs. Accordingly, PMH receives payments on a reasonable and allowable cost basis for inpatient and most outpatient services provided to eligible Medicare and Medicaid patients.

Public Employees Insurance Agency (PEIA): Payments for outpatient services rendered to PEIA program beneficiaries are based upon the Health System'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 and Managed Care insurance carriers: Patient services are rendered primarily on a fee-for-service basis. Hospital inpatient services for certain commercial carriers, health maintenance organizations, and preferred provider organizations are paid based on a prospective payment system using diagnosis related groups.

Laws and regulations concerning government programs, including Medicare and Medicaid, are extremely complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Health System’s compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Health System. In addition, the contracts the Health System has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, review, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Health System’s historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. In 2019 and 2018, net patient service revenue increased (decreased) approximately $694,000 and $(705,000), respectively, due to changes in previously recorded estimates.

The Health System provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. Patients who are covered by third-party payors are responsible for related deductibles and coinsurance. The Health System estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. Subsequent changes that are determined to be the result of an adverse change in the patient’s ability to pay are recorded as bad debt expense. Bad debt expense for the years ended June 30, 2019 and 2018, were considered immaterial.

The Health System has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Health System's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Health System does, in rare instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is deemed to be insignificant to the contract.

The Health System has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are primarily affected by the payor and service line. Because all of the Health System's revenue originates in the same general geographic area, it was not considered to be a factor.

The following tables provide details of these factors:

The Health System's net patient service revenue by primary payor during the years ended June 30 is as follows:

	2019		2018	
Medicare	**$ 95,621,090**	**26%**	$ 88,093,738	26%
Blue Cross	**106,214,385**	**29**	103,455,251	30
Commerical	**63,953,169**	**17**	58,623,769	17
Medicare Managed Care	**43,496,290**	**12**	37,682,414	11
Medicaid Managed Care	**25,809,976**	**7**	22,516,185	7
Medicaid	**5,319,986**	**1**	3,922,509	1
Self-pay	**3,787,959**	**1**	4,077,696	1
Other	**27,160,848**	**7**	25,171,896	7
	$ 371,363,703	**100%**	$ 343,543,458	100%

The Health System's net patient service revenue by service line during the years ended June 30 is as follows:

	2019		2018	
Hospital Inpatient	**$ 178,780,357**	**48%**	$ 168,703,654	49%
Hospital Outpatient	**145,315,358**	**39**	132,742,851	39
Physician Services	**46,567,566**	**13**	41,622,535	12
Home Care	**700,422**	**-**	474,418	-
	$ 371,363,703	**100%**	$ 343,543,458	100%

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 divided by gross patient service revenue.

The estimated cost of providing charity care amounted to $1,905,000 and $1,984,000 for the years ended June 30, 2019 and 2018, respectively.

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, 2019 or 2018, 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 $1,103,000 and $1,193,000 for the years ended June 30, 2019 and 2018, respectively.

Reclassifications: Certain amounts in the 2018 consolidated financial statements have been reclassified to conform to the 2019 presentation.

Subsequent events: The Health System evaluated the effect subsequent events would have on the consolidated financial statements through September 25, 2019, which is the date the consolidated financial statements were issued.

Recent Accounting Pronouncements

Revenue Recognition: In May 2014, the FASB issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers*, which clarifies the principles for recognizing revenue and develops a common revenue standard for U.S. GAAP. This ASU attempts to remove inconsistencies and weaknesses in the current revenue recognition requirements, provides a more robust framework for addressing issues, improves comparability across entities and industries, provides more useful information to the users of the financial statements, and simplifies the preparation of financial statements by consolidating the number of requirements required to be referenced. The guidance permits the use of either a retrospective or modified retrospective (cumulative effect) transition method. The Health System adopted this guidance for the year ended June 30, 2019, using the full retrospective transition method. Adoption of this guidance did not have a material impact on the Health System's consolidated financial statements.

Leases: In February 2016, the FASB issued ASU No. 2016-02, *Leases* (Topic 842), which supersedes FASB ASC Topic 840, Leases, and makes other conforming amendments to U.S. GAAP. This ASU requires, among other changes to the lease accounting guidance, lessees to recognize most leases on the balance sheet via a right-of-use asset and lease liability, and additional qualitative and quantitative disclosures. The Health System is currently evaluating the impact, if any, that adoption will have on its June 30, 2020, consolidated financial statements.

Not-for-Profit Entities: In August 2016, the FASB issued ASU 2016-14, (Topic 958): *Presentation of Financial Statements of Not-for-Profit Entities*. The amendments of this ASU change presentation and disclosure requirements for not-for-profit entities to provide more relevant information about their resources (and the changes in those resources) to donors, grantors, creditors, and other users. The amendments include qualitative and quantitative requirements in the financial statement presentation and disclosures regarding net asset classes, investment return, expenses, liquidity and availability of resources, and presentation of operating cash flows. The Health System adopted this guidance during the year ended June 30, 2019. The Health System applied the ASU retrospectively to all periods presented, except for the disclosures around liquidity and availability of resources as allowed by ASU 2016-14.

Statement of Cash Flow: In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* (Topic 230), which requires companies to include cash and cash equivalents that have restrictions on withdrawal or use in total cash and cash equivalents on the statement of cash flows. The Health System is currently evaluating the impact, if any, that adoption will have on its June 30, 2020, consolidated financial statements.

Intangibles: In January 2017, the FASB issued ASU 2017-04, *Intangibles – Goodwill and Other* (Topic 350): *Simplifying the Test for Goodwill Impairment*, 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. 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 June 30, 2023, consolidated financial statements.

In May 2019, the FASB issued ASU 2019-06, *Intangibles – Goodwill and Other (Topic 350), Business Combinations (Topic 805), and Not-for-Profit Entities (Topic 958)*. The amendments in this Update provide not-for-profit entities the ability to apply private company alternatives from Topic 350 and Topic 805. Amendments to Topic 350 allow not-for-profit entities to amortize goodwill on a straight-line basis, test for impairment upon a triggering event, and elect to test for impairment at the entity level, while amendments to Topic 805 should allow not-for-profit entities to recognize fewer separate intangible assets in an acquisition. The Health System is currently evaluating the impact, if any, that adoption will have on its June 30, 2020, consolidated financial statements.

Net Periodic Pension and Postretirement Benefit Cost: In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits* (Topic 715): *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Post Retirement Benefit Cost*. This guidance requires that an employer disaggregate the service cost component from the other components of net benefit cost. The amendments also provide explicit guidance on how to present the service cost component and the other components of net benefit cost on the income statement and allow only the service cost component of net benefit cost to be eligible for capitalization. Early adoption is permitted. The Health System is currently evaluating the impact, if any, that adoption will have on its June 30, 2020, consolidated financial statements.

