



**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Consolidated Financial Statements
as of and for the Years Ended June 30, 2012 and 2011 and
Schedule of Expenditures of Federal Awards
for the Year Ended June 30, 2012 and
Independent Auditors' Report in Connection with
OMB Circular A-133 for the Year Ended June 30, 2012

WEST PENN ALLEGHENY HEALTH SYSTEM, INC. AND SUBSIDIARIES

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Independent Auditors' Report

The Board of Directors
West Penn Allegheny Health System, Inc.:

We have audited the accompanying consolidated balance sheets of West Penn Allegheny Health System, Inc. and Subsidiaries (WPAHS) as of June 30, 2012 and 2011, and the related consolidated statements of operations, changes in net deficit, and cash flows for the years then ended. These consolidated financial statements are the responsibility of WPAHS' management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of WPAHS' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of West Penn Allegheny Health System and Subsidiaries as of June 30, 2012 and 2011, and the results of their operations, their changes in net deficit and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

As discussed in note 3(r) to the consolidated financial statements, WPAHS adopted the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries* effective July 1, 2011 and retrospectively applied the provisions to June 30, 2011.

In accordance with *Government Auditing Standards*, we have also issued our report dated July 15, 2013 on our consideration of WPAHS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and is not a required part of the 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 financial statements. The information has been subjected



to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditure of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

July 15, 2013

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Consolidated Balance Sheets

June 30, 2012 and 2011

(Amounts in thousands)

Assets	2012	2011
Current assets:		
Cash and cash equivalents	\$ 193,816	164,595
Short-term investments	5,108	5,075
Assets limited or restricted as to use	5,744	5,464
Receivables:		
Patient accounts – net of allowance for uncollectible accounts of \$44,116 and \$30,592 in 2012 and 2011, respectively	141,964	132,154
Other	25,094	32,845
Estimated third-party payor settlements	—	13,563
Inventories	21,289	22,554
Prepaid expenses	15,193	19,619
Total current assets	408,208	395,869
Assets limited or restricted as to use	395,487	425,554
Property and equipment, net	406,936	369,218
Other assets, net	75,296	80,008
Total assets	\$ 1,285,927	1,270,649

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
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Consolidated Balance Sheets

June 30, 2012 and 2011

(Amounts in thousands)

Liabilities and Net Deficit	2012	2011
Current liabilities:		
Current portion of long-term debt	\$ 15,866	14,742
Accounts payable	94,317	106,879
Accrued expenses	17,445	15,855
Accrued interest	6,699	4,954
Accrued salaries and vacation	55,843	63,309
Current portion of deferred revenue	59,941	10,699
Current portion of self-insurance liabilities	2,954	2,610
Estimated third-party payor settlements	1,163	—
Other current liabilities	12,197	11,855
	266,425	230,903
Total current liabilities		
Deferred revenue	42,560	42,772
Self-insurance liabilities	77,744	83,229
Long-term debt	878,836	792,492
Accrued pension obligation	278,663	196,256
Other noncurrent liabilities	23,168	24,090
	1,567,396	1,369,742
Total liabilities		
Net (deficit) assets:		
Unrestricted	(527,751)	(356,631)
Temporarily restricted	23,210	23,425
Permanently restricted	223,072	234,113
	(281,469)	(99,093)
Total net deficit		
Total liabilities and net deficit	\$ 1,285,927	1,270,649

See accompanying notes to consolidated financial statements.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Consolidated Statements of Operations

Years ended June 30, 2012 and 2011

(Amounts in thousands)

	2012	2011
Unrestricted revenues and other support:		
Net patient service revenue	\$ 1,479,569	1,503,824
Other revenue	80,980	87,359
Net assets released from restrictions	3,652	4,900
Total unrestricted revenues and other support	1,564,201	1,596,083
Expenses:		
Salaries, wages, and fringe benefits	866,488	848,956
Patient care supplies	279,937	275,392
Professional fees and purchased services	164,437	158,043
General and administrative	172,515	171,162
Provision for bad debts	80,805	69,092
Depreciation and amortization	65,740	60,507
Interest	40,335	37,941
Restructuring	8,841	26,782
Total expenses	1,679,098	1,647,875
Operating loss	(114,897)	(51,792)
Investment income	14,242	17,884
Gifts and donations	14,045	50,652
Gain from divestiture	—	9,606
Gain (loss) in joint venture investment	1,863	(5,908)
(Deficiency) excess of revenues over expenses	(84,747)	20,442
Net assets released for property acquisitions and donated capital	781	2,400
Pension changes other than periodic benefit cost	(86,954)	55,707
Other transfers	(200)	(183)
(Decrease) increase in unrestricted net assets	\$ (171,120)	78,366

See accompanying notes to consolidated financial statements.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Consolidated Statements of Changes in Net Deficit

Years ended June 30, 2012 and 2011

(Amounts in thousands)

	2012	2011
Unrestricted net deficit:		
(Deficiency) excess of revenues over expenses	\$ (84,747)	20,442
Net assets released for property acquisitions and donated capital	781	2,400
Pension changes other than periodic benefit cost	(86,954)	55,707
Other transfers	(200)	(183)
	<u>(171,120)</u>	<u>78,366</u>
(Increase) decrease in unrestricted net deficit		
Temporarily restricted net assets:		
Contributions	3,081	3,562
Investment income	882	1,168
Net assets released from restrictions used for:		
Operations	(3,652)	(4,900)
Acquisition of equipment	(781)	(2,400)
Change in net unrealized gains on other than trading securities	—	803
Other transfers	255	(407)
	<u>(215)</u>	<u>(2,174)</u>
Decrease in temporarily restricted net assets		
Permanently restricted net assets:		
Contributions	4	447
Investment income	7,205	8,632
Change in net unrealized (losses) gains other than trading securities	(8,574)	27,475
Transfers out of endowments/participating trust to investment income and operations	(9,695)	(9,911)
Other transfers	19	369
	<u>(11,041)</u>	<u>27,012</u>
(Decrease) increase in permanently restricted net assets		
(Increase) decrease in net deficit	(182,376)	103,204
Net deficit – beginning of year	<u>(99,093)</u>	<u>(202,297)</u>
Net deficit – end of year	<u>\$ (281,469)</u>	<u>(99,093)</u>

See accompanying notes to consolidated financial statements.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Consolidated Statements of Cash Flows

Years ended June 30, 2012 and 2011

(Amounts in thousands)

	2012	2011
Cash flows from operating activities:		
(Increase) decrease in net deficit	\$ (182,376)	103,204
Adjustments to reconcile (increase) decrease in net deficit to net cash (used in) provided by operating activities:		
Depreciation and amortization	65,740	60,507
Unrealized losses (gains) on unrestricted investments	1,286	(4,519)
Gain from divestiture	—	(9,606)
Noncash premium amortization	(299)	(304)
Change in pension liability	86,954	(55,707)
Noncash pension expense	27,492	29,850
Provision for bad debts	80,805	69,092
Unrealized losses (gains) on restricted investments	8,574	(28,278)
Realized gains on investments	(7,359)	(6,913)
Restricted contributions	(3,085)	(4,009)
Increase (decrease) in cash from changes in:		
Receivables	(82,864)	(48,043)
Prepaid expenses	4,426	(5,301)
Inventories	1,265	1,747
Accounts payable and accrued expenses	(31,253)	17,819
Estimated third-party payor settlements	14,726	(6,366)
Deferred revenue	49,030	2,981
Self-insurance liabilities	(5,141)	1,723
Pension contributions	(32,039)	(75,710)
Other assets	3,877	2,832
Other liabilities	(580)	(248)
Net cash (used in) provided by operating activities	(821)	44,751
Cash flows from investing activities:		
Acquisition of property and equipment	(88,063)	(101,050)
Proceeds from divestiture	—	10,245
Purchase of assets limited or restricted as to use and short-term investments	(449,149)	(657,230)
Sales of assets limited or restricted as to use and short-term investments	476,402	700,539
Net cash used in investing activities	(60,810)	(47,496)
Cash flows from financing activities:		
Repayments of long-term debt	(15,370)	(12,980)
Proceeds from issuance of long-term debt	103,137	7,643
Proceeds from restricted contributions	3,085	4,009
Net cash provided by (used in) financing activities	90,852	(1,328)
Net increase (decrease) in cash and cash equivalents	29,221	(4,073)
Cash and cash equivalents – beginning of year	164,595	168,668
Cash and cash equivalents – end of year	\$ 193,816	164,595
Supplemental disclosures:		
Cash paid for interest – net of amounts capitalized of \$2,984 and \$3,440 for 2012 and 2011, respectively	\$ 38,560	34,572
Property additions in accounts payable and other liabilities	25,037	10,477

See accompanying notes to consolidated financial statements.

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Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Amounts in thousands)

(1) Organization

West Penn Allegheny Health System, Inc. and Subsidiaries (WPAHS or the System) is a Pennsylvania nonprofit charitable corporation that provides routine and tertiary healthcare services.

WPAHS operates Allegheny General Hospital (AGH), The Western Pennsylvania Hospital (WPH) and Forbes Regional Hospital (FRH). In addition, the System consists of the following entities, with WPAHS as the sole member of these entities:

Alle-Kiski Medical Center (AKMC) and its wholly owned subsidiary, Alle-Kiski Medical Center Trust (AKMC Trust)	West Penn Allegheny Oncology Network (WPAON)
Canonsburg General Hospital (CGH) and its wholly owned subsidiary, Canonsburg General Hospital Ambulance Service (CGH Ambulance)	Allegheny Singer Research Institute (ASRI)
West Penn Allegheny Foundation, LLC (WPAF)	Suburban Health Foundation (SHF)
The Western Pennsylvania Hospital Foundation (WPHF)	West Penn Corporate Medical Services, Inc. (WPCMSI)
Forbes Health Foundation (FHF) Allegheny Medical Practice Network (AMPN) Allegheny Specialty Practice Network (ASPN)	Friendship Insurance Company, Ltd.* (FIC)
West Penn Physician Practice Network (WPPPN)	* since dissolved

Each member of the Obligated Group (the Obligated Group) is jointly and severally liable for the satisfaction of the outstanding bond debt of WPAHS (note 11). All members of the System with the exception of FIC, AKMC Trust, and WPAF are members of the Obligated Group.

(2) Significant Developments and Other Considerations

WPAHS has seen continued operating losses throughout the last several fiscal years, including through the first three quarters of its fiscal year 2013. In addition to these recurring losses, WPAHS has experienced a significant decline in volumes within a challenging service area that includes significant competition and declining demographics. Based on these experiences, management has developed and the board of directors approved a strategy to expand and adjust operations, a key component of which was to affiliate with Highmark Health Services (formerly known as Highmark Inc.).

On June 28, 2011, WPAHS announced its intention, via the signing of a term sheet, to pursue an affiliation with Highmark Health Services. On October 31, 2011, WPAHS, Highmark Health Services and various other parties executed an Affiliation Agreement pursuant to which Highmark Health Services and WPAHS agreed to establish a new integrated health system to improve quality and access to care in the Western

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June 30, 2012 and 2011

(Amounts in thousands)

Pennsylvania region under the common control of a new nonprofit parent company, Highmark (formerly known as Ultimate Parent Entity (UPE)), subject to satisfaction of stated closing conditions (the Transaction). Upon the closing of the Transaction on April 29, 2013, Highmark became the parent company of Highmark Health Services and Allegheny Health Network (formerly known as UPE Provider Sub) and Allegheny Health Network became the sole member of WPAHS. Highmark has certain reserved powers in WPAHS and seventy-five percent of the board of directors of WPAHS is appointed by Highmark; the remaining twenty-five percent is self-perpetuating.

In accordance with the terms of the Affiliation Agreement, through June 30, 2012, Highmark Health Services has provided \$200,000 in the form of loans and unrestricted payments to WPAHS. Included in this total is an initial \$50,000 unrestricted payment, which was made upon the signing of the Term Sheet and is included in gifts and donations as of June 30, 2011 on the accompanying consolidated statement of operations. When the Affiliation Agreement was signed on October 31, 2011 an additional \$100,000, comprised of a \$50,000 unrestricted payment (which is included as deferred revenue as of June 30, 2012 on the accompanying consolidated balance sheet) and a \$50,000 note payable (see note 11), was provided by Highmark Health Services. On April 27, 2012, a loan of \$50,000 (see note 11) was made to WPAHS by Highmark Health Services. On April 29, 2013, an additional loan of \$100,000 was made to WPAHS and an additional \$75,000, less advances of \$19,158 and certain accounts payable of \$16,240, was paid to WPAHS in the form of an unconditional, unrestricted grant. All loans from Highmark Health Services are secured by security interests in and mortgages of real and personal property of WPAHS and certain of its affiliates. An additional \$100,000 in the form of loans is expected to be made on April 30, 2014. Under the terms of the Affiliation Agreement, WPAHS will remain the primary obligor for repayment of its obligations.

On April 29, 2013, Highmark Health Services acquired \$604,170 of the outstanding 2007A Bonds in a cash tender offer. At the same time, the master indenture and related bond indenture for the 2007A Bonds were amended to, among other changes, eliminate debt service coverage ratio, days cash on hand and certain other covenants of WPAHS, defer interest and principal payments on certain maturities of the tendered bonds, and to permanently waive prior defaults. Additionally, the Highmark Health Services note payable loan agreements (see note 11) were amended to, among other changes, forgive interest on the related notes if certain conditions are met. Highmark may, at its discretion, implement additional deferrals on the repayment options for WPAHS, including the pursuit of alternative financing arrangements. The Board of Directors of Highmark has authorized WPAHS to enter into agreements that would refinance the 2007A bonds that Highmark Health Services currently holds. WPAHS has received commitments from several financial institutions to consummate this refinancing plan. WPAHS anticipates that closing on the financing agreements will occur in the first quarter of fiscal year 2014, subject to receipt of approval by the Pennsylvania Insurance Department. These actions should provide WPAHS the financial flexibility required to permit management to implement additional turnaround initiatives, which may include consolidating lines of service among Highmark's provider operations, increasing patient volumes through continued recruitment of primary care and specialty physicians, designing new insurance products with Highmark Health Services, and implementing certain revenue cycle improvement plans, among other initiatives. Management believes that these initiatives coupled with the financial flexibility provided by the

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June 30, 2012 and 2011

(Amounts in thousands)

Affiliation will continue to improve the operating results of WPAHS, although there can be no assurance that this will occur.

Subsequent to the signing of the Affiliation Agreement there was turnover in WPAHS senior management. Beginning November 7, 2011, WPAHS' daily operations were managed by interim executives from a turnaround firm, including its interim chief executive officer, interim chief operating officer and interim chief financial officer positions. The interim management team was in place through April 29, 2013, the date of the Closing of the Affiliation. Since April 29, 2013, WPAHS has been under new management and Allegheny Health Network is providing management and administrative support to WPAHS. These executives are continuing to execute the turnaround initiatives discussed above.

