Consolidated Financial Statements and Supplementary Information

Memorial Hermann Health System
Years Ended June 30, 2018 and 2017
With Report of Independent Auditors

Ernst & Young LLP

Building a better working world

Memorial Hermann Health System

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2018 and 2017

Contents

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Report of Independent Auditors

Management and the Board of Directors
Memorial Hermann Health System

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Memorial Hermann Health System (the Health System), which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States 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 consolidated financial statements are free of material misstatement.

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Health System as of June 30, 2018 and 2017, and the changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying Schedule of Expenditures of Federal Awards as required by Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our report dated October 1, 2018 on our consideration of the Health System's 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 solely 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 effectiveness of the Health System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control over financial reporting and compliance.

Ernst + Young LLP

October 1, 2018, except for the schedule
of expenditure of federal awards for which
the date is March 27, 2019

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Report of Independent Auditors 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

Management and Board of Directors
Memorial Hermann Health System

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Memorial Hermann Health System (the Health System), which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements, and have issued our report thereon dated October 1, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Health System's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

A *deficiency in internal control* 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, 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. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

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Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's 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*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

October 1, 2018

Memorial Hermann Health System

Consolidated Balance Sheets

(In Thousands)

	June 30 2018	June 30 2017
Assets		
Current assets:		
Cash and cash equivalents, including $6,656 and $27,334 of assets limited as to use in 2018 and 2017, respectively	**$ 371,026**	$ 337,551
Patient accounts receivable, net of allowances for bad debt (2018 – $561,415; 2017 – $702,890)	**665,617**	654,465
Other current assets	**215,710**	214,895
Total current assets	**1,252,353**	1,206,911
Investments	**2,354,526**	2,159,276
Assets limited as to use, less current portion	**250,275**	335,068
Property, plant, and equipment, net	**3,029,293**	2,905,581
Other assets	**217,777**	212,753
Total assets	**$ 7,104,224**	$ 6,819,589
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 298,593**	$ 299,452
Accrued payroll and related expenses	**223,090**	218,504
Other accrued expenses	**206,472**	206,426
Current portion of long-term debt, including capital lease obligations	**52,475**	51,654
Long-term debt subject to liquidity agreements	**454,966**	383,721
Total current liabilities	**1,235,596**	1,159,757
Long-term debt, including capital lease obligations	**1,799,296**	1,870,843
Other long-term obligations	**490,932**	528,844
Total liabilities	**3,525,824**	3,559,444
Net assets, including noncontrolling interest of $130,928 and $124,936 in 2018 and 2017, respectively	**3,578,400**	3,260,145
Total liabilities and net assets	**$ 7,104,224**	$ 6,819,589

See accompanying notes.

Memorial Hermann Health System

Consolidated Statements of Operations and Changes in Net Assets

(In Thousands)

	Year Ended June 30	
	2018	**2017**
Revenues, gains, and other support:		
Net patient service revenue before bad debt provision	**$ 5,522,555**	$ 5,280,121
Provision for bad debt	**(668,061)**	(656,675)
Net patient service revenue	**4,854,494**	4,623,446
Premium revenue, net	**144,318**	167,141
Other revenue	**259,322**	270,939
Total revenues, gains, and other support	**5,258,134**	5,061,526
Expenses:		
Salaries, benefits, and related personnel costs	**2,303,629**	2,282,729
Services and other	**1,438,477**	1,393,490
Supplies and medicines	**920,957**	862,988
Outside medical claims	**85,416**	91,226
Depreciation and amortization	**287,725**	271,544
Interest	**93,237**	88,914
Total expenses	**5,129,441**	4,990,891
Operating income	**128,693**	70,635
Nonoperating activities:		
Investment gains, net	**190,866**	218,673
Interest rate swap agreements	**13,544**	26,596
Revenues in excess of expenses	**333,103**	315,904
Revenues in excess of expenses attributable to noncontrolling interests	**(64,013)**	(61,375)
Revenues in excess of expenses attributable to the Health System	**269,090**	254,529
Other changes in net assets:		
Change in pension obligation	**31,646**	39,188
Contributions and grants received and other changes in net assets, net	**11,527**	22,343
Change in noncontrolling interests	**5,992**	(3,055)
Change in net assets	**318,255**	313,005
Net assets at beginning of year	**3,260,145**	2,947,140
Net assets at end of year	**$ 3,578,400**	$ 3,260,145

See accompanying notes.

Memorial Hermann Health System

Consolidated Statements of Cash Flows

(In Thousands)

	Year Ended June 30 2018	2017
Operating activities		
Cash received for patient services	**$ 4,858,787**	$ 4,608,716
Cash paid to or on behalf of employees	**(2,278,435)**	(2,272,173)
Cash paid for supplies and services	**(2,461,340)**	(2,353,430)
Other receipts from operations, including premiums	**401,923**	450,820
Investment gains realized	**79,336**	44,494
Interest paid	**(98,043)**	(91,097)
Net cash provided by operating activities	**502,228**	387,330
Investing activities		
Capital expenditures, net	**(364,208)**	(390,567)
Change in assets limited as to use	**61,507**	129,770
Change in investments	**(104,776)**	(46,871)
Other	**–**	91
Net cash used in investing activities	**(407,477)**	(307,577)
Financing activities		
Payments on long-term debt and note payable	**(41,528)**	(36,459)
Proceeds from sales of medical office buildings subject to leaseback	**–**	8,343
Restricted contributions	**36,994**	34,412
Noncontrolling interest	**(56,742)**	(56,187)
Net cash used in financing activities	**(61,276)**	(49,891)
Net increase in cash and cash equivalents	**33,475**	29,862
Cash and cash equivalents at beginning of year	**337,551**	307,689
Cash and cash equivalents at end of year	**$ 371,026**	$ 337,551
Supplemental information – reconciliation of change in net assets to net cash provided by operating activities		
Change in net assets	**$ 318,255**	$ 313,005
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	**287,725**	271,544
Unrealized net gain on investments and interest swap agreements	**(120,977)**	(201,182)
Change in pension obligation	**(31,646)**	(39,188)
Other changes in net assets, including noncontrolling interest	**38,066**	31,785
Change in patient accounts receivable, net of provision for bad debt	**(11,154)**	16,402
Change in other assets	**(1,733)**	(14,826)
Change in accounts payable, accrued payroll, and other accrued expenses	**3,829**	20,363
Change in other long-term obligations	**19,863**	(10,573)
	183,973	74,325
Net cash provided by operating activities	**$ 502,228**	$ 387,330

See accompanying notes.

1. Mission and Organization

Memorial Hermann Health System (the Health System), a Texas nonprofit membership corporation, controls and coordinates the activities of certain other affiliates. The Health System Board of Directors exercises governance control for the Health System and retains significant reserved powers regarding its affiliates. The Health System is exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code (IRC). The Health System owns and operates 13 nonsectarian general acute care hospitals (including Memorial Hermann – Texas Medical Center, the primary teaching hospital for The University of Texas Health Science Center-Houston McGovern Medical School), a research and rehabilitation hospital (TIRR Memorial Hermann) in the Texas Medical Center, a Medicare-certified home health agency, and a comprehensive ambulatory care network of facilities and services — all serving to position Memorial Hermann Health System as the market-share leader in the greater Houston, Texas, area. The Health System includes one of the nation's largest Independent Practice Association models, through which more than 5,000 physicians are clinically integrated with the Health System for clinical practice standards, two insurance companies that underwrite group health coverage for employers and the Medicare Advantage program, a captive casualty and liability insurance company, and an accountable care organization. Additionally, the Health System is supported by the Memorial Hermann Foundation (the Foundation). The consolidated financial statements include the accounts of the Health System and its controlled affiliates. All significant intercompany accounts and transactions have been eliminated.

2. Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues, expenses, and disclosure of contingent assets and liabilities, at the date of the financial statements. Because of the subjectivity inherent in this process, actual results may differ from those estimates.

Subsequent Events

The Health System evaluates the impact of subsequent events, events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the consolidated financial statements as of the consolidated balance sheets' date or disclosure in the

2. Significant Accounting Policies (continued)

notes to the consolidated financial statements. The Health System evaluated events occurring subsequent to June 30, 2018 through October 1, 2018, the date on which the accompanying consolidated financial statements were issued.

Net Assets and Contributions

To ensure compliance with restrictions placed on the resources available to the Health System, the Health System's accounts are maintained in accordance with the existence or absence of donor-imposed restrictions. This is the procedure by which resources are classified for accounting and reporting into funds established according to their nature and purposes. In the consolidated financial statements, funds that have similar characteristics have been consolidated into three net asset categories: permanently restricted, temporarily restricted, and unrestricted.

- Permanently restricted net assets contain donor-imposed restrictions that stipulate the resources be maintained permanently, but permit the Health System to use the income derived from the donated assets for donor-specified purposes.

