JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2018 and 2017

(With Independent Auditors' Report Thereon)

JOHN MUIR HEALTH AND SUBSIDIARIES

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KPMG LLP
Suite 1400
55 Second Street
San Francisco, CA 94105

Independent Auditors' Report

The Board of Directors
John Muir Health and Subsidiaries:

We have audited the accompanying consolidated financial statements of John Muir Health and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of John Muir Health and Subsidiaries as of December 31, 2018 and 2017, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in Note 1 to the financial statements, in 2018, John Muir Health and Subsidiaries adopted Financial Accounting Standards Board Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)* and ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities (Topic 958)*. Our opinion is not modified with respect to this matter.

Other Matter

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

KPMG LLP

San Francisco, California
April 19, 2019

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidated Balance Sheets

December 31, 2018 and 2017

(In thousands)

Assets		2018	2017
Current assets:			
Cash and cash equivalents	$	97,461	72,616
Accounts receivables for patient services – less allowance for uncollectible accounts of $34,489 for 2017		265,998	259,675
Other receivables		37,376	49,940
Receivable from government agency		2,527	2,342
Supply inventories		9,360	8,895
Assets limited as to use		65	125
Prepaid expenses and deposits		20,030	32,940
Total current assets		432,817	426,533
Assets limited as to use:			
Board-designated assets		1,208,486	1,287,324
Investments related to restricted net assets		25,636	26,485
Pledges receivable		13,254	9,332
Held pursuant to bond indenture agreements for capital projects		33,080	50,374
Total assets limited as to use – net of current portion		1,280,456	1,373,515
Property and equipment – net		996,900	1,027,807
Other assets:			
Real estate held for future use – at cost		5,903	5,903
Ownership interests in health-related ventures		149,582	147,117
Intangible assets and other		37,971	33,139
Total other assets		193,456	186,159
Total assets	$	2,903,629	3,014,014

(Continued)

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidated Balance Sheets

December 31, 2018 and 2017

(In thousands)

Liabilities and Net Assets		2018	2017
Current liabilities:			
Current maturities of long-term debt	$	12,798	101,490
Current maturities of financing obligation		1,090	989
Accounts payable		117,218	119,212
Other payables – medical groups		2,697	770
Payables to government agencies		4,438	3,693
Accrued liabilities:			
Payroll and payroll taxes		49,991	38,698
Vacation and other compensation		39,230	37,697
Employee medical benefit claims and workers' compensation benefits		16,545	14,795
Interest		4,807	4,364
Other		71,866	80,194
Total current liabilities		320,680	401,902
Long-term debt – less current maturities		615,610	535,209
Other long-term liabilities:			
Workers' compensation benefits		39,026	42,895
Professional and general liability		6,595	4,994
Pension benefits		30,663	31,052
Postretirement medical benefits		67,077	64,030
Financing obligation – less current maturities		38,593	39,914
Asset retirement obligations		15,991	16,176
Other		24,491	29,499
Total other long-term liabilities		222,436	228,560
Total liabilities		1,158,726	1,165,671
Net assets:			
Without donor restrictions		1,704,887	1,810,600
With donor restrictions		38,890	35,816
Total net assets – attributable to John Muir Health		1,743,777	1,846,416
Without donor restrictions – attributable to noncontrolling interest		1,126	1,927
Total net assets		1,744,903	1,848,343
Total liabilities and net assets	$	2,903,629	3,014,014

See accompanying notes to consolidated financial statements.

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Revenue, gains, and other support without donor restrictions:		
Patient service – less provision for uncollectable accounts of $41,866 for 2017	$ 1,644,106	1,523,413
Premium revenue	127,354	150,888
Other operating revenue	52,801	65,434
Net investment income – including realized gains and losses on investments	34,763	91,857
Total operating revenue	1,859,024	1,831,592
Operating expenses:		
Salaries and wages	696,843	679,058
Employee benefits	180,965	170,800
Medical fees	216,258	197,292
Supplies	194,975	184,554
Purchased services	271,000	290,206
Insurance	7,465	7,318
Utilities and rent	45,058	41,327
Depreciation and amortization	98,100	92,304
Interest – net	20,054	20,268
Other	86,267	55,114
Total operating expenses	1,816,985	1,738,241
Excess of revenue over expenses	42,039	93,351
Less excess of revenue over expenses – attributable to noncontrolling interest	1,070	1,100
Excess of revenue over expenses – attributable to John Muir Health	$ 40,969	92,251

See accompanying notes to consolidated financial statements.

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidated Changes in Net Assets

Years ended December 31, 2018 and 2017

(In thousands)

	John Muir Health			Noncontrolling interest without donor restriction	Total
	Without donor restriction	With donor restriction	Total		
Net assets – December 31, 2016	$ 1,573,850	27,523	1,601,373	1,848	1,603,221
Excess of revenue over expenses	92,251	—	92,251	1,100	93,351
Change in unamortized loss and prior service costs related to pension and postretirement benefit plans	49,922	—	49,922	—	49,922
Net change in unrealized gains and losses on investments	94,092	1,605	95,697	—	95,697
Restricted contributions and investment income	—	8,198	8,198	—	8,198
Distributions	—	—	—	(1,021)	(1,021)
Net assets released from restrictions:					
To other operating revenue for operating expenditures	—	(476)	(476)	—	(476)
For the purchase of property and equipment	505	(505)	—	—	—
Other	(20)	(529)	(549)	—	(549)
Increase in net assets	236,750	8,293	245,043	79	245,122
Net assets – December 31, 2017	1,810,600	35,816	1,846,416	1,927	1,848,343
Excess of revenue over expenses	40,969	—	40,969	1,070	42,039
Change in unamortized loss and prior service costs related to pension and postretirement benefit plans	(39,225)	—	(39,225)	—	(39,225)
Net change in unrealized gains and losses on investments	(111,796)	(1,768)	(113,564)	—	(113,564)
Restricted contributions and investment income	—	11,478	11,478	—	11,478
Distributions	(563)	—	(563)	(1,871)	(2,434)
Net assets released from restrictions:					
To other operating revenue for operating expenditures	—	(2,114)	(2,114)	—	(2,114)
For the purchase of property and equipment	4,249	(4,249)	—	—	—
Other	653	(273)	380	—	380
Increase/(Decrease) in net assets	(105,713)	3,074	(102,639)	(801)	(103,440)
Net assets – December 31, 2018	$ 1,704,887	38,890	1,743,777	1,126	1,744,903

See accompanying notes to consolidated financial statements.

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In thousands)

	2018	2017
Cash flows from operating activities:		
(Decrease) Increase in net assets	$ (103,440)	245,122
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Realized and net change in unrealized gains and losses on investments	98,085	(172,385)
Restricted contributions and investment income received	(11,478)	(8,198)
Change in unamortized net loss and prior service costs related to pension and postretirement benefit plans	39,225	(49,922)
Provision for uncollectible accounts	—	41,886
Loss on disposal of property and equipment	(2)	(315)
Loss on early retirement of debt	2,529	4,359
Depreciation and amortization	98,100	92,304
Equity in earnings of health-related ventures	(5,150)	(12,516)
Amortization of premium on bond issuances – net	(782)	(592)
Changes in assets and liabilities:		
Receivables for patient services	(6,323)	(60,385)
Other receivables and other assets	3,810	(8,186)
Supply inventories, prepaid expenses, and deposits	12,445	(11,665)
Accounts payable	12,444	8,404
Receivables from and payables to government agencies	560	(3,277)
Accrued liabilities	5,921	36,123
Pension and other liabilities	(44,074)	22,883
Net cash provided by operating activities	101,870	123,640
Cash flows from investing activities:		
Purchases of investments	(596,484)	(691,780)
Proceeds from sales of investments	595,440	673,617
Purchases of property and equipment including construction in progress	(77,490)	(86,937)
Proceeds from sales of property and equipment	106	39
Investment in health-related ventures	(20,319)	(9,481)
Distributions from health-related ventures	23,004	16,852
Net cash used in investing activities	(75,743)	(97,690)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	91,949	94,467
Repayment of long-term debt	(103,720)	(100,738)
Proceeds received from restricted contributions and restricted investment income	11,478	8,198
Payment of principal related to financing obligation	(989)	(888)
Net cash (used in) provided by financing activities	(1,282)	1,039
Net increase in cash and cash equivalents	24,845	26,989
Cash and cash equivalents – beginning of year	72,616	45,627
Cash and cash equivalents – end of year	$ 97,461	72,616
Supplemental disclosure of cash flow information – interest paid – net of capitalized interest	$ 20,279	19,629
Supplemental disclosures of noncash investing activities:		
(Decrease) Increase in accrued purchases of property and equipment	$ (11,741)	5,490
Acquisition property and equipment through capital lease	1,733	2,060

See accompanying notes to consolidated financial statements.

(1) Nature of Organization and Summary of Significant Accounting Policies

(a) Organization Description

John Muir Health and its subsidiaries (the Health System) is a healthcare delivery system in Contra Costa and Alameda Counties in California. The Health System includes John Muir Health (the Corporation), various California nonprofit public benefit corporations for which the Corporation is the sole corporate sponsor, and certain joint ventures in which the Corporation participates.