Note 2. Supplemental Medicaid Funding

Supplemental Medicaid Funding - Upper Payment Limit (UPL) Program: In 2012, the West Virginia Medicaid Program received federal Centers for Medicare and Medicaid Services (CMS) approval to implement the Upper Payment Limit program. The UPL program provides for supplemental Medicaid payments to MHMC and SJMH. The payment is computed primarily on the Health System's hospitals allowable total cost to charge ratio and the amount 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 tax of 2.50% currently imposed on providers of hospital services, there is an additional tax of 0.75% in 2019 and 2018 on gross revenue. The UPL program was expanded effective January 1, 2014, for the expanded portion of the Medicaid population resulting from the State of West Virginia's adoption of new eligibility criteria afforded states as a part of the Affordable Care Act (ACA) that covers the gap in coverage for the poorest Americans. The ACA created a minimum Medicaid income eligibility level that resulted in a substantial increase in Medicaid eligible recipients in West Virginia. The State of West Virginia implemented the Direct Payment Program (DPP) to continue supplemental payments upon transition to managed care. As of June 30, 2019, the State of West Virginia had outstanding payments under the DPP for the state fiscal year 2019 (July 1, 2018, through June 30, 2019).

During 2019 and 2018, MHMC and SJMH in total recorded $2,008,665 and $1,678,877, respectively, in taxes related to the supplemental Medicaid programs, 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 DPP program. The supplemental reimbursement for these services of $7,798,910 and $7,952,293 for 2019 and 2018, 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, 2019 and 2018, of $4,527,612 and $5,501,264, respectively.

Note 3. 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:

	2019	2018
By Board for capital improvements:		
RIIFL Multi-Asset Core Plus Fund	**$ 56,379,276**	$ 60,257,657
RIIFL Core Bond Fund	**37,787,408**	39,844,192
Equities	**25,162,471**	25,613,870
Fixed income:		
Government agency bonds	**2,101,745**	1,699,080
Corporate bonds	**1,454,868**	1,562,845
Mutual funds	**2,230,848**	-
Interest-bearing cash	**14,088,457**	14,577,947
	139,205,073	143,555,591
Under professional liability self-insurance funding arrangement held by trustee:		
Fixed income:		
Government agency bonds	**4,475,402**	4,136,269
Corporate bonds	**2,524,511**	2,235,659
Mutual funds	**1,217,794**	3,216,113
Preferred and common stocks	**2,678,073**	4,260,477
Interest-bearing cash	**431,704**	317,043
	11,327,484	14,165,561
Tax increment financing bonds and bond indenture agreements held by trustee:		
Fixed income:		
Municipal bonds	**1,866,955**	2,306,955
Money market funds	**8,465,906**	8,450,643
	10,332,861	10,757,598
By donor		
Pledges receivable,net	**287,405**	-
Equities	**347,185**	-
Fixed income:		
Mutual funds	**4,711,157**	-
Interest-bearing cash	**142,818**	-
	5,488,565	-
Total investments, at fair value, whose use is limited	**166,353,983**	168,478,750
Less: current portion of assets whose use is limited	**17,862,913**	15,519,112
Investments, at fair value, whose use is limited	**$ 148,491,070**	$ 152,959,638

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:

	2019	2018
Debt service fund - principal and interest	**$ 3,853,407**	$ 3,699,503
Project fund	**3,833,332**	3,759,473
Physician service fund	**779,167**	991,667
Tax increment financing funds	**1,866,955**	2,306,955
	$ 10,332,861	$ 10,757,598

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

	2019	2018
Interest and dividend income	**$ 2,839,566**	$ 2,416,578
Investment fees	**(640,519)**	(824,061)
Unrealized gains on change in fair value	**3,793,312**	1,201,437
Realized gains on sale of securities	**5,698,215**	5,502,105
	$ 11,690,574	$ 8,296,059

Note 4. 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 16% 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 44.9% 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 $132,346 during the years ended June 30, 2019 and 2018, respectively.

MHS has a 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, 2019 and 2018, was $820,848 and $2,051,754, 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.

MHMC has a 20% ownership interest in Amedisys Hospice, a for-profit entity. Amedisys provides personalized home health, hospice, and personal care as well as rehabilitation after an operation or surgery.

The Health System accounts for its investments in Care Partners, Mountaintop, MTOP, MPTA, MAL, Fairmont, MMAB, OSC, and Amedisys 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.

	2019	2018
Current assets	**$ 7,076,430**	$ 6,851,025
Property and equipment, net	**35,904,849**	36,564,880
Other assets	**1,530,626**	1,529,078
Total assets	**$ 44,511,905**	$ 44,944,983
Current liabilities	**$ 5,308,327**	$ 4,849,198
Long-term debt	**23,476,216**	24,259,699
Total liabilities	**28,784,543**	29,108,897
Stockholders' equity	**15,727,362**	15,836,086
Total liabilities and stockholders' equity	**$ 44,511,905**	$ 44,944,983
Total revenue	**$ 23,557,145**	$ 22,380,479
Health System's share of net (loss)	**$ (460,420)**	$ (136,725)

Long-Term Acute Care Hospital Joint Venture

MHMC and Acuity Healthcare, L.P. (Acuity) executed a joint venture effective July 18, 2019, to develop a 25-bed long-term acute care hospital, LTACH, on the campus of MHMC. The venture will lease space from MHMC and will be separately licensed and it is expected to begin servicing patients in the fall of 2019.

Premier

The Health System has an investment in a group purchasing organization, Premier, LP (Premier), which is recorded under the equity method and amounts to $1,146,316 and $2,213,482 as of June 30, 2019 and 2018, 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 (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, 2019, the Health System exchanged 53,514 of its Class B common units and received 53,514 shares of Class A common stock. During the year ended June 30, 2018, the Health System exchanged none of its Class B common units for shares of Class A common stock. 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 $1,062,156 and $891,584 for the years ended June 30, 2019 and 2018, 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.

West Virginia Rehabilitation Hospital, Inc.

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, 2019 and 2018. The Rehab Hospital paid dividends of $0 and $481,480 during the years ended June 30, 2019 and 2018, 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 Internal Revenue Code (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, 2019 and 2018, the Trust totaled $2,605,991 and $3,376,863, respectively.

Other investments consist of the following as of June 30:

	2019	2018
Investments:		
Equity method	**$ 10,756,996**	$ 11,061,635
At cost	**2,192,100**	1,808,404
Rabbi Trust	**2,605,991**	3,376,863
	$ 15,555,087	$ 16,246,902

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, 2019 or 2018.

Note 5. Acquisition

Effective October 1, 2017, MHS became the sole member of Stonewall Jackson Memorial Hospital Company. No consideration was exchanged at the acquisition date and MHS recognized an inherent contribution representing the excess of assets acquired over liabilities assumed as summarized below.

The following summarizes the recorded values of the assets acquired over the liabilities assumed at the acquisition date based on estimated fair values:

Cash and cash equivalents	$	1,424,214
Patient accounts receivable		6,852,768
Other receivables		962,329
Estimated third-party payor settlements		1,188,125
Supplies inventory		1,394,117
Prepaid expenses and other assets		170,003
Assets whose use is limited		41,770,086
Property and equipment, net		18,132,771
Other assets		75,807
Total assets acquired	$	71,970,220
Current liabilities	$	8,222,354
Long-term liabilities		1,239,232
Accrued malpractice expense, net of current portion		3,114,000
Total liabilities assumed	$	12,575,586
Total excess of assets acquired over liabilities assumed	$	59,394,634

Reflected on the consolidated statement of changes in net assets for the year ended June 30, 2018, as follows:

Included in consolidated excess of revenue and gains over expenses and losses for the year ending June 30, 2018, is $52,844,942 attributable to SJMH. This includes $(6,549,692) from operations since the acquisition date and $59,394,634 from the excess of unrestricted net assets acquired over liabilities assumed.