- Temporarily restricted net assets contain donor-imposed restrictions that permit the Health System to use or expend the assets as specified. The restrictions are satisfied either by the passage of time or by actions of the Health System.

- Unrestricted net assets are not restricted by donors, or the donor-imposed restrictions have expired or been met. When a donor restriction expires, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

At June 30, 2018 and 2017, the Health System had $119,887,000 and $127,993,000, respectively, in temporarily restricted net assets and $9,434,000 and $9,219,000, respectively, in permanently restricted net assets. For the years ended June 30, 2018 and 2017, the Health System received $33,914,000 and $43,188,000, respectively, in restricted contributions and income. During 2018 and 2017, $41,805,000 and $31,642,000, respectively, in net assets were used for their restricted purpose.

Unrestricted and restricted donations are recognized when received. Unrestricted and restricted pledges are reported as revenue in the period the pledge is made at the present value of estimated future cash flows. Amortization of the discount is included in contribution income. Pledges are

2. Significant Accounting Policies (continued)

recorded net of an allowance for uncollectibles. This allowance is determined based upon historical collection and write-off experience. Donor-restricted pledges and donations are recorded in the appropriate donor-restricted fund until restrictions are met, at which time they are contributed to the affiliate beneficiary. Gifts of property other than cash are recorded at fair market value at the dates the gifts are received.

The Health System holds donor-restricted endowment funds established primarily to fund specified activities for and within the Health System and the medical community as a whole. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Contributions are recorded as revenue at the present value of estimated future cash flows when an unconditional promise is received. At June 30, 2018 and 2017, the Health System had $30,245,000 and $32,292,000, respectively, in pledges receivable, net of discount and allowance for uncollectibles of $2,807,000 and $1,272,000, respectively. Pledges receivable are recorded as assets limited as to use in the accompanying consolidated balance sheets and are due, based on gross pledges, as follows:

	Pledges
June 30, 2019	$ 6,813,000
June 30, 2020	5,465,000
June 30, 2021	4,968,000
June 30, 2022	4,206,000
June 30, 2023	3,400,000
Thereafter	8,200,000

Net Patient Service Revenue and Patient Accounts Receivable

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients or third-party payors for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. For participants in the Medicare and Medicaid programs, and certain managed care programs, the Health System ultimately collects amounts that are generally less than standard charges. Medicare and Medicaid are federal and state programs

2. Significant Accounting Policies (continued)

generally designed to provide services to elderly and indigent patients, respectively. Medicare and Medicaid together constituted 51% and 50% of the Health System's standard charges for June 30, 2018 and 2017, respectively. The Health System has also entered into multiple payment agreements with commercial insurance carriers, health maintenance organizations, and preferred provider organizations (managed care companies). The basis for payment to the Health System under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined fee schedules for episodic services. The revenues derived from these agreements constituted 37% and 39% of the Health System's standard charges in 2018 and 2017, respectively.

Self-pay revenues are derived primarily from patients who do not have any form of health coverage. The revenues associated with self-pay patients are generally reported at the Health System's gross charges. The Health System evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines and qualifications for Medicaid or other governmental assistance programs, as well as the Health System's policy for charity care. The Health System provides care without charge to certain patients who qualify under its charity care policy.

The Health System's net patient service revenue before bad debt by payor, and approximate percentages of total, were as follows for the years ended June 30 (in thousands):

	2018		**2017**	
	Amount	**Ratio**	**Amount**	**Ratio**
Managed care	**$ 2,706,656**	**49%**	$ 2,571,040	49%
Medicare	**1,382,040**	**25**	1,217,569	23
Medicaid	**610,092**	**11**	652,453	12
Self-pay	**648,354**	**12**	630,023	12
Other	**175,413**	**3**	209,036	4
Total	**$ 5,522,555**	**100%**	$ 5,280,121	100%

Effective April 2018, the Health System has adopted an uninsured discount policy whereby certain patients without insurance coverage receive discounts from established charges. The resulting adjustment is recorded as revenue deductions from gross charges to arrive at net patient service revenue before bad debt provision. The Health System recorded uninsured discounts of $293,443,000 during the three months ended June 30, 2018.

2. Significant Accounting Policies (continued)

Patient Accounts Receivable

Patient accounts receivable are reported net of estimated allowances for contractual allowances, bad debt, and other discounts. The Health System's recorded allowances for bad debt are based on expected net collections, after contractual adjustments, primarily from patients. Management routinely assesses these recorded allowances relative to changes in payor mix, cash collections, write-offs, recoveries, and market conditions. Unpaid accounts are written off as bad debts upon reaching delinquent status. Charity care accounts are written off as identified or qualified under the Health System's charity care policy. The Health System's concentration of credit risk with respect to patient accounts receivable is limited due to the diversity of patients and payors.

The Health System's accounts receivable by payor as a percentage of total accounts receivable were as follows for the years ended June 30:

	2018	**2017**
Managed care	**29%**	29%
Medicare	**22**	21
Medicaid	**9**	15
Self-pay	**22**	25
Other	**18**	10
Total	**100%**	100%

A summary of activity in the Health System's allowance for bad debt is as follows (in thousands):

	Balances at Beginning of Year	**Provision for Bad Debt, Net of Recoveries**	**Accounts Written Off**	**Balances at End of Year**
Year ended June 30, 2018	**$ 702,890**	**$ 668,061**	**$ (809,536)**	**$ 561,415**
Year ended June 30, 2017	735,260	656,675	(689,045)	702,890

2. Significant Accounting Policies (continued)

Medicare and Medicaid Programs

While laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation, the Health System intends to be in compliance with all applicable laws and regulations and, to that end, has implemented a comprehensive organization-wide corporate compliance policy.

Annual retroactive settlements with the Medicare and Medicaid programs are subject to review by appropriate governmental authorities or their agents. Settlements are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as final settlements are determined. Accruals for possible settlements are calculated based on historical experience.

The Health System's Medicare and Medicaid cost reports have been audited by the applicable fiscal intermediary through June 30, 2013, for all hospitals and up to 2016 for certain entities. However, certain prior cost reports have been reopened by the fiscal intermediary for further review. Additionally, from time to time, the Health System appeals decisions of the fiscal intermediary in order to recover funds it believes are appropriately due to the Health System for services rendered to Medicare and/or Medicaid beneficiaries. Processes related to recovering these funds are often long and complex. The Health System's policy is to record any funds received from appeals as income in the year in which the notice of cost report settlement is received.

At June 30, 2018 and 2017, aggregate accruals and allowances for possible settlements, and pending reviews, as discussed above, of $34,907,000 and $41,575,000, respectively, are included in the accompanying consolidated balance sheets in other accrued expenses (2018: $2,484,000; 2017: $2,778,000) and other long-term obligations (2018: $32,423,000; 2017: $38,797,000). It is reasonably possible that these estimates could differ from actual settlements and, thus, change in the near term by material amounts.

During 2018 and 2017, the Health System recognized $31,570,000 and $12,657,000, respectively, in net patient service revenue from differences between estimated and actual cost report settlements and appeals.

2. Significant Accounting Policies (continued)

Medicaid Supplemental Payments

During fiscal years 2018 and 2017, the Health System participated in the Medicaid Disproportionate Share hospital funding program, established by the state of Texas and administered by the Texas Health and Human Services Commission (HHSC), which created additional federal matching funds to increase access to health care by Texas' indigent patients and defray the cost of treating indigent patients. Funds are distributed to hospitals providing a high volume of services to Medicaid and uninsured patients. During fiscal year 2012, a new Medicaid supplemental payment program was established in Texas under an 1115 Waiver (Waiver). The Waiver program was initially a five-year federally approved program designed to supplement the unreimbursed costs of providing care to Medicaid and uninsured patients, as discussed in Note 3. This program has been extended until September 2022. There are two pools of funds established under the Waiver program: an uncompensated care (UC) pool and a delivery system reform incentive payment (DSRIP) pool. To receive payments from the UC pool, a hospital must submit an application (referred to as the Waiver tool) estimating its uncompensated costs for services provided to Medicaid and uninsured patients. In March 2018, an additional Medicaid supplemental funding program, the Uniform Hospital Rate Increase Program (UHRIP) was implemented. As part of this program, hospital providers receive an additional payment for certain Medicaid managed care patients. The funding of these programs are dependent on intergovernmental transfers from state-owned and local governmental entities to draw down federal funds to finance both pools. Medicaid supplemental funds, which include Medicaid Disproportionate Share, DSRIP, UHRIP, and UC payments, of approximately $268,850,000 and $342,815,000, were recorded in 2018 and 2017, respectively. Net patient service revenue includes UC, UHRIP, and Disproportionate Share supplemental funds as a reduction of contractual allowances. DSRIP is recorded as other revenue. At June 30, 2018 and 2017, the Health System has receivables recorded of $40,588,000 and $62,469,000 for Medicaid supplement payments, respectively. These amounts are included in other current assets in the accompanying consolidated balance sheets. Medicaid supplemental payments have been recognized based on the most recent information available, but it is reasonably possible that the recorded estimates may change by a material amount in the near term. Management believes adequate allowance has been provided for possible adjustments that might result from adjustments to the Medicaid supplemental payment programs.