The Corporation is a California nonprofit public benefit corporation, exempt from federal and state income taxes. The Corporation includes the following activities:

John Muir Medical Center–Walnut Creek and Concord Campuses: John Muir Medical Center–Walnut Creek (JMMC–Walnut Creek) is a 554-licensed- bed general acute care facility located in Walnut Creek, California. John Muir Medical Center–Concord (JMMC–Concord) is a 245-licensed- bed general acute care facility located in Concord, California. JMMC–Walnut Creek and JMMC–Concord provide a comprehensive array of inpatient and outpatient healthcare services.

The Corporation constitutes an Obligated Group used to access capital markets. The Obligated Group is liable for the long- term debt outstanding under the Obligated Group's Master Trust Indenture.

The Corporation is the sole corporate member of several California nonprofit public benefit corporations and participates in joint ventures, all of which provide certain types of healthcare services. The following is a brief description of the Corporation's subsidiaries and other activities through which it provides healthcare services outside the Obligated Group:

John Muir Physician Network: The John Muir Physician Network (the Physician Network) is a nonprofit public benefit corporation that provides healthcare, charitable, research, and educational services to its community. The Physician Network coordinates and integrates the provision of hospital, physician, and ancillary healthcare services to enrollees of certain health maintenance organizations (HMOs). The Physician Network has entered into long- term contracts with a primary care medical group and several specialty care medical groups (the Groups) and a Physician Independent Practice Association (IPA). Costs incurred under these long- term contracts for the Groups are included in medical fees and purchased services in the consolidated statements of operations and changes in net assets. The agreement between the Physician Network and the IPA expired on December 31, 2017. As of January 1, 2018, the Physician Network directly contracted with physicians to provide certain primary care and specialty services for managed care enrollees.

The Groups' physicians provide primary care and specialty care services at clinics and urgent care centers owned by the Physician Network and provide certain hospitalist services at both JMMC–Walnut Creek and JMMC–Concord. The fee- for- service revenue of these practices is reflected as revenue of the Physician Network under the terms of the professional services agreements between the Physician Network and the Groups and is included in net patient revenue in the accompanying consolidated statements of operations and changes in net assets. The current professional services agreements between the Physician Network and the Groups continue through 2038.

Neuroscan: The Corporation is the sole corporate member of Neuroscan which provides computed tomography (CT) imaging services at a center located on the JMMC – Walnut Creek campus.

John Muir Behavioral Health: The Corporation is the sole corporate member of John Muir Behavioral Health, which is a nonprofit public benefit corporation that owns and operates a freestanding acute care psychiatric facility and residential care facility.

Other Activities: The Corporation is the sole corporate member of John Muir Health Foundation, which raises funds and otherwise supports programs and activities of the Corporation. The Corporation is also the sole corporate member of the Community Health Fund (CHF). CHF receives a minimum of $1 million annually from the Corporation that is used to make grants to local agencies to further the health of the community.

The Corporation holds, directly or indirectly, an ownership interest in a number of health- related partnerships and limited liability companies that provide outpatient surgery, imaging, and occupational health services as either a majority or minority owner. The Corporation holds a 49% ownership interest in San Ramon Regional Medical Center, which provides a comprehensive array of inpatient and outpatient healthcare services and is further disclosed in note 9. The Corporation holds ownership interest in other health- related ventures as described in note 9.

At December 31, 2018, approximately 19% of the Corporation's total labor force was covered under collective bargaining agreements. None of the collective bargaining agreements were scheduled to expire within one year.

(b) Consolidation

The accompanying consolidated financial statements include the accounts of the Health System. All significant intercompany transactions and balances have been eliminated in consolidation.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period. Key estimates include allowances for contractual discounts, implicit price concessions and bad debt, premium deficiency reserves, workers' compensation benefits and professional liabilities, pension and postretirement benefit liabilities, and estimated third-party payor settlements.

(d) Cash and Cash Equivalents

Cash and cash equivalents consist primarily of cash, time deposits, certificates of deposit, and government securities that when acquired had original or remaining maturities of three months or less. Financial instruments that potentially subject the Health System to concentrations of credit risk include cash, investments, and marketable securities. Generally, the Health System places its cash in banks that are federally insured in limited amounts. However, in the normal course of business, cash balances often exceed the Federal Deposit Insurance Corporation's insurance limit by material amounts.

(e) Receivables for Patient Services

Accounts receivable primarily comprise amounts due for healthcare services from patients and third-party payors and are recorded net of amounts for contractual adjustments, implicit price concessions and bad debts.

(f) Supply Inventories

Supply inventories are stated at the lower of cost, determined on the first- in, first- out basis, or market value.

(g) Assets Limited as to Use

The Health System's board of directors has a policy of funding depreciation, to the extent that funds are available, to be used for future replacement of property and equipment. These assets, along with assets set aside for payment of certain employee benefits, restricted donations, and restricted contribution receivable are classified as assets limited as to use. Assets designated by the board of directors remain discretionary and may subsequently be used for other purposes. Amounts required to meet current liabilities of the Health System have been recorded as current assets in the accompanying consolidated balance sheets.

(h) Investments

Investments in equity securities with readily determinable fair values and all investments in debt securities designated as available for sale are measured at fair value and classified as assets limited as to use. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in excess of revenue over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments in marketable equity and debt securities are excluded from excess of revenue over expenses but are included in changes in net assets.

The Health System periodically evaluates investments in equity and debt securities to determine whether declines in fair value below amortized cost are other- than- temporary. New information and the passage of time can change those judgments. The Health System revises impairment judgments when new information becomes known. If any of these investments experience a decline in value that is determined to be other than temporary, based on analysis of relevant factors, the Health System records a realized loss in net investment income for unrestricted assets and in the appropriate net asset category for restricted assets in the consolidated statements of operations and changes in net assets.

The Health System also invests in alternative investments through limited partnerships. Alternative investments comprise commingled funds, hedge funds, and private equity funds. The Health System receives a proportionate share of investment gains and losses of the partnerships. These alternative investment vehicles invest in domestic and foreign fixed- income and equity securities, venture capital, leveraged buyout, mezzanine debt, and distressed debt.

The Health System accounts for its ownership interests in these alternative investments under the equity method, under which the value is generally based on the net asset value (NAV) of the investments. NAV approximates fair value and is determined using investment valuation provided by

the external managers and fund managers or the general managers. Realized and unrealized gains and losses on alternative investments are included in the excess of revenue over expenses.

(i) Property and Equipment – Net

Property and equipment acquisitions are recorded at cost, if purchased, and at fair value at the date of donation, if donated. Depreciation is provided over the estimated useful life of each class of depreciable asset and is calculated using the straight- line method. The range of estimated useful lives by classification is as follows:

Land improvements	2–25 years
Buildings and building improvements	5–40 years
Equipment	3–25 years
Software	3–10 years

Property and equipment under capital leases are amortized using the straight- line method over the shorter period of the lease term or the estimated useful life of the asset.

The Health System reviews long- lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of the assets may not be recoverable. An impairment loss is recognized when the sum of the undiscounted future net cash flows expected to result from the use of the asset and its eventual disposal is less than its carrying amount. In addition to consideration of impairment due to events or changes in circumstances described above, management regularly evaluates the remaining useful lives of its long- lived assets. If estimates are revised, the carrying value of affected assets is depreciated or amortized over the remaining lives. No impairment losses have been identified as a result of these reviews for the year ended December 31, 2018 or 2017.

(j) Capitalized Interest

Interest expense incurred during construction of long- lived assets is capitalized as a component of the cost of acquiring those assets. Interest components include the following (in thousands):

		2018	2017
Total interest expense	$	21,192	21,076
Capitalized interest expense		(1,138)	(808)
Interest expense – net	$	20,054	20,268

(k) Fair Value of Financial Instruments

The carrying amounts reported in the consolidated balance sheets for cash and cash equivalents, receivables for patient services, accounts payable, accrued liabilities, amounts receivable from and payable to governmental agencies, and asset retirement obligations approximate fair value.

(l) Ownership Interest in Other Entities

When the ownership interest in other entities is more than 50% or the Health System has the ability to control the investee, the activities are consolidated. The portion of the excess of revenue over expenses attributable to a noncontrolling interest is recorded as a separate component within the consolidated statements of operations and changes in net assets. When the Health System has the ability to exercise significant influence over operating and financing policies of the investee, or when ownership interest is at least 20% but not more than 50%, it is accounted for under the equity method. The proportionate share of equity in net income of these unconsolidated affiliates is reported in other operating revenue in the consolidated statements of operations and changes in net assets. Activities, other than alternative investments, with less than 20% ownership are carried at cost.

(m) Medical Benefits

The Health System is self- insured for its employee medical benefits. An actuarially determined liability for payment of incurred and unpaid claims is included in accrued liabilities – employee medical benefit claims and workers' compensation benefits.

(n) Workers' Compensation

The Health System is designated by the State of California as a self- insured workers' compensation employer. The Health System purchases excess workers' compensation insurance, which provides coverage above the $1,500,000 self- insured retention.

The Health System records actuarially determined estimates of liabilities under the self- insured program. As of December 31, 2018 and 2017, $5,425,000 and $5,553,000, respectively, has been accrued and is classified as a component of accrued liabilities – employee medical benefit claims and workers' compensation benefits. As of December 31, 2018 and 2017, $39,026,000 and $42,895,000, respectively, has been accrued and is classified as other long- term liabilities – workers' compensation benefits.