(3) Summary of Significant Accounting Policies

The significant accounting policies applied in preparing the accompanying consolidated financial statements are summarized below:

(a) Basis of Accounting

WPAHS maintains its accounts on the accrual basis of accounting.

(b) Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the entities identified in note 1. Joint venture investments, investments in limited partnerships, and investments with an ownership interest greater than 20% where control is not demonstrated are accounted for using the equity method.

All significant intercompany balances and transactions have been eliminated in consolidation.

(c) Use of Estimates in the Preparation of Consolidated Financial Statements

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Investment securities and pension obligations are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities and interest rates, it is at least reasonably possible that these changes in risks in the near term could materially affect the amounts reported in the accompanying consolidated balance sheets, statements of operations, and statements of changes in net assets.

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(Amounts in thousands)

(d) *Net Patient Service Revenue*

WPAHS has agreements with third-party payors that provide for payments to WPAHS at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services as they are rendered and includes estimated retroactive revenue adjustments due to future retrospective audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations. A summary of the payment arrangements with major third-party payors is as follows:

Medicare – Inpatient acute care services and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. WPAHS is reimbursed for services rendered at a tentative rate with a final settlement determined after submission of annual cost reports by WPAHS and audits thereof by the Medicare fiscal intermediary. As of June 30, 2012, WPAHS' entities' Medicare cost reports have been audited by the Medicare fiscal intermediary through the year ended June 30, 2007 for all hospitals. Through the subsequent events period, WPAHS' entities' Medicare cost reports were audited by the Medicare fiscal intermediary through the year ended June 30, 2009 for all hospitals.

Medical Assistance – Inpatient care and outpatient services rendered to Medical Assistance eligible patients are paid at prospectively determined rates.

Blue Cross – Inpatient and outpatient services rendered to Blue Cross subscribers are reimbursed at prospectively determined rates.

WPAHS has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to WPAHS under these agreements includes prospectively determined rates and discounts from established charges.

During the years ended June 30, 2012 and 2011, net patient service revenue increased \$4,313 and \$1,917, respectively, due to prior year retroactive adjustments in excess of amounts previously estimated.

Revenue from the Medicare and Medical Assistance programs accounted for approximately 42% and 8%, respectively, of WPAHS' net patient service revenue for the year ended June 30, 2012, and 39% and 8%, respectively, for the year ended June 30, 2011. Laws and regulations governing the Medicare and Medical Assistance programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

On July 9, 2010, the Pennsylvania General Assembly passed the Medicaid Modernization and Hospital Fair Payment Act (Act 49), and as a result, healthcare providers in Pennsylvania are subject to a statewide hospital assessment (known as the Quality Care Assessment) dependent upon the

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(Amounts in thousands)

conditions and requirements specified in Act 49 during the three-year period July 1, 2010 through June 30, 2013. Act 49 has the following goals: provide savings to the Commonwealth of Pennsylvania and to provide fairness and accuracy in payments to hospitals for inpatient services by funding the All Patient Refined-Diagnostic Related Groups (APR-DRG) prospective payment system.

Revenues generated from the assessment under Act 49 requires the Department of Public Welfare (DPW) to use a new prospective payment system (APR-DRG) to pay hospitals in the Medical Assistance fee-for-service program for inpatient services provided on or after July 1, 2010. In addition, it requires DPW to make supplemental payments to hospitals, such as inpatient disproportionate share and medical and health professional education hospitals, in accordance with the state plan approved by the federal government.

The net patient services revenue impact of Act 49 on WPAHS in fiscal year 2012 was \$29,242, while the expense impact of the assessment on WPAHS in fiscal year 2012 was \$23,588. The net patient services revenue impact of Act 49 on WPAHS in fiscal year 2011 was \$30,827, while the expense impact of the assessment on WPAHS in fiscal year 2011 was \$21,610. These amounts are included in patient service revenue and general administrative expenses, respectively.

WPAHS grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net receivables from patients and third-party payors at June 30, 2012 and 2011 is as follows:

	2012	2011
Medicare	31%	36%
Medical assistance	14	11
Blue Cross	19	21
Other third-party payors	34	30
Patients	2	2
	100%	100%

WPAHS was a party to a settlement agreement dated April 5, 2012 with the United States Department of Health and Human Services (HHS), the Secretary of HHS and the Centers for Medicare & Medicaid Services (CMS). WPAHS, along with a group of other Medicare providers, challenged HHS's calculation of the rural floor budget neutrality adjustment for the Medicare Program's inpatient prospective payment system pursuant to the Balanced Budget Act of 1997. Under the settlement agreement, WPAHS received \$9,170 during the year ended June 30, 2012 and recognized this amount as net patient services revenue in the accompanying consolidated statements of operations. Related professional fees of \$917 are included in professional fees and purchased services in the accompanying consolidated statements of operations.

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(e) *Excess (Deficiency) of Revenues over Expenses*

The consolidated statements of operations and changes in net assets include an excess (deficiency) of revenues over expenses as a performance indicator. Changes in unrestricted net deficit, which are excluded from deficiency of revenues over expenses for the year ended June 30, 2012 and an excess of revenues over expenses at June 30, 2011, consistent with industry practice, include changes in permanent transfers of assets to and from affiliates for other than goods and services, pension liability adjustments not reflected in pension expense, 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).

(f) *Cash and Cash Equivalents*

Cash and cash equivalents include highly liquid investments purchased with original maturities of three months or less. Cash equivalents are stated at cost, which approximates fair value.

(g) *Inventories*

Inventories, consisting of drugs and medical supplies, are stated at the lower of cost (first-in, first-out) or market value.

(h) *Investments and Assets Limited or Restricted as to Use*

Investments classified as assets limited or restricted as to use in the accompanying consolidated balance sheets primarily include assets held by trustees under indenture agreements, temporarily and permanently restricted assets, and designated assets set aside by the board of directors for future capital improvements, over which the board retains control and may use for other purposes at its discretion. Amounts required to meet current liabilities have been included in current assets in the accompanying consolidated balance sheets at June 30, 2012 and 2011. Short-term investments include certificates of deposit with original maturities of greater than three months that will come due in one year or less.

Investment income or loss (including realized gains and losses on investments, interest and dividends, and unrealized gains and losses on investments) is included in the excess (deficiency) of revenues over expenses unless this income or loss is restricted by donor or law. Investment income (including realized gains and losses on investments and unrealized gains and losses on temporarily and permanently restricted gifts) is recorded based on donor restriction as part of the corresponding net asset class within the consolidated statements of changes in net assets.

Debt and equity securities are recorded at fair value. Beneficial interests in perpetual trusts are recorded at the fair value of the underlying assets in the trust. The present value of the estimated future cash receipts from the trusts approximates the fair value.

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(Amounts in thousands)

(i) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors for a specific purpose or time period. Permanently restricted net assets have been restricted by donors to be maintained in perpetuity, except as provided by the provisions of Section 8113 of the Pennsylvania Probate, Estate, and Fiduciaries Code (note 5). Temporarily restricted net assets released from restriction, as their specific purpose or time period has been met during the reporting period, are reflected in the accompanying consolidated statements of operations.

(j) Property and Equipment

Property and equipment acquisitions are recorded at cost, less accumulated depreciation. Depreciation is provided using the straight-line method over the estimated useful lives of the related asset, which are as follows:

	Life
Description of assets:	
Buildings and building improvements	10 – 40 years
Equipment	3 – 30 years
Leasehold improvements	5 – 25 years
Land improvements	10 – 20 years

(k) Other Assets

Deferred financing costs are being amortized over the respective terms of the related bond issues utilizing the effective-interest method. Other assets include noncompete arrangements and signing bonuses, which are amortized over the life of the respective arrangement.

(l) Long-Lived Assets and Goodwill

WPAHS reviews long-lived assets and certain identifiable intangible assets for impairment whenever events or changes in circumstances indicate that the carrying amount of such assets may not be recoverable. Goodwill is reviewed for impairment at least annually. Management has reviewed the carrying amount of these assets and has determined that they are not currently impaired.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to WPAHS are reported at fair market value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair market value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net

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assets released from restrictions. Donor-restricted contributions, whose restrictions are met within the same year as received, are reported as unrestricted contributions in the accompanying consolidated statements of operations.

(n) *Income Taxes*

WPAHS and all other member entities, with the exception of WPCMSI, WPAF, and FIC, are not-for-profit corporations that have been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code (IRC). WPCMSI is a taxable corporation. WPAF is a single member limited liability corporation. FIC is registered under the laws of the Cayman Islands.

WPAHS adopted Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 740, *Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements. FASB ASC 740 prescribes a more-likely than-not recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken. Under FASB ASC 740, tax positions will be evaluated for recognition, de-recognition, and measurement using consistent criteria and will provide more information about the uncertainty in income tax assets and liabilities. Based on an analysis prepared by WPAHS, it was determined that the application of FASB ASC 740 had no material effect on the recorded tax assets and liabilities of WPAHS.

(o) *Other Revenue*

Other revenue is derived from services other than providing healthcare services to patients. Included in other revenue are meaningful use incentive payments, grants, rent, parking, cafeteria, tuition, contract revenue, and sale leaseback gain amortization.

CMS has implemented provisions of the American Recovery and Reinvestment Act of 2009 to provide incentive payments for the meaningful use of certified electronic health record (EHR) technology. CMS has defined meaningful use as meeting certain objectives and clinical quality measures based on current and updated technology capabilities over predetermined reporting periods as established by CMS. The Medicare EHR incentive program provides annual incentive payments to eligible professionals, hospitals, and critical access hospitals that are meaningful users of certified EHR technology. The Medicaid EHR incentive program provides annual payments to eligible professionals and hospitals for efforts to adopt, implement, and meaningfully use certified EHR technology. WPAHS utilized a grant accounting model to recognize EHR incentive revenues. WPAHS records EHR incentive revenue ratably throughout the incentive reporting period when it is reasonably assured that it will meet the meaningful use objectives for the required reporting period and that the grants will be received. The EHR reporting period for the hospitals is based on the federal fiscal year, which runs from October 1 through September 30. In 2012, WPAHS recorded \$4,442 of Medicare revenues and \$5,350 of Medicaid revenues, for a total of \$9,792 in EHR incentives. Such amounts are included in other revenue on the consolidated statements of operations.

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(p) *Asset Retirement Obligations (ARO)*

WPAHS accounts for asset retirement obligations in accordance with FASB ASC 410, *Asset Retirement and Environmental Obligations*. FASB ASC 410 clarifies an entity is required to recognize a liability and capitalize costs for the fair value of a conditional ARO when incurred if the fair value of the liability can be reasonably estimated or when the entity has sufficient information to reasonably estimate the fair value of the ARO. FASB ASC 410 requires an ARO liability be recognized at its net present value, with a corresponding increase to the carrying amount of the long-lived asset to which the ARO relates. The ARO liability is accreted through periodic charges to accretion expense. The initially capitalized ARO long-lived asset cost is depreciated over the useful life of the related long-lived asset.

In the normal course of operations, WPAHS performs repairs and maintenance on its buildings. Additionally, WPAHS is involved in ongoing construction and renovation projects. WPAHS has identified costs that may be incurred for asbestos abatement, which would be legally required, if exposed as a result of such construction and renovation projects.

The significant assumptions and estimates used in the calculation of the AROs are based on the facts and circumstances reasonably known at that time of estimation. They include the estimated settlement date of the obligation, the estimated retirement obligation cost, the assumed inflation rate, and the discount rate.

WPAHS has an ARO liability to recognize the costs associated with future asbestos removal. This represents the present value of the expected future cash flows based on various potential settlement possibilities, including normal repairs and maintenance and currently known renovation plans between 2013 and 2049, which represents management's estimated time period for removal. The liability was \$4,280 and \$4,038 at June 30, 2012 and 2011, respectively. WPAHS has incurred costs of \$130 and \$548 in 2012 and 2011, respectively, relating to asbestos removal. Accretion expense and estimate revisions were \$372 in 2012 and \$364 in 2011. The ARO liability has been discounted using a rate of 9.0% as of the date of adoption.

(q) *Restructuring Expenses*

WPAHS has incurred various costs associated with its turnaround plans described in note 2 and has included these expenses as a separate caption on the consolidated statements of operations. These expenses primarily consist of severance, consulting and other professional services.

(r) *Recently Issued Accounting Pronouncements*

In July 2011, the FASB issued Accounting Standards Update (ASU) No. 2011-07 (ASU 2011-07), *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. ASU 2011-07 requires health care entities that recognize significant amounts of patient service revenue at the time the services are rendered, even though they do not assess the patient's ability to pay, to present the provision for bad debts related to patient service revenue as a deduction from

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patient service revenue (net of contractual allowances and discounts) on their statement of operations. ASU 2011-07 will reclassify the provision for bad debts from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additional disclosures are required related to policies for recognizing revenue and assessing bad debts and disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. This ASU is effective for the System on July 1, 2012. The System is currently evaluating the impact on its disclosures from the adoption of this pronouncement.

In May 2011, the FASB issued ASU No. 2011-04 (ASU 2011-04), *Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs*. ASU 2011-04 resulted in common fair value measurement and disclosure requirements in U.S. GAAP and International Financial Reporting Standards (IFRSs). ASU 2011-04 is intended to clarify requirements in Topic 820, but also includes amendments where a particular principle or requirement for measuring fair value or for disclosing information about fair value measurements has changed. For many of the requirements, this ASU is not intended to result in a change in the application of the requirements in Topic 820. This ASU is effective for the System on July 1, 2012. The adoption of this guidance is not expected to have a material effect on the System's consolidated financial statements.

In August 2010, the FASB issued ASU No. 2010-23 (ASU 2010-23), *Health Care Entities (Topic 954): Measuring Charity Care for Disclosure*. ASU 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU 2010-23 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct and indirect costs of providing the charity care, and requires disclosure of the method used to identify or determine such costs. This ASU is effective for the System on July 1, 2011. The System adopted the provisions of this standard on July 1, 2011 and retrospectively applied the provisions to all periods presented. The adoption had no impact on the previously reported excess of expenses over revenues or net assets.

In August 2010, the FASB issued ASU No. 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*. The amendments in the ASU clarify that a healthcare entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries (see notes 9 and 15). This ASU is effective for the System on July 1, 2011. The System adopted the provisions of this standard on July 1, 2011 and retrospectively applied the provisions to all periods presented. The adoption had no impact on the previously reported excess of expenses over revenues or net assets.

In January 2010, the FASB issued ASU No. 2010-06 (ASU 2010-06), *Fair Value Measurements and Disclosures*, which clarifies certain existing fair value measurement disclosure requirements of ASC Topic 820 (Topic 820): *Fair Value Measurement* (formerly SFAS No. 157, *Fair Value Measurements*) and also requires additional fair value measurement disclosures. Specifically, ASU 2010-06 clarifies that assets and liabilities must be categorized by major class, or level, of asset

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or liability, and provides guidance regarding the identification of such major classes. Additionally, disclosures are required about valuation techniques and the inputs to those techniques, for those assets or liabilities designated as Level 2 or Level 3 instruments. Disclosures regarding transfers between Level 1 and Level 2 assets and liabilities are required, as well as a deeper level of disaggregation of activity within existing rollforwards of the fair value of Level 3 assets and liabilities. These additional fair value measurement disclosure requirements are applicable for interim and annual periods beginning after December 15, 2009, excluding the additional requirements related to Level 3 rollforward activity. This ASU is effective for the System on July 1, 2011. The System adopted the provisions of this standard on July 1, 2011 and retrospectively applied the provisions to all periods presented. The adoption had no impact on the previously reported excess of expenses over revenues or net assets.