2. Significant Accounting Policies (continued)

Premium Revenues, Claims Payable, and Medical Claims Expenses

Premium revenues are recognized in the month in which members are entitled to health care services. Premiums collected in advance are recorded as unearned premiums and are included in accrued liabilities on the accompanying consolidated balance sheets.

The estimated cost of all health services rendered to members through June 30 but not yet paid as of that date is included in other accrued expenses. This claims expense estimate is developed using actuarial assumptions based on historical experience with respect to the timing of payments in relation to the dates of service. Subsequent changes to prior period estimates are reflected in the current period. Losses on contracts are recognized in the period when health care costs are expected to exceed premium revenue.

Cash Equivalents

Liquid investments with an original maturity of three months or less are reported as cash equivalents, except for those held for long-term investing purpose or subject to restrictions, which are reported as investments or assets limited to use.

Investments, Assets Limited to Use, and Investment Income

Investments are reflected as investments or assets limited as to use in the consolidated balance sheets and include fixed income, equity securities, master limited partnerships (MLPs), and alternative investments. Investments in equity securities and all debt securities are carried at fair value. Fixed income includes U.S. government securities, mortgage-backed securities, asset-backed securities and other securitized credit, corporate obligations, and non-U.S. sovereign and corporate securities, in pooled funds and separate accounts. Equity securities include domestic and international equities in pooled funds and separate accounts. Pooled funds are professionally managed and include institutional mutual funds, fixed income funds, equity funds, and commingled accounts. MLPs include domestic MLPs in pooled funds and separate accounts and represent limited partnerships that are typically publicly traded. Other characteristics often associated with these MLPs include the requirement that the partnerships must generate most of their cash flows from particular businesses (including commodities).

2. Significant Accounting Policies (continued)

Alternative investments include ownership interests in hedge funds and limited partnerships that may employ various investment strategies through the use of publicly traded securities, market neutral arbitrage, floating rate loans and debt securities, fixed income swaps, private real assets, and private equity. The Health System's alternative investments include certain investments whose reported values had been estimated by fund managers in the absence of readily available market values or cannot otherwise be substantiated. Because of the inherent uncertainty of valuations, fund managers' estimates of fair value may differ from the values that would have been used had a ready market for the securities existed, and the differences could be material. Additionally, risks in certain of the Health System's alternative investments include limited transparency where funds are not required to disclose the holdings in their portfolios to the Health System and limitations on liquidity as funds may impose lockup periods or holdback provisions that limit the Health System's ability to redeem those investments. The Health System records its alternative investments at estimated fair value. As of June 30, 2018, the unfunded commitment related to alternative investments is approximately $388,006,000.

Investments are classified as noncurrent assets, regardless of their maturity date due to the Health System's primary intent not to utilize these assets to meet current obligations, capital, and other cash flow needs, and the investments have exposure to asset classes with longer term investment horizons. Assets limited as to use are funds legally restricted by bond indentures, internally restricted in connection with self-insurance programs, externally restricted by donor specifications, restricted by resident agreements, or internally restricted for charity care or other purposes. Assets limited as to use are classified as noncurrent assets, except for assets limited as to use that are required to meet current liabilities, which are classified as current assets.

Substantially all of the Health System's investments are designated as trading investments. Investment income, including realized and unrealized gains and losses on investments, interest and dividend income, and equity in earnings of alternative investments, is recorded as a nonoperating activity and included in revenues in excess of expenses in the accompanying consolidated statements of operations and changes in net assets, unless the income or loss is restricted by donor or law. Net purchases and sales of investments are reported as a component of net cash used in investing activities in the accompanying consolidated statements of cash flows, as the net proceeds were used primarily to fund the Health System's acquisition of capital assets.

The Health System maintains investments with various financial institutions and investment management firms, and its policy is designed to limit exposure to any one institution or investment, therefore reducing overall risk.

2. Significant Accounting Policies (continued)

Property, Plant, and Equipment

Property, plant, and equipment are carried at cost or fair value at the time of donation and include expenditures for new facilities and equipment and those expenditures that substantially increase the useful life of existing facilities and equipment. Ordinary maintenance and repairs are charged to expense when incurred. Depreciation is provided using the straight-line method over 20 to 40 years for buildings, five to ten years for improvements (limited to the term of the related lease, if applicable), and 3 to 12 years for equipment. Assets accounted for as capital leases are amortized over the terms of the respective leases, and such amortization is included in depreciation and amortization expense.

When events, circumstances, or operating results indicate that the carrying values of certain long-lived assets might be impaired, the Health System prepares undiscounted projections of cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate that the recorded amounts are not expected to be recoverable, the related asset's carrying value is reduced to estimated fair value. Fair value may be estimated based upon internal evaluations that include quantitative analyses of revenues and cash flows, reviews of recent sales of similar assets, and independent appraisals. Property and equipment to be disposed of are reported at the lower of the carrying amounts or fair value less costs to sell or close. The estimates of fair value are usually based upon recent sales of similar assets and market responses based upon discussions with and offers received from potential buyers.

Interest Rate Swap Agreements

The Health System records its interest rate swap agreements at fair value in the consolidated balance sheets and the change in the fair values and net interest payments under swaps as a component of interest rate swap agreements on the consolidated statements of operations and changes in net assets.

2. Significant Accounting Policies (continued)

Investments in Joint Ventures

The Health System has entered into multiple joint venture and partnership arrangements for the provision of medical services to patients. For those ventures where the Health System has a controlling interest through majority ownership, management control, or both, the ventures' assets, liabilities, and operating results have been included in the consolidated financial statements of the Health System. At June 30, 2018 and 2017, the Health System has recognized net assets attributable to noncontrolling interest of $130,928,000 and $124,936,000, respectively, representing the venture partners' interest in the equity and undistributed earnings of the consolidated ventures. For those ventures where the Health System does not maintain a controlling interest, the Health System accounts for its investment under the equity method of accounting.

Goodwill

The Health System records goodwill arising from a business combination as the excess of the purchase price and related costs over the fair value of the identifiable tangible and intangible assets acquired and liabilities assumed. At June 30, 2018 and 2017, the Health System had goodwill of $195,996,000 and $195,110,000, respectively, which relates to the purchase of several entities from 2010 to 2018, including purchases made by consolidated joint ventures. Goodwill is reflected in other long-term assets.

Goodwill is tested at least annually for impairment at the reporting unit level. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. Additional impairment assessments may be performed on an interim basis if the Health System encounters events or changes in circumstances that would indicate that it is more likely than not that the carrying value of goodwill has been impaired. The Health System has determined that its reporting units are geographic or service-line-based depending on the nature of operations. The first step in the impairment process is to determine the fair value of the reporting unit and then compare it to the carrying value, including goodwill. If the fair value exceeds the carrying value, no further action is required and no impairment loss is recognized. The Health System applied the optional provisions of Accounting Standards Update (ASU) No. 2011-08, *Intangibles – Goodwill and Other (Topic 350): Testing Goodwill for Impairment*, which provides for a qualitative impairment analysis. A qualitative impairment analysis concluded that it was more likely than not that the fair value exceeded the carrying value of the applicable reporting units. Therefore, the two-step impairment analysis was not required and no impairment charges were recorded for fiscal year 2018 or 2017.

2. Significant Accounting Policies (continued)

Taxes

The Health System and certain other affiliates are Texas nonprofit corporations and have been recognized as tax-exempt pursuant to Section 501(c)(3) of the IRC. The Health System owns certain taxable subsidiaries and engages in certain activities that are unrelated to its exempt purpose and, therefore, subject to tax.

Management annually reviews its tax positions and has determined that there are no material uncertain tax positions that require recognition in the accompanying consolidated balance sheets. The tax returns are subject to Internal Revenue Service (IRS) review for three years subsequent to the dates they are filed. The Health System has net operating losses (NOLs) tax carryforwards that will expire between 2022 and 2037. Due to the age of these NOLs and the fact that management is uncertain that the full amount of the NOLs will be realized in the future, no deferred tax asset has been recorded.

The Tax Cuts and Jobs Act (the Act) was enacted on December 22, 2017. The provisions of the Act do not have a material tax effect on the Health System's consolidated financial statements. Certain regulatory guidance provides for a measurement period of up to one year during which accounting for the tax effects of the Act may be completed. The Health System will continue to evaluate the impact of the Act and may record adjustments as additional information and guidance is released by the IRS.