As of December 31, 2018 and 2017, the Health System has recorded insurance recoverables of $10,239,000 and $13,256,000, respectively, which are classified as components of other assets.

(o) Professional Liability and General Liability

The Health System maintains coverage for professional liability and general liability exposures. This coverage is provided under one contract with the coverage for professional liability written on a claims- made basis and general liability written on an occurrence basis. The Health System is responsible for a maximum deductible of $25,000 and any legal liability in excess of the $45,000,000 coverage contract limits. The claims- made coverage contract requires claims to occur and be reported within the applicable retroactive and contract period dates. If the claims- made coverage contract is not renewed or replaced with equivalent coverage or insurance, claims that occur during its term and are reported after it has termed will become self- insured losses.

As of December 31, 2018 and 2017, actuarial estimates of self- insured losses of $6,595,000 and $4,994,000, respectively, for current and prior insurance policies and coverage contracts have been accrued.

As of December 31, 2018 and 2017, related to the gross professional and general liability balance noted above the Health System has recorded insurance recoverables of $2,666,000 and $953,000, respectively, which are classified as components of other assets.

(p) Net Assets with Donor Restrictions

Gifts are reported as support with donor restrictions if they are received with donor stipulations that restrict the use of the donated assets to a specific time or purpose or have been restricted by donors and are maintained by the Health System in perpetuity. When restricted funds to be used for operations are expended for their restricted purposes or by the occurrence of the passage of time, these amounts are released from restrictions for operations and are classified as revenues, gains and other support without donor restrictions. When restricted funds are expended for the acquisition of property, plant, and equipment, these amounts are recognized in net assets without donor restrictions as net assets released from restrictions – capital acquisitions

Net assets with donor restrictions are restricted for the following purposes and/or periods (in thousands):

		2018	2017
Donor-restricted endowments subject to spending policy and appropriation to support the following purposes:			
Education	$	1,956	1,859
Programs		9,258	8,814
Other		6,064	4,693
		17,278	15,366
Subject to expenditure for specified purposes:			
Capital		1,728	1,923
Community services		1,818	823
Education		1,637	1,270
Programs		9,607	10,203
Research		18	8
Other		6,804	6,223
		21,612	20,450
Total	$	38,890	35,816

(q) Contributions

Cash and other assets received from donations are reported at fair value at the date of their receipt. These donations are reported as either with donor restrictions, if they are received with donor stipulations that limit the use of the donated asset, or as without donor restrictions if the contribution has no stipulations. When a donor restriction expires, that is, when a stipulated time restriction ends or the purpose restriction is accomplished, net assets with donor restrictions are reclassified as without

donor restriction and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows as other receivables. The discounts on those amounts are computed using risk- free interest rates applicable to the years in which the payments are received. Amortization of the discounts is included as a component of net assets with donor restriction if the promises to give have donor- imposed restrictions that have not yet been met or other operating revenue for unrestricted promises to give. Conditional promises to give are not recorded until the conditions are substantially met.

(r) Income Taxes

The Health System is a nonprofit public benefit corporation and has been recognized as exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code as an organization described in Section 501(a)(1) of the Internal Revenue Code. However, the Health System is subject to income taxes on any net income that is derived from a trade or business and not in furtherance of the purposes for which it was granted exemption. No income tax provision has been recorded as the net income, if any, from any unrelated trade or business, in the opinion of management, is not material to the financial statements taken as a whole.

The Health System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured using the largest amount that exceeds a 50% probability of being realized. Changes in recognition or measurement are reflected in the period in which the change in estimated occurs.

(s) Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include excess of revenue over expenses. Changes in net assets, which are excluded from excess of revenue over expenses, consistent with industry practice, include the change in unamortized loss and prior service costs related to pension and postretirement benefit plans, change in unrealized gains and losses on investments, contributions and the investment income (loss), and contributions of long- lived assets (including assets acquired using contributions, which, by donor restriction, were to be used for the purposes of acquiring such assets). Within the consolidated financial statements, management considers the excess of revenue over expenses to be the Health System’s performance indicator.

(t) Recently Issued Accounting Standards

On January 1, 2018, the Health System adopted Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with customers (Topic 606)*, which clarifies the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of the new standard is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to receive in exchange for those goods or services. Additional disclosures have been added in note 2 to the consolidated financial statements including the disaggregation of revenue and treatment of implicit price concessions, which includes the provision for bad debts as of the date of adoption.

On January 1, 2018 the Health System adopted ASU No. 2016- 14, *Presentation of Financial Statements of Not-for-Profit Entities*, which reduces the diversity of reporting practice, reduces complexity, and enhances understandability of not-for-profit financial statements.

On January 1, 2019 the Health System adopted ASU No. 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract*, which requires implementation costs incurred by customers in a cloud computing arrangement to be deferred and recognized over the term of the arrangement if those costs could be capitalized by the customer in a software licensing arrangement under the internal-use software guidance in ASU Subtopic (350-40).

In January 2016, the FASB issued ASU No. 2016- 01, *Financial Instruments – Overall (Subtopic 825- 10)*. The standard requires entities to measure equity investments that are not accounted for under the equity method or do not result in consolidation to be recorded at fair value and recognize any changes in fair value to excess of revenue over expenses. The new standard is effective for the Health System on January 1, 2019. The standard requires the use of the cumulative-effect transition method except for equity securities without readily determinable fair values, for which the standard requires the application of the prospective transition method. Management expects to record a cumulative effect adjustment upon adoption of approximately $96,000,000 as of January 1, 2019.

In February 2016, the FASB issued ASU No. 2016- 02, *Leases (Topic 842)*, aimed at making leasing activities more transparent and comparable. The new standard requires substantially all leases, including operating leases, be recognized by lessees on their balance sheet as a right- of- use asset and corresponding lease liability. ASU No. 2016- 02 is effective for the Health System on January 1, 2019. Management is evaluating the effect that the standard will have on its consolidated financial statements and related disclosures. At the date of adoption, the Health System will record an incremental right-of-use asset and corresponding liability ranging from approximately $65,000,000 to $75,000,000.

In March 2017, the FASB issues ASU No. 2017- 07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The amendments in this update require that an employer disaggregate the service cost component from the other components of net benefit cost and provide explicit guidance on how to present the service cost component and the other components of net benefit cost in the income statement. The new standard is required to be adopted by January 1, 2019. The standard requires the use of the retrospective transition method. The impact of adoption results in the nonservice cost components of pension and postretirement benefit costs, previously classified as an operating expense, being reported as other income and expense. Management is currently evaluating the impact this update will have on its consolidated financial statements.

In June 2018, FASB issued ASU No. 2018-08, *Not-for-Profit Entities (Topic 958), Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. This standard should assist entities in evaluating whether transactions should be accounted for as contributions (nonreciprocal transactions) or as exchange (reciprocal) transactions, which is subject to other accounting guidance and determining whether a contribution is conditional. The provisions of this ASU are effective for the Health System for the year beginning January 1, 2019. Management is currently evaluating the impact this update will have on its consolidated financial statements.

(2) Revenue Recognition

Revenue from contracts with customers is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by the Health System and are recognized either over time or at a point in time. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred through a point in time in relation to total actual charges incurred. The Health System believes that this method provides useful depiction of the provision of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligation satisfied over time relate to patients in the hospitals or clinics receiving inpatient or outpatient services. The Health System measures an inpatient performance obligation from time of admission to time of discharge and an outpatient performance obligation from the start of the outpatient service to the completions of the outpatient service. Revenue for the performance obligation satisfied at a point in time are recognized when goods or services are provided to patients and customers and it is not required to provided additional goods or services.

The Health System has elected to apply the optional exemption in ASC 606-10-50-14a as all of the Health System's performance obligations relate to contracts with a duration of less than one year. Under the exemption, the Health System was not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. Any unsatisfied or partially unsatisfied performance obligations at the end of the year are completed in less than a year.

Upon the adoption of ASU 2014-09, net patient services revenue is reported at the amount that reflects the consideration to which the Health System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of ongoing future audits, reviews and investigations.

The Health System uses a portfolio approach to account for categories of patient contracts as collective groups rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient and outpatient revenue. The financial statement effects of using this approach are not materially different from an individual contract approach.

The Health System determines the transaction price based on the total standard charges for goods and services provided by various elements of variable consideration, including contractual adjustments, discounts provided to uninsured patients in accordance with the Health System policy, and implicit price concessions provided to uninsured patients. The Health System determines its estimate of contractual adjustments and discounts based on contractual agreements, discount policies and historical experience. For uninsured and under-insured patients, the Health System determines the transaction price associated with services rendered on the basis of charges reduced by historical collection experience for applicable portfolios.