Note 6. 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	2019	2018
Land and improvements	**N/A**	**$ 21,116,061**	$ 20,996,114
Road improvements	**8 years**	**1,148,705**	1,148,705
Buildings and improvements	**5 - 39 years**	**246,163,225**	243,033,259
Equipment	**3 - 10 years**	**197,387,830**	187,958,478
Furniture and fixtures	**5 - 10 years**	**4,253,953**	3,523,131
Vehicles	**5 years**	**2,416,781**	2,344,456
		472,486,555	459,004,143
Property held for leasing:			
Land		**14,308,980**	13,348,873
Buildings and improvements		**68,693,660**	58,070,798
Equipment		**1,693,719**	1,643,974
		84,696,359	73,063,645
		557,182,914	532,067,788
Less accumulated depreciation		**301,154,836**	277,700,861
		256,028,078	254,366,927
Construction in progress		**10,949,054**	12,139,830
Property and equipment, net		**$ 266,977,132**	$ 266,506,757

Depreciation expense amounted to $25,403,185 and $24,810,659 for the years ended June 30, 2019 and 2018, respectively.

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

	2019	2018
Capital lease assets	**$ 50,866,371**	$ 50,866,371
Less accumulated amortization	**5,204,966**	3,678,066
	$ 45,661,405	$ 47,188,305

Note 7. Beneficial Interest in Assets Held by Others

The Foundation was established as a Section 501(c)(3) organization within the meaning of the Internal Revenue Service (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 $0 and $9,994,387 as of June 30, 2019 and 2018, respectively, are included in the accompanying consolidated financial statements. The Foundation was consolidated effect July 1, 2018. The Foundation does not guarantee any obligations of the Health System.

Note 8. Long-Term Debt and Capital Lease Obligations

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

	2019	2018
Variable Rate Hospital Refunding and Improvement Revenue Bonds, Series 2008A, dated February 6, 2008, with variable interest rates (3.124% and 2.93% as of June 30, 2019 and 2018, 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 $11,600,000 of the bonds were refunded with the issuance of the Series 2011 bonds on April 20, 2011.	**$ 34,330,000**	$ 34,395,000
Taxable Variable Rate Hospital Bonds, Series 2008B, dated February 6, 2008, with adjustable interest rates (3.4298% and 2.95% as of June 30, 2019 and 2018, 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.	**11,905,000**	12,195,000
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 $404,000 and $420,000 as of June 30, 2019 and 2018, respectively.		
Hospital	**7,056,035**	7,250,656
MES	**9,234,900**	9,489,619
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. Paid off in 2019.	**-**	35,382
Note payable to bank, with adjustable interest rate (5.5% as of June 30, 2019), with monthly principal and interest payments of $1,471 through April 2027, collateralized by real estate.	**110,923**	122,097

		2019		2018
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 $2,446,000 and $2,904,000 as of June 30, 2019 and 2018, and unamortized discount of approximately $217,000 and $228,000 as of June 30, 2019 and 2018, respectively.	**$**	**50,084,434**	$	52,100,921
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.		**24,401,885**		24,831,280
Note payable to bank, with adjustable interest rate (3.71% as of June 30, 2019). Monthly principal and interest payments of $59,947 beginning in August 2015 through July 2040, collateralized by all personal property and revenue of PMH.		**10,436,392**		10,756,756
Note payable, payable in monthly payments of $6,090, including interest at 1.71%, through January 2020, secured by related property.		**42,301**		114,086
Note payable, bank, payable in monthly payments of $9,107, including interest at 3.5%, through November 2018, secured by related equipment. Paid off 2019.		**-**		45,130
Capital lease obligations, payable in monthly installments ranging from $1,169 to $37,502 with final payment due 2019 - 2022, including interest from 1.12% to 5.29%, secured by related equipment.		**1,217,503**		1,810,519
Capital lease obligation for medical office park with imputed interest rate of 3.76% and monthly principal and interest payments of $198,160 through November 2055, collateralized by the buildings.		**47,276,241**		47,872,016
		196,095,614		201,018,462
Less: unamortized deferred financing costs		**1,321,183**		1,431,527
		194,774,431		199,586,935
Less: current portion of long-term debt		**4,785,679**		5,199,445
Long-term debt, net of current portion	**$**	**189,988,752**	$	194,387,490

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, 2019:

Years Ending June 30:	
2020	$ 3,727,486
2021	3,800,945
2022	3,920,215
2023	4,047,026
2024	4,186,701
Thereafter	127,919,497
	$ 147,601,870

As of June 30, 2019, 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:	
2020	$ 3,101,368
2021	2,534,000
2022	2,408,278
2023	2,377,909
2024	2,377,909
Thereafter	75,032,607
	87,832,071
Less: amounts representing various interest rates	39,338,327
Net present value of future minimum capital lease payments	48,493,744
Less: current portion	1,058,193
Capital lease obligations	$ 47,435,551

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. Effective July 2, 2019, the Obligated Group entered into a two-year term rate period extension through July 1, 2021.

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 were 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) with 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.

In November 2017, SJMH obtained a line of credit of $1,000,000 from a bank with a variable interest that is based on an independent index rate plus 2.00% (4.49% as of June 30, 2019). The line of credit was renewed in January of 2019 and expires January 31, 2020. The line of credit is secured by the hospital's investment funds. As of June 30, 2019 and 2018, $900,000 and $1,000,000 was outstanding on the line of credit, respectively.

Note 9. 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:

	2019	2018
Advance rent	**$ 958,646**	$ 1,007,598
Rent revenue recognized	**(48,952)**	(48,952)
Deferred revenue for advance rent	**$ 909,694**	$ 958,646

Note 10. 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 1, 2017, 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 participant had terminated employment on or prior to July 1, 2017. The participants had a window from September 18, 2017, through November 7, 2017, 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 $7,252,000.

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*, 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 net assets without donor restrictions 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:

	2019	2018
Change in benefit obligation:		
Benefit obligation at beginning of year	**$ 210,678,012**	$ 227,908,422
Service cost	**610,000**	1,030,000
Interest cost	**8,275,326**	7,655,268
Actuarial loss (gain)	**17,106,043**	(9,185,904)
Benefits paid	**(10,105,118)**	(16,729,774)
Benefit obligation at end of year	**226,564,263**	210,678,012
Change in plan assets:		
Fair value of plan assets at beginning of year	**196,505,228**	203,472,184
Actual return on plan assets	**19,063,630**	5,262,818
Employer contributions	**3,500,000**	4,500,000
Benefits paid	**(10,105,118)**	(16,729,774)
Fair value of plan assets at end of year	**208,963,740**	196,505,228
Unfunded status	**$ (17,600,523)**	$ (14,172,784)
Amounts recognized on the consolidated statements of financial position:		
Noncurrent liabilities	**$ (17,600,523)**	$ (14,172,784)
Components of net periodic (benefit) cost:		
Service cost	**$ 610,000**	$ 1,030,000
Interest cost	**8,275,326**	7,655,268
Expected return on plan assets	**(12,173,706)**	(12,849,460)
Amortization of prior service cost	**(51,236)**	(51,236)
Recognized actuarial loss	**2,697,661**	2,952,845
Net periodic (benefit)	**$ (641,955)**	$ (1,262,583)

Other changes in plan assets and benefit obligations recognized in unfunded accumulated benefit obligation for the years ended June 30:

	2019	2018
Net gain (loss) arising during the period	**$ (10,161,879)**	$ 1,693,021
Prior service credit	**(51,236)**	(51,236)
Amortization and curtailment recognition accumulated loss	**2,697,661**	2,952,845
Total changes recognized in other changes in net assets without donor restrictions	**$ (7,515,454)**	$ 4,594,630

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 $(2,697,661) and $51,236, respectively.