(s) ***Reclassifications***

Certain amounts included in the 2011 consolidated financial statements have been reclassified to conform with the 2012 presentation.

(4) Uncompensated Care and Community Service Benefits

To improve the health of the people of the Western Pennsylvania region and consistent with its tax-exempt status, WPAHS provides needed healthcare services to individuals regardless of their ability to pay for all or part of the services rendered. These services include both inpatient and outpatient services as well as maintaining five emergency departments that are available 24 hours a day, including a Level I regional resource trauma center, air and ground emergency transportation, and many primary care and specialty care practices that provide services to the community without regard to the ability to pay for services rendered.

WPAHS maintains a written charity care policy that defines the levels of household income that would qualify for various levels of charity care. Patients can qualify for charity care with household incomes of up to four times the federal poverty guidelines. WPAHS does not pursue collection of amounts that qualify as charity care in accordance with the policy, and as a result, these amounts are not reported as revenue. The cost for services and supplies provided for those individuals who applied for and qualified under the system charity care policy amount to \$4,832 and \$4,649 for the years ended June 30, 2012 and 2011, respectively. The System estimated these costs by applying the cost of total direct and indirect costs of each procedure to the individual charity care cases. Patients are required to apply for the charity care discount, but often do not complete the necessary paperwork to determine if they qualify. As a result, there is an unquantifiable amount of uncompensated services that would potentially be considered charity care under the policy, but rather are ultimately reflected in bad debt expense.

In addition to uncompensated care, WPAHS provides free and below cost services and programs for the benefit of the community. The cost of these programs is included in salaries, wages, and fringe benefits; patient care supplies; professional fees and purchased services; and other expense lines in the accompanying consolidated statements of operations.

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Services are also provided to beneficiaries of government-sponsored programs, including state Medical Assistance and indigent care programs. Reimbursement from these programs is often less than the cost of providing these services.

(5) Cash, Short-Term Investments, and Assets Limited or Restricted as to Use

Cash, short-term investments, and assets limited or restricted as to use as of June 30, 2012 and 2011 consist of the following components:

	2012	2011
Cash and cash equivalents	\$ 193,816	164,595
Short-term investments	5,108	5,075
Assets limited or restricted as to use:		
Unrestricted:		
Designated by board of directors for:		
Capital improvements	32,754	31,570
Foundation	41,088	39,693
Capital project funds	—	26,899
Debt service reserve	57,479	57,175
Self-insurance	12,331	6,517
Grant funds and other	11,297	11,626
Total unrestricted	154,949	173,480
Temporarily restricted	23,210	23,425
Permanently restricted	223,072	234,113
Total assets limited or restricted as to use and beneficial interest in perpetual trust	401,231	431,018
Less current portion	5,744	5,464
Assets limited or restricted as to use, including beneficial interests in perpetual trusts – net of current portion	395,487	425,554
Total cash, short-term investments and assets limited or restricted as to use	\$ 600,155	600,688

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Cash, short-term investments, and assets limited or restricted as to use by investment type as of June 30, 2012 and 2011 consisted of the following:

	Fair value	
	2012	2011
Cash and short-term investments	\$ 237,258	245,625
Government and corporate obligations	158,118	125,633
Marketable equity securities	165	2,520
Endowments managed by donor selected trustees	196,062	207,020
Collective funds and fund of funds	122	4,506
Tactical asset allocation fund	165	7,137
Pledges receivable	828	1,032
Certificates of deposit	7,437	7,215
	\$ 600,155	600,688

The System's investments in collective funds and fund of funds are valued using net asset value (NAV) as a practical expedient for fair value. As of June 30, 2012 and 2011, there are no unfunded commitments to these investments. The conditions of withdrawal vary by individual investment and generally require a minimum notification of 90 days for withdrawal of funds as of quarterly measurement dates. Certain investments contain lock-up provisions for the first twelve months.

Investment income for the years ended June 30, 2012 and 2011 consisted of the following:

	2012		
	Unrestricted	Temporarily restricted	Permanently restricted
Dividends and interest – net of trustee fees	\$ 11,546	872	3,838
Net realized gains on investments	3,982	10	3,367
Net unrealized losses	(1,286)	—	(8,574)
	\$ 14,242	882	(1,369)

	2011		
	Unrestricted	Temporarily restricted	Permanently restricted
Dividends and interest – net of trustee fees	\$ 11,162	1,057	4,033
Net realized gains on investments	2,203	111	4,599
Net unrealized gains	4,519	803	27,475
	\$ 17,884	1,971	36,107

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The recognition of unrealized gains and losses on investments that are restricted as to use are recorded directly to temporarily and permanently restricted net assets as required by donor or regulation. These investments consist primarily of marketable equity securities, federal agency mortgages, corporate bonds, and U.S. Treasury obligations. All unrealized gains and losses on unrestricted investments are recognized as part of investment income within the consolidated statements of operations.

During May 2000, the Orphan's Court of Pennsylvania permitted the election of a fixed investment income distribution under the provisions of Section 8113 (the Election) of the Pennsylvania Probate, Estate, and Fiduciaries Code for certain trust accounts, which name applicable WPAHS entities as the sole beneficiary. The Pennsylvania legislature enacted legislation with respect to charitable Trusts, which permits a Trustee of a charitable Trust to adopt a total return investment policy and, by doing so, to redefine income as a percentage of a rolling average market value of the charitable Trust as averaged over a period of at least three years; provided, however, that such election is not in contravention of the terms of the charitable Trust agreement and is consistent with the long term preservation of the principal value of the charitable Trust.

The provisions of the law governing these changes are found at 20 PA.C.S.A. 8113 and took effect December 21, 1998. If an election is made under this law, the percentage of the market value of the charitable Trust to be treated as income and the rolling time period upon which the percentage is based is to be redetermined annually by the Trustee; such election is to be in writing. Further, the percentage that may be elected is limited to a range between 2% – 7%. Lastly, the statute contains language that cautions against electing the highest ranges of 6% and 7% on a regular basis. Distributions from these charitable Trusts are included in investment income in the accompanying consolidated statements of operations and totaled \$5,620 and \$7,013 for the years ended June 30, 2012 and 2011, respectively. Under the provisions of the Election, there is no settlement required with the Trustee should the Trustee be permitted to revoke the Election.

(6) Fair Value Measurements and the Fair Value Option

The following methods and assumptions were used in estimating the fair value of WPAHS' financial instruments:

(a) Fair Value of Financial Instruments

Cash and Cash Equivalents – The carrying value reported in the consolidated balance sheets for cash and cash equivalents approximates their fair value.

Marketable Securities, Short-Term Investments, and Assets Limited or Restricted as to Use – Fair values of the securities are reported in the consolidated balance sheets and are based on quoted market prices, if available, or estimated using quoted market prices for similar securities. Certain investments are considered alternative investments are reported at NAV, which is used as a practical expedient for fair value.

Accounts Payable and Other Accrued Liabilities – The carrying value reported in the consolidated balance sheets for these obligations approximates their fair value.

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Self-Insurance Liabilities – The carrying and fair values of the self-insurance liabilities are actuarially determined.

Long-Term Debt – Fair value of WPAHS' revenue bonds and notes are based on current traded value. The fair value and carrying amounts of the Series 2007 A bonds were \$605,825 and \$725,775, respectively, at June 30, 2012 and \$622,731 and \$736,999, respectively, at June 30, 2011. WPAHS has determined that it is not practical to estimate the fair value of the Floating Rate Restructuring Certificates and the Series 2006 A and B notes without incurring excessive costs as a quoted market price is not available. The fair value of the mortgage loan approximates its carrying value as it is a resettable rate debt. The fair value of the Highmark Health Services Note Payable approximates its carrying value.

Endowments Managed by Donor-Selected Trustees – Permanently restricted net assets consist of amounts held in perpetuity as designated by donors, including the System's portion of beneficial interests in several endowments managed by donor-selected trustees. The interest in these trusts is measured at the fair market value of the underlying investments, which approximates the present value of the expected future cash flows, for which the System is an income beneficiary.

Pledges Receivable – Pledges receivable are recorded upon receipt of written correspondence from the donor for the original amount of the pledge, less a reserve for potential uncollectible amounts estimated by management. This amount is assumed to approximate the fair value of the pledge receivable balance.

(b) Fair Value Hierarchy

ASC 820, *Fair Value Measurement* establishes a framework in generally accepted accounting principles for measuring fair value and expands disclosures about fair value measurements. Although it does not require any new fair value measurements, ASC 820 emphasizes that fair value is a market-based measurement, not an entity-specific measurement, and should be determined based on the assumptions that market participants would use in pricing the asset or liability.

ASC 820 establishes a hierarchy for ranking the quality and reliability of the information used to determine fair values. The hierarchy gives the highest priority to unadjusted quoted prices in active markets (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of fair value hierarchy are as follows:

Level 1 – Unadjusted quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than quoted prices in Level 1. Inputs such as quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar liabilities that are not active, or other inputs that are observable or can be corroborated by observable market data.

Level 3 – Unobservable inputs that are significant to the valuation of assets or liabilities and are supported by little or no market data.

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Quoted market prices are used when available to determine the fair value of investment securities and these are categorized as Level 1. The inputs used to fair value Level 1 instruments are unadjusted quoted prices derived from stock exchanges as provided by the trustee. Level 1 instruments primarily consist of cash and cash equivalents, domestic equities, foreign equities, exchange traded funds, regulated investment companies, and exchange traded American deposit receipts and certain government securities.

Investments in Level 2 primarily comprise corporate bonds, international bonds, and asset-backed securities and agency bonds. Level 2 inputs primarily consist of contract prices, quotes from independent pricing vendors based on recent trading activity and other relevant information including matrix pricing, market corroborated pricing, yield curves and other indices, which are used as provided by the trustee when Level 1 inputs are not available.

Investments classified as Level 3 in the fair value hierarchy include collective funds, the tactical asset allocation fund, and fund of funds. These assets are valued using inputs such as the funds' net asset value as of year-end as a practical expedient for the fair value of the investment.

The following table presents assets that are measured at fair value on a recurring basis at June 30, 2012:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets measured at fair value:				
Cash and cash equivalents	\$ 237,019	239	—	237,258
Government and corporate obligations	71,222	86,896	—	158,118
Marketable equity securities	165	—	—	165
Endowments managed by donor selected trustees	—	—	196,062	196,062
Collective funds and fund of funds	—	—	122	122
Tactical asset allocation fund	—	—	165	165
Pledges receivable	—	—	828	828
Certificates of deposit	7,437	—	—	7,437
	<u>315,843</u>	<u>87,135</u>	<u>197,177</u>	<u>600,155</u>
Total assets measured at fair value	\$ <u>315,843</u>	<u>87,135</u>	<u>197,177</u>	<u>600,155</u>

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The following table presents assets that are measured at fair value on a recurring basis at June 30, 2011:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Assets measured at fair value:				
Cash and cash equivalents	\$ 245,332	293	—	245,625
Government and corporate obligations	60,070	65,563	—	125,633
Marketable equity securities	2,520	—	—	2,520
Endowments managed by donor selected trustees	—	—	207,020	207,020
Collective funds and fund of funds	—	—	4,506	4,506
Tactical asset allocation fund	—	—	7,137	7,137
Pledges receivable	—	—	1,032	1,032
Certificates of deposit	7,215	—	—	7,215
	<u>315,137</u>	<u>65,856</u>	<u>219,695</u>	<u>600,688</u>
Total assets measured at fair value	\$ <u>315,137</u>	<u>65,856</u>	<u>219,695</u>	<u>600,688</u>

WPAHS holds assets valued using unobservable inputs (Level 3) at June 30, 2012. These assets increased (decreased) as a result of the changes below:

	<u>Tactical asset allocation fund</u>	<u>Collective funds and fund of funds</u>	<u>Endowments managed by donor selected trustees</u>	<u>Pledges receivable</u>	<u>Total</u>
Beginning balance	\$ 7,137	4,506	207,020	1,032	219,695
Realized and unrealized gains	425	214	7,211	—	7,850
Realized and unrealized losses	(425)	(470)	(8,474)	—	(9,369)
Disbursements and transfers out	(6,972)	(4,128)	(9,695)	(17)	(20,812)
Contributions and transfers in	—	—	—	131	131
Collection of pledges	—	—	—	(318)	(318)
Ending balance	\$ <u>165</u>	<u>122</u>	<u>196,062</u>	<u>828</u>	<u>197,177</u>

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WPAHS holds assets valued using unobservable inputs (Level 3) at June 30, 2011. These assets increased (decreased) as a result of the changes below:

	Tactical asset allocation fund	Collective funds and fund of funds	Endowments managed by donor selected trustees	Pledges receivable	Total
Beginning balance	\$ 5,689	8,150	181,508	2,004	197,351
Realized and unrealized gains	1,448	1,252	38,639	—	41,339
Realized and unrealized losses	—	—	(3,269)	—	(3,269)
Disbursements and transfers out	—	(4,896)	(9,911)	—	(14,807)
Contributions and transfers in	—	—	53	389	442
Collection of pledges	—	—	—	(1,361)	(1,361)
Ending balance	<u>\$ 7,137</u>	<u>4,506</u>	<u>207,020</u>	<u>1,032</u>	<u>219,695</u>

(c) Fair Value Option

WPAHS elected the fair value option for its unrestricted investments effective July 1, 2008. As a result, all unrealized gains and losses on unrestricted investments are included in the excess (deficiency) of revenues over expenses. The System has recorded \$1,286 of net unrealized losses and \$4,519 of net unrealized gains (included in investment income) in 2012 and 2011, respectively.

(7) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets at June 30, 2012 and 2011 are available for the following purposes:

	2012	2011
Capital expansion and renovation	\$ 9,651	9,488
Clinical programs	13,559	13,937
	<u>\$ 23,210</u>	<u>23,425</u>

Temporarily restricted net assets for capital expansion and renovation represent donations, gifts, and pledges made for specific capital projects at WPAHS hospitals and other facilities. Temporarily restricted net assets for clinical programs represent donations, gifts, and pledges made to support specific clinical programs or departments at WPAHS hospitals.

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Permanently restricted net assets totaling \$223,072 and \$234,113 at June 30, 2012 and 2011, respectively, are restricted to be invested in perpetuity. Income distributions generated from these net assets are either classified as unrestricted and may be used for any purpose or are classified as temporarily restricted based on donor restrictions. At June 30, 2012, permanently restricted net assets consist of endowments managed by donor-selected trustees of \$196,062 and endowments managed by the System of \$27,010. Collectively, all these funds are included as permanently restricted assets within limited or restricted as to use. The System has determined that all such funds are donor restricted.