Contractual agreements with third-party payors provide for payments at amounts less than the Health System's established charges. A summary of the payment arrangements with major third-party payors is as follows:

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, which provides for reimbursement based on

Medicare Severity Diagnosis-Related Groups (MS-DRGs). These rates vary according to a patient classification system that is based on clinical diagnosis, acuity, and expected use of hospital resources. The majority of Medicare outpatient services are reimbursed under prospective payment methodology, the Ambulatory Payment Classification System (APCs), or fee schedule

- Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a prospective payment system similar to Medicare, however, Medicaid utilizes All Payor Refined Diagnosis-Related Groups (APR-DRGs) as opposed to Medicare's MS-DRGs. The majority of Medicaid outpatient services are reimbursed under a prospective payment methodology, the Enhanced Ambulatory Patient Groups (EAPG), or fee schedule.
- Other – the Health System has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Health System under these agreements include prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates and fee schedules.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretations. As a result of investigations by government agencies, various healthcare organizations have received request for information and notices regarding alleged noncompliance with those laws and regulations that, in some instances, have resulted in organizations entering into significant settlement agreements with the government. Compliance with such laws and regulations may also be subject to future government exclusion from related programs. There can be no assurance that regulatory or government 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, that such claims or penalties would have upon the Health System. In addition, the contracts with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the current 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 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, or as years are settled and no longer subject to such audits, reviews and investigations. The estimated amounts due to or from Medicare and Medicaid programs are reviewed and adjusted periodically based on all relevant information as it becomes available. Differences between final settlements and amounts accrued in previous years are reported as adjustments to the current year's net revenue. Adjustments arising from a change in transaction price were $908,000 and ($1,045,000) for 2018 and 2017 respectively.

Generally, patients who are covered by third-party payors are responsible for related deductibles and co-insurance, which vary in amount. The Health System also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Health Systems estimates the transaction price for patients with deductibles and co-insurance from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charges by any contractual adjustments,

discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Additional revenue due to changes in estimates of implicit price concessions, discounts and contractual adjustments for prior years were not significant for 2018 or 2017. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay and deemed uncollectable are recorded as bad debt expense.

Consistent with the Health Systems' mission, care is provided to patients regardless of their ability to pay. The Health System has determined that it has provided implicit price concessions to uninsured patients and patients with other uninsured balances. The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amount the Health System expects to receive based on its collection history with those patients. Patients who meet the criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity are not reported as revenue.

Accounts Receivable for Patient Services:

Accounts receivable comprises the following components (in thousands):

		December 31	
		2018	**2017**
Patient receivables	$	233,786	294,164
Contract assets		32,212	—
Allowance for uncollectable accounts		—	(34,489)
Total	$	265,998	259,675

Contract assets are related to in-house patients who were provided services during the reporting period but were not discharged as of the reporting date and for which the Health System does not have the right to bill.

Net Patient Services Revenue Disaggregated by Payor:

Net patient service revenue disaggregated by payor is presented based on an allocation of the estimated transaction price between the primary patient classifications of insurance coverage (in thousands):

		2018	**2017**
Medicare (including managed Medicare)	$	495,493	424,160
MediCal (included managed MediCal)		125,157	116,938
Commerical and managed care		967,656	920,666
Self-pay and other fee for service		55,800	61,649
Total	$	1,644,106	1,523,413

(Continued)

Net Patient Services Revenue Disaggregated by Lines of Service:

Net patient service revenue disaggregated by line of service is presented based on the transaction price between lines of service (in thousands).

		2018	2017
Inpatient services	$	992,350	880,564
Outpatient services, including emergency services		467,961	472,883
Physician Services		131,952	118,273
All Other		51,843	51,693
Total	$	1,644,106	1,523,413

Premium Revenue

The Health System recognizes revenue based on the estimated transaction price they expect to collect as a result of satisfying their performance obligations. Premium revenue consists primarily of capitation amounts received to provide medical services under contracts with various HMOs. Capitation revenue under HMO contracts is prepaid monthly based on the number of enrollees assigned to the Health System, regardless of the level of actual medical services utilized. Capitation revenue is reported as revenue in the month in which enrollees are entitled to receive services. In 2018, two HMOs accounted for 44% and 16% of premium revenue. In 2017, two HMOs accounted for 37% and 18% of premium revenue.

Premium Deficiency Reserves

Premium deficiency reserves are recognized when it is probable that expected healthcare and maintenance costs under a contract will exceed the anticipated future premiums and reinsurance recoveries over the contract period. At December 31, 2018 and 2017, premium deficiency reserves of $39,098,000 and $26,719,000 are recorded in other current liabilities, respectively. Given the inherent variability of such estimates, the ultimate deficiencies could differ significantly from the estimated amounts.

Charity Care and Community Service

The Health System provides a variety of uncompensated healthcare services to the communities it serves. Collection of amounts determined to qualify as charity care is not pursued. The Health System estimates the transaction price, which is represented by the difference between amounts billed to patients and the amount the Health System expects to receive based on its historical collections with these patients. Patients who meet the criteria of the Health System's charity care policy are eligible to receive these services without charge or at an amount less than the Health System's established rates. Amounts determined to qualify as charity care are not reported as revenue. In 2018 and 2017, the estimated cost of these services was $5,595,000 and $5,838,000, respectively, calculated using the cost- to- charge method.

(Continued)

(3) Concentration of Credit Risk

The Health System grants credit without collateral to its patients, most of whom are local residents and are covered by third- party payor agreements. The mix of net accounts receivables from patients and third- party payors as of December 31, 2018 and 2017 is as follows:

	2018	2017
Contracted rate payors	67%	65%
Medicare	24	26
Commercial insurance, self-pay, and other payors	5	5
Medi-Cal	4	4
Total	100%	100%

(4) Assets Limited as to Use

The composition of assets limited as to use as of December 31, 2018 and 2017 is as follows (in thousands):

		2018	2017
Cash and cash equivalents	$	54,198	72,927
Equity securities		300,245	343,694
Mutual funds		594,499	620,620
Commingled funds		101,164	116,531
Hedge funds		95,076	101,641
Private equity		120,906	107,902
Pledges receivable		13,254	9,332
Interest receivable		1,179	993
Total		1,280,521	1,373,640
Current portion necessary to meet current obligations		(65)	(125)
Total	$	1,280,456	1,373,515

(Continued)

Net investment income for the years ended December 31, 2018 and 2017 comprises the following (in thousands):

	2018	2017
Interest income	$ 1,832	351
Dividends	22,482	19,226
Net realized gains on sales of securities and other-than-temporary impairment	32,605	57,078
Changes in fair value of alternative investments	(17,125)	19,610
Total	39,794	96,265
Less management fees	(5,031)	(4,408)
Net investment income	$ 34,763	91,857

The Health System held a total of 402 securities as of December 31, 2018. 168 of these investments were in a continuous loss position at December 31, 2018 for less than one year. These had a fair market value of $136,140,939 and an unrealized loss position of $29,902,408 as of December 31, 2018. The Health System held one investments in a continuous loss position for more than one year with a fair market value of $83,500,991 and unrealized loss position of $1,953,166 as of December 31, 2018. The fair value of these investments declined due to various reasons, including changes in interest rates, changes in economic conditions, and changes in market outlook. The Health System recognized an other- than- temporary impairment loss of $31,855,574 in net investment income as of December 31, 2018 related to these 169 securities, which the Health System continues to hold. The Health System held six mutual funds in a loss position at December 31, 2018 with unrealized losses of $17,601,000. These funds were not in a continuous loss position for more than a year therefore no impairment losses were recorded. The Health System has the intent and ability to hold these mutual funds and securities in a continuous loss position until their values recover and believes the remaining unrealized losses to be temporary.

The Health System held a total of 385 securities as of December 31, 2017. 40 of these investments were in a continuous loss position at December 31, 2017 for less than one year. They had a fair market value of $24,842,107 and an unrealized loss position of $2,513,049 as of December 31, 2017. The Health System held two investments in a continuous loss position for more than one year with a fair market value of $88,531,515 and unrealized loss position of $1,325,569 as of December 31, 2017. The fair value of these investments declined due to various reasons, including changes in interest rates, changes in economic conditions, and changes in market outlook. The Health System recognized an other- than- temporary impairment loss of $3,838,618 in net investment income as of December 31, 2017 related to these 42 securities, which the Health System continues to hold. The Health System did not have any mutual funds in a loss position as of December 31, 2017 that was not impaired.

(Continued)

(5) Fair Value of Financial Assets

Assets recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Investments measured and reported at fair value are classified in one of the following categories:

Level 1 – Observable inputs, such as quoted prices, in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; these include quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, or inputs other than quoted prices that are observable for the asset or liability

Level 3 – Pricing inputs are generally unobservable for the asset or liability; these inputs reflect the reporting entity's own assumptions about the assumptions that market participants would use in pricing the asset or liability.

In certain instances, fair value is estimated using quoted market prices obtained from external pricing services. In obtaining such data from the pricing services, the Health System has evaluated the methodologies used to develop the estimates of fair value in order to assess whether such valuations are representative of fair value. For alternative investments, such as commingled funds, hedge funds, and private equity, the Heath System's equity method accounting is based primarily on the NAV as reported by the investment manager.

The following is a description of the valuation methodologies and inputs used to measure fair value for major categories of investments.

(a) Equity Securities

Equities (including common and preferred shares, domestic and foreign listed, and mutual funds) are generally valued at the closing price reported on the major market on which the individual securities are traded at the measurement date. As all equity securities held by the Health System are publicly traded in active markets, the securities are classified within Level 1 of the fair value hierarchy.

(b) Commingled Funds

Commingled funds are accounted for under the equity method. The fair value of the majority of these funds have been estimated using NAV, while the fair values of certain funds are based on readily determinable fair value.

These funds invest primarily in U.S. companies experiencing significant corporate change. This class is redeemable monthly with a notice period of 10 days. There are no unfunded commitments as of December 31, 2018 or 2017.