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

	2019	2018
Accrued benefit cost	**$ 17,600,523**	$ 14,172,784
Additional minimum pension income adjustment	**(7,515,454)**	4,594,630
Net periodic (benefit) cost	**(641,955)**	(1,262,583)

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

	2019	2018
Discount rate	**3.60%**	4.28%

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

	2019	2018
Discount rate	**4.28%**	3.94%
Expected long-term return on plan assets	**6.00%**	6.40%

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:

	2019	2018	Target Range
Asset category			
Equity securities	**35%**	35%	40 - 50%
Debt securities	**65**	65	50 - 60%
	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, 2019 or 2018:

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 in 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, 2019			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market fund *	**$ 1,844,484**	**$ 1,844,484**	**$ -**	**$ -**
Common collective trusts *				
Equity:				
Large cap	**21,037,391**	**-**	**21,037,391**	**-**
Small/mid cap	**7,160,811**	**-**	**7,160,811**	**-**
International	**42,251,014**	**-**	**42,251,014**	**-**
Fixed income:				
Long duration	**129,071,585**	**-**	**129,071,585**	**-**
Opportunistic	**7,598,455**	**-**	**7,598,455**	**-**
Total assets at fair value	**$ 208,963,740**	**$ 1,844,484**	**$ 207,119,256**	**$ -**

	June 30, 2018			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market fund *	$ 644,411	$ 644,411	$ -	$ -
Common collective trusts *				
Equity:				
Large cap	21,296,313	-	21,296,313	-
Small/mid cap	7,432,629	-	7,432,629	-
International	40,295,618	-	40,295,618	-
Fixed income:				
Long duration	119,618,417	-	119,618,417	-
Opportunistic	7,217,840	-	7,217,840	-
Total assets at fair value	$ 196,505,228	$ 644,411	$ 195,860,817	$ -

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

Contributions and estimated future benefits: The Health System made contributions totaling $3,500,000 and $4,500,000 to the MHS Plan for the plan years ended June 30, 2019 and 2018, respectively. The Health System expects to contribute $4,000,000 during fiscal year 2020.

Expected pension benefits to be paid in future years are as follows as of June 30, 2019:

Years Ending June 30:	
2020	$ 11,056,236
2021	11,496,678
2022	11,917,631
2023	12,281,707
2024	12,584,919
2025 to 2029	65,664,679

Preston Memorial Retirement Plan

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, 2019 or 2018. The most recent actuarial valuation was performed as of December 31, 2018, with a mid-year update for reporting purposes showing plan assets of $3,995,211 and actuarial accrued liability of $5,049,280. The resulting unfunded status of the PMH Plan in the amount of $1,054,069 as of June 30, 2019, is recorded as part of the consolidated accrued pension obligation on the accompanying consolidated statements of financial position. The unfunded status of the PMH Plan as of June 30, 2018, amounted to $1,691,611. The change in minimum pension obligation amounted to $(475,437) and $(0) for the years ended June 30, 2019 and 2018, respectively, which is recorded as part of the change in minimum pension obligation on the accompanying consolidated statements of operations.

	2019	2018
Reconciliation of Accrued Pension:		
Unfunded status at end of year - MHS Plan	**$ 17,600,523**	$ 14,172,784
Unfunded status at end of year - PMH Plan	**1,054,069**	1,691,611
Accrued Pension Obligation	**$ 18,654,592**	$ 15,864,395

Note 11. Net Assets With Donor Restrictions

Net assets with donor restrictions are restricted for the following purposes as of June 30:

	2019	2018
Health care programs and services	**$ 3,478,849**	$ 5,174,325
Acquisition of building and equipment	**138,313**	220,920
Educational seminars, scholarships, and other	**2,327,675**	2,069,282
Net assets with donor restrictions	**$ 5,944,837**	$ 7,464,527

Net assets released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by donors is as follows for the years ended June 30:

	2019	2018
Health care programs and services	**$ 2,138,948**	$ -
Acquisition of building and equipment	**190,157**	-
Educational seminars, scholarships, and other	**312,031**	-
Net assets released from restrictions	**$ 2,641,136**	$ -

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 12. Related Party Transactions

Morgantown Physical Therapy Associates, Inc.: MHS charged MPTA $23,148 for rent for each of the years ended June 30, 2019 and 2018.

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

	2019	2018
MGH Surgery, LLC	**$ 117,719**	$ 165,912
Mountaintop Limited Partnership	**1,177**	21,686
The Auxiliary of Monongalia General Hospital	**19,758**	18,862
The Foundation of Monongalia General Hospital	**-**	17,884
Fairmont Home Equipment and Supply Company	**4,370**	2,849
Care Partners, Inc.	**29**	101
Other affiliated entities	**1,434**	9,499
Due from affiliated entities	**$ 144,487**	$ 236,793

Note 13. 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. The Health System was not required to make contributions to the self-insurance trust during the years ended June 30, 2019 or 2018. Investment income on self-insurance trust investments totaled approximately $127,000 and $116,000 for the years ended June 30, 2019 and 2018, 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 $1,586,000 and $1,014,000 as of June 30, 2019 and 2018, 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, 2019 and 2018, the Health System has recorded approximately $6,535,000 and $7,671,000, respectively, as the liability for professional and general liability claims. The estimated current portion of approximately $192,000 in 2019 and $83,000 in 2018 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 2.5% in 2019 and 2018. 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.

SJMH was totally self-insured for medical malpractice claims for the period March 1, 2003, to August 31, 2006. Effective September 1, 2006, SJMH obtained occurrence based coverage of $1,000,000 per each loss event with a $3,000,000 annual aggregate, subject to a $1,000,000 deductible per claim. The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, are accrued when the incidents that give rise to the claims occur. Estimated losses from asserted and unasserted claims are accrued based on the best estimates of the ultimate costs of the claims and the relationship of past reported incidents to eventual claims payments. All relevant information, including industry experience, actuarial calculations, historical experience, existing asserted claims, and reported incidents, is used in estimating the expected amount of claims to be paid. The accrual includes an estimate of the losses that will result from unreported incidents, which are probable of having occurred before the end of the reporting period. Accrued malpractice costs discounted at 2.5% were $3,625,810 as of June 30, 2019, and discounted at 3.5% were $3,766,000 as of June 30, 2018. Accrued unpaid claims and expenses that are expected to be paid during the normal operating cycle (generally within one year of the date of the financial statements) are classified as current liabilities. All other accrued unpaid claims and expenses are classified as noncurrent liabilities. SJMH also maintains a medical malpractice reserve fund, which is included in assets limited as to use. As of June 30, 2019 and 2018, the fund had a balance of approximately $5,865,000 and $9,014,000, respectively.