Changes in System-Managed Endowment Net Assets

	<u>2012</u>	<u>2011</u>
Beginning balance	\$ 27,093	25,593
Investment return:		
Interest and dividend income	25	55
Realized (losses) gains	(31)	25
Unrealized (losses) gains	(100)	657
Total investment (losses) gains	(106)	737
Contributions	4	447
Other transfers	19	316
Ending balance	\$ <u>27,010</u>	<u>27,093</u>

(8) Property and Equipment

Property and equipment at June 30, 2012 and 2011 consist of the following:

	<u>2012</u>	<u>2011</u>
Buildings and building improvements	\$ 597,888	595,211
Equipment	547,174	477,916
Leasehold improvements	43,203	37,377
Total depreciable assets	1,188,265	1,110,504
Less accumulated depreciation and amortization	(862,496)	(811,276)
Net depreciable assets	325,769	299,228
Land and land improvements	29,228	28,755
Construction in progress	51,939	41,235
Property and equipment – net	\$ <u>406,936</u>	<u>369,218</u>

WPAHS capitalizes interest on certain assets that require a period of time to prepare for their intended use. The amount capitalized is based on the weighted average outstanding borrowing rate of WPAHS'

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indebtedness. During the years ended June 30, 2012 and 2011, WPAHS capitalized \$2,984 and \$3,440, respectively, of related interest costs. Depreciation expense was \$64,905 and \$59,156 for the years ended June 30, 2012 and 2011, respectively.

(9) Other Assets

Other assets at June 30, 2012 and 2011 consist of the following:

	<u>2012</u>	<u>2011</u>
Prefunded insurance deductible (note 15)	\$ 25,510	26,407
Deferred bond financing costs – net of accumulated amortization of \$3,965 and \$3,200, respectively	13,154	13,919
Note receivable in CHA RRG	3,185	3,185
Investment in CHA RRG (note 15)	4,465	2,602
Intangibles – net of accumulated amortization of \$10,587 and \$10,105, respectively	5,223	5,705
Insurance recoveries (note 15)	18,960	23,525
Other	4,799	4,665
Total	<u>\$ 75,296</u>	<u>80,008</u>

(10) Medical Resident FICA Refund

In March 2010, the Internal Revenue Service (IRS) issued an administrative determination to accept the position that physicians in graduate medical education programs are excepted from FICA taxes based on the resident exception for tax periods ending prior to April 1, 2005. The System had previously remitted such FICA taxes to the IRS, but had also filed protective claims pending the IRS administrative determination. The System has filed perfected claims with the IRS and has recorded \$16,652 and \$23,307 as the anticipated employer refund, including accrued interest. This amount is included in other receivables at June 30, 2012 and 2011, respectively. The System also recorded amounts payable to the former residents of approximately \$7,700 within other current liabilities at June 30, 2012 and 2011.

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(11) Long-Term Debt

Long-term debt as of June 30, 2012 and 2011 consists of the following:

	2012	2011
Allegheny County Hospital Development Authority (ACHDA) – Series 2007 A with maturity dates through November 15, 2040, and interest rates ranging from 5.00% to 5.375%, including a net unamortized premium of \$4,605 and \$4,904 at June 30, 2012 and 2011, respectively	\$ 725,775	736,999
Floating Rate Restructuring Certificates (FRRC) – payable based on attainment of defined income and cash levels, with a variable interest rate of the three-month London InterBank Offered Rate (LIBOR), plus 0.25% (0.72% and 0.50% at June 30, 2012 and 2011, respectively), thereafter until maturity on June 30, 2030	37,084	37,084
	2012	2011
Series 2006 B Health Facilities Revenue Notes – payable in monthly principal and interest payments through October 2015, with interest rates ranging from 4.55% to 4.61%	\$ 18,450	19,741
Series 2006 A Health Facilities Revenue Notes – payable in monthly principal and interest payments through December 2016, at a fixed interest rate of 5.25% for all payments	1,811	2,450
Highmark Notes Payable – principal is payable in two \$50,000 payments due in 2023 and 2024 with interest payable semi-annually based on the prime rate plus 2.00% (5.25% at June 30, 2012)	100,000	—
Equipment Notes – payable in monthly principal and interest payments through June 2016, with interest rates ranging from 7.00% to 7.55%	8,516	7,466
Mortgage loan	3,066	3,205
Other	—	289
Total	894,702	807,234
Less current portion	15,866	14,742
Total long-term debt	\$ 878,836	792,492

(a) Series 2007 A

In June 2007, the System issued \$752,400 of Allegheny County Hospital Development Authority (ACHDA) Health System Revenue Bonds (West Penn Allegheny Health System Series 2007 A, the Series 2007 A bonds). Proceeds of the Series 2007 A bonds were used to advance refund the

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outstanding Allegheny County Hospital Development Authority Series 2000 A and B bond issues and to current refund the Dauphin County General Authority Series 1992 A and B Hospital Revenue Bonds, the Pennsylvania Higher Education Facility Authority Series 1991 A Revenue Bonds, the Monroeville Hospital Authority Series 1992 and 1995 Revenue Bonds, and partially refund an outstanding loan from Highmark Health Services (formerly Highmark Inc.).

The Series 2007 A bonds are a liability of the Obligated Group. Each member of the Obligated Group is jointly and severally liable for payment of this obligation.

The Series 2007 A bonds are subject to mandatory redemption on November 15, 2017, November 15, 2028, and November 15, 2040, based on the mandatory sinking fund dates as disclosed in the official statement. They are subject to redemption prior to their respective stated maturity dates, in part, or by lot, on variable dates as disclosed in the official statement at the discretion of WPAHS and the ACHDA. Under the Master Indenture of Trust (MIT), interest is payable to the bondholders semiannually on each May 15 and November 15.

The Series 2007 A bonds are secured by (i) first mortgage liens on certain real property, (ii) security interests in certain equipment and other tangible and intangible personal property of the Obligated Group, and (iii) gross revenues of the Obligated Group. Debt service reserve accounts in the amount of \$51,735 and \$51,711 at June 30, 2012 and 2011, respectively, exist for the Series 2007 A bonds, which must be maintained at required reserve levels.

Prior to the Transaction (see note 2), the Obligated Group had covenants under the MIT including, but not limited to; a long-term debt service coverage ratio of 1.1 and days cash on hand of 35 (both measured annually at June 30). As of June 30, 2012 (most recent measurement date), WPAHS was not in compliance with all required covenants. See discussion in note 2 of waiver and modification of debt covenants.

In connection with the Transaction (see note 2), an Amendment to Bond Indenture (ABI) was executed to create a separate subaccount (Highmark Bonds Subaccount of the Reserve Fund (HBSRF)) within the debt service reserve fund. This newly created subaccount was required to equal a certain balance as defined by the ABI. The balance was allowed to equal zero if written notice was given by the holders of the bonds tendered by Highmark Health Services (Highmark Bonds). The ABI further provided that upon delivery of such notice, all monies on deposit in the HBSRF would be transferred to a project fund, and the balance in the HBSRF would be zero. Such a notice was given at the closing of the Transaction and all funds in the HBSRF were transferred to a project fund. The Debt Service Reserve Fund for untendered bonds will be maintained.

The principal of and interest owed on the bonds tendered to and acquired by Highmark Health Services as part of the Transaction (see note 2) is deferred until November 15, 2015 (fiscal year 2016) and is reflected accordingly in the schedule of principal payments at 11(e).

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(b) *FRRCs*

In 2000, certain creditors of AGH and its affiliates restructured approximately \$114,000 of indebtedness by exchanging such indebtedness for approximately \$76,900 in cash and approximately \$37,100 in principal amount of FRRCs. Initially, no interest accrued on the FRRCs. Beginning July 1, 2003, the FRRCs bear interest at the three-month LIBOR plus 0.25%. Payment of interest is contingent upon AGH achieving certain profitability thresholds and maintaining specified liquidity levels. AGH has never been required to make an interest payment. The Highmark Health Services loan documents contemplate that no payments will be made on the FRRCs until all loans made by Highmark Health Services have been paid in full. Management believes the probability of future interest payments on the FRRCs to be remote and has, therefore, not recorded interest to date.

Subject to the FRRC Cap (as defined by the FRRC indenture), if applicable, the owners of the FRRCs are entitled to receive an annual single payment of 25% (30% if unenhanced indebtedness of any other member of the Obligated Group is rated A or better) of the adjusted net operating income of the Obligated Group as defined in the FRRC indenture, calculated as of each June 30 commencing June 30, 2004. Payments are also contingent upon achieving and maintaining specified liquidity levels. No payments have been due under the FRRCs.

(c) *Series 2006 B & A*

In December 2006, WPAF entered into two agreements with respect to the issuance of Series 2006 B notes in the amount of \$24,000 and Series 2006 A note in the amount of \$4,950 to purchase four new helicopters and hospital beds, respectively. The notes are collateralized by the acquired helicopters and beds, respectively.

The Series 2006 B Health Facilities Revenue Notes (Series 2006 B Notes), and the Series 2006 A Health Facilities Revenue Note (Series 2006 A Note), and the mortgage loan are solely the obligation of WPAF.

(d) *Highmark Health Services Notes Payable*

In October 2011, WPAHS received \$50,000 in the form of an unsecured loan from Highmark Health Services, evidenced by a note payable with principal payments of \$25,000 each due in 2023 and 2024. In April 2012, WPAHS received an additional \$50,000 unsecured loan from Highmark Health Services, evidenced by a note payable with principal payments of \$25,000 each due in 2023 and 2024. Prior to the closing of the Transaction, interest on both notes was payable semi-annually based on the prime rate plus 2.00% (subject to a 6% cap). Upon closing, interest became payable annually.

In connection with the Transaction, the unsecured loans from Highmark Health Services became secured (see note 2). Additionally, WPAHS received a new \$100,000 secured loan from Highmark Health Services, evidenced by a note payable with principal payments of \$50,000 each due in 2025 and 2026. Interest on this note is payable annually based on the prime rate plus 2.00% (subject to a 6% cap).

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Interest accruing on all the above notes in any fiscal year, commencing with fiscal year 2013, will be forgiven if WPAHS' debt service coverage is less than 3 to 1 for such fiscal year. Mandatory prepayments of the notes is required if at any time the WPAHS Days Cash on Hand exceeds 100 days at the end of any fiscal quarter or at the end of the last month immediately preceding the end of any fiscal year.

(e) ***Other Long-Term Debt***

The System has entered into other notes and mortgages to finance various capital purchases. The interest and principal on these instruments are payable through 2026 at interest rates ranging from 2.16% to 7.55%.

Scheduled principal repayments and sinking fund requirements on all long-term debt for the next five years and thereafter as of June 30, 2012 are as follows:

	Total obligated group	WPAF	Total consolidated group
	<u> </u>	<u> </u>	<u> </u>
Year ending June 30:			
2013	\$ 13,764	2,102	15,866
2014	4,237	1,959	6,196
2015	4,270	8,958	13,228
2016	35,734	7,844	43,578
2017	14,134	340	14,474
Thereafter	794,631	2,124	796,755
	<u>\$ 866,770</u>	<u>23,327</u>	<u>890,097</u>

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(12) Deferred Revenue

Deferred revenue at June 30, 2012 and 2011 consists of the following:

	<u>2012</u>	<u>2011</u>
Deferred revenue from Affiliation Agreement (see note 2)	\$ 50,000	—
Deferred grant revenue	8,044	9,176
Unamortized gains	707	707
Other	<u>1,190</u>	<u>816</u>
Total current deferred revenue	<u>59,941</u>	<u>10,699</u>
Prepaid patient service revenue	25,000	25,000
Deferred grant revenue	14,905	14,319
Unamortized gains	2,416	3,123
Other	<u>239</u>	<u>330</u>
Total noncurrent deferred revenue	<u>42,560</u>	<u>42,772</u>
Total	<u>\$ 102,501</u>	<u>53,471</u>

In December 2006, WPAHS entered into a long-term contract with a commercial payor whereby System facilities and providers would make available healthcare services to the payor's members at discounted amounts for a period of approximately 10 years. The System received \$35,000 in connection with this agreement, which has been reflected as deferred revenue in the accompanying consolidated financial statements and is being amortized on a straight-line basis over the life of the related contracts consistent with the earnings process. At June 30, 2010, \$23,333 received from the agreements was included in deferred revenue within the accompanying consolidated balance sheets. During 2011 the agreement between the commercial payor and the System was terminated. The terms of the termination agreement allowed the System to retain the remaining unamortized deferred revenue. The remaining unamortized deferred revenue of \$23,333 was recognized into income as other revenue on the consolidated statements of operations.

In April 2011, WPAHS received an advance in the amount of \$25,000 from a commercial payor. This amount will be used to offset future reimbursements from the commercial payor. The terms of this agreement and the term for recognition have not been finalized.

The System records deferred revenue as nongovernmental grant monies are received. Revenue is subsequently recognized as grant proceeds are expended. During the years ended June 30, 2012 and 2011, grant proceeds of \$23,092 and \$21,461, respectively, were expended and recognized as other revenue. The System also records, as deferred revenue, governmental grant monies received for the acquisition of property and equipment. The amount deferred is amortized over the estimated useful life of the assets acquired. At June 30, 2012 and 2011, \$22,949 and \$23,495, respectively, of grant funds are included in deferred revenue within the accompanying consolidated balance sheets.

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During the years ended June 30, 1997 and 1996, AGH sold certain nonclinical assets, which are being leased back by AGH over 20 years. These transactions resulted in gains, which have been deferred and will be amortized on a straight-line basis into income over the lease terms. The annual amortization is included in other revenue in the accompanying consolidated statements of operations. Unamortized gains of \$3,123 and \$3,830 are included in deferred revenue at June 30, 2012 and 2011, respectively.

(13) Commitments

Rental expense consists of amounts paid to lease property for physician offices, a network of ambulatory locations, parking garages, and administrative offices. In addition, WPAHS leases clinical and administrative equipment. Equipment leases involve both noncancelable operating leases as well as ordinary month-to-month rentals for items that are used as the need arises based on the volume or mix of procedures and, therefore, are not practical to purchase. The components of rental expense, which are recorded within general and administrative on the consolidated statements of operations for the years ended June 30, 2012 and 2011, are as follows:

	2012	2011
Property rentals	\$ 32,031	28,194
Equipment rentals and other	16,515	17,558
Total	\$ 48,546	45,752

The future minimum lease payments under noncancelable operating leases entered into as of June 30, 2012 are as follows:

Year ending June 30:	
2013	\$ 30,353
2014	25,967
2015	22,518
2016	21,719
2017	15,189
Thereafter	77,517
Total minimum payments	\$ 193,263

The System renewed a noncancelable sponsorship and advertising agreement in 2010 that includes performance obligations that requires the System to spend an additional \$21,805 through 2020.