(c) Hedge and Private Equity Funds

The valuation of limited partnership interests in hedge and private equity funds may require significant management judgment. The NAV reported by the asset manager is adjusted when management determines that NAV is not representative of fair value. In making such an assessment, a variety of factors are considered, including, but not limited to, the timeliness of the NAV, as reported by the asset

manager, and changes in general economic and market conditions subsequent to the last NAV reported by the asset manager. The fair value of these hedge funds and private equity funds has been estimated using NAV.

The Health System invests in hedge funds that pursue diversification of both domestic and foreign fixed- income and equity securities through multiple investment strategies. The primary objective for these funds is to maximize returns while limiting volatility by allocating capital to external portfolio managers for expertise in one or more investment strategies, which may include, but are not limited to, long/short equity, credit driven, event driven, relative value, and global asset allocation. There are no unfunded commitments as of December 31, 2018 or 2017. These investments are redeemable in 30 to 90 days, with a 30 to 90 days' notice.

The Health System invests in private equity funds that specialize in providing capital to a variety of investment groups, including but not limited to venture capital, leveraged buyout, mezzanine debt, and distressed debt. There is no provision for redemptions during the life of these funds. Unfunded commitments for private equity funds totaled approximately $76,480,000 and $77,607,000 as of December 31, 2018 and 2017, respectively.

The following tables summarize fair value measurement by level at December 31, 2018 and 2017 for financial assets measured at fair value on a recurring basis and certain assets accounted for under the equity method (in thousands):

	Fair values as of December 31, 2018 (in thousands)			
	Alternative Investment Valued at NAV	**Quoted prices in active markets for identical assets Level 1**	**Significant other observable inputs Level 2**	**Total**
Assets:				
Cash and cash equivalents	$ —	151,659	—	151,659
Equity securities:				
Information technology	—	62,565	—	62,565
Healthcare	—	37,708	—	37,708
Financial	—	57,826	—	57,826
Consumer	—	92,194	—	92,194
Energy	—	7,167	—	7,167
Materials	—	7,572	—	7,572
Industrials	—	28,585	—	28,585
Real Estate	—	4,241	—	4,241
Telecommunications and utilities	—	2,387	—	— 2,387
Subtotal – equity securities	—	300,245	—	300,245

(Continued)

	Fair values as of December 31, 2018 (in thousands)			
	Alternative Investment Valued at NAV	Quoted prices in active markets for identical assets Level 1	Significant other observable inputs Level 2	Total
Mutual funds	$ —	594,499	—	594,499
Commingled funds	75,621	—	25,543	101,164
Hedge funds	95,076	—	—	95,076
Private equity	120,906	—	—	120,906
Total	$ 291,603	1,046,403	25,543	1,363,549

	Fair values as of December 31, 2017 (in thousands)			
	Alternative Investment Valued at NAV	Quoted prices in active markets for identical assets Level 1	Significant other observable inputs Level 2	Total
Assets:				
Cash and cash equivalents	$ —	145,543	—	145,543
Equity securities:				
Information technology	—	58,053	—	58,053
Healthcare	—	35,750	—	35,750
Financial	—	63,944	—	63,944
Consumer	—	152,617	—	152,617
Energy	—	3,228	—	3,228
Materials	—	9,549	—	9,549
Industrials	—	16,295	—	16,295
Telecommunications and utilities	—	4,258	—	4,258
Subtotal – equity securities	—	343,694	—	343,694
Mutual funds	—	620,620	—	620,620
Commingled funds	89,588	—	26,943	116,531
Hedge funds	101,641	—	—	101,641
Private equity	107,902	—	—	107,902
Total	$ 299,131	1,109,857	26,943	1,435,931

During the year ended December 31, 2018 and 2017, there were no significant transfers between assets with quoted prices in active markets for identical assets (Level 1) or assets with observable inputs other than quoted prices in active markets (Level 2).

(6) Liquidity and Availability of Financial Assets

The Health System monitors the availability of resources required to meet its operating obligations and other contractual commitments, while also striving to maximize investment returns of its available funds. To help meet its general obligations, the Health System can also access the credit market as a means of producing liquidity, if needed. For purposes of analyzing resources available to meet general expenditures over a twelve-month period, the Health System considers all expenditures related to its ongoing activities to provide integrated healthcare delivery as well as the conduct of services undertaken to support these activities to be general expenditures.

At December 31, 2018, the Health System's financial resources are as follows (in thousands):

		2018
Cash and cash equivalents	$	97,461
Accounts receivable, net		265,998
Other current assets, net		69,358
Pledge receivable		13,254
Investments		1,208,486
Total financial assets:		1,654,557
Less: Amounts not available to be used within a year:		
Prepaid assets and bonds funds held in in trust included in other curent assets, net		(20,030)
Asset limited as to use		(65)
Pledge receivable with donor restrictions		(12,998)
Investments with redemption limitations of greater than one year		(122,501)
Total financial assets available to meet general expenditures within one year	$	1,498,963

In addition to financial assets available to meet general expenditures over the next twelve months, the Health system operates mostly using revenues, gains and other support without donor restrictions and anticipates collecting sufficient revenues to cover general expenditures. The Health System also has a $50,000,000 line of credit that can be accessed to cover general expenditures.

(Continued)

(7) Property and Equipment – Net

Property and equipment as of December 31, 2018 and 2017 consist of the following amounts (in thousands):

		2018	2017
Land	$	46,561	46,561
Land improvements		77,272	75,483
Buildings and building improvements		1,022,851	962,907
Equipment		779,878	734,395
Total		1,926,562	1,819,346
Accumulated depreciation		(958,086)	(860,680)
Subtotal		968,476	958,666
Construction in progress		28,424	69,141
Property and equipment – net	$	996,900	1,027,807

Depreciation and amortization expense of $98,100,000 and $91,830,000 for the years ended December 31, 2018 and 2017, respectively, is recorded in the accompanying consolidated statements of operations and changes in net assets.

(8) Other Assets

Other assets are as follows at December 31, 2018 and 2017 (in thousands):

		2018	2017
Real estate held for future use	$	5,903	5,903
Physician loans		604	753
Cloud computing		11,001	—
Other assets		26,366	32,386
Other assets	$	43,874	39,042

(9) Ownership Interests in Health- Related Ventures

The Corporation has four ownership interests, as further described below, that are accounted for under the equity method and are classified in the accompanying consolidated balance sheets as ownership interests in health- related ventures:

- The Corporation and Tenet Healthcare Corporation (Tenet) participate in a joint venture to operate San Ramon Regional Medical Center (SRRMC), whereby the Corporation holds a 49% interest in SRRMC.

(Continued)

The following table summarizes the financial position and results of operations for SRRMC for the years ended December 31, 2018 and 2017 (in thousands):

	SRRMC	
	2018	2017
Total assets	$ 164,537	201,773
Total liabilities	22,244	21,651
Total members' equity	141,843	154,367
Total revenue, net	196,300	197,895
Excess of revenue over expenses	33,114	36,925
Investment at December 31 recorded in ownership interests in health-related ventures	127,021	133,631
Earnings recorded in other operating revenue	16,226	15,968

- The Corporation and Tenet participate in a joint venture to develop and expand physician and outpatient services in the Tri- Valley area and nearby communities in Northern California (the Network Joint Venture). The Corporation's ownership interest in the Network Joint Venture is 49%.
- The Corporation and the University of California, on behalf of its San Francisco Campus (UCSF Medical Center), entered into a Limited Liability Company Agreement to work collaboratively to expand and integrate healthcare services in support of a Bay Area wide delivery network for health plans and employers (Bay Health). The Corporation and UCSF Medical Center equally participate in the ownership and operation of Bay Health with individual membership interests of 50%. In 2019, the Health System agreed to additional contribution of $9.5 million.
- The Corporation, UCSF Medical Center, and other Bay Area healthcare providers have invested in a collaborative effort to form a regional healthcare network known as Canopy Health (Canopy). Establishing a Bay Area wide network provides patients from throughout the Bay Area and Northern California with a competitively priced option to access many of the most trusted and respected hospitals, health systems, and physician organizations. The Corporation has committed to fund $15,000,000 for capital projects and operations relating to Canopy. As of December 31, 2018, the Corporation's commitment to Canopy has been fully funded. In 2019, the Health System agreed to additional contribution of $2.8 million in return for additional 606,912 common shares of Canopy.
- The Corporation, Dignity/USP NorCal Surgery Centers, L.L.C., and Dignity/USP/John Muir East Bay Surgery Centers, LLC participate in a joint venture to operate Hacienda Outpatient Surgery Center, LLC. The Corporation invested $3,902,529 in February 2017 for a 24.95% interest in Dignity/USP/John Muir East Bay Surgery Centers, LLC.

For the remaining health- related ventures discussed above, the Corporation's aggregate investment balances recorded in ownership interests in health- related ventures as of December 31, 2018 and 2017 are $22,561,000 and $13,486,000, respectively, and aggregate losses recorded in other operating revenue for the years ended December 31, 2018 and 2017 are $11,076,000 and $3,452,000, respectively.