Note 14. 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 $24,540,000 and $24,032,000 for the years ended June 30, 2019 and 2018, respectively. The Health System has provided a reserve of $1,762,000 and $2,155,000 as of June 30, 2019 and 2018, respectively, to cover the employer portion of any claims incurred but not yet reported or reported but not paid as of June 30, 2019 and 2018, respectively. This reserve is included with accounts payable and accrued expenses on the accompanying consolidated statements of financial position.

SJMH is partially self-insured with respect to employee health insurance claims. The Stonewall Jackson Memorial Hospital Health Benefit Plan (Plan), which is funded by SJMH and its employees, was formed to pay ordinary health care claims of qualified participants. To protect itself against extraordinary claims of its employees, SJMH has purchased stop-loss insurance. SJMH's cost is limited to $65,000 per claim and approximately $650,000 maximum annual aggregate payments. Amounts payable under this plan as of June 30, 2019 and 2018, was $596,539 and $446,147, respectively. Total health insurance expense for the year ended June 30, 2019 and 2019, was $1,397,092 and $1,377,314, respectively.

Note 15. Commitments and Contingencies

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.

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, 2019, MHMC has two interest rate swap agreements outstanding with notional amounts and maturity dates as follows:

		Notional Amounts	
	Maturity	**2019**	2018
2008A Series	July 1, 2040	**$ 34,330,000**	$ 34,395,000
2008B Series	July 1, 2040	**11,905,000**	12,195,000

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, 2019 and 2018. The fair value of the interest rate swap agreement as of June 30, 2019 and 2018, was a liability of $11,473,649 and $8,095,488, 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, 2019 and 2018. The fair value of the interest rate swap agreement as of June 30, 2019 and 2018, was a liability of $3,519,428 and $2,397,629, respectively.

The following table summarizes the location and amounts of the values for MHMC's interest rate swap agreements as of June 30:

	Liability Derivatives			
	June 30, 2019		June 30, 2018	
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**	**$ 14,993,077**	Long-term liabilities	$ 10,493,117

The following table summarizes the location and amounts of derivative gains (losses) on MHMC's interest rate swap agreements for the years ended June 30:

Derivatives not designated as hedging instruments	**Location of gain recognized**	**Years Ended June 30, 2019**	2018
Change in fair value of derivative obligation	Nonoperating gains (losses)	**$ (4,499,960)**	$ 3,232,244

Management obtained valuations 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, 2019 and 2018, was determined to be approximately $15,579,000 and $11,178,000, respectively, and the fair value measurement valuation resulted in an increase (decrease) of this amount by $4,401,000 and $(685,000), respectively.

Note 16. 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 net receivables from patients and third-party payors is as follows as of June 30:

	2019	2018
Medicare and Medicaid	**42%**	39%
Other third-party payors (none over 10%)	**30**	30
Blue Cross	**23**	25
Patients	**5**	6
	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 17. 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 $1,550,000 and $1,631,000 during the years ended June 30, 2019 and 2018, 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, 2018, the RSC contribution to the 403(b) Plan was approximately $3,393,000. As of June 30, 2019 and 2018, the RSC accrual was approximately $1,724,000 and $1,850,000, 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 $346,400 and $308,900 during the years ended June 30, 2019 and 2018, respectively. Contributions made by PMH vest over a five year period at 20% per year.

Note 18. 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 $83,400 and $80,800 during the years ended June 30, 2019 and 2018, 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, 2018, the RSC contribution to the 401(k) Plan was approximately $59,400. As of June 30, 2019 and 2018, the RSC accrual was approximately $27,900 and $27,400, respectively.

Note 19. 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 20. Fair Value of Financial Assets and Liabilities

Authoritative guidance regarding *Fair Value Measurements* establishes a framework for measuring fair value. This guidance defines fair value, establishes a framework and hierarchy for measuring fair value, and outlines the related disclosure requirements. The guidance indicates that a fair value measurement assumes that the transaction to sell an asset or transfer a liability occurs in the principal market for the asset or liability or, in the absence of a principal market, the most advantageous market for the asset or liability based upon an exit price model. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level I measurements) and the lowest priority to unobservable inputs (Level III measurements). The levels in the fair value hierarchy are as follows:

Level I Quoted prices in active markets for identical assets or liabilities.

Level II Observable inputs other than Level I prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level III Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The Health System has no financial assets or liabilities measured at fair value on a non-recurring basis.

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, 2019 or 2018:

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

Equities, equity mutual funds, and fixed income funds: Based upon quoted market prices.

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'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. Because these financial instruments are not readily marketable, the estimated carrying value is subject to uncertainty, and, therefore, may differ from the value that would have been used had a market for such financial instruments existed.

Interest rate swaps: The fair values are 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, 2019 and 2018, 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, 2019 and 2018, by caption, on the consolidated statements of financial position by the guidance valuation hierarchy defined above.

	June 30, 2019			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market funds *	**$ 8,465,906**	**$ 8,465,906**	**$ -**	**$ -**
Equities	**28,187,729**	**-**	**28,187,729**	**-**
Fixed income:				
Government bonds	**6,577,147**	**-**	**6,577,147**	**-**
Municipal bonds	**1,866,955**	**-**	**1,866,955**	**-**
Corporate bonds	**3,979,379**	**-**	**3,979,379**	**-**
Mutual funds	**8,159,799**	**-**	**8,159,799**	**-**
Total assets in the fair value hierarchy	**57,236,915**	**8,465,906**	**48,771,009**	**-**
Institutional funds measured at NAV	**94,166,684**	**-**	**-**	**-**
Total investments and assets limited as to use	**$ 151,403,599**	**$ 8,465,906**	**$ 48,771,009**	**$ -**
Liabilities:				
Interest rate swaps at fair value	**$ 14,993,077**	**$ -**	**$ 14,993,077**	**$ -**

	June 30, 2018			
	Total	**Level I**	**Level II**	**Level III**
Assets:				
Money market funds *	$ 8,450,643	$ 8,450,643	$ -	$ -
Equities	29,874,347	-	29,874,347	-
Fixed income:				
Government bonds	5,835,349	-	5,835,349	-
Municipal bonds	2,306,955	-	2,306,955	-
Corporate bonds	3,798,504	-	3,798,504	-
Mutual funds	3,216,113	-	3,216,113	-
Total assets at fair value	53,481,911	8,450,643	45,031,268	-
Institutional funds measured at NAV	100,101,849	-	-	-
Total investments and assets limited as to use	$ 153,583,760	$ 8,450,643	$ 45,031,268	$ -
Liabilities:				
Interest rate swaps at fair value	$ 10,493,117	$ -	$ 10,493,117	$ -

* 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, 2019 or 2018. Transfers are recognized at the end of the reporting period.

The Health System has approximately $39,253,000 and $36,468,000 of cash as of June 30, 2019 and 2018, respectively, which was not classified as a Level as prescribed within the topic on FASB ASC 820. As of June 30, 2019 and 2018, approximately $14,663,000 and $14,895,000, 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.