During 2011, the System renegotiated its previous agreements that provided the core clinical and decision support software licensing and related computer system maintenance for most of the WPAHS entities and subsequently entered into one Master agreement committing approximately \$43,500. Of this amount, approximately \$16,000 has been expended at June 30, 2012. The new Master agreement is in effect until 2018; however the agreement includes certain provisions for early termination by WPAHS after March 2012.

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Approximately, 22% of employees are covered by collective bargaining agreements through participation in nine bargaining units. These bargaining units have expiration dates ranging between 2013 and 2015.

WPAHS has employment agreements with physicians, specialists, and others. These agreements are for periods up to 10 years and require services to be performed.

(14) Income Taxes

No provision for income taxes has been recognized in the accompanying consolidated financial statements as WPCMSI has incurred net operating losses in most years prior to fiscal year 2012, which are available to offset current and future taxes payable. A valuation allowance of approximately \$18,000 has been established to fully reserve the deferred tax asset associated with the cumulative net operating losses of approximately \$44,500, which expires between 2013 and 2031, as future earnings are not estimated to be sufficient to realize the asset before the net operating loss carry forward expires.

(15) Insurance

(a) Workers' Compensation

Prior to 1999, WPAHS was self-insured for workers' compensation claims. From 1999 through October 14, 2004, WPAHS purchased occurrence-based commercial insurance for workers' compensation claims. The coverage was for \$250 per claim at AKMC, CGH, and FRC and \$350 per claim at AGH and WPH. From October 15, 2004, through October 15, 2011, WPAHS was self-insured for workers' compensation claims and purchased excess insurance coverage of \$350 per claim for all of its hospitals on an occurrence-basis. On October 15, 2011, WPAHS purchased high-deductible occurrence-based commercial insurance for workers' compensation claims. The coverage requires WPAHS to pay the first \$350 per claim. During the 12 months ended June 30, 2012 and 2011, WPAHS' workers' compensation expense was \$3,415 and \$2,875, respectively, and is recorded within the consolidated statements of operations. A liability for WPAHS' self-insured workers' compensation of \$9,799 and \$9,301 as of June 30, 2012 and 2011, respectively; this amount includes a related insurance recovery of \$3,160 and \$3,325, which is included in other assets.

(b) General and Professional Liability

Beginning in 2003, the System has been insured through Community Health Alliance Reciprocal Risk Retention Group (CHA), a Vermont domiciled risk retention group. The System owns 53% of CHA and has a 20% voting interest. The investment in CHA is accounted for using the equity method. The System's share of equity income or loss from CHA is included as a nonoperating income or loss. CHA provides medical professional liability and general liability coverages to the System and its physicians. The coverages provided are comprised of several layers, as described below.

The primary layer provides claims made medical professional liability coverage with limits of \$500 per occurrence for hospitals and physicians with annual aggregates of \$2,500 per hospital and \$1,500 per physician. The System records an actuarially determined reserve for aggregate primary layer losses in excess of the annual aggregate. The primary layer also provides occurrence basis general

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liability coverage to hospitals of \$1,000 per occurrence and \$3,000 in the annual aggregate. Defense costs do not erode the coverage limits provided within the primary layer. Policies in this layer are subject to various retroactive dates. The policy offers tail coverage to departing physicians for an additional premium. The coverage provided in the primary layer is retained 100% by CHA.

The limits within the primary layer are subject to a self-funded \$250 per occurrence deductible. The deductible paid by the System in any policy year is limited by a stop loss point. This stop loss point is calculated as two times the actuarially determined estimated deductible layer losses. The losses estimated to reach the deductible layer have been paid to CHA by the System. The amounts paid in for the deductible layer may be assessed in future years for additional amounts in the event that the System has loss experience pertaining to the deductible layer over and above the amounts paid in. Additional amounts charged in future periods will not exceed the stop loss point. Furthermore, these deposits may be refunded if the System's loss experience applied against the deductible layer is less than the amounts paid in.

The coverages provided by CHA are subjected to MCARE (Medical Care Availability and Reduction of Error Fund). Participation in the MCARE fund is required for all Pennsylvania hospitals and hospital physicians. System hospitals and physicians are required to pay assessments into the MCARE fund on an annual basis. The MCARE fund provides medical professional liability coverage in excess of the required primary layer coverages as described above. The coverage provided by the MCARE fund is \$500 per occurrence and \$1,500 in the annual aggregate for both hospitals and physicians. Claims, which penetrate the MCARE fund's limits, are filed directly with the Commonwealth of Pennsylvania. CHA bills the System for MCARE assessment and remits the entire amount to the MCARE Fund.

The first excess layer provides claims made medical professional liability coverage and occurrence based general liability coverage to the System in excess of the primary and MCARE layers. Additionally, the first excess layer provides occurrence basis coverage for employer's liability in excess of the System's third party coverage. Limits on coverage are the difference between \$2,000 plus the remaining amount of the underlying coverage per occurrence and \$5,000 in the annual aggregate for the System with a shared maximum annual aggregate of \$10,000 for CHA. The annual aggregate and shared annual aggregate is shared among all lines of coverage noted above. Coverage is subject to various retroactive dates. Defense costs erode the coverage limits provided in the first excess layer and coverage is 100% retained by CHA.

The second excess layer provides claims made medical professional liability coverage and occurrence based general liability coverage to hospitals in excess of the primary, MCARE and first excess layers. Additionally, the second excess layer provides occurrence basis coverage for employer's liability in excess of the System's third party coverage and the first excess layer. Limits on coverage are \$9,000 per occurrence and \$18,000 in the annual aggregate for the System. This coverage is subject to a shared maximum annual aggregate of \$45,000 for CHA. The annual aggregate and shared annual aggregate is shared among all lines of coverage noted above. Coverage is subject to various retroactive dates. Defense costs erode the coverage limits provided in the excess layer. Reinsurance has been obtained by CHA for the second excess layer from two commercial

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reinsurers. The reinsurance agreement provides for coverage of \$9,000 per occurrence with a shared maximum annual aggregate of \$27,000 in excess of an \$18,000 shared maximum annual aggregate retention by the CHA. Reinsurance coverage includes defense costs and a one-year extended reporting period option.

The System's first and second excess layers are subject to a self-insured retention layer of \$5,000. The System records an actuarially determined reserve for estimated losses in the self-insured retention layer.

The third excess layer provides claims made medical professional liability coverage and occurrence based general liability coverage to hospitals in excess of the primary, MCARE, first and second excess layers. Additionally, the third excess layer provides employers' liability occurrence basis coverage in excess of the System's third party coverage and the first and second excess layers. Limits on coverage are \$10,000 per occurrence and \$10,000 in the annual aggregate for the System with a shared maximum annual aggregate of \$30,000 for CHA. The annual aggregate and shared annual aggregate is shared among all lines of coverage noted above. Coverage is subject to various retroactive dates. Defense costs erode the coverage limits provided in this excess layer. This layer is 100% reinsured by CHA in the commercial market with one reinsurer. Reinsurance coverage includes defense costs.

The unaudited financial statement information as of and for the year ended June 30, 2012 and 2011 of CHA RRG, which has a calendar year-end, is as follows:

	<u>2012</u>	<u>2011</u>
Total assets	\$ 135,070	142,079
Total liabilities	117,940	128,171
Total equity	17,131	13,908
Total revenue	19,209	19,045
Total expense	16,162	30,091
Net income (loss) (including federal income tax benefit)	3,047	(11,046)

WPAHS provides for the costs associated with general and professional liability claims based on actuarially determined projected settlements, which include estimates for claims incurred but not reported. There exists, however, inherent risks in the areas of general and professional liability insurance that stem from, among other things, coverage availability and the financial viability of the underlying insurance carrier.

During the 12 months ended June 30, 2012 and 2011, WPAHS' general and professional liability expense was \$22,060 and \$25,578, respectively. WPAHS' self-insured general and professional liability was \$70,899 and \$76,538, as of June 30, 2012 and 2011, respectively; this amount includes a related insurance recovery of \$15,800 and \$20,200, which is included in other assets.

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(16) Pension Plans

(a) Defined Benefit Plans

WPAHS maintains a defined benefit cash balance pension plan for its employees. Under this cash balance plan, pension accruals are determined using a defined percentage of an employee's current compensation based upon the employee's age and years of service. Each employee's individual retirement benefit is defined within the plan's obligation as notational cash balance retirement accounts and is credited with interest based upon a defined interest rate.

WPAHS' investment policy is to provide for the benefit obligations earned by employees during their career at the System. Plan assets are invested to generate earnings over an extended time period to help fund the cost of benefits under the plan while controlling investment fees.

WPAHS' funding policy is to contribute such amounts, as necessary, on an actuarial basis to provide the plan with assets sufficient to meet benefits to be paid to retirees or their beneficiaries, and to satisfy minimum funding requirements of Employee Retirement Income Security Act of 1974, and the IRC. Plan assets are invested primarily in corporate common stocks, fixed income obligations of the United States government and corporations, and interests in collective trusts and mutual funds.

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The funded status at measurement dates of June 30, 2012 and 2011 and amounts recognized in the consolidated financial statements at June 30, 2012 and 2011, relating to employee retirement benefits are as follows:

	<u>2012</u>	<u>2011</u>
Accumulated benefit obligation, including vested benefits of \$581,106 and \$560,472 in 2012 and 2011, respectively	\$ 756,539	641,481
Change in projected benefit obligation:		
Projected benefit obligation – beginning	\$ 652,597	673,336
Service cost	21,198	22,269
Interest cost	33,447	33,281
Plan participants' contributions	205	—
Actuarial loss (gain)	104,744	(19,937)
Benefits paid	(43,638)	(56,352)
Projected benefit obligation – ending	<u>768,553</u>	<u>652,597</u>
Change in plan assets:		
Fair value plan assets – beginning	456,341	375,513
Actual gain on plan assets	44,943	61,470
Employer contributions	32,039	75,710
Plan participants' contributions	205	—
Benefits paid	(43,638)	(56,352)
Fair value of plan assets – ending	<u>489,890</u>	<u>456,341</u>
Projected benefit obligation in excess of fair value of plan assets	<u>\$ 278,663</u>	<u>196,256</u>
Weighted average assumption used to determine benefit obligations:		
Discount rate	3.90%	5.30%
Rate of compensation increase	2.9% – 6.1% Graded	2.9% – 6.1% Graded

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	2012	2011
Components of net periodic pension costs:		
Service cost	\$ 21,198	22,269
Interest cost	33,447	33,281
Expected return on plan assets	(37,909)	(37,258)
Amortization of actuarial losses	17,194	18,332
Amortization of prior service cost	(6,438)	(6,773)
Net periodic pension cost	\$ 27,492	29,851
Weighted average assumptions used to determine net cost:		
Discount rate	5.30%	5.20%
Expected long-term return on plan assets	7.65	7.65
Rate of compensation increase	2.9% – 6.1%	2.9% – 6.1%
	Graded	Graded

The net actuarial loss and prior service cost (credit) not yet recognized into net periodic pension cost was \$353,363 and \$(40,902), respectively, at June 30, 2012. The net actuarial loss and prior service cost (credit) not yet recognized into net periodic pension cost was \$272,852 and \$(47,340), respectively, at June 30, 2011. The net actuarial losses and prior service costs (credits) that were amortized from unrestricted deficit into net periodic pension cost were \$17,194 and \$(6,439) in 2012 and \$18,332 and \$(6,773) in 2011. The net actuarial loss and prior service cost (credit) that will be amortized from unrestricted deficit into net periodic pension cost in 2013 is \$25,141 and \$(5,713).

The System is required to abide by the minimum funding requirements of Section 412 of the IRC. Based on most recent actuarial estimates, the System is required to fund \$37,651 during the year ending June 30, 2013.

The discount rate used to value plan liabilities is a weighted average spot rate generated by bond yield curves, rounded down to the next five basis points.

The long-term expected rate of return on pension investments is developed by independent estimates of forward looking rates of return by investment category, multiplied by the target investment allocation mix.

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WPAHS' pension plan weighted average asset allocation at June 30, 2012 and 2011 by asset category are as follows:

	<u>Actual 2012</u>	<u>Actual 2011</u>	<u>Target ranges</u>
Plan assets:			
Domestic equity securities and funds	37%	40%	35% – 45%
Debt securities and funds	40	40	35% – 45%
International equity securities and funds	11	17	8% – 18%
Alternative investment fund of funds	—	—	4% – 10%
Cash, cash equivalents, and others	12	3	0% – 10%
Total	<u>100%</u>	<u>100%</u>	

The adoption of Topic 715 required that the fair value hierarchy disclosures as defined by FASB ASC 820 be applied to assets held within the Plan. Refer to note 6 for Level definitions.

The following table presents assets that are measured at fair value on a recurring basis at June 30, 2012:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Plan assets:				
Domestic equity securities and funds	\$ 185,450	—	—	185,450
Debt securities and funds	54,480	137,268	—	191,748
International equity securities and funds	51,739	—	—	51,739
Alternative investment fund of funds	—	—	1,568	1,568
Cash and cash equivalents	—	59,385	—	59,385
Total	<u>\$ 291,669</u>	<u>196,653</u>	<u>1,568</u>	<u>489,890</u>

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The following table presents assets that are measured at fair value on a recurring basis at June 30, 2011:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Plan assets:				
Domestic equity securities and funds	\$ 184,134	—	—	184,134
Debt securities and funds	49,266	132,338	—	181,604
International equity securities and funds	76,324	—	—	76,324
Alternative investment fund of funds	—	—	1,568	1,568
Cash and cash equivalents	—	12,711	—	12,711
Total	<u>\$ 309,724</u>	<u>145,049</u>	<u>1,568</u>	<u>456,341</u>

The Plan holds certain alternative investments including hedge fund of funds and global real estate. Refer to note 6 for asset valuation information. The Plan holds assets valued using unobservable inputs (Level 3) at June 30, 2012. These assets did not fluctuate materially in value during the year ended June 30, 2012.

The Plan held assets valued using unobservable inputs (Level 3) at June 30, 2011. These assets increased (decreased) as a result of the changes below:

	<u>International equity securities and funds</u>	<u>Tactical asset allocation fund</u>	<u>Alternative investment fund of funds</u>	<u>Total</u>
Beginning balance	\$ 16,558	52,971	30,506	100,035
Realized and unrealized gains	9,219	13,248	1,881	24,348
Realized and unrealized losses	(5,882)	(1,776)	(1,128)	(8,786)
Contributions and cash receipts	—	—	2	2
Disbursements and transfers out	(19,895)	(64,443)	(29,693)	(114,031)
Ending balance	<u>\$ —</u>	<u>—</u>	<u>1,568</u>	<u>1,568</u>

WPAHS maintains no significant concentrations of a single investment within the plan assets.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Amounts in thousands)

The following benefit payments, which reflect future service, as appropriate, are expected to be paid by WPAHS:

	<u>Total pension benefits</u>
Year ending June 30:	
2013	\$ 42,361
2014	43,521
2015	46,266
2016	48,933
2017	52,758
2018 – 2022	310,691

Plan Changes

Two changes in plan provisions were made to the Union Plan effective January 1, 2012:

- Members of Local Union 95 IUOE bargained to cease benefit accruals. As a result, employees of Suburban Hospital who are and who become employees of AGH by merger do not receive annual retirement credits for service after July 14, 2011. Additionally, employees of WPH who are members of Local Union 95 IUOE do not receive Annual Retirement credits for service after November 23, 2010.
- A change was also made to the prior vesting service for employees of Western Penn Medical Associates, PC, so that these participants now receive prior vesting service credit for periods before November 30, 2010.