Performance Indicator

The Health System's consolidated statements of operations and changes in net assets contain a performance indicator titled revenues in excess of expenses. Revenues in excess of expenses include the Health System's results from operations and nonoperating activities, and exclude changes in noncontrolling interest, changes in unfunded pension obligations, restricted contributions and grants received, and certain other changes in net assets. Health System activities directly related to the furtherance of the Health System's purpose, as discussed in Note 1, are considered to be operating activities. Other activities that result in gains or losses are considered to be nonoperating and primarily include investment earnings, losses on extinguishment of debt, and other nonoperating gains/losses, including unusual or infrequent recoveries or costs not directly related to operating activities.

2. Significant Accounting Policies (continued)

Pending Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to clarify the principles for recognizing revenue and to improve financial reporting by creating common revenue recognition guidance for U.S. GAAP and International Financial Reporting Standards. The core principle of ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

Management has evaluated the requirements of ASU 2014-09 to ensure that the Health System has processes, systems and internal controls in place to collect the necessary information to implement the standard. The Health System used a modified retrospective method of application to adopt ASU 2014-09 on July 1, 2018. The Health System used a portfolio approach to apply the new model to classes of payers with similar characteristics and analyzed cash collection trends over an appropriate collection look-back period. Adoption of ASU 2014-09 will result in changes to the Health System's presentation for and disclosure of revenue related to uninsured or underinsured patients. Currently, a significant portion of the Health System's provision for doubtful accounts relates to self-pay patients. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are considered a direct reduction to net patient service revenue and, correspondingly, result in a material reduction in the amounts presented separately as provision for doubtful accounts. Management has completed the assessment of the impact of the new standard on various reimbursement programs that represent variable consideration and concluded that the accounting for these programs under ASU 2014-09 is substantially consistent with the Health System's historical accounting. These include supplemental state Medicaid programs, disproportionate share payments and settlements with third party payers. While the adoption of ASU 2014-09 will have a material effect on the presentation of net patient service revenue in the Health System's consolidated statements of operations and on certain disclosures, it will not materially impact the consolidated results of operations or cash flows. The cumulative effect of the change in accounting principle effective July 1, 2018, if any, will be immaterial.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*. ASU 2016-02 requires companies that lease assets to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments, in their balance sheets. The pronouncement will also require additional disclosures about the amount, timing and uncertainty of cash flows arising from

2. Significant Accounting Policies (continued)

leases. The provisions of ASU 2016-02 are effective for the Health System starting July 1, 2019, including interim periods within that reporting period, and early adoption is permitted. Management is currently evaluating the impact of this pronouncement on the Health System's consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958) Presentation of Financial Statements of Not-for-Profit Entities.* ASU 2016-14 sets forth the FASB's improvements to net asset classification requirements and the information presented about a not-for-profit entity's liquidity, financial performance, and cash flows. The provisions of ASU 2016-14 are effective for the Health System's annual financial statements for the fiscal year starting July 1, 2018, and early adoption is permitted. Application to interim financial statements is permitted but not required in the initial year of application, but is required starting July 1, 2019. Management is currently evaluating the impact of this pronouncement on the Health System's consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The amendments in ASU 2017-07 require that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. It also requires the other components of net periodic pension cost and net periodic postretirement benefit cost to be presented in the income statement separately from the service cost component and outside a subtotal of income from operations. The provisions of ASU 2017-07 are effective for the Health System starting July 1, 2018, including interim periods within that reporting period, and the provisions regarding the presentation of the components of net periodic cost must be applied retrospectively upon adoption. The adoption of ASU 2017-07 will result in a reclassification of the other components of net periodic pension cost and net periodic postretirement benefit cost from salaries, benefits, and related personnel costs in the consolidated statement of operations and changes in net assets to a component of non-operating activities. The adoption of ASU 2017-07 will result in an increase in the amount reported as salaries, benefits, and related personnel costs for fiscal year 2018 and 2019 of approximately $9,000,000 and $10,000,000, respectively, with a corresponding increase in non-operating activities.

2. Significant Accounting Policies (continued)

In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities, (Topic 958); Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. The amendments in ASU 2018-08 clarify and improve the scope and the accounting guidance for contributions received and contributions made. The amendments in ASU 2018-08 provide guidance for evaluating whether transactions should be accounted for as contributions (nonreciprocal transactions) within the scope of Topic 958, *Not-for-Profit Entities*, or as exchange (reciprocal) transactions subject to other guidance, and for determining whether a contribution is conditional. The provisions of ASU 2018-08 are effective for the Health System starting July 1, 2018, including interim periods within that reporting period. The adoption of ASU 2018-08 is not expected to have a material impact to the Health System's consolidated financial statements.

3. Community Service

In accordance with its purpose and values, the Health System is committed to providing high-quality, cost-effective health services to the community, including such underserved groups as the indigent and the elderly. Self-pay revenues are derived primarily from patients who do not have any form of health coverage. The revenues associated with self-pay patients are generally reported at the Health System's gross charges. The Health System evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, or qualifications for Medicaid or other governmental assistance programs, as well as the Health System's policy for charity care. The Health System provides care without charge to certain patients who qualify under the local charity care policy. The Health System's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Health System's charity care policies. The Health System does not report a charity care patient's charges in revenues or in the provision for doubtful accounts, as it is the Health System's policy not to pursue collection of amounts related to these patients. In addition, the Health System contributes to Harris County Clinical Services, Inc. (HCCS), which provides health care services to low-income and needy residents in the community.

3. Community Service (continued)

The Health System's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Health System's gross charges provided. These costs are as follows:

	Year Ended June 30	
	2018	**2017**
	(In Thousands)	
Charity care costs	**$ 235,959**	$ 261,214
HCCS payments	**141,475**	141,967
	$ 377,434	$ 403,181

The Health System operates emergency rooms at its hospitals that are open to the public 24 hours a day, 7 days a week. The Health System also operates Life Flight, an air ambulance service based at the Memorial Hermann Texas Medical Center (Level I trauma center); a burn unit; a transplant center; a Level II trauma center in the Woodlands, and one Level IV and one Level III neonatal intensive care units that provide services to many infants whose mothers have not had access to appropriate prenatal care. Furthermore, the Health System provides various community screenings for the detection of diseases and disorders, as well as a forum for various wellness activities and community health education classes.

In addition to the uncompensated care provided to patients, the Health System funds various community projects as part of its ongoing community benefit plan. These projects are developed in response to specific community needs in the Health System's service area identified through community needs assessments. Examples of projects funded include ten school-based health centers and three mobile dental vans serving 72 schools in five school districts, an ER Navigator program educating primary care patients about the importance of finding an appropriate medical home other than the emergency room; two neighborhood health centers serving the primary care needs of un- and underinsured patients; a nurse help-line providing nurse triage to greater Houston to educate and assist on the appropriate use of health resources; initiatives internal and external to Memorial Hermann regarding Food as Health and Exercise is Medicine, and providing financial support to primary care clinics and social service agencies that support Memorial Hermann Community Benefit Corporation's four driving pillars of access, emotional health, food and exercise. Additionally, the Health System supports various community and city-wide task forces committed to building toward a healthier and more vital Houston community.

3. Community Service (continued)

As a part of its approval of the 1997 merger between Memorial Hospital System and Hermann Hospital Estate, a Harris County District Court entered an Agreed Order stipulating that the Health System will continue providing charity care and community service in the amount of 6% of net revenue or $22,500,000, whichever is greater. This amount is an additional 1% above the percentage required of all Texas nonprofit hospitals under the charity care provision of the Texas Health & Safety Code. During fiscal years 2018 and 2017, the Health System believes it has met all stipulations of the agreement. Revenues of the other Health System entities are not obligated under the agreement.

4. Investments and Assets Limited as to Use

Investments

The Health System maintains investments with various financial institutions and investment management firms, and its policy is designed to limit exposure to any one institution or investment, therefore reducing overall investment risks. The following is a summary of unrestricted investments by classification:

	June 30	
	2018	**2017**
	(In Thousands)	
Cash and cash equivalents	**$ 12,896**	$ 48,631
Fixed income	**340,085**	410,183
Equity securities	**993,614**	993,406
Alternative investments	**1,007,931**	707,056
Total investments	**$ 2,354,526**	$ 2,159,276

4. Investments and Assets Limited as to Use (continued)

Assets Limited as to Use

The following table sets forth the restricted purpose of the Health System's assets limited as to use:

	June 30 2018	June 30 2017
	(In Thousands)	
Bond indenture agreements	**$ –**	$ 117,387
Self-insurance programs	**120,095**	107,828
Donor restrictions	**132,676**	132,775
Charity care and depreciation funds	**4,160**	4,412
	256,931	362,402
Less current portion required for current liabilities	**(6,656)**	(27,334)
	$ 250,275	$ 335,068

Investment Income

Investment income related to unrestricted net assets comprises the following:

	Year Ended June 30 2018	Year Ended June 30 2017
	(In Thousands)	
Interest and dividend income	**$ 27,939**	$ 18,738
Realized gains, net	**69,977**	43,005
Unrealized gains, net	**92,950**	156,930
	$ 190,866	$ 218,673

5. Property, Plant, and Equipment

Property, plant, and equipment consist of the following:

	June 30	
	2018	**2017**
	(In Thousands)	
Buildings and improvements	**$ 3,180,266**	$ 3,030,644
Building and equipment under capital lease	**804,965**	757,191
Equipment	**2,119,350**	1,986,761
Less accumulated depreciation	**(3,643,870)**	(3,372,469)
	2,460,711	2,402,127
Land	**144,009**	144,020
Construction-in-progress	**424,573**	359,434
	$ 3,029,293	$ 2,905,581

At June 30, 2018, the Health System had remaining commitments for planned construction of approximately $407,691,000. The Health System has previously leased a 255-licensed-bed general acute care hospital in north Houston. In May 2016, the Health System purchased the leased facilities for $55,000,000. As part of the purchase agreement, the Health System has an obligation to operate the hospital for at least 10 years and to construct a new hospital tower with an expected cost of approximately $70,000,000 with the Northeast Hospital Authority contributing $10,000,000 toward the cost.