Fair Value of Investments that Calculate Net Asset Value

The following tables summarize investments measured at fair value based on NAVs per share as of June 30:

	Fair Value		Unfunded	Redemption Frequency (if	Redemption Notice
	2019	2018	**Commitments**	**currently eligible)**	**Period**
RIIFL MULTI-ASSET CORE PLUS Fund (a)	**$ 56,379,276**	$ 60,257,657	$ -	Daily	1 day notice / 30 days for full redemption
RIIFL CORE BD Fund (b)	**37,787,408**	39,844,192	-	Daily	1 day notice / 30 days for full redemption
Total	**$ 94,166,684**	$ 100,101,849			

(a) The Russell Investments Institutional Funds, LLC (RIIFL) Multi-Asset Core Plus Fund seeks to provide long-term capital growth and offers a convenient way to diversify a portfolio by combining funds and separate accounts investing in U.S. and non-U.S. stocks, bonds, global commodities, listed real estate, and infrastructure into one fund. It holds a dynamic mix of underlying Russell Investments funds and/or separate accounts.

(b) The RIIFL Core Bond Fund provides participation in the full spectrum of investment opportunities in primarily U.S. debt markets. The fund seeks to take advantage of market trading opportunities, to generate current income, as well as provide a competitive rate of return on assets with a moderate to low level of absolute volatility.

Note 21. 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, 2019 or 2018, to the Health System's valuation techniques used to measure or disclose fair value of long-term obligations.

	June 30, 2019		June 30, 2018	
	Fair Value	**Carrying Value**	Fair Value	Carrying Value
Series 2011 Revenue Bonds	**$ 18,053,992**	**$ 16,290,935**	$ 18,851,224	$ 16,740,275
Series 2015 Revenue Bonds	**51,657,566**	**50,084,434**	53,034,083	52,100,921

Note 22. 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:

	2019			
	Health Care Services	**Fundraising**	**Management and General**	**Total**
Wages, salaries, and benefits	**$ 165,067,168**	**$ 40,657**	**$ 37,204,614**	**$ 202,312,439**
Supplies and other	**87,827,660**	**30,281**	**19,550,765**	**107,408,706**
Purchased services	**29,996,182**	**5,157**	**6,444,427**	**36,445,766**
Depreciation	**20,792,559**	**622**	**4,610,004**	**25,403,185**
Interest	**7,028,307**	**-**	**1,536,188**	**8,564,495**
Insurance	**974,592**	**575**	**169,961**	**1,145,128**
	$ 311,686,468	**$ 77,292**	**$ 69,515,959**	**$ 381,279,719**

	2018			
	Healthcare Services	**Fundraising**	**Mangement and General**	**Total**
Wages, salaries, and benefits	$ 165,120,297	$ -	$ 36,088,663	$ 201,208,960
Supplies and other	82,737,638	-	17,603,958	100,341,596
Purchased services	29,471,465	-	6,437,023	35,908,488
Depreciation	20,310,674	-	4,499,985	24,810,659
Interest	6,991,479	-	1,529,978	8,521,457
Insurance	2,891,081	-	626,423	3,517,504
	$ 307,522,634	$ -	$ 66,786,030	$ 374,308,664

Note 23. Liquidity and Availability

As of June 30, 2019, the Health System has working capital of approximately $75,018,000 and approximately 190 days cash on hand.

Financial assets available for general expenditure within one year of the consolidated statement of financial position date consist of the following as of June 30, 2019:

Cash and cash equivalents	$ 24,590,243
Patient accounts receivable	50,925,373
Assets limited as to use:	
Board designated funds	160,865,418
Other assets	4,542,980
	$ 240,924,014

The Health System estimates that the majority of Board designated funds are available for general expenditure within one year in the normal course of operations. The Health System has other assets whose use is limited for professional and general liability insurance and for donor-restricted purposes. These assets whose use is limited are not available for general expenditure within the next year and are not reflected in the amounts above.

Note 24. Subsequent Event

Effective September 16, 2019, the Health System entered into a Management Services Agreement with Grafton City Hospital, an unrelated third party, to provide certain management services, including hospital management, marketing and public relations, human resources, financial, purchasing, and limited legal services.

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF FINANCIAL POSITION
June 30, 2019 (with comparative totals for 2018)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital Corporation	Stonewall Jackson Memorial Hospital Company	Foundation of Monongalia General Hospital, Inc	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2019 Consolidated**	2018 Consolidated
CURRENT ASSETS													
Cash and cash equivalents	$ 1,545,571	$ 17,495,508	$ 310,604	$ -	$ 19,351,683	$ 3,475,405	$ 897,089	$ 194,309	$ 405,900	$ 265,857	$ -	**$ 24,590,243**	$ 21,572,830
Assets whose use is limited	-	8,619,622	1,663,429	-	10,283,051	5,236,061	-	2,343,801	-	-	-	**17,862,913**	15,519,112
Patient accounts receivable, net	-	39,666,305	34,427	-	39,700,732	4,010,634	6,086,757	-	406,702	720,548	-	**50,925,373**	50,385,564
Due from affiliated entities	3,067,577	846,764	97,647	(127,565)	3,884,423	-	-	-	-	-	(3,739,936)	**144,487**	236,793
Due from third-party payors	-	2,207,605	-	-	2,207,605	361,445	2,413,866	-	-	-	-	**4,982,916**	5,817,703
Other receivables	930,502	3,704,560	(423)	-	4,634,639	48,527	799,555	30,228	92,012	1,961,759	-	**7,566,720**	6,525,952
Inventories	-	7,446,179	15,992	-	7,462,171	752,631	1,099,627	13,690	-	258,318	-	**9,586,437**	9,127,072
Prepaid expenses and other assets	106,675	3,338,802	51,234	-	3,496,711	212,575	280,746	102,597	9,522	45,125	-	**4,147,276**	5,365,688
Total current assets	5,650,325	83,325,345	2,172,910	(127,565)	91,021,015	14,097,278	11,577,640	2,684,625	914,136	3,251,607	(3,739,936)	**119,806,365**	114,550,714
INVESTMENTS, AT FAIR VALUE, WHOSE USE IS LIMITED													
By Board for capital improvements	-	76,962,999	18,574,212	-	95,537,211	8,761,941	32,675,073	2,230,848	-	-	-	**139,205,073**	143,555,591
Professional liability self-insurance funding arrangement held by trustee	-	5,462,144	-	-	5,462,144	-	5,865,340	-	-	-	-	**11,327,484**	14,165,561
Tax increment financing bonds held by trustee	-	1,866,955	-	-	1,866,955	-	-	-	-	-	-	**1,866,955**	2,306,955
By donor	125,000	-	1,139	-	126,139	97,915	-	5,264,511	-	-	-	**5,488,565**	-
Under bond indenture agreements held by trustee	-	8,465,906	-	-	8,465,906	-	-	-	-	-	-	**8,465,906**	8,450,643
	125,000	92,758,004	18,575,351	-	111,458,355	8,859,856	38,540,413	7,495,359	-	-	-	**166,353,983**	168,478,750
Less current portion	-	8,619,622	1,663,429	-	10,283,051	5,236,061	-	2,343,801	-	-	-	**17,862,913**	15,519,112
Total investments, at fair value, whose use is limited	125,000	84,138,382	16,911,922	-	101,175,304	3,623,795	38,540,413	5,151,558	-	-	-	**148,491,070**	152,959,638
OTHER ASSETS													
Property and equipment, net	76,955,000	130,371,008	13,171,510	-	220,497,518	30,717,060	13,461,485	22,840	1,248,434	1,029,795	-	**266,977,132**	266,506,757
Long-term physician loans receivable	-	143,635	-	-	143,635	-	-	-	-	-	-	**143,635**	394,062
Goodwill	-	3,416,779	-	-	3,416,779	-	-	-	-	-	-	**3,416,779**	3,416,779
Other investments	15,959,149	3,244,130	-	-	19,203,279	-	67,668	-	-	(141,753)	(3,574,107)	**15,555,087**	16,246,902
Other long-term assets	2,161,152	-	-	-	2,161,152	-	-	178,712	-	-	-	**2,339,864**	-
Insurance recoveries receivable	-	849,720	11,786	-	861,506	191,326	532,810	-	-	-	-	**1,585,642**	1,013,582
Beneficial interest in assets held by others	-	-	-	-	-	-	456,272	707,169	-	-	-	**1,163,441**	10,450,295
Patient accounts receivable, special payment arrangements, net of allowance for doubtful accounts	-	201,429	-	-	201,429	-	-	-	19,770	-	-	**221,199**	297,146
Total other assets	95,075,301	138,226,701	13,183,296	-	246,485,298	30,908,386	14,518,235	908,721	1,268,204	888,042	(3,574,107)	**291,402,779**	298,325,523
Total assets	$ 100,850,626	$ 305,690,428	$ 32,268,128	$ (127,565)	$ 438,681,617	$ 48,629,459	$ 64,636,288	$ 8,744,904	$ 2,182,340	$ 4,139,649	$ (7,314,043)	**$ 559,700,214**	$ 565,835,875