These plan changes had a negligible effect on the results of the valuation.

There were no material changes to the plans for the year ended June 30, 2011.

(b) Defined Contribution Plans

WPAHS sponsors a defined contribution savings plan, which is available to substantially all employees in order to provide additional security during retirement by creating an incentive for employees to make regular contributions on their own behalf. Under these plans and as determined on an individual basis, WPAHS contributed an amount equal to 50% of an employee's contribution up to 2.5% of such employee's base salary in a given year. WPAHS suspended their contribution to this plan in April 2009 for nonrepresented employees. Such expense related to these plans was based on actual contributions made.

WPAHS' expense associated with its contributions to these savings plans was \$629 and \$535 for the years ended June 30, 2012 and 2011, respectively.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Amounts in thousands)

(17) Functional Expenses

WPAHS provides general healthcare services. Expenses related to such services for the years ended June 30, 2012 and 2011 are as follows:

	<u>2012</u>	<u>2011</u>
Healthcare services	\$ 1,496,720	1,465,136
General	158,425	161,961
Research	21,895	18,475
Fund-raising and other	<u>2,058</u>	<u>2,303</u>
Total	<u>\$ 1,679,098</u>	<u>1,647,875</u>

(18) Gain on Divestiture

On August 2, 2010 WPAHS entered into an agreement for the sale of the assets and inventory of its dialysis business with total book value of \$639. The dialysis business was sold for \$10,245, resulting in a net gain of \$9,606 in fiscal year 2011.

(19) Legal Matters

The United States Securities and Exchange Commission (SEC or Commission) recently concluded a formal investigation into the consolidated financial statement adjustments reported by WPAHS in July 2008 and certain disclosures made by WPAHS in 2009. WPAHS cooperated fully with the Commission during its investigation, and has been informed that the staff of the SEC has no intentions, at this time, to recommend any enforcement action with respect to WPAHS.

Specifically, the Commission began its inquiry in August 2008; and, on November 27, 2012, the Staff of the SEC issued a "Wells Notice" to WPAHS, which is neither a formal allegation of wrongdoing nor a determination of wrongdoing, indicating it may recommend that the Commission institute a civil injunctive action or public administrative proceeding against the System. The notice provided the System with an opportunity to provide the Commission with information as to why such action or proceeding should not be brought against the System. WPAHS furnished a "Wells Submission" to the Commission on December 28, 2012, setting forth the bases for the System's belief that such action or proceeding was not warranted. On May 20, 2013, WPAHS received notice from the SEC stating the investigation has been concluded.

In April 2009, a putative collective action was filed in the United States District Court for the Western District of Pennsylvania alleging claims under ERISA, RICO, and the Fair Labor Standards Act against WPAHS, certain of its related entities, and certain WPAHS executives. The suit alleges that current and former employees did not receive compensation for all hours worked. A companion class action suit alleging various state court claims was filed in the Court of Common Pleas of Allegheny County. In late December 2011, the District Court for the Western District of Pennsylvania denied the certification of the class action suit and the case is currently pending before the federal Third Circuit Court of Appeals. In the state suit, the judge dismissed the meal break claims but preserved potential nonmeal break wage claims. That case is stayed pending the outcome of the federal appeal. Although WPAHS believes the matter will

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Amounts in thousands)

be resolved without any material adverse impact on WPAHS' financial condition, particularly in light of the district court's decision to deny collective action certification to the federal action, the final outcome and effect on WPAHS is unknown at this time.

In 2010, the System was informed by Highmark Health Services that it took exception to the conversion of several oncology infusion centers from free-standing to hospital-based. In August 2010, Highmark Health Services exercised its right under its provider contract to submit the dispute to binding arbitration. The System believes that the conversions of all of these sites are permissible under the provider contract and believes its position will prevail in the arbitration. At June 30, 2010, the System reserved \$8,500 of incremental revenue received from Highmark Health Services as a result of these conversions. In October 2011, Highmark Health services dismissed with prejudice all claims asserted against WPAHS in the arbitration, which resolution included Highmark Health Service's agreement not to dispute past payments nor adjust ongoing payments for disputed claims prior to the resolution date.

WPAHS has conducted an investigation of its leasing activity with independent physicians. Certain of these arrangements potentially implicate the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)), the civil monetary penalty authorities (42 U.S.C. § 1320a-7a), and the physician self-referral law (42 U.S.C. § 1395nn) (the Stark law). WPAHS submitted a preliminary self-disclosure report of certain of these arrangements to the HHS Office of Inspector General (OIG) pursuant to the OIG's self-disclosure protocol on December 20, 2012. WPAHS received a letter from the OIG dated February 27, 2013 accepting the submission into the OIG's self-disclosure protocol. WPAHS submitted a supplemental disclosure report to the OIG on March 22, 2013, identifying certain additional lease arrangements that it requests to be included in the self-disclosure protocol. On May 31, 2013, WPAHS disclosed certain other lease arrangements involving potential noncompliance with the Stark law to the Centers for Medicare and Medicaid Services (CMS). These disclosure reports are not an admission of liability with respect to the disclosed matters, but are intended to facilitate a resolution by settlement of potential violations of the aforementioned laws. WPAHS may be subject to fines and penalties with respect to the lease arrangements that are the subject of the disclosures. At June 30, 2012, the System recorded an estimated liability of \$2,200 in the accompanying consolidated balance sheet for potential fines and penalties related to the OIG self-disclosure. WPAHS is unable to determine a reasonable estimate of any financial liability that may result from its self-disclosure report to CMS at this time. WPAHS cannot be assured that the amount provided in the financial statements relating to these matters will be sufficient to address all potential liabilities given that the outcomes of these self-disclosures are unknown as of the opinion date. Accordingly, the impact to the consolidated financial statements could be material.

WPAHS is additionally subject to various legal proceedings and claims consistent with an organization of its size arising in the ordinary course of its business and not yet adjudicated.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Notes to Consolidated Financial Statements

June 30, 2012 and 2011

(Amounts in thousands)

Based upon information known to WPAHS, and after consultation with legal counsel, the ultimate outcome of the lawsuits and claims discussed above are unlikely to have a material adverse effect on the consolidated balance sheet, results of operations, or cash flows of WPAHS.

(20) Subsequent Events

WPAHS has evaluated subsequent events through July 15, 2013, the date the financial statements were issued. See also discussion of subsequent events in note 2 and note 19.

SUPPLEMENTARY INFORMATION

WEST PENN ALLEGHENY HEALTH SYSTEM, INC. AND SUBSIDIARIES

Schedule of Expenditures of Federal Awards

Year ended June 30, 2012

Federal Grantor/Program/Grant	Pass-through grantor	CFDA Number	Expenditures
RESEARCH & DEVELOPMENT CLUSTER			
U.S. Department of Health and Human Services			
Oral Diseases and Disorders Research	NIH – National Institute of Dental and Craniofacial Research	93.121	\$ 202,292
Oral Diseases and Disorders Research	RTI International	93.121	42,625
Total CFDA # 93.121			<u>244,917</u>
Research Related to Deafness and Communication Disorders	NIH – National Institute on Deafness and Other Communication Disorders	93.173	458,767
Research Related to Deafness and Communication Disorder	Novoflux Technologies	93.173	51,570
Total CFDA # 93.173			<u>510,337</u>
Mental Health Research Grants	NIH – National Institute of Mental Health	93.242	380,233
Mental Health Research Grants	Los Angeles Biomedical Research Institut	93.242	16,290
Mental Health Research Grants	University of Pittsburgh	93.242	31,616
Mental Health Research Grants	University of Texas	93.242	27,365
Total CFDA # 93.242			<u>455,504</u>
Substance Abuse and Mental Health Services Projects of Regional and National Significance	Substance Abuse and Mental Health Services Administratio	93.243	515,551
Substance Abuse and Mental Health Services Projects of Regional and National Significance	American Psychiatric Associator	93.243	7,733
Substance Abuse and Mental Health Services Projects of Regional and National Significance	Research Foundation	93.243	3,700
Total CFDA # 93.243			<u>526,984</u>
Discovery and Applied Research for Technological Innovations to Improve Human Health	Carnegie Mellon University	93.286	10,092
Total CFDA # 93.286			<u>10,092</u>
Cancer Detection and Diagnosis Research	NSABP Foundation	93.394	6,325
Total CFDA # 93.394			<u>6,325</u>
Cancer Treatment Research	American College of Radiology Imaging	93.395	14,528
Cancer Treatment Research	American College of Surgical Oncology	93.395	18,153
Cancer Treatment Research	CTSU/ECOG	93.395	11,389
Cancer Treatment Research	CTSU/NSABP	93.395	37,820
Cancer Treatment Research	Duke University	93.395	1,251
Cancer Treatment Research	NSABP Foundation	93.395	457,696
Cancer Treatment Research	Radiation Therapy Oncology Group	93.395	3,046
Cancer Treatment Research	The Cleveland Clinic Foundatio	93.395	3,669
Cancer Treatment Research	University of Chicag	93.395	144,690
Total CFDA # 93.395			<u>692,242</u>
Cancer Control	NSABP Foundation	93.399	149,133
Total CFDA # 93.399			<u>149,133</u>
ARRA – Trans-NIH Recovery Act Research Support	NIH – National Institute of Dental and Craniofacial Research	93.701	95,426
ARRA – Trans-NIH Recovery Act Research Support	NIH – National Institute of Allergy and Infectious Disease	93.701	167,885
ARRA – Trans-NIH Recovery Act Research Support	NIH – National Institute of Neurological Disorders and Stroke	93.701	138,484
ARRA – Trans-NIH Recovery Act Research Support	Blenderhouse LLC	93.701	780
ARRA – Trans-NIH Recovery Act Research Support	Cytokinetics, Inc.	93.701	33,157
ARRA – Trans-NIH Recovery Act Research Support	The Emmes Corporation	93.701	42,465
ARRA – Trans-NIH Recovery Act Research Support	University of Cincinnati	93.701	17,918
ARRA – Trans-NIH Recovery Act Research Support	University of Pittsburgh	93.701	8,704
Total CFDA # 93.701			<u>504,819</u>
Cardiovascular Diseases Research	Pennsylvania State University	93.837	20,925
Cardiovascular Diseases Research	University of Pittsburgh	93.837	79,465
Cardiovascular Diseases Research	Yale University	93.837	3,438
Total CFDA # 93.837			<u>103,828</u>
Blood Diseases and Resources Research	Duke University	93.839	15,400
Blood Diseases and Resources Researcl	Washington University	93.839	7,819
Total CFDA # 93.839			<u>23,219</u>
Arthritis, Musculoskeletal and Skin Diseases Research	NIH – National Institute of Arthritis and Musculoskeletal and Skin Diseases	93.846	172,430
Arthritis, Musculoskeletal and Skin Diseases Researcl	Columbia University	93.846	12,984
Arthritis, Musculoskeletal and Skin Diseases Researcl	Duquesne University	93.846	11,566
Arthritis, Musculoskeletal and Skin Diseases Researcl	University of Michigar	93.846	972
Arthritis, Musculoskeletal and Skin Diseases Researcl	University of Pittsburgh	93.846	147,944
Total CFDA # 93.846			<u>345,896</u>
Diabetes, Digestive, and Kidney Diseases Extramural Research	Queens University	93.847	202,098
Total CFDA # 93.847			<u>202,098</u>
Extramural Research Programs in the Neurosciences anc Neurological Disorders	Johns Hopkins University	93.853	35,732
Extramural Research Programs in the Neurosciences anc Neurological Disorders	Massachusetts General Hospital	93.853	30,675
Extramural Research Programs in the Neurosciences anc Neurological Disorders	Mt.Sinai School of Medicine	93.853	76,763
Extramural Research Programs in the Neurosciences anc Neurological Disorders	Optima Neuroscience	93.853	57,376
Extramural Research Programs in the Neurosciences anc Neurological Disorders	The University of Medicine and Dentistry, New Jerse	93.853	4,133
Extramural Research Programs in the Neurosciences anc Neurological Disorders	Temple University	93.853	5,281
Extramural Research Programs in the Neurosciences anc Neurological Disorders	University of Cincinnati	93.853	47,855
Extramural Research Programs in the Neurosciences anc Neurological Disorders	Yale University	93.853	65,381
Total CFDA # 93.853			<u>323,196</u>

WEST PENN ALLEGHENY HEALTH SYSTEM, INC. AND SUBSIDIARIES

Schedule of Expenditures of Federal Awards

Year ended June 30, 2012

<u>Federal Grantor/Program/Grant</u>	<u>Pass-through grantor</u>	<u>CFDA Number</u>	<u>Expenditures</u>
Allergy, Immunology and Transplantation Research	NIH – National Institute of Allergy and Infectious Diseases	93.855	\$ 300,287
Allergy, Immunology and Transplantation Research	Duke University	93.855	7,566
Allergy, Immunology and Transplantation Research	Feinstein Institute	93.855	500
Allergy, Immunology and Transplantation Research	University of Pittsburgh	93.855	200,482
Total CFDA # 93.855			<u>508,835</u>
Biomedical Research and Research Training	University of Pittsburgh	93.859	17,892
Total CFDA # 93.859			<u>17,892</u>
Child Health and Human Development Extramural Research	John Hopkins University	93.865	8,114
Child Health and Human Development Extramural Research	Magee-Women's Research Institute and Foundation	93.865	50,558
Child Health and Human Development Extramural Research	University of Michigan	93.865	4,692
Total CFDA # 93.865			<u>63,364</u>
National Institute of Health			
Contracted Services	National Institute of Health	HHSN2752021100444P	26,444
U.S. Department of Defense: W81XWH-09-1-0275-0740		W81XWH-09-1-0275-0740	114,363
The Major Extremity Trauma Research Consortium	Johns Hopkins University	W81XWH1020090	177,054
Military Medical Research and Development	Department of the United States Army	12.420	454,257
Military Medical Research and Development	Drexel University	12.420	17,023
Total CFDA # 12.420			<u>471,280</u>
Total Research & Development Cluster			<u>5,477,822</u>
STUDENT FINANCIAL AID CLUSTER			
U.S. Department of Health and Human Services Federal Nursing Student Loan		93.364	121,750
U.S. Department of Education: West Penn School of Nursing	Federal Pell Grant	84.063	103,165
Citizens School of Nursing	Federal Pell Grant	84.063	425,175
Total CFDA # 84.063			<u>528,340</u>
Federal Supplemental Education Opportunity Grant		84.007	15,863
Federal Direct Student Loans		84.268	1,771,923
Total Student Financial Aid Cluster			<u>2,437,876</u>
OTHER PROGRAMS			
U.S. Department of Health and Human Services Health Care and Other Facilities	Health Resources and Services Administration	93.887	237,880
National Bioterrorism Hospital Preparedness Program (SAP#4100050919)	Commonwealth of Pennsylvania	93.889	41,789
National Bioterrorism Hospital Preparedness Program (SAP#4100051025)	Commonwealth of Pennsylvania	93.889	37,090
National Bioterrorism Hospital Preparedness Program (SAP#4100051115)	Commonwealth of Pennsylvania	93.889	43,187
National Bioterrorism Hospital Preparedness Program (SAP#4100051117)	Commonwealth of Pennsylvania	93.889	52,782
National Bioterrorism Hospital Preparedness Program (SAP#4100045910)	Emergency Medical Services Institute	93.889	5,523
Total CFDA # 93.889			<u>180,371</u>
HIV Care Formula Grants	Jewish Healthcare Foundation	93.917	42,469
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	Health Resources and Services Administration	93.918	533,031
Total U.S. Department of Health and Human Services			<u>993,751</u>
U.S. Department of Energy: Office of Science Financial Assistance Program	Frac Biologics Inc.	81.049	14,949
Total U.S. Department of Energy			<u>14,949</u>
U.S. Department of Justice: Crime Victim Assistance/Discretionary Grant	American Psychological Association	16.582	6,126
Total U.S. Department of Justice			<u>6,126</u>
Total Federal Award Expenditures			\$ <u>8,930,524</u>

See accompanying independent auditors' report and notes to schedule of expenditures of federal awards.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Notes to Schedule of Expenditures of Federal Awards

June 30, 2012

(1) General

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) presents the activity of all federal financial assistance programs of West Penn Allegheny Health System, Inc. and Subsidiaries (WPAHS) for the year ended June 30, 2012. Federal awards received directly from federal agencies as well as federal awards passed through other government or not for profit agencies are included in the accompanying schedule.