Under the provisions of ASC 840-40, *Leases – Sale-Leaseback Transactions*, the Health System is required to continue to capitalize medical office buildings sold and leased back and to recognize an obligation for the sales proceeds received. A prior year gain on the sale of approximately $127,112,000 has been deferred until specified forms of continuing involvement have ceased.

The medical office buildings are depreciated over the economic lives when placed in service. As of June 30, the following amounts are recorded in property, plant, and equipment, net and other long-term obligations:

	Property, Plant, and Equipment June 30		Other Long-term Obligations June 30	
	2018	**2017**	**2018**	**2017**
Medical office buildings and improvements	**$ 62,442,000**	$ 64,737,000	**$ 218,708,000**	$ 225,619,000

6. Indebtedness

Long-term debt at June 30 consisted of the following:

	2018	2017
	(In Thousands)	
Obligations issued under the Memorial Hermann Health Master Trust Indenture:		
Revenue bonds, in variable rate demand mode, with interest rates ranging from 1.35% to 1.89% at June 30, 2018, due in varying installments through June 1, 2046:		
Series 2014C and D	**$ 70,400**	$ 70,400
Series 2015A, B and C	**247,700**	255,600
Series 2016B, C, D and E	**315,305**	320,935
Revenue bonds, in variable rate mode, with interest rate ranging from 1.51% to 2.09% at June 30, 2018, due in annual installments through December 1, 2042:		
Series 2013B	**67,210**	78,275
Series 2014B	**70,425**	70,425
Revenue bonds, in fixed rate mode, bearing interest from 2.40% to 5.30%, due in annual installments through July 1, 2046:		
Series 2010A	**36,135**	41,230
Series 2013A	**301,945**	308,870
Series 2014A	**139,775**	143,680
Series 2016A	**132,900**	132,900
Other long-term debt obligations:		
Capital lease obligations	**826,096**	779,238
Line of credit and other notes	**67,888**	68,972
	2,275,779	2,270,525
Premiums on long-term debt, net	**39,230**	44,118
Less deferred financing fees	**(8,272)**	(8,425)
	2,306,737	2,306,218
Less current portion, including amounts subject to self-liquidity	**(507,441)**	(435,375)
	$ 1,799,296	$ 1,870,843

6. Indebtedness (continued)

Debt Obligations

The Health System has issued revenue bonds through the Harris County Health Facilities Development Corporation and the Harris County Education Facilities Finance Corporation. Payments to the bondholders are funded by the issuing affiliates under a master trust indenture with the trustees of the respective bond issues. The Health System and substantially all operating affiliates have agreed to arrangements and indentures related to the bonds to abide by guidelines regarding repayment, financial performance, organizational changes, reporting, and additional borrowing. Certain variable rate demand bonds were issued under the Health System's self-liquidity program, and therefore, have been classified as current liabilities. The Health System will provide its own liquidity to purchase any tendered bonds that cannot be successfully remarketed.

In February 2017, the Health System renewed a syndicated revolving line of credit agreement for a term of five years with a maximum amount available of $300,000,000. The purpose of this line of credit facility is to provide a source of liquidity in the case of emergency or disaster, or to provide a means of bridge financing in advance of any permanent debt financing transaction. As of June 30, 2018 and 2017, $36,500,000 was outstanding.

On December 15, 2015, the Health System refinanced its Series 2010B ($162,400,000) variable rate demand bonds by issuing the Series 2015A ($81,200,000) and Series 2015B ($81,200,000) refunding bonds. The Series 2008A-1 ($107,800,000) variable rate demand bonds were refinanced by issuing the Series 2015C ($107,800,000) refunding bonds.

In May 2018, the Health System converted the modes of the Series 2015A, Series 2015B, and Series 2015C bonds. The Series 2015A and Series 2015B bonds ($162,400,000) were converted to privately placed floating rate notes for a term of three years. The Series 2015C bonds ($93,200,000) were converted to variable rate demand bonds under the Health System's self-liquidity program and, therefore, are classified as current liabilities. The amortization and final maturity of the bonds remained unchanged.

The bank notes associated with the Series 2015A and Series 2015B bonds contain certain criteria under which the respective banks can call for the repayment of the debt in advance of the stated maturities. Management has evaluated these criteria and believes the debt is appropriately classified as long-term.

6. Indebtedness (continued)

On June 8, 2016, the Health System issued the Series 2016A fixed rate bonds in the amount of $132,900,000 due on July 1, 2046. The Series 2016A bonds were sold at a net premium of $18,316,215.

On June 8, 2016, the Health System issued the Series 2016B variable rate demand bonds in commercial paper mode in the amount of $150,000,000. On June 8, 2016, the Health System refinanced the 2013C and 2013D bonds by issuing the Series 2016C ($62,370,000) and 2016D ($41,605,000), which are variable rate demand bonds.

On June 8, 2016, the Health System restructured the Series 2008A-2 into 2016E Series ($72,300,000) variable rate demand refunding bonds.

The 2014C and D and 2016B, C, D, and E Series bonds were issued under the Health System's self-liquidity program and, therefore, have been classified as current liabilities.

Other notes consist of secured loans by financial institutions to finance the equipment purchases of the Health System's joint venture partnerships.

As of June 30, 2018, scheduled principal payments for outstanding debt (excluding capital leases and other notes) for the next five fiscal years are as follows: $42,055,000 in 2019, $41,135,000 in 2020, $40,280,000 in 2021, $42,090,000 in 2022, and $44,085,000 in 2023.

The estimated fair value of the Health System's serial and term fixed rate bonds at June 30, 2018 and 2017 was approximately $659,348,000 and $691,328,000, respectively. The valuation of the bonds is based on a combination of quoted market prices for identical securities when available, a Level 1 input, and quoted market prices for similarly rated health care revenue bond issues, a Level 2 input. The Health System considers the carrying value of its variable rate long-term debt to approximate fair value at June 30, 2018 and 2017, due to the variable nature of the interest rate.

Leases

The Health System leases certain health facilities located in the Houston metropolitan area. One such leasing arrangement, which is reflected as a capital lease in the accompanying consolidated financial statements, consists of a 520-licensed-bed general acute care hospital and rehabilitation

6. Indebtedness (continued)

care facility located in west Houston. All revenues and income from the operation of the leased facilities during the lease term accrue to the Health System. The Health System is responsible under the lease for ad valorem taxes, normal maintenance, utilities, and other operating costs.

The Health System leases certain land, buildings, and medical offices near the west Houston location. These agreements are recorded as operating leases with rental payments reflected in the accompanying consolidated statements of operations and changes in net assets.

The Health System also leases other office space and equipment under noncancelable leases. Rental expense under noncancelable leases, including the operating leases discussed above, aggregated $124,600,000 and $105,532,000 in 2018 and 2017, respectively.