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF FINANCIAL POSITION (CONTINUED)
June 30, 2019 (with comparative totals for 2018)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital Corporation	Stonewall Jackson Memorial Hospital Company	Foundation of Monongalia General Hospital, Inc	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2019 Consolidated**	2018 Consolidated
CURRENT LIABILITIES													
Accounts payable and accrued expenses	$ 1,685,714	$ 24,889,590	$ 621,462	$ -	$ 27,196,766	$ 2,147,008	$ 5,338,284	$ 35,710	$ 597,868	$ 362,472	$ -	**$ 35,678,108**	$ 40,168,689
Line of credit	-	-	-	-	-	-	900,000	-	-	-	-	**900,000**	1,000,000
Current portion of long-term debt	618,562	2,545,228	241,074	-	3,404,864	791,156	589,659	-	-	-	-	**4,785,679**	5,199,445
Due to third-party payors	-	957,899	-	-	957,899	2,267,936	-	-	-	-	-	**3,225,835**	2,892,828
Due to affiliates	-	97,647	29,918	(127,565)	-	242,692	3,240,598	53,576	-	203,070	(3,739,936)	**-**	-
Prospective resident and security deposits	1,829	-	196,710	-	198,539	-	-	-	-	-	-	**198,539**	128,191
Total current liabilities	2,306,105	28,490,364	1,089,164	(127,565)	31,758,068	5,448,792	10,068,541	89,286	597,868	565,542	(3,739,936)	**44,788,161**	49,389,153
LONG-TERM LIABILITIES													
Long-term debt, net of current portion	46,657,679	99,725,633	8,777,251	-	155,160,563	34,158,044	670,145	-	-	-	-	**189,988,752**	194,387,490
Other long-term liabilities	84,115	-	-	-	84,115	-	-	112,600	-	-	-	**196,715**	82,148
Rabbi Trust liability	1,751,168	854,823	-	-	2,605,991	-	-	-	-	-	-	**2,605,991**	3,376,863
Derivative obligation	-	14,993,077	-	-	14,993,077	-	-	-	-	-	-	**14,993,077**	10,493,117
Accrued pension obligation	-	17,600,523	-	-	17,600,523	1,054,069	-	-	-	-	-	**18,654,592**	15,864,395
Refundable fees	-	-	13,943,424	-	13,943,424	-	-	-	-	-	-	**13,943,424**	13,506,941
Deferred revenue for advance fees	-	-	906,523	-	906,523	-	48,340	46,050	-	-	-	**1,000,913**	708,830
Deferred revenue for advance rent	909,694	-	-	-	909,694	-	-	-	-	-	-	**909,694**	958,646
Estimated professional and general liability obligation	-	5,086,981	68,328	-	5,155,309	1,379,952	3,625,810	-	-	-	-	**10,161,071**	11,353,576
Total long-term liabilities	49,402,656	138,261,037	23,695,526	-	211,359,219	36,592,065	4,344,295	158,650	-	-	-	**252,454,229**	250,732,006
NET ASSETS													
Net assets without donor restrictions	49,016,865	138,939,027	7,482,299	-	195,438,191	6,490,687	49,767,180	3,232,457	1,584,472	3,574,107	(3,574,107)	**256,512,987**	258,250,189
Net assets with donor restrictions	125,000	-	1,139	-	126,139	97,915	456,272	5,264,511	-	-	-	**5,944,837**	7,464,527
Total net assets	49,141,865	138,939,027	7,483,438	-	195,564,330	6,588,602	50,223,452	8,496,968	1,584,472	3,574,107	(3,574,107)	**262,457,824**	265,714,716
Total liabilities and net assets	$ 100,850,626	$ 305,690,428	$ 32,268,128	$ (127,565)	$ 438,681,617	$ 48,629,459	$ 64,636,288	$ 8,744,904	$ 2,182,340	$ 4,139,649	$ (7,314,043)	**$ 559,700,214**	$ 565,835,875