The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Therefore, some of the amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic financial statements.

The American Recovery and Reinvestment Act of 2009 (Recovery Act) was enacted to promote economic recovery, make investments, and to minimize and avoid reductions in state and local government services. The stimulus dollars are identified in the accompanying schedule as "ARRA".

(2) Basis of Presentation

The accompanying Schedule is presented using the accrual basis of accounting. Funds received under various government grant programs are recognized as support over the grant period as expenditures are incurred.

(3) Loans Made

WPAHS does not receive any direct federal funds for the Federal Direct Student Loan (Direct) program, which includes Stafford Loans and Parents Loans for Undergraduate Students (PLUS). WPAHS processes student loan applications and the loans, which are guaranteed under this program, are ultimately made by banks. Loan disbursements under Direct (CFDA 84.268) for the year ended June 30, 2012, amounted to \$1,771,923. WPAHS also administers the Federal Nursing Student Loan Program (CFDA 93.364). Loan disbursements under this Program for the year ended June 30, 2012 amounted to \$121,750. The loans outstanding at June 30, 2012 under this program amounted to \$427,985.

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Notes to Schedule of Expenditures of Federal Awards

June 30, 2012

(4) Subrecipients

During the year ended June 30, 2012, WPAHS passed through to subrecipients \$543,157 of federal funding in the following programs:

CFDA	Passed through to subrecipients
12.420	\$ 94,600
93.121	5,209
93.173	87,207
93.242	138,112
93.243	108,221
93.701	89,284
93.846	20,524
	<hr/> \$ 543,157 <hr/>



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**Independent Auditors' Report on Internal Control Over Financial Reporting
and on Compliance and Other Matters Based on an Audit of
Financial Statements Performed in Accordance With
*Government Auditing Standards***

The Board of Directors
West Penn Allegheny Health System, Inc.:

We have audited the consolidated financial statements of West Penn Allegheny Health System, Inc. and Subsidiaries (WPAHS) as of and for the year ended June 30, 2012, and have issued our report thereon dated July 15, 2013. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control over Financial Reporting

Management of WPAHS is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered WPAHS' internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of WPAHS' internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of WPAHS' internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all deficiencies, significant deficiencies, or material weaknesses have been identified. However, as described below, we identified a combination of deficiencies in internal control that we consider to be a material weakness and other deficiencies that we consider to be significant deficiencies.

A deficiency in internal control over financial reporting exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. We consider the deficiencies described in the accompanying schedule of findings and questioned costs as 2012-02, 2012-03 and 2012-04 to be a material weakness in internal control over financial reporting.

A significant deficiency is a deficiency, or combination of deficiencies, in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiency described in the accompanying schedule of findings and questioned costs as 2012-01 to be a significant deficiency in internal control over financial reporting.



Compliance and Other Matters

As part of obtaining reasonable assurance about whether WPAHS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

We noted certain matters that we reported to management of WPAHS in a separate letter dated July 15, 2013.

WPAHS' responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. We did not audit WPAHS' response and, accordingly, we express no opinion on it.

This report is intended solely for the information and use of management, the Board of Directors, others within the entity, and granting agencies and pass-through entities, and is not intended to be and should not be used by anyone other than these specified parties.

KPMG LLP

July 15, 2013



KPMG LLP
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Independent Auditors' Report on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance With OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*

The Board of Directors
West Penn Allegheny Health System, Inc.:

Compliance

We have audited West Penn Allegheny Health System, Inc. and Subsidiaries' (WPAHS) compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Circular A-133 Compliance Supplement* that could have a direct and material effect on each of WPAHS's major federal programs for the year ended June 30, 2012. WPAHS's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of WPAHS's management. Our responsibility is to express an opinion on WPAHS's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about WPAHS's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of WPAHS's compliance with those requirements.

In our opinion, WPAHS complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2012.

Internal Control Over Compliance

Management of WPAHS is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered WPAHS's internal control over compliance with the requirements that could have a direct and material effect on a major federal program to determine the auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of WPAHS's internal control over compliance.



A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A material weakness in internal control over compliance is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above.

WPAHS's responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. We did not audit WPAHS's responses and, accordingly, we express no opinion on the responses.

This report is intended solely for the information and use of the Board of Directors, management, others within the entity, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

KPMG LLP

July 29, 2013

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
AND SUBSIDIARIES**

Schedule of Findings and Questioned Costs

June 30, 2012

(1) Summary of Auditors' Results

(a) The type of report issued on the consolidated financial statements:	Unqualified opinion
(b) Significant deficiencies in internal control were disclosed by the audit of the consolidated financial statements:	Yes
Material weaknesses:	Yes
(c) Noncompliance which is material to the consolidated financial statements:	No
(d) Significant deficiencies in internal control over major programs:	No
Material weaknesses:	No
(e) The type of report issued on compliance for major programs:	Unqualified opinion
(f) Any audit findings which are required to be reported under Section 510(a) of OMB Circular A-133:	Yes
(g) Major programs: Research and Development Cluster	
(h) Dollar threshold used to distinguish between Type A and Type B programs:	\$ 300,000
(i) Auditee qualified as low-risk auditee under Section 530 of OMB Circular A-133:	Yes

(2) Findings Relating to the Financial Statements Reported in Accordance with *Government Auditing Standards*

Finding 2012-01: *IT General Controls*

During 2012, the System continued to work toward implementing improvements to its IT environment. However, during our testing we noted opportunities for further improvements, specifically related to the following exceptions noted:

- The approval for system access to the System's LAN is not consistently documented on an Access Request Form. It is recommended that the forms are centrally approved and managed in digital form by IT security for all systems and applications. Currently, both digital and paper forms exist, creating a decentralized environment which leads to inconsistent audit evidence and control breakdowns and/or failures.
- System access for terminated employees is not consistently disabled on a timely basis. Systems impacted include: Active Directory and Meditech. It is recommended that the System move to a

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state where IT security is centrally managed for all applications. Currently, multiple shadow IT groups exist creating a decentralized environment which leads to inconsistent practices and control breakdowns and/or failures.

- Password history, expiration, complexities, and length constraints are not enforced on a variety of systems. Additionally, the lockout threshold is not enforced on a variety of systems. It is recommended that a tool such as single sign-on be adopted where a single password policy could be applied to all applications and systems. It is also recommended that application integration through Active Directory be a selection criteria going forward for new or updated applications.
- Logical access to certain financial applications and their supporting platforms tested by KPMG were not reviewed at least annually within the reporting period. The systems impacted include: Intergy and Athena. It is recommended that the System centralize access administration and staffing to support this initiative, which would allow for the System to implement quarterly reviews for each application to validate and verify the appropriateness of their administrative and privileged users.
- Inappropriate users with privileged access retained logical access to certain financial applications and their supporting platforms tested by KPMG. The systems impacted include: Meditech and Invision. It was noted that contractors/consultants comprise the majority of these users identified as inappropriate users. It is recommended that the System centralize access administration and staffing to support this initiative, which would allow for the System to implement quarterly reviews for each application to validate and verify the appropriateness of their administrative and privileged users.
- Physical access for terminated employees is not consistently disabled on a timely basis. It is recommended that the System centralize access administration and staffing to support this initiative, which would allow for the System to implement quarterly reviews for each high risk data area to validate and verify the appropriateness of users with access.
- Employees have physical access to the data centers that is not necessary to perform their job functions. It is recommended that the System centralize access administration and staffing to support this initiative, which would allow for the System to implement quarterly reviews for each high risk data area to validate and verify the appropriateness of users with access.
- The approval for physical access to the System's data center is not consistently documented on an Access Request Form. It is recommended that the forms are centrally approved and managed in digital for by IT security for all WPAHS data center locations. Currently, both digital and paper forms exist, creating a decentralized environment which leads to inconsistent audit evidence and control breakdowns and/or failures.

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- Operating system patching is not consistently logged on a timely basis, resulting in a lack of documentation that verifies systems were updated on a timely basis. Currently 16 of the 16 servers housing financially significant systems were missing “important” security patches. It is recommended that the System invest in tools/technology that to help identify, evaluate, approve, test, install, and document security patches.

These deficiencies, in aggregate, create risk to the integrity of the data maintained within the IT environment. We recommend that IT management continue to develop system improvements and processes to mitigate the risk arising from these items.

Management Response and Corrective Action Plan:

Many of the deficiencies identified by the independent auditors have been raised in prior communication; however, the System has not been able to address them properly due to resource constraints (capital and personnel) and product limitations (outdated software and limited vendor support). More specifically:

LAN ID’s are being processed through the Archer electronic LAN ID request form. A few requests still come through the paper based forms as users adjust to the process. The goal is to be 100% compliant with the electronic form by July 2013.

Human Resources (HR) implemented a new system to manage the termination process and make it easier for managers to complete these requests. The system is web-based and collects all of the necessary information to process the termination. Upon submittal, the form is sent to HR for processing and an email is immediately sent to IT to terminate access.

Currently access management is not a centralized function. Access management exists within IT security, individual IT departments, and sometimes within the business units. IT security has assessed centralizing access administration; however additional funding for staff as well as technology would be required to centralize management of all 200+ applications. Reallocating staff currently performing access administration functions was assessed; however these individuals currently perform other operational functions where access administration is a small portion of their responsibilities. Reallocating these individual’s time would have a significant impact on the daily operational functions of their teams.

Physical access to the datacenter has been addressed and access reviews now occur every six months. Access to the datacenter requires a form to be signed off on by the manager and reviewed by IT security. This currently remains a paper-based process.

Password Management

Meditech (two versions, two facilities), Athena (Physician Organization) and Invision (three versions and three facilities) had their password complexities adjusted to meet requirements, where feasible.

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For example, due to the age of the Invision software, some of the settings that would be expected are not possible to configure.

Single sign-on is in the process of being implemented at the hospitals. Currently parts of Allegheny General Hospital (AGH) and The Western Pennsylvania Hospital (WPH) have been established. Additional funding is required to complete the rollout of the solution and integration with the applications supported by WPAHS.

Application integration with Active Directory is the recommended direction for applications that can support it, unfortunately Meditech, Athena and Invision as well as most other system employed by WPAHS do not have that capability in their current versions. IT leadership is awaiting new versions from the vendors and/or funding to implement the upgrades.

Patch Management

A vulnerability management program is in place to identify system and application vulnerabilities. Regular vulnerability scans are performed quarterly on all servers and a sampling of desktops. PCI compliant scans are performed quarterly on Internet-facing systems.

Patching solutions for desktops are in place and updating desktops every 30 days or sooner, depending on the threat level of the vulnerability.

Patching issues do not apply to:

- Athena which is a vendor managed cloud-based solution
- Invision which is a mainframe environment, also managed by the vendor
- Meditech which is a closed, proprietary system

Application teams will work closely with the server team to ensure appropriate patches are applied to the server operating system. When the application itself is undergoing an upgrade or point release, missing operating system patches will be reviewed and applied as well.

Investment in tools to automate the process is required, primarily from a staffing perspective. In some cases additional server environments will need to be purchased and installed to address testing and staging environments.

Finding 2012-02: *Lease Management*

Management frequently enters into leasing arrangements for its facilities with physicians and physician practice groups. During the course of our audit procedures, we noted that management does not have a process in place to manage and monitor these leases, possibly resulting in: a) expired leases and a new lease has not yet been executed but the tenant continues to occupy the space, b) leases not renewed at their fair market value, and c) leases that do not represent the entire space used by the tenant. If unmonitored, these arrangements could result in potential violations of law, in accordance with the federal anti-kickback statute (42 U.S.C. §1320a-7b(b)), the civil monetary

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penalty authorities (42 U.S.C. §1320a-7a), and the physician self-referral law (42 U.S.C. §1395nn) (the Stark Law).

We recommend that management implement the following items that were proposed as a part of its self-disclosure to the Office of Inspector General as a corrective action to detect and prevent further possible violations of law:

- Space in the System's facilities should be evaluated to ensure that space rented to physicians is appropriately measured and corresponds to actual use;
- Vacant space in the hospital-owned facilities should be identified and tracked;
- Lease documentation should appropriately identify the specific premises to be used by the physician-tenant; and
- Periodic physical inventories of WPAHS owned/leased space should be conducted.