As of June 30, 2018, minimum future rentals under noncancelable leases, for the next five fiscal years and in aggregate, are as follows:

	Capital Leases	Operating Leases
2019	$ 55,109,149	$ 123,018,378
2020	58,210,622	119,592,223
2021	61,168,999	95,562,403
2022	61,313,615	73,356,245
2023	61,733,974	60,637,177
Thereafter	1,416,967,516	339,626,705
Total minimum lease payments	1,714,503,875	$ 811,793,131
Less portion representing interest	(888,408,031)	
Capital lease obligations	$ 826,095,844	

7. Interest Rate Swap Agreements

The Health System utilizes interest rate swap agreements to manage its capital costs and interest rate risk. The following table summarizes the Health System's swap portfolio, the fair values at June 30, 2018 and 2017, the change in value, and the net amounts paid and received for the years ended June 30, 2018 and 2017 (in thousands):

Swap Description	Term Date	Interest Rate Agreements	Aggregate Notional Amount	Fair Value Liability June 30 2018	Fair Value Liability June 30 2017	Change in Fair Value June 30 2018	Change in Fair Value June 30 2017	Settlement Activity Paid June 30 2018	Settlement Activity Paid June 30 2017
LIBOR-based to fixed (5.343%)	2032	1	$ 113,120	**$ (28,586)**	$ (38,665)	**$ 10,079**	$ 17,165	**$ 4,331**	$ 5,226
LIBOR-based to fixed (3.629%)	2029	3	131,700	**(17,271)**	(24,620)	**7,349**	11,467	**3,293**	4,106
LIBOR-based to fixed (3.635%)	2024	1	27,100	**(2,283)**	(2,786)	**503**	1,893	**887**	1,141
LIBOR-based to fixed (3.630%)	2024	1	45,300	**(1,516)**	(4,132)	**2,616**	2,738	**1,098**	1,633
LIBOR-based to fixed (3.690%)	2027	1	39,400	**(3,314)**	(5,304)	**1,990**	2,961	**1,345**	374
LIBOR-based to fixed (3.685%)	2027	2	111,600	**(9,336)**	(14,419)	**5,083**	8,027	**3,122**	5,175
		9	$ 468,220	**$ (62,306)**	$ (89,926)	**$ 27,620**	$ 44,251	**$ 14,076**	$ 17,655

The notional amounts under each of the interest rate swap agreements are reduced in conjunction with the Health System's principal payments on the associated bonds. At June 30, 2018 and 2017, the fair value of swap agreements was a liability of $62,306,000 and $89,926,000, respectively, and has been included in other long-term liabilities in the accompanying consolidated balance sheets. As of June 30, 2018 and 2017, none of the Health System's swap agreements include provisions that would require posting of collateral.

The Health System classified the net interest cost on its interest rate swaps for the years ended June 30, 2018 and 2017 of $14,076,000 and $17,655,000, respectively, in nonoperating expenses (interest rate swap agreements) in the consolidated statements of operations and changes in net assets.

8. Fair Value Measurement

The Health System categorizes, for disclosure purposes, assets and liabilities measured at fair value in the consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability, based on the best information available in the circumstances.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement of the asset or liability. The Health System's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment, and considers factors specific to the asset or liability.

The Health System follows the three-level fair value hierarchy to categorize these assets and liabilities recognized at fair value at each reporting period, which prioritizes the inputs used to measure such fair values. Level inputs are defined as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities on the reporting date.

Level 2 – Inputs to the valuation methodology other than quoted market prices included in Level 1 that are observable for the asset or liability. Level 2 pricing inputs include quoted prices for similar assets and liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument.

Level 3 – Inputs that are unobservable for the asset or liability.

The following tables present financial instruments carried at fair value as of June 30, 2018 and 2017 on a recurring basis. The tables do not include contributions receivable of $30,245,000 and $32,292,000 at June 30, 2018 and 2017, respectively, and real estate of $187,000 that are not carried at fair value, and are included in assets limited as to use in the consolidated balance sheets. The tables also do not include Level 3 alternative investments of $1,049,014,000 and $747,024,000 at June 30, 2018 and 2017, respectively, which are measured at fair value using net asset value as a practical expedient, as allowed under ASU 2009-12, *Fair Value Measurements*

8. Fair Value Measurement (continued)

and Disclosures (Topic 820): Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent). Valuations provided by the respective investment's management consider variables, such as the financial performance of underlying investments, recent sales prices of underlying investments, and other pertinent information. In addition, actual market exchanges at year-end provide additional observable market inputs of the exit price. The majority of these funds have restrictions on the timing of withdrawals, which may reduce liquidity, in some cases for up to 12 months.

	June 30, 2018			
	Level 1	Level 2	Level 3	Total
	(In Thousands)			
Assets				
Investments:				
Cash and equivalents	$ 12,896	$ –	$ –	$ 12,896
U.S. government securities	34,882	7,454	–	42,336
Pooled funds:				
Domestic equities	2,119	60,813	–	62,932
Global equities	128,380	223,758	–	352,138
Risk parity	26,419	34,012	–	60,431
Fixed income	176,398	–	–	176,398
Hedge fund	–	82,417	–	82,417
Corporate obligations	–	22,374	–	22,374
Corporate equities	222,518	–	–	222,518
Global equities	97,557	–	–	97,557
MLPs	137,136	–	–	137,136
Public REITs	60,902	–	–	60,902
Assets limited as to use:				
Cash and equivalents	57,791	–	–	57,791
Pooled funds:				
Domestic equities	9,698	–	–	9,698
Global equities	54,714	8,504	–	63,218
Fixed income	44,372	–	–	44,372
MLPs	5,725	–	–	5,725
Corporate equities	9,109	–	–	9,109
Public REITs	5,407	–	–	5,407
Total assets	$ 1,086,023	$ 439,332	$ –	$ 1,525,355
Liabilities				
Interest rate swap agreements	$ –	$ 62,306	$ –	$ 62,306
Total liabilities	$ –	$ 62,306	$ –	$ 62,306

8. Fair Value Measurement (continued)

	June 30, 2017			
	Level 1	Level 2	Level 3	Total
	(In Thousands)			
Assets				
Investments:				
Cash and equivalents	$ 48,631	$ –	$ –	$ 48,631
U.S. government securities	12,077	28,328	–	40,405
Pooled funds:				
Domestic equities	1,845	52,376	–	54,221
Global equities	191,682	154,089	–	345,771
Risk parity	60,084	60,821	–	120,905
Fixed income	259,533	–	–	259,533
Hedge fund	–	69,330	–	69,330
Public REITs	36,324	–	–	36,324
Corporate obligations	–	15,699	–	15,699
Corporate equities	238,912	–	–	238,912
Global equities	62,896	–	–	62,896
MLPs	134,378	–	–	134,378
Assets limited as to use:				
Cash and equivalents	155,732	–	–	155,732
Pooled funds:				
Domestic equities	9,431	–	–	9,431
Global equities	57,081	–	–	57,081
Fixed income	46,812	–	–	46,812
MLPs	4,960	–	–	4,960
Corporate equities	13,820	–	–	13,820
Total assets	$ 1,334,198	$ 380,643	$ –	$ 1,714,841
Liabilities				
Interest rate swap agreements	$ –	$ 89,926	$ –	$ 89,926
Total liabilities	$ –	$ 89,926	$ –	$ 89,926

The fair values of the securities included in Level 1 were determined through quoted market prices, and include money market funds, mutual funds, and marketable debt and equity securities. The fair values of Level 2 securities were determined through evaluated bid prices based on recent trading activity, and other relevant information, including market interest rate curves and referenced credit spreads, and estimated prepayment rates, where applicable, are used for valuation

8. Fair Value Measurement (continued)

purposes and are provided by third-party services where quoted market values are not available. The fair values of the interest rate swap agreements included in Level 2 were determined using third-party models that use as their inputs observable market conditions.

9. Pension Plans

The Health System sponsors a cash balance defined benefit pension plan covering all eligible employees. The Health System's funding policy is to contribute amounts to the plan sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, plus such additional amounts as the Health System may determine to be appropriate from time to time. Funding requirements are determined through consultation with an independent actuary. Effective July 1, 2011, the Health System closed the plan to new participants. Participants as of June 30, 2011 continue to accrue benefits.

The Health System recognizes the funded status (that is, the difference between the fair value of plan assets and the projected benefit obligations) of its plan in the consolidated balance sheets, with a corresponding adjustment to net assets. Actuarial gains and losses that arise and are not recognized as net periodic pension cost in the same periods are recognized as a component of net assets.

The assumptions used in calculating the pension amounts recognized in the Health System's consolidated financial statements include discount rates, interest costs, expected return on plan assets, retirement and mortality rates, inflation rates, salary growth, and other factors. While the Health System believes the assumptions used are appropriate, differences in actual experience or changes in assumptions may affect future pension obligations and expense.

The following tables set forth the plan's funding status as of the measurement dates, amounts recognized in the consolidated financial statements, and assumptions used. The plan's measurement dates were June 30, 2018 and 2017, with participant census dates of July 1, 2017 and 2016, respectively.

9. Pension Plans (continued)

	Year Ended June 30	
	2018	**2017**
	(In Thousands)	
Change in projected benefit obligation:		
Benefit obligation, beginning of year	**$ 660,595**	$ 649,167
Service cost	**31,604**	33,620
Interest cost	**24,581**	23,598
Actuarial gain, net	**(22,953)**	(10,196)
Benefits paid	**(39,247)**	(32,573)
Administrative expenses paid	**(3,879)**	(3,021)
Projected benefit obligation (including $607,760 and $614,018 in 2018 and 2017, respectively, in accumulated benefit obligation), end of year	**$ 650,701**	$ 660,595
Change in plan assets:		
Fair value of assets, beginning of year	**$ 599,445**	$ 551,674
Employer contributions	–	25,000
Return on plan assets	**41,813**	58,365
Benefits paid	**(39,247)**	(32,573)
Administrative expenses paid	**(3,879)**	(3,021)
Fair value of assets, end of year	**$ 598,132**	$ 599,445
Funded status:		
Pension liability recorded in other long-term obligations in the consolidated balance sheets	**$ (52,569)**	$ (61,150)

At June 30, 2018, unrestricted net assets include $156,475,000 of primarily unrecognized actuarial losses of the Health System's defined benefit plan that have not yet been recognized in net periodic benefit cost, of which $10,483,000 will be amortized in fiscal year 2019.