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF OPERATIONS
Year Ended June 30, 2019 (with comparative totals for 2018)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital Corporation	Stonewall Jackson Memorial Hospital Company	Foundation of Monongalia General Hospital, Inc	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2019 Consolidated**	2018 Consolidated
REVENUE													
Net patient service revenue	$ -	$ 274,104,358	$ 5,816,868	$ -	$ 279,921,226	$ 42,222,378	$ 42,491,180	$ -	$ 2,981,413	$ 3,747,506	$ -	**$ 371,363,703**	$ 343,543,458
Rental income	3,215,103	-	-	-	3,215,103	-	-	-	-	-	(2,556,515)	**658,588**	534,085
Other revenue	6,427,679	865,823	166,905	(4,181,812)	3,278,595	1,129,159	1,971,036	-	51,053	(37,929)	(1,601,581)	**4,790,333**	3,360,392
Net assets released from restrictions used for operations	-	-	-	-	-	-	-	2,450,979	-	-	-	**2,450,979**	-
Total revenue	9,642,782	274,970,181	5,983,773	(4,181,812)	286,414,924	43,351,537	44,462,216	2,450,979	3,032,466	3,709,577	(4,158,096)	**379,263,603**	347,437,935
EXPENSES													
Wages, salaries, and benefits	6,075,354	136,062,898	3,173,651	-	145,311,903	24,924,238	27,314,281	332,419	3,108,227	1,321,371	-	**202,312,439**	201,208,960
Supplies and other	(26,571)	79,535,034	1,004,671	-	80,513,134	9,261,048	16,198,396	2,611,913	637,030	2,947,388	(4,760,203)	**107,408,706**	100,341,596
Purchased services	202,327	28,588,268	210,383	-	29,000,978	4,633,005	2,475,772	42,161	283,839	10,011	-	**36,445,766**	35,908,488
Depreciation	2,027,634	16,114,274	916,297	-	19,058,205	3,094,619	2,606,247	5,084	320,822	318,208	-	**25,403,185**	24,810,659
Management fees	-	4,121,860	59,952	(4,181,812)	-	650,175	883,073	-	30,860	37,473	(1,601,581)	**-**	-
Interest	1,783,441	4,838,613	608,691	-	7,230,745	1,267,700	66,131	-	-	(81)	-	**8,564,495**	8,521,457
Insurance	47,424	713,613	15,020	-	776,057	105,849	(25,028)	4,700	222,362	61,188	-	**1,145,128**	3,517,504
Total expenses	10,109,609	269,974,560	5,988,665	(4,181,812)	281,891,022	43,936,634	49,518,872	2,996,277	4,603,140	4,695,558	(6,361,784)	**381,279,719**	374,308,664
Operating income (loss)	(466,827)	4,995,621	(4,892)	-	4,523,902	(585,097)	(5,056,656)	(545,298)	(1,570,674)	(985,981)	2,203,688	**(2,016,116)**	(26,870,729)
NONOPERATING GAINS (LOSSES)													
Investment gains (losses)	2,939,339	5,381,090	890,634	-	9,211,063	224,468	1,956,973	295,142	2,929	(1)	-	**11,690,574**	8,296,059
Donations	-	2,282,133	(136)	-	2,281,997	124,619	21,921	186,934	2,106,077	(6,659)	(4,276,953)	**437,936**	2,415,308
Change in beneficial interest in assets held by others	-	-	-	-	-	-	-	-	-	-	-	**-**	28,089
Net gain (loss) from equity affiliates	(860,818)	399,879	-	-	(460,939)	-	-	-	-	519	-	**(460,420)**	(136,725)
Excess of unrestricted assets acquired over liabilities assumed in acquisition of Stonewall Jackson Memorial Hospital	-	-	-	-	-	-	-	-	-	-	-	**-**	59,394,634
Change in fair value of derivative obligation	-	(4,499,960)	-	-	(4,499,960)	-	-	-	-	-	-	**(4,499,960)**	3,232,244
Other gains (losses)	(2,073,265)	(51,564)	-	-	(2,124,829)	12,208	-	-	-	-	2,073,265	**(39,356)**	(6,525)
Total nonoperating gains (losses)	5,256	3,511,578	890,498	-	4,407,332	361,295	1,978,894	482,076	2,109,006	(6,141)	(2,203,688)	**7,128,774**	73,223,084
Excess (deficiency) of revenue and gains over expenses and losses	(461,571)	8,507,199	885,606	-	8,931,234	(223,802)	(3,077,762)	(63,222)	538,332	(992,122)	-	**5,112,658**	46,352,355
OTHER CHANGES IN NET ASSETS WITHOUT DONOR RESTRICTIONS													
Net asset transfers	7,215,330	(10,477,994)	-	-	(3,262,664)	-	-	3,262,664	-	-	-	**-**	-
Net asset released from restrictions used for capital expenditures	-	-	-	-	-	157,142	-	33,015	-	-	-	**190,157**	-
Change in net assets from Mon Health Care, Inc., excluding dividends	(992,122)	-	-	-	(992,122)	-	-	-	-	-	992,122	**-**	-
Other changes in net assets without donor restrictions	-	-	-	-	-	-	-	-	-	917,598	(917,598)	**-**	-
Change in minimum pension obligation	-	(7,515,454)	-	-	(7,515,454)	475,437	-	-	-	-	-	**(7,040,017)**	4,594,630
Increase (decrease) in net assets without donor restrictions	$ 5,761,637	$ (9,486,249)	$ 885,606	$ -	$ (2,839,006)	$ 408,777	$ (3,077,762)	$ 3,232,457	$ 538,332	$ (74,524)	$ 74,524	**$ (1,737,202)**	$ 50,946,985

MONONGALIA HEALTH SYSTEM, INC. AND SUBSIDIARIES

CONSOLIDATING SCHEDULE OF CHANGES IN NET ASSETS
Year Ended June 30, 2019 (with comparative totals for 2018)

	Monongalia Health System, Inc.	Monongalia County General Hospital Company	Mon Elder Services, Inc.	Eliminations	Obligated Group	Preston Memorial Hospital Corporation	Stonewall Jackson Memorial Hospital Company	Foundation of Monongalia General Hospital, Inc	Monongalia Emergency Medical Services, Inc.	Mon Health Care, Inc.	Eliminations	**2019 Consolidated**	2018 Consolidated
NET ASSETS WITHOUT DONOR RESTRICTIONS													
Excess (deficiency) of revenue and gains over expenses and losses	$ (461,571)	$ 8,507,199	$ 885,606	$ -	$ 8,931,234	$ (223,802)	$ (3,077,762)	$ (63,222)	$ 538,332	$ (992,122)	$ -	**$ 5,112,658**	$ 46,352,355
Net asset transfers	7,215,330	(10,477,994)	-	-	(3,262,664)	-	-	3,262,664	-	-	-	**-**	-
Net asset released from restrictions used for capital expenditures	-	-	-	-	-	157,142	-	33,015	-	-	-	**190,157**	-
Change in net assets from Mon Health Care, Inc., excluding dividends	(992,122)	-	-	-	(992,122)	-	-	-	-	-	992,122	**-**	-
Other changes in net assets without donor restrictions	-	-	-	-	-	-	-	-	-	917,598	(917,598)	**-**	-
Change in minimum pension obligation	-	(7,515,454)	-	-	(7,515,454)	475,437	-	-	-	-	-	**(7,040,017)**	4,594,630
Increase (decrease) in net assets without donor restrictions	5,761,637	(9,486,249)	885,606	-	(2,839,006)	408,777	(3,077,762)	3,232,457	538,332	(74,524)	74,524	**(1,737,202)**	50,946,985
NET ASSETS WITH DONOR RESTRICTIONS													
Change in beneficial interest in assets held by others	-	-	-	-	-	-	364	-	-	-	-	**364**	(1,357,157)
Net asset transfers	-	(6,731,723)	-	-	(6,731,723)	-	-	6,731,723	-	-	-	**-**	-
Change in net unrealized gains (losses) on investments	-	-	-	-	-	-	-	192,564	-	-	-	**192,564**	-
Net assets released from restrictions	-	-	-	-	-	(157,142)	-	(2,483,994)	-	-	-	**(2,641,136)**	-
Beneficial interest in assets held by others	-	-	-	-	-	-	-	-	-	-	-	**-**	455,908
Contributions	-	-	-	-	-	104,300	-	824,218	-	-	-	**928,518**	-
Increase (decrease) in net assets with donor restrictions	-	(6,731,723)	-	-	(6,731,723)	(52,842)	364	5,264,511	-	-	-	**(1,519,690)**	(901,249)
Change in net assets	5,761,637	(16,217,972)	885,606	-	(9,570,729)	355,935	(3,077,398)	8,496,968	538,332	(74,524)	74,524	**(3,256,892)**	50,045,736
Net assets:													
Beginning of year	43,380,228	155,156,999	6,597,832	-	205,135,059	6,232,667	53,300,850	-	1,046,140	3,648,631	(3,648,631)	**265,714,716**	215,668,980
End of year	$ 49,141,865	$ 138,939,027	$ 7,483,438	$ -	$ 195,564,330	$ 6,588,602	$ 50,223,452	$ 8,496,968	$ 1,584,472	$ 3,574,107	$ (3,574,107)	**$ 262,457,824**	$ 265,714,716