Management Response and Corrective Action Plan:

Management acknowledges that WPAHS did not effectively handle the lease administration process for a significant period of time, resulting in a number of problematic lease arrangements with physicians and physician groups which occurred primarily between 2007 and 2010. Prior to the fall of 2009, WPAHS used a decentralized lease administration process resulting in each hospital or corporate entity within the System conducting its own leasing activities, with minimal coordination or oversight by the parent organization. The decentralized authority for lease arrangements led to inconsistent practices and a lack of effective internal controls across the System. In addition, WPAHS experienced significant turnover in management and administrative staff at AGH and WPH (the location of most of the problematic leases). This turnover contributed to gaps in management of the leasing activity. Since the fall of 2009, WPAHS has contracted with a third party real estate management company to establish internal controls and centralize and improve the lease administration process. Beginning in 2012, the following additional measures have been implemented by management:

1. Full-time, executive now serves as the Corporate Vice President for Facilities/Real Estate.
2. Procedure has been implemented that requires every new lease and lease renewal to be approved by this executive. The procedure has been communicated to all hospital leadership. All new leases are (a) referred to the Facilities/Real Estate Department for development and (b) prepared using standard, commercial lease agreements that have been reviewed by the Legal Department and contain rental rates that have been determined to be fair market value based on industry-acceptable data and criteria.
3. The third party real estate management company is monitoring its lease administration database for lease renewals. The management company alerts the WPAHS Facilities/Real Estate and Legal Departments at least 90 days prior to the expiration date of the term.

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4. Committee has been established to develop new policies pertaining to WPAHS' lease negotiation and oversight processes – composed of representatives from the Legal Department, Facilities/Real Estate Department, and the third party real estate management company. The committee has been meeting regularly to develop policies for negotiating and monitoring leases, validating space used by or rented from physicians, producing vacancy and occupancy reports, and handling market analysis to ensure fair market value rental rates are used in lease arrangements.

Finding 2012-03: *Accounts Receivable*

During the course of our audit procedures, we identified that gross accounts receivable were significantly increasing as compared to prior periods. Upon further discussions with revenue cycle management and others within the System, it was noted that the gross receivable balances were increasing due to a variety of factors, including: insufficient denials management process, decreased overall collection activities (including both front and back-end collections), incomplete charge capture, and insufficient monitoring of underpayments. While the gross accounts receivable was increasing, management was performing an analysis over the net patient accounts receivable to be received and as such, the allowances on patient accounts receivable increased accordingly. Additionally, during the course of our audit procedures we were informed of a misappropriation of funds from a former employee in the physician revenue cycle which was the result of a lack of internal controls surrounding the posting of cash for physician practice platforms.

We recommend that management put in place procedures to increase the efficiency and effectiveness of the revenue cycle surrounding charge capture, collection activities (on both the front and back-end), as well as a review of the payments received as compared to its contracts to identify underpayments received. Additionally, we recommend that management put in place procedures to reconcile on a timely basis the cash posted per the patient billing systems to the cash deposited in the respective bank accounts.

Management Response and Corrective Action Plan:

Management provided supporting evidence to substantiate the net realizable value of the accounts receivable as stated at June 30, 2012 through, among other items, subsequent collections analysis. Per the request of KPMG, the subsequent collection review was extended through mid-December 2012. KPMG reviewed this analysis and concurred with management that no adjustment to the June 30, 2012 net realizable accounts receivable value was warranted.

Management reviewed the following initiatives with KPMG to address concerns raised during the audit:

Technology Enhancement

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Manual processes associated with the working of the accounts receivable have resulted in collections not being posted in a timely manner. To that end, management has developed a plan to improve technology over the next 6-9 months. Management has engaged Siemens Corporation to assist in implementing their Receivable Policy Manager product to eliminate the majority of these manual processes and establish management tools for work distribution and analysis of collector performance.

Management also implemented the Mede-Analytics denials management tool that now enables denials to be identified and categorized for resolution within the same week in which they occur. Extensive training was held with clinical leadership to identify areas of opportunity and management is currently establishing a dedicated team to work denials on a daily basis.

Finally, plans are underway to install a new claims “scrubber” over the next 90-120 days to enhance the “clean claim” rate and eliminate significant manual intervention in the processing of billing edits. Management is also dedicating a team to evaluate the root cause of the rejections to help eliminate future processing delays.

Incomplete Charge Capture

Management hired a national firm to evaluate chargemaster pricing, the integrity of the charge capture and reconciliation process and determine if adequate resources were present to ensure the timely and accurate processing of charges. Their findings revealed an annual \$6-8 million net opportunity, accounting for the staffing that would be required to ensure sustainable results. The individual Hospital findings were shared with each facility. Management is currently evaluating next steps to implement their recommendations.

Underpayments

Management currently utilizes an outside vendor to identify underpayments due to limitations with internal system capabilities. Management has dedicated resources over the last several months to enhance the Contract Manager product and is positioned in the next 3-6 months to bring this function back in-house. Management is currently renegotiating lower fees for this service during the transition period, and identifying internal resources to develop a revenue integrity group.

Staff Redeployment

Management is redeploying staff to migrate away from a combined approach of Billing/Collections to a specialized model utilizing their areas of expertise in a more focused manner. Daily monitoring tools have been developed to ensure productivity goals are obtained and staffing dependency on outsourced vendors is mitigated.

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Cash Controls

Management has implemented a comprehensive plan to mitigate potential inappropriate activity in the cash processing area. Management closed all post office boxes where cash was being manually processed and redirected these receipts directly to the System established bank lockboxes. Controls were established to minimize the manual processing of checks coming to the Corporate Offices, with redirection of these to the lockboxes as well. Accounting is working with management to establish daily reconciliation processes between the deposits, bank records and the internal systems. Credit card processing resulting from customer service calls has also been streamlined. The group continues to meet regularly to further strengthen these processes.

Finding 2012-04: *Review of Significant Transactions and Events*

The last two years have seen the System operate in a very fluid environment, such as it has not encountered in recent history. There were several significant transactions and negotiations, the potential outcome of which impacted the classification of certain items in the financial statements, (assets, liabilities, revenues or expenses).

We recommend that management enhance its procedures to review all aspects of the System's significant transactions, based on the latest information available, to ensure that matters are appropriately reflected in the financial statements with respect to classification.

Management Response and Corrective Action Plan:

Management currently reviews the accounting impact of significant transactions as they arise, though such review should be performed prospectively and more fully documented. In going forward, management will develop a formal policy regarding the accounting treatment of significant transactions.

(3) Findings and Questioned Costs Relating to Federal Awards:

None noted.

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(1) Findings Relating to the Financial Statements Reported in Accordance with *Government Auditing Standards*

Finding 2011-01: IT General Controls

During 2011, the System continued to work toward implementing improvements to its IT environment. However, during our testing we noted opportunities for further improvements, specifically related to the following exceptions noted:

- System access for terminated employees is not consistently disabled on a timely basis. Systems impacted include: Novell, Active Directory, Invision, IDX, Signature Meditech, McKesson, and Athena health. It is recommended that the System move to a state where IT security is centrally managed for all applications. Currently, multiple shadow IT groups exist creating a decentralized environment which leads to inconsistent practices and control breakdowns and/or failures.
- Password history, expiration, complexities, and length constraints are not enforced on a variety of systems. Additionally, the lockout threshold is not enforced on a variety of systems. It is recommended that a tool such as single sign-on be adopted where a single password policy could be applied to all applications and systems. It is also recommended that application integration through Active Directory be a selection criteria going forward for new or updated applications.
- Operating system patching is not consistently logged on a timely basis, resulting in a lack of documentation that verifies systems were updated on a timely basis. It is recommended that the System invest in tools/technology that to help identify, evaluate, approve, test, install, and document security patches.
- Inappropriate users with privileged access retained logical access to certain financial applications and their supporting platforms tested by KPMG. The systems impacted include: Invision, IDX, Signature, Athena health. It was noted that contractors/consultants comprise the majority of these users identified as inappropriate users. Remediation of this finding is, in part, dependent on centralization of access administration and staffing to support this initiative, which would allow for the System to implement quarterly reviews for each application to validate and verify the appropriateness of their administrative and privileged users.

These deficiencies, in aggregate, create risk to the integrity of the data maintained within the IT environment. We recommend that IT management continue to develop system improvements and processes to mitigate the risk arising from these items.

Management Response and Corrective Action Plan:

- Access administration is not centralized currently within the WPAHS business enterprise or within Information Technology department. Within the IT group, the Access Administration team handles account management for roughly 15% of the applications used. Other applications

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are supported by the IT department that owns/manages the application or are supported by the business units/departments directly.

Currently, IT Security receives a termination report from HR Monday of each week following payroll. This report is used by IT Security to terminate the accounts in the system managed by the team. IT Security forwards this report to all of the team members who have access administration functions for the various other applications. Each team is responsible for managing and auditing the accounts and access of their respective application(s).

IT Security has evaluated costs associated with centralizing account management and provisioning for the approximately 280 applications currently deployed. When evaluating technology to help address this issue, the project was estimated at over \$1 million dollars to create a centralized management, provisioning, and auditing solution for the key 5-10 clinical applications.

IT Security evaluated transitioning employees that are performing the access administration functions for the non-centrally managed systems; unfortunately those resources are not dedicated to access administration and would not result in a net zero gain of FTE's. To migrate all account services to IT Security, it is estimated an additional 18 to 22 employees would need to be added to the team to support all 280 applications.

Given the volume of changes and the scope of this issue, IT and the other teams that support administrative access rights need additional resources to provide the access management services recommended above.

IT recommends the consolidation of shadow IT groups into IT in order to centralize and standardize the ongoing management and maintenance of critical applications within WPAHS.

UPDATE -

LAN ID's are being processed through the Archer electronic LAN ID request form. A few requests still come through the paper based forms as users adjust to the process. The goal is to be 100% compliant with the electronic form by July 2013.

Human Resources (HR) implemented a new system to manage the termination process and make it easier for managers to complete these requests. The system is web-based and collects all of the necessary information to process the termination. Upon submittal, the form is sent to HR for processing and an email is immediately sent to IT to terminate access.

Currently access management is not a centralized function. Access management exists within IT security, individual IT departments, and sometimes within the business units. IT security has assessed centralizing access administration; however additional funding for staff as well as technology would be required to centralize management of all 200+ applications. Reallocating staff currently performing access administration functions was assessed; however these individuals currently perform other operational functions where access administration is a small portion of their responsibilities. Reallocating these individual's time would have a significant impact on the daily operational functions of their teams.

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Physical access to the datacenter has been addressed and access reviews now occur every six months. Access to the datacenter requires a form to be signed off on by the manager and reviewed by IT security. This currently remains a paper-based process.

Password Management

Meditech (two versions, two facilities), Athena (Physician Organization) and Invision (three versions and three facilities) had their password complexities adjusted to meet requirements, where feasible. For example, due to the age of the Invision software, some of the settings that would be expected are not possible to configure.

Single sign-on is in the process of being implemented at the hospitals. Currently parts of Allegheny General Hospital (AGH) and The Western Pennsylvania Hospital (WPH) have been established. Additional funding is required to complete the rollout of the solution and integration with the applications supported by WPAHS.

Application integration with Active Directory is the recommended direction for applications that can support it, unfortunately Meditech, Athena and Invision as well as most other system employed by WPAHS do not have that capability in their current versions. IT leadership is awaiting new versions from the vendors and/or funding to implement the upgrades.

Patch Management

A vulnerability management program is in place to identify system and application vulnerabilities. Regular vulnerability scans are performed quarterly on all servers and a sampling of desktops. PCI compliant scans are performed quarterly on Internet-facing systems.

Patching solutions for desktops are in place and updating desktops every 30 days or sooner, depending on the threat level of the vulnerability.

Patching issues do not apply to:

- Athena which is a vendor managed cloud-based solution
- Invision which is a mainframe environment, also managed by the vendor
- Meditech which is a closed, proprietary system

Application teams will work closely with the server team to ensure appropriate patches are applied to the server operating system. When the application itself is undergoing an upgrade or point release, missing operating system patches will be reviewed and applied as well.

Investment in tools to automate the process is required, primarily from a staffing perspective. In some cases additional server environments will need to be purchased and installed to address testing and staging environments.

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- A formal process for Application Risk Assessment was initiated in June 2010. This assessment collects information about the security configurations to help determine compliance with acceptable password standards. Currently 140 of the 280 applications have been assessed. The remaining 140 applications will be complete by June 2012.

Where possible, application access control is being migrated to Active Directory. Unfortunately, many of the applications do not support this capability to integrate with Active Directory. It should also be noted that given the age and capabilities of certain health care applications at WPAHS, certain applications will NOT be able to comply with best-practice password standards (for example, some applications do not permit special characters and others only permit a maximum of 6 characters). In these cases, other mitigating controls will be identified, the systems will be upgraded, or the specific level of risk will be deemed acceptable.

A single sign-on solution will be reviewed in 2012 as part of the IT strategic planning process for capital requirements and enterprise-wide system integration.

UPDATE

Risk assessments were completed for all current applications at the end of FY12. Applications that required changes to strengthen passwords were identified and prioritized. We have prioritized the applications requiring changes to the password settings and are beginning the conversions as current resources are available.

Our recommendation to implement single sign-on and identity management are awaiting funding decisions.

Integration issues with Active Directory still exist with current and legacy applications. A migration to the EPIC platform will make significant strides to address these issues as well as single sign-on and password management.

Allscripts Enterprise, Sunrise, Meditech and Athena passwords were addressed to meet the minimum strength requirements. Ancillary systems still require changes. Due to the number of systems supported and that these systems do not consistently allow for the same password settings, employees and Physicians are struggling with the number of passwords required to be remembered. An implementation of EPIC will help to address this issue by reducing the overall number of systems.

- While a formal Patch Management process exists, appropriate tools to manage and report on the patch management process did not exist until recently. In FY2011, a new licensing agreement was signed with Microsoft that provides WPAHS access to its suite of system management tools to help address this issue. Employees are scheduled for training on the tool in the month of October and will begin implementing the technology this year. Due to the number of systems, this will be a multi-year project focusing on first patching our servers hosting critical applications. WPAHS has also implemented vulnerability scanning of servers and desktops to help identify system vulnerabilities and remediate issues found in this process.

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There are certain applications and systems that require 3rd party vendor involvement for patching. In some cases, vendors will not allow certain patches to be applied (or operating systems to be upgraded). In these cases, other mitigating controls are in place, such as anti-virus systems and robust system monitoring.

UPDATE –

Patch management is still in the process of being rolled out for the enterprise.

Vulnerability scanning has been implemented and is in use. Scans are run quarterly and the results are provided to the system owners to address. This issue is considered closed.

Third party products still exist in the environment that patching is a responsibility of the vendor. WPAHS is contractually prevented from apply patches to these components. This issue is considered closed.

A patch management process to identify and inform the teams of the issues they need to remediate is in place. Patching of desktops and laptops occurs every month. Patching of servers occur ad-hoc due to lack of resources to thoroughly test patches and the lack of testing environments for many applications.

- Audits of user accounts are ad-hoc due to the number of applications in the environment and the number of FTEs supporting them. IT agrees that these issues are related to centralization of access administration and staffing. As stated in the management responses above, IT recommends centralization of shadow IT groups to help remediate this issue. In addition, significant additional resources will be required to complete this process for the approximately 280 applications within the WPAHS enterprise.

UPDATE -

Audits of user accounts are still ad-hoc due to the number of applications in the environment and the number of FTE's supporting them.

A migration to the EPIC platform will make significant strides to address these issues since it's an integrated healthcare platform and will significantly reduce the number of systems supported today.