(10) Long- Term Debt

Long- term debt as of December 31, 2018 and 2017 is summarized below (in thousands):

	2018	2017
Series 2018 A California Statewide Communities Development Authority Revenue Bonds, including unamortized premium of $5,357, with interest ranging from 4% to 5%	$ 92,025	—
Series 2017 A and B California Statewide Communities Development Authority Revenue Bonds, with variable interest rates calculated daily based on LIBOR	—	90,703
Series 2016A, 2016B, and 2016C California Statewide Communities Development Authority Bonds, including unamortized premium of $23,222, payable from 2016 through 2051, Series 2016A with fixed interest ranging from 3.000% to 5.000%, Series 2016B with variable rates ranging from 0.899% to 1.013%, Series 2016C with variable rates ranging from 0.889% to 1.003%	350,824	351,713
Series 2013 Term Loan payable in amounts through 2023 with a fixed interest rate of 2.90%	109,204	112,205
Series 2012A and 2012B tax-exempt California Statewide Communities Development Authority fixed-rate bonds in private placement with JP Morgan Chase payable through 2022 and from 2026 through 2036, respectively, with fixed interest rates of 2.01% and 2.02%, respectively	66,550	70,425
Series 2009A California Statewide Communities Development Authority Revenue Bonds payable through 2039, with fixed interest rates ranging from 3.000% to 5.125%	2,615	4,151
Other	11,415	12,608
Bond issuance costs	(4,225)	(5,106)
Total	628,408	636,699
Current maturities	(12,798)	(101,490)
Total	$ 615,610	535,209

The bonds may be redeemable (some requiring a redemption premium) prior to the stated maturities.

During 2018, the Health System redeemed the outstanding Series 2017A and B with proceeds from the 2018 A and B Bonds, resulting in a loss on early redemption of $2,529,000.

(Continued)

Scheduled principal repayments, including sinking fund requirements, on long- term debt are as follows (in thousands):

2019	$	12,798
2020		9,809
2021		9,260
2022		8,625
2023		97,531
Thereafter		466,388
Total principal payable		604,411
Less:		
Unamortized debt issuance cost		(4,225)
Original issue discount		(357)
Plus original issue premium		28,579
Total long-term debt	$	628,408

The bonds are secured by the operating revenue of the Obligated Group's members under the Master Trust Indenture of the Obligated Group. The Master Trust Indenture of the Obligated Group includes, among other things limitations on additional indebtedness, liens on property, restrictions on the disposition or transfer of assets, and the maintenance of certain cash balances, historical debt service coverage ratio, and other financial ratios. Management believes that the Health System is in compliance with the financial covenants contained in the Master Trust Indenture as of December 31, 2018.

The Health System maintains a $50,000,000 line of credit with a bank that expires on August 24, 2019. There were no borrowings under the line of credit in 2018 or 2017.

(11) Retirement Plans

Certain employees of the Health System are covered by a noncontributory defined-benefit pension plan. This plan covers substantially all eligible employees except those whose retirement benefits are provided under union-sponsored plans.

Benefits are based on years of service and the employee's compensation. Contributions to the plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to plan participants.

In addition to providing retirement benefits, the Health System provides healthcare benefits for certain retired employees. Eligible employees who have 10 years of service and retire at age 55 or older qualify for these benefits. Contributions to the plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to plan participants.

(Continued)

The following table summarizes plan activities for the years ended December 31, 2018 and 2017 and the funded status recognized as a noncurrent liability in the consolidated balance sheets (in thousands):

	2018		2017	
	Pension benefits	Post retirement benefits	Pension benefits	Post retirement benefits
Change in benefit obligation:				
Benefit obligation – beginning of year	$ 552,202	64,030	525,686	57,798
Service cost	36,809	2,996	37,314	2,584
Interest cost	19,378	2,233	21,198	2,298
Amendments	690	—	(7,048)	—
Actuarial loss (gain)	(22,836)	2,053	5,677	4,496
Special contribution term benefits	—	—	872	439
Benefits and administrative expense paid	(44,681)	(4,235)	(31,497)	(3,585)
Benefit obligation – end of year	541,562	67,077	552,202	64,030
Change in plan assets:				
Fair value of plan assets – beginning of year	521,150	—	462,409	—
Actual return on plan assets	(28,570)		75,938	—
Employer contribution	63,000	4,235	14,300	3,585
Benefits and administrative expense paid	(44,681)	(4,235)	(31,497)	(3,585)
Fair value of plan assets – end of year	510,899	—	521,150	—
Funded status	$ (30,663)	(67,077)	(31,052)	(64,030)

The accumulated benefit obligation for the defined-benefit pension plan was $516,468,000 and $526,515,000 as of December 31, 2018 and 2017, respectively.

(Continued)

The following tables present the net loss and prior service costs recognized in net assets without donor restriction for the Health System's defined-benefit pension plan and postretirement benefit plan (in thousands):

	December 31, 2018	
	Pension benefits	**Post retirement benefits**
Net loss	$ 120,778	13,746
Prior service cost/(credit)	(2,633)	—

	December 31, 2017	
	Pension benefits	**Post retirement benefits**
Net loss	$ 84,177	12,061
Prior service cost/(credit)	(3,606)	34

The following table presents the estimated net loss and estimated prior service costs of the Health System's significant retirement-related benefit plans that will be amortized from net assets without donor restrictions into net periodic costs and recorded in the consolidated statements of operations and changes in net assets in 2019 (in thousands):

	Pension benefits	**Post retirement benefits**
Net loss	$ 5,477	448
Prior service cost/(credit)	(226)	—

(Continued)

Weighted average assumptions used to determine net periodic benefit costs and benefit obligations as of and for the years ended December 31, 2018 and 2017 are as follows:

	2018		2017	
	Pension benefits	**Post retirement benefits**	**Pension benefits**	**Post retirement benefits**
Weighted average assumptions used to determine net periodic benefit costs for the year ended December 31:				
Discount rate	3.65%	3.60%	4.15%	4.10%
Expected return of plan assets	6.25	—	6.50	—
Rate of compensation increase	3.50	—	3.50	—
Weighted average assumptions used to determine benefit obligations as of December 31:				
Discount rate	4.30%	4.30%	3.65%	3.60%
Rate of compensation increase	3.50	—	3.50	—

Postretirement medical benefits are measured assuming a 6.5% annual rate of increase in the per capita cost of covered healthcare benefits for the years ended December 31, 2018 and 2017. The rate is assumed to decrease each year to 4.75% until 2025 and remain at that level thereafter.

(Continued)

The amounts recognized in the net periodic benefit costs included the following (in thousands):

	2018		2017	
	Pension benefits	**Postretirement benefits**	**Pension benefits**	**Postretirement benefits**
Components of net periodic benefit costs:				
Service cost	$ 36,809	2,996	37,314	2,584
Interest cost	19,378	2,233	21,198	2,298
Expected return on plan assets	(33,138)	—	(30,067)	—
Amortization of prior service cost/(credit)	(283)	34	587	252
Recognized net actuarial loss	2,271	367	6,210	125
Net periodic benefit cost	25,037	5,630	35,242	5,259
Special termination benefits	—	—	872	439
Total benefit cost	$ 25,037	5,630	36,114	5,698

One factor in determining pension expense is the assumption for the expected long- term rate of return on plan assets. Various factors are considered in the development of this assumption, including past market performance, the relationship between fixed-maturity securities and equity securities, interest rates, and the asset allocation.

For postretirement medical benefits, at December 31, 2018, the impact of a +1% and –1% change in assumed healthcare cost trend rates on the total service and interest cost components is $553,072 and $(455,788), respectively.

Plan assets for the defined-benefit pension plan are allocated across a diversified mix of fixed-maturity securities, alternative investments, and equity securities in various sectors and levels of capitalization to

(Continued)

maximize the long- term return for a prudent level of risk. As of the measurement date, the targeted and actual asset allocation by asset category is as follows:

	Target allocation	Actual allocation	
		2018	2017
Domestic equities	31%	32%	41%
International equities	23	18	21
Fixed-maturity securities	27	27	22
Other	19	23	16
Total	100%	100%	100%

The long- term rate of return is the product of the expected returns of the various assets classes at the target allocation noted above. The expected returns of the asset classes are based on historical experience with a margin for future expectations.

(Continued)

The fair values of the Health System's pension plan assets at December 31, 2018 and 2017 by asset class are as follows (see note 4 for description of level classifications) (in thousands):

	2018			
	Alternative Investment valued at NAV	**Quoted prices in active markets for identical assets Level 1**	**Significant other observable inputs Level 2**	**Total**
Cash and cash equivalents	$ —	35,754	—	35,754
Equity securities:				
Information technology	—	20,980	—	20,980
Healthcare	—	13,143	—	13,143
Financial	—	17,554	—	17,554
Consumer	—	31,379	—	31,379
Energy	—	2,579	—	2,579
Materials	—	10,130	—	10,130
Industrials	—	14,510	—	14,510
Real Estate	—	3,144	—	3,144
Telecommunications and utilities	—	1,862	—	1,862
Subtotal – equity securities	—	115,281	—	115,281
Mutual funds	—	251,910	—	251,910
Commingled funds	14,106	—	14,317	28,423
Hedge funds	44,928	—	—	44,928
Private equity	34,603	—	—	34,603
Total	$ 93,637	402,945	14,317	510,899

(Continued)

	2017			
	Alternative Investment valued at NAV	Quoted prices in active markets for identical assets Level 1	Significant other observable inputs Level 2	Total
Cash and cash equivalents	$ —	12,815	—	12,815
Equity securities:				
Information technology	—	21,856	—	21,856
Healthcare	—	11,834	—	11,834
Financial	—	19,623	—	19,623
Consumer	—	57,095	—	57,095
Energy	—	655	—	655
Materials	—	6,166	—	6,166
Industrials	—	9,631	—	9,631
Telecommunications and utilities	—	728	—	728
Subtotal – equity securities	—	127,588	—	127,588
Mutual funds	—	273,547	—	273,547
Commingled funds	14,106	—	15,102	29,208
Hedge funds	52,672	—	—	52,672
Private equity	25,320	—	—	25,320
Total	$ 92,098	413,950	15,102	521,150

The strategy is to fund an amount at least equal to the minimum required funding as required by the Employee Retirement Income Security Act of 1974, with consideration of factors, such as the minimum pensions liability requirement. Discretionary contributions may also be made. For the years ended December 31, 2018 and 2017, contributions totaling $63,000,000 and $14,300,000, respectively, were made to the pension plan. For the years ended December 31, 2018 and 2017, contributions totaling $4,235,000 and $3,585,000, respectively, were made to the postretirement benefits plan.