9. Pension Plans (continued)

	Year Ended June 30	
	2018	**2017**
	(In Thousands)	
Components of net periodic cost:		
Service cost	**$ 31,604**	$ 33,620
Interest cost	**24,581**	23,598
Expected return on plan assets	**(47,470)**	(45,707)
Amortization of prior service cost	**15**	19
Amortization of losses and other, net	**14,166**	16,777
Net periodic cost included in salaries, benefits, and related personnel costs in the consolidated financial statements	**$ 22,896**	$ 28,307
Weighted average assumptions for determining benefit obligations at end of year and net periodic costs for the year:		
Discount rates – benefit obligations	**4.34%**	3.90%
Discount rates – net periodic costs	**3.90**	3.77
Rates of increase in future compensation levels	**3.50**	4.00
Expected long-term rate of return on plan assets	**8.20**	8.20

The assumption for the expected return on assets is derived from a study conducted by the Health System's actuaries and financial management. The study includes a review of the plan's asset allocation strategy, anticipated long-term performance of individual asset classes, risks and correlations of asset classes, and general economic conditions of the investment marketplace. Because of revisions to the plan's investment policy, asset allocation strategy, and changes in professional managers utilized, historical returns performance of the plan was not a significant factor in the analysis.

9. Pension Plans (continued)

The assets of the pension plan by weighted average asset allocation categories are set forth in the following table:

	2018	**2017**
Asset category:		
Short-term investments	**2%**	4%
Fixed income	**22**	27
Domestic equity	**20**	20
Global equity	**5**	–
International equity	**16**	20
Risk parity	**1**	3
Private equity and hedge funds	**34**	26
Total	**100%**	100%

The plan's general investment objective is to seek to achieve attractive long-term total return from income and growth of capital over a full market cycle with a low-to-moderate level of risk, emphasizing, primarily, the preservation of principal and, secondarily, the real purchasing power of assets over the long term while maintaining adequate liquidity to meet benefits and expense cash flow requirements when due through the utilization of investments in a balanced and diversified portfolio of equity, fixed income, short-term liquid securities, and alternative investments. Investments will be well-diversified across individual issuers, economic sectors, and asset classes to ensure a level of risk that is comparable to the general investment markets. At June 30, 2018, the unfunded commitment related to the plan's assets is $26,627,000.

The Plan's assets measured at fair value on a recurring basis were determined using the following inputs at June 30, 2018 and 2017. The tables do not include Level 3 alternative investments of $218,993,000 and $167,852,000, respectively, which are measured at fair value using net asset value as a practical expedient.

9. Pension Plans (continued)

	June 30, 2018			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Cash and cash equivalents	**$ 20,858**	**$ –**	**$ –**	**$ 20,858**
U.S. government securities	**16,354**	**3,047**	**–**	**19,401**
Pooled funds:				
Domestic equities	**–**	**14,262**	**–**	**14,262**
Global equities	**30,402**	**66,252**	**–**	**96,654**
Risk parity	**1,111**	**4,320**	**–**	**5,431**
Fixed income	**63,976**	**–**	**–**	**63,976**
Hedge fund	**–**	**18,091**	**–**	**18,091**
Corporate obligations	**–**	**10,520**	**–**	**10,520**
Corporate equities	**62,761**	**–**	**–**	**62,761**
Global equities	**28,309**	**–**	**–**	**28,309**
MLPs	**27,859**	**–**	**–**	**27,859**
Public REITs	**11,017**	**–**	**–**	**11,017**
Total	**$ 262,647**	**$ 116,492**	**$ –**	**$ 379,139**

	June 30, 2017			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Cash and cash equivalents	$ 33,010	$ –	$ –	$ 33,010
U.S. government securities	6,492	14,902	–	21,394
Pooled funds:				
Domestic equities	–	15,901	–	15,901
Global equities	43,158	47,029	–	90,187
Risk parity	9,267	12,110	–	21,377
Fixed income	95,567	–	–	95,567
Hedge fund	–	17,262	–	17,262
Corporate obligations	–	8,546	–	8,546
Corporate equities	72,678	–	–	72,678
Global equities	27,213	–	–	27,213
MLPs	28,458	–	–	28,458
Total	$ 315,843	$ 115,750	$ –	$ 431,593

9. Pension Plans (continued)

At June 30, 2018 and 2017, the Plan's investment in alternative investments of $218,993,000 and $167,852,000, respectively, is included in hedge funds, private equity, and real assets.

As described in Note 8, management has elected to use the net asset value per share, or its equivalent, as a practical expedient for fair value of the plan's interest in alternative investments. The majority of these funds have restrictions on the timing of withdrawals, which may reduce liquidity, in some cases for up to 12 months.

All of the assets are managed by external investment managers and are maintained in actively managed security portfolios. Derivative investments are not allowed except by fund managers who employ such techniques to offset or reduce the risk associated with an existing group of investments. Management expects to make contributions of at least $24,000,000 for fiscal year 2019.

	Estimated
	(In Thousands)
Expected benefit payments estimated for fiscal years:	
2019	$ 46,582
2020	49,427
2021	50,668
2022	53,201
2023	53,246
2024–2028	260,765

In addition to the defined benefit plan discussed above, eligible employees participate in certain other retirement plans, including defined contribution plans with employer matches of $68,183,000 and $61,703,000 for 2018 and 2017, respectively.

10. Self-Funded Liabilities

The Health System is self-insured for general and professional liability, errors and omissions, and workers' compensation claims, and maintains excess insurance coverage at varying levels. A provision is made for estimated losses and related expenses on risks not covered by insurance. The provision includes estimated amounts for asserted claims, reported incidents for which a claim has not been asserted, and claims incurred but not reported. The provision is based on specific claim loss estimates by the Health System's management and on estimates of total annual losses by an independent consulting actuary using the Health System and similar facility experience.

10. Self-Funded Liabilities (continued)

The Health Professionals Insurance Company, Ltd. (HePIC), a wholly owned subsidiary, is a captive insurance company that provides professional liability, general liability, and other insurance coverage for the Health System's affiliates. The Health System funds HePIC's required insurance reserves. Funding amounts are based on actuarial recommendations. The assets of HePIC and the established liability for self-funded losses are reported in the consolidated balance sheets. Investment income from the assets and the provision for estimated self-funded losses and administrative costs are reported in the consolidated statements of operations and changes in net assets. The Health System's established liability for self-funded losses was $63,533,000 and $65,361,000 as of June 30, 2018 and 2017, respectively, and is recorded in accrued payroll and related expenses, other accrued expenses, and other long-term obligations in the accompanying consolidated balance sheets.

11. Commitments and Contingencies

Litigation

From time to time, the Health System is subject to litigation in the ordinary course of its operations. In management's opinion, any future settlements or judgments on asserted or unasserted claims will not have a material effect on the Health System's consolidated financial position.

Various federal and state agencies have initiated investigations regarding reimbursement claimed by the Health System and other matters. The investigations are in various stages of discovery, and the ultimate resolution of these matters, including the liabilities, if any, cannot be readily determined; however, in the opinion of management, the results of these investigations will not have a material adverse impact on the consolidated financial statements of the Health System.

Other

Under terms of an agreement, as amended, originally dated January 1, 1968 and superseded with a new agreement dated August 16, 2004, the Health System and the University of Texas Health Science Center at Houston (the University) affiliated to operate and maintain a patient care, medical teaching, research, and community service facility. The agreement specifies that Memorial Hermann Hospital will serve as the primary private hospital teaching site for the University, and operate and maintain a fully accredited hospital, while maintaining final authority over operational policy. The University agrees to offer the hospital the opportunity to

11. Commitments and Contingencies (continued)

accommodate all teaching programs and clinical programs, maintain fully accredited educational programs, and conduct research activities while utilizing Memorial Hermann Hospital. Mutual commitments include administrative appointments and sharing of certain operational and research costs. Expenses for obligations to the University for the years ended June 30, 2018 and 2017 totaled $302,590,000 and $286,079,000, respectively. Following the initial term, this agreement will automatically renew on October 15, 2019 for an additional 10 years. The parties are in active discussions to establish a long-term extension to this academic and clinical affiliation agreement.

12. Impact of Hurricane Harvey

On August 24, 2017, Hurricane Harvey made landfall on the Southeast coast of Texas, which included many of the service areas where the Health System owns and operates its facilities. Widespread flooding occurred over several days in Houston and the surrounding area. The Health System temporarily evacuated one of its acute care facilities for several days and closed some of its smaller physician and ambulatory locations. All other Health System hospitals remained open throughout the period; however, certain services at all Health System hospitals were disrupted or cancelled, including elective admissions and surgeries. The hospitals subsequently returned to normal operations.