The estimated future payments for pension benefits and postretirement benefits are as follows (in thousands):

		Pension benefits	Postretirement benefits
2019	$	35,293	4,451
2020		38,035	4,363
2021		41,033	4,371
2022		43,794	4,327
2023		45,914	4,402
2024–2028		253,318	23,881
Total	$	457,387	45,795

The Health System also makes contributions to the union pension plans of two employee groups at JMMC – Concord, which are defined benefit pension multiemployer plans. The Health System's participation in these plans for the year ended December 31, 2018 is outlined in the table below. The most recent Pension Protection Act zone status is based on information that the Health System received from the plan and is certified by each plan's actuary. Among other factors, plans in the red zone are generally less than 65% funded, and plans in the green zone are at least 80% funded. The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The last column lists the expiration dates of the collective bargaining agreements to which the plans are subject. There have been no significant changes that affect the comparability of 2018 or 2017 contributions and the Health System has not provided more than 5% of the total contributions for these plans:

Pension fund	EIN/ pension plan number	Pension protection act zone status As of January 1 2018	Pension protection act zone status As of January 1 2017	FIP/RP status pending/ implemented	Contributions (in thousands) 2019 (expected)	Contributions (in thousands) 2018	Contributions (in thousands) 2017	Surcharge imposed (during 2018)	Collective bargaining agreement expiration date
S.E.I.U. National Industry	52-6148540/001	Red	Red	Implemented	Not Available	$ 2,394	2,359	Yes	4/15/2020
IUOE Stationary Engineers Local 39	94-6118939/001	Green	Green	No	Not Available	379	343	No	10/31/2020

The risk of participating in a multiemployer plan is different from single-employer plans in the following aspects: (a) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers; (b) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers; and (c) if the Health System chooses to stop participating in the multiemployer plan, the Health System may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

(Continued)

A tax deferred annuity plan and defined-contribution retirement plan are also offered to certain employees. Employer contributions to these plans included in employee benefits expense during 2018 and 2017 were approximately $10,935,000 and $10,409,000, respectively.

(12) Endowment Funds

The Health System's endowments consist of 12 individual funds established for a variety of purposes. They include both endowment funds with donor restrictions and funds designated without donor restrictions by the board of directors of its foundations to function as endowments. Net assets associated with endowment funds, are classified and reported on the existence or absence of donor-imposed restrictions and nature of restrictions, if any.

The following tables present the Health Systems endowment net asset composition as well as associated changes (in thousands):

		With donor restrictions
Endowment net assets, beginning of year	$	15,366
Investment income		861
Unrealized gains and losses		(1,768)
Total investment return		14,459
Contributions		3,198
Appropriations of endowment assets for expenditure		(698)
Other		319
Endowment net assets, end of year	$	17,278

(13) Financing Obligation

The Health System leases space in an office building, which is used for medical and administrative offices. The Health System arranged for significant construction activities to prepare the building for its intended use. Based on relevant accounting guidance, the Health System is considered the accounting owner of the office building. Because this transaction does not qualify for sale- leaseback accounting, it is treated as a financing transaction. Accordingly, a financing obligation of $39,683,000 and $40,903,000 is recorded as of December 31, 2018 and 2017, respectively. The financing obligation associated with this transaction will not result in cash payments in excess of amounts paid under the related lease payments.

Future payments related to this financing obligation are as follows (in thousands):

2019	$	2,501
2020		2,565
2021		2,629
2022		2,696
2023		2,764
Thereafter		18,013
Total payments	$	31,168

(14) Lease Commitments

The Health System leases certain office space and equipment under noncancelable operating leases expiring at various dates through 2038. In addition, the Health System subleases certain office space to subtenants under noncancelable operating leases expiring at various dates through 2022. Total rent expense, net of sublease income was approximately $20,921,000 and $18,796,000 for the years ended December 31, 2018 and 2017, respectively.

Net future minimum lease payments under operating leases as of December 31, 2018 are as follows (in thousands):

		Operating leases	Operating subleasing income	Net operating lease payments
2019	$	19,744	3,700	16,044
2020		18,633	3,370	15,263
2021		15,656	2,877	12,779
2022		13,593	2,481	11,112
2023		10,964	2,118	8,846
Thereafter		35,605	4,752	30,853
Total	$	114,195	19,298	94,897

(Continued)

(15) Natural Classification of Expenses

Expenses related to providing general healthcare services to residents within the Health System's geographic location. Expenses based on actual cost by service line are as follows (in thousands):

	2018					
	Acute	Ambulatory	Medical Services	Fundraising	General and Admin	Total
Salaries and Wages	$ 234,071	369,586	53,087	2,343	37,756	696,843
Employee Benefits	59,652	94,187	16,741	677	9,708	180,965
Medical Fees	25,279	39,914	150,338	17	710	216,258
Supplies	67,989	107,351	15,494	51	4,090	194,975
Purchased Services	51,276	80,962	103,637	1,476	33,649	271,000
Insurance	2,062	3,255	—	—	1,779	7,096
Utilities and Rent	11,607	18,327	15,784	191	470	46,379
Depreciation	30,478	48,123	12,197	—	7,302	98,100
Interest	6,889	10,879	1,267	—	1,019	20,054
Other	29,186	46,082	31	252	9,764	85,315
Total	$ 518,489	818,666	368,576	5,007	106,247	1,816,985

	2017
Healthcare services and programs	$ 1,581,129
General and administrative	151,594
Fund-raising	5,518
Total	$ 1,738,241

(16) Contingencies

(a) Litigation

The Health System is a defendant in various actions arising from its healthcare service and related activities. Management assesses the probable outcome of unresolved litigation and records contingent liabilities reflecting estimated liability exposure. In the opinion of management, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the financial position of the Health System. The outcome of litigation and other legal matters is inherently uncertain; however, it is possible that one or more of the legal matters currently pending or threatened could have a material adverse effect.

(Continued)

(b) Laws and Regulations

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, and government healthcare program participation requirements, payments for patient services, and Medicare and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Health System is in material compliance with fraud and abuse and other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

(17) Provider Fee Program

The State of California has enacted legislation for a quality assurance fee program for hospitals to obtain federal matching funds for Medi- Cal patients. The proceeds of the program and the federal matching funds are to be redistributed to hospitals that treat Medi- Cal patients and to fund certain Medi- Cal coverage expansion.

In conjunction with the Hospital Fee Program, the California Hospital Association created a private program, the California Health Foundation and Trust (CHFT), to pool and redistribute funds from hospitals subject to the Hospital Fee Program.

Existing programs cover the periods 2014–2016 and 2017–2019. Rates for these programs are only partially approved by the Centers for Medicare and Medicaid Services (CMS) as of December 31, 2018. The Health System has fully recognized revenue and expenses for the 2014-2016 program period and has recognized revenue and expenses for approved portions of the 2017-2019 program period as follows (in thousands):

	Fiscal year ended December 31		
	2016	2017	2018
Net patient service revenue	$ 44,698	12,546	54,721
Quality assurance fees	44,698	32,182	57,432
Net revenue less expenses	$ —	(19,636)	(2,711)

(18) Subsequent Events

The Health System has evaluated subsequent events from the consolidated balance sheet date through April 19, 2019, which is the date that the consolidated financial statements were issued, and concluded there were no other events or transactions during this period, other than those described in these notes, that required recognition or disclosure in these consolidated financial statements.

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidating Schedule – Balance Sheet Information

December 31, 2018

(In thousands)

Assets	Obligated Group	John Muir Physician Network	John Muir Behavioral Health	Community Health Fund	John Muir Health Foundation	Other Health-Related Ventures	Eliminations	Consolidated
Current assets:								
Cash and cash equivalents	$ 49,123	8,434	—	169	8,459	31,276	—	97,461
Receivables for patient services	242,274	9,543	7,827	—	—	6,968	(614)	265,998
Other receivables	49,454	9,997	13	544	—	78	(22,710)	37,376
Receivables from government agency	2,527	—	—	—	—	—	—	2,527
Supply inventories	8,377	—	85	—	—	898	—	9,360
Assets limited as to use	65	—	—	—	—	—	—	65
Prepaid expenses and deposits	19,189	316	172	—	—	353	—	20,030
Total current assets	371,009	28,290	8,097	713	8,459	39,573	(23,324)	432,817
Assets limited as to use:								
Board-designated assets	1,207,220	—	—	—	1,266	—	—	1,208,486
Investments related to restricted net assets	801	—	—	—	24,835	—	—	25,636
Pledges receivable	—	—	—	—	13,254	—	—	13,254
Held pursuant to bond indenture agreements for capital projects	33,080	—	—	—	—	—	—	33,080
Total assets limited as to use – net of current portion	1,241,101	—	—	—	39,355	—	—	1,280,456
Property and equipment – net	874,939	100,295	12,648	—	—	9,018	—	996,900
Other assets:								
Real estate held for future use – at cost	5,903	—	—	—	—	—	—	5,903
Ownership interests in health-related ventures	149,582	—	—	—	—	—	—	149,582
Intangible assets and other	44,156	3,062	65	—	230	2,918	(12,460)	37,971
Total other assets	199,641	3,062	65	—	230	2,918	(12,460)	193,456
Total assets	$ 2,686,690	131,647	20,810	713	48,044	51,509	(35,784)	2,903,629

See accompanying independent auditors' report.

(Continued)

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidating Schedule – Balance Sheet Information

December 31, 2018

(In thousands)

Liabilities and Net Assets	Obligated Group	John Muir Physician Network	John Muir Behavioral Health	Community Health Fund	John Muir Health Foundation	Other Health-Related Ventures	Eliminations	Consolidated
Current liabilities:								
Current maturities of long-term debt	$ 11,531	—	—	—	—	1,267	—	12,798
Current maturities of financing obligation	—	1,090	—	—	—	—	—	1,090
Accounts payable	103,226	4,622	2,398	—	6,510	797	(335)	117,218
Other payables – Medical groups	—	2,697	—	—	—	—	—	2,697
Payables to government agencies	4,392	—	46	—	—	—	—	4,438
Accrued liabilities:								
Payroll and payroll taxes	44,086	3,395	1,175	—	109	1,226	—	49,991
Vacation and other compensation	36,265	2,183	782	—	—	—	—	39,230
Employee medical benefit claims and workers' compensation benefits	15,282	940	323	—	—	—	—	16,545
Interest	4,807	—	—	—	—	—	—	4,807
Other	60,833	4,772	369	—	—	28,881	(22,989)	71,866
Total current liabilities	280,422	19,699	5,093	—	6,619	32,171	(23,324)	320,680
Long-term debt – less current maturities	609,748	—	—	—	—	5,862	—	615,610
Other long-term liabilities:								
Workers' compensation benefits	39,026	—	—	—	—	—	—	39,026
Professional and general liability	6,595	—	—	—	—	—	—	6,595
Pension benefits	30,663	—	—	—	—	—	—	30,663
Postretirement medical benefits	67,077	—	—	—	—	—	—	67,077
Financing obligation – less current maturities	—	38,593	—	—	—	—	—	38,593
Asset retirement obligations	15,991	—	—	—	—	—	—	15,991
Other	18,696	2,521	1,007	—	—	2,267	—	24,491
Total other long-term liabilities	178,048	41,114	1,007	—	—	2,267	—	222,436
Total liabilities	1,068,218	60,813	6,100	—	6,619	40,300	(23,324)	1,158,726
Net assets:								
Without donor restriction	1,617,670	70,834	14,710	713	3,337	11,209	(13,586)	1,704,887
With donor restriction	802	—	—	—	38,088	—	—	38,890
Total net assets – attributable to Health System	1,618,472	70,834	14,710	713	41,425	11,209	(13,586)	1,743,777
Without donor restrictions – attributable to noncontrolling interest	—	—	—	—	—	—	1,126	1,126
Total net assets	1,618,472	70,834	14,710	713	41,425	11,209	(12,460)	1,744,903
Total liabilities and net assets	$ 2,686,690	131,647	20,810	713	48,044	51,509	(35,784)	2,903,629

See accompanying independent auditors' report.

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidating Schedule – Statement of Operations

Year ended December 31, 2018

(In thousands)

	Obligated Group	John Muir Physician Network	John Muir Behavioral Health	Community Health Fund	John Muir Health Foundation	Other Health-Related Ventures	Eliminations	Consolidated
Operating revenue:								
Net patient service revenue	$ 1,430,943	131,952	36,126	—	—	56,003	(10,918)	1,644,106
Premium revenue	31,656	95,698	—	—	—	—	—	127,354
Other operating revenue	30,030	93,936	324	1,652	7,108	464	(80,713)	52,801
Net investment income – including realized gains and losses on investment	34,763	—	—	—	—	—	—	34,763
Total operating revenue	1,527,392	321,586	36,450	1,652	7,108	56,467	(91,631)	1,859,024
Operating expenses:								
Salaries and wages	612,000	53,087	20,447	222	2,343	8,744	—	696,843
Employee benefits	158,528	16,742	5,092	69	677	1,441	(1,584)	180,965
Medical fees	87,432	149,498	1,669	—	17	315	(22,673)	216,258
Supplies	171,338	15,494	996	7	51	7,089	—	194,975
Purchased services	227,027	71,643	3,384	1,064	1,469	19,479	(53,066)	271,000
Insurance	6,828	369	—	—	—	268	—	7,465
Utilities and rent	27,352	14,975	1,999	7	199	4,183	(3,657)	45,058
Depreciation and amortization	83,092	12,197	786	—	—	2,025	—	98,100
Interest – net	18,544	1,267	—	—	—	243	—	20,054
Health System assessment	(39,024)	32,352	6,672	—	—	—	—	—
Other	90,614	952	286	217	251	4,598	(10,651)	86,267
Total operating expenses	1,443,731	368,576	41,331	1,586	5,007	48,385	(91,631)	1,816,985
Excess (deficit) of revenue over expenses	83,661	(46,990)	(4,881)	66	2,101	8,082	—	42,039
Less excess of revenue over expenses – attributable to noncontrolling interest	—	—	—	—	—	—	1,070	1,070
Excess (deficit) of revenue over expense – attributable to Health System	$ 83,661	(46,990)	(4,881)	66	2,101	8,082	(1,070)	40,969

See accompanying independent auditors' report.

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidating Schedule – Changes in Net Assets Information

Year ended December 31, 2018

(In thousands)

	Obligated Group		John Muir Physician Network - without donor restriction	John Muir Behavioral Health - without donor restriction	Community Health Fund - without donor restriction	John Muir Health Foundation	
	Without donor restriction	With donor restriction				Without donor restriction	With donor restriction
Excess (deficit) of revenue over expenses	$ 83,661	—	(46,990)	(4,881)	66	2,101	—
Change in unamortized loss and prior service costs related to pension and postretirement benefit plans	(39,225)	—	—	—	—	—	—
Net change in unrealized gains and losses on investments	(111,796)	—	—	—	—	—	(1,768)
Restricted contributions and investment income	—	347	—	—	—	—	11,129
Capital transactions among affiliates	(49,304)	—	40,042	9,479	—	(217)	—
Distributions	5,973	—	—	—	—	—	—
Net assets released from restrictions:							
To other operating revenue for operating expenditures	—	—	—	—	—	—	(1,675)
For the purchase of property, plant, and equipment	6,128	—	—	—	—	(1,879)	(4,249)
Other	753	(439)	—	—	1	(101)	(271)
(Decrease) Increase in net assets	(103,810)	(92)	(6,948)	4,598	67	(96)	3,166
Net assets – December 31, 2017	1,721,480	894	77,782	10,112	646	3,433	34,922
Net assets – December 31, 2018	$ 1,617,670	802	70,834	14,710	713	3,337	38,088

See accompanying independent auditors' report.

(Continued)

JOHN MUIR HEALTH AND SUBSIDIARIES

Consolidating Schedule – Changes in Net Assets Information

Year ended December 31, 2018

(In thousands)

	Other Health-related ventures without donor restriction	Health system Eliminations	Noncontrolling interest without donor restriction	Consolidated			
				Health system		Noncontrolling interest without donor restriction	Total
				Without donor restriction	With donor restriction		
Excess (deficit) of revenue over expenses	$ 8,082	(1,070)	1,510	40,969	—	1,070	42,039
Change in unamortized loss and prior service costs related to pension and postretirement benefit plans	—	—	—	(39,225)	—	—	(39,225)
Net change in unrealized gains and losses on investments	—	—	—	(111,796)	(1,768)	—	(113,564)
Restricted contributions and investment income	—	—	—	—	11,478		11,478
Distributions	(9,724)	3,188	(2,311)	(563)	—	(1,871)	(2,434)
Net assets released from restrictions:							
To other operating revenue for operating expenditures	—	—	—	—	(2,114)	—	(2,114)
For the purchase of property, plant, and equipment	—	—	—	4,249	(4,249)	—	—
Other	—	—	—	653	(273)	—	380
(Decrease) Increase in net assets	(1,642)	2,118	(801)	(105,713)	3,074	(801)	(103,440)
Net assets – December 31, 2017	12,851	(15,704)	1,927	1,810,600	35,816	1,927	1,848,343
Net assets – December 31, 2018	$ 11,209	(13,586)	1,126	1,704,887	38,890	1,126	1,744,903

See accompanying independent auditors' report.