The Health System maintains insurance policies covering property damage, business interruption, and related costs, subject to applicable deductibles. Further, recovery of certain losses and costs may be provided by the Federal Emergency Management Agency (FEMA). Management is continuing to evaluate potential recoveries and file claims under existing insurance policies and FEMA. As of June 30, 2018, the Health System has incurred net expenses of approximately $17,000,000 related to Hurricane Harvey.

13. Subsequent Events

In July 2018, a partnership in which the Health System had an equity method investment sold a medical office building in the Texas Medical Center, and the Health System received its share of the net sale proceeds of approximately $115,000,000.

13. Subsequent Events (continued)

On September 28, 2018, the Health System executed a letter of intent with Baylor Scott & White Holdings and Its Controlled Affiliates (collectively referred to as Baylor Scott & White Health) to pursue merging the operations of the two health systems through the creation of a new nonprofit, tax-exempt parent corporation. The boards of the two health systems are continuing to evaluate the potential alignment and are initiating the due diligence process. A definitive agreement is subject to negotiation and approval of appropriate regulatory bodies and Board approvals. The potential combination would strengthen our respective communities, advance the health of Texans and transform the delivery of care. The Health System can give no assurance that the transaction will occur.

Supplementary Information

Memorial Hermann Health System

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Grant Number	Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Transportation				
National Highway Traffic Safety Administration				
Passed - Through Texas Department of Transportation				
State and Community Highway Safety	20.600	2017-MHH-G-1YG-0044	$ 11,461	$ -
		2018-MHH-G-1YG-0060	49,732	-
Total U. S. Department of Transportation			61,193	-
U.S Department of Health and Human Services				
Administration for Community Living:				
CIL-Net	93.432	90ILTA0001-01-01	685,220	308,165
SILC-Net	93.369	90ISTA0001-01-01	119,692	62,313
Total U. S. Department of Health and Human Services			804,912	370,478
Research & Development Cluster:				
U.S. Department of Health and Human Services				
Direct Agency Funded Programs:				
Centers for Independent Living Program Training and Technical Assistance (ILNET)	93.432	90TT0001-03-02	726,934	-
Statewide Independent Living Council Training and Technical Assistance Center (SILC T&TA)	93.369	90IT0001-02-00	234,137	-
National Institute on Disability, Independent Living, and Rehabilitation Research:				
Southwest ADA Center (SWADA)	93.433	90DP0022-02-02	319,913	-
		90DP0092-02-01	982,707	258,297
Texas Traumatic Brain Injury Model System (TBI)	93.433	90DP0028-03-01	341,745	24,880
		90DPTB0016-01-00	233,426	12,387
Community & Work Participation Disparities (ADA PARC)	93.433	90DP0026-03-01	447,522	404,617
ADA PARC II	93.433	90DPAD0001-01-01	123,580	30,389
Multi-Center Evaluation of Memory Remediation After TBI with Donepezil (MEMRI)	93.433	90DP0060-04-01	544,996	443,164
Rehabilitation Research Training Centers Developing Strategies to Foster Community Integration and				
The Relation among Pain, Depression, Resilience and Prediction of Life Satisfaction with SCI (SCI Pain)	93.433	90IF0099-03-02	161,097	13,304
Texas Model Spinal cord injury System (SCI Texas Spinal Cord Injury System)	93.433	90SI5027-02-02	497,500	61,091
National Institute of Health, National Library of Medicine: NLM Health Website	93.879	1G08LM012702-01	18,883	1,042
Total Direct Agency Funded Programs			4,632,440	1,249,171

Continued

Memorial Hermann Health System

Notes to the Schedule of Expenditures of Federal Awards

Year Ended June 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Grant Number	Federal Expenditures	Expenditures to Subrecipients
Pass - Through Programs:				
Passed - Through The Regents of the University of California:				
Transforming Research and Clinical Knowledge in Traumatic Brain Injury	93.853	5U01NS086090-05	$ 105,620	$ -
Passed - Through The Trustees of Indiana University:				
Examining Determinants of Negative Attribution Bias in People with Traumatic Brain Injury	93.433	90IF0095-03-00	23,035	-
Passed - Through Regents of the University of Michigan:				
Quality of Life in Caregivers of Traumatic Brain Injury	93.361	R01NR013658	33,459	-
Passed – Through Washington State University:				
The Collaborative on Health Reform and Independent Living	93.433	90DP0075-03-00	103,011	24,837
Passed - Through Johns Hopkins University:				
Patch Study	93.865	5R01HD074944-03	17,427	-
Passed – Through National Association of Areas Agencies:				
Learning Collab for ABA	93.048	90PPBA0001-02	10,094	-
Passed - Through University of Iowa:				
Medication Focused Outpatient Center for Underutilization of Secondary Prevention	93.853	5R18HL116259/W000863685	6,876	-
Total Agency Pass Through Programs			299,522	24,837
Total U.S. Department of Health and Human Services			5,736,874	1,644,486
U.S. Department of Education				
Passed – Through The University of Texas Health Science Center at Houston:				
Enhancing Early Learning for Infants with Disabilities: A Responsive Parenting Intervention	84.324A	R324A120363	72,240	-
Total U.S. Department of Education			72,240	-
Total Research and Development Cluster			5,809,114	1,644,486
Total Expenditures of Federal Awards			$ 5,870,307	$ 1,644,486

1. Basis of Presentation

The Schedule of Expenditures of Federal Awards (the Schedule) presents federal grant activities of the Health System and is reported on the accrual basis of accounting, in accordance with the generally accepted accounting principles in the United States of America. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*.

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MEMORIAL HERMANN HEALTH SYSTEM

INDEPENDENT AUDITOR'S REPORT
IN ACCORDANCE WITH THE UNIFORM
GUIDANCE

YEAR ENDED JUNE 30, 2018

MEMORIAL HERMANN HEALTH SYSTEM

JUNE 30, 2018

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McCONNELL & JONES LLP
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE FOR EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

The Board of Directors
Memorial Hermann Health System
Houston, Texas

Report on Compliance for Each Major Federal Program

We have audited Memorial Hermann Health System's (MHHS) compliance with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Compliance Supplement* that could have a direct and material effect on each of MHHS' major federal programs for the year ended June 30, 2018. MHHS' major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of MHHS' major federal programs based on our audit of the types of compliance requirements referred to above. 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 the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance 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 MHHS' compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

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We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of MHHS' compliance.

Opinion on Each Major Federal Program

In our opinion, MHHS complied, in all material respects, with the types of 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, 2018.

Report on Internal Control Over Compliance

Management of MHHS is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered MHHS' internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, 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 MHHS' 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. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

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 material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of our report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

McConnell & Jones LLP

Houston, Texas
March 27, 2019

MEMORIAL HERMANN HEALTH SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

YEAR ENDED JUNE 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Grant Number	Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Transportation				
National Highway Traffic Safety Administration				
Passed - Through Texas Department of Transportation				
State and Community Highway Safety	20.600	2017-MHH-G-1YG-0044	$ 11,461	$ -
		2018-MHH-G-1YG-0060	49,732	-
Total U. S. Department of Transportation			61,193	-
Research & Development Cluster:				
U.S. Department of Health and Human Services				
Direct Agency Funded Programs:				
Administration for Community Living:				
CIL-Net	93.432	90ILTA0001-01-01	685,220	308,165
SILC-Net	93.369	90ISTA0001-01-01	119,692	62,313
Centers for Independent Living Program Training and Technical Assistance (ILNET)	93.432	90TT0001-03-02	726,934	-
Statewide Independent Living Council Training and Technical Assistance Center (SILC T&TA)	93.369	90IT0001-02-00	234,137	-
National Institute on Disability, Independent Living, and Rehabilitation Research:				
Southwest ADA Center (SWADA)	93.433	90DP0022-02-02	319,913	-
		90DP0092-02-01	982,707	258,297
Texas Traumatic Brain Injury Model System (TBI)	93.433	90DP0028-03-01	341,745	24,880
		90DPTB0016-01-00	233,426	12,387
Community & Work Participation Disparities (ADA PARC)	93.433	90DP0026-03-01	447,522	404,617
ADA PARC II	93.433	90DPAD0001-01-01	123,580	30,389
Multi-Center Evaluation of Memory Remediation After TBI with Donepezil (MEMRI)	93.433	90DP0060-04-01	544,996	443,164
Rehabilitation Research Training Centers Developing Strategies to Foster Community Integration and The Relation among Pain, Depression, Resilience and Prediction of Life Satisfaction with SCI (SCI Pain)	93.433	90IF0099-03-02	161,097	13,304
Texas Model Spinal cord injury System (SCI Texas Spinal Cord Injury System)	93.433	90SI5027-02-02	497,500	61,091
National Institute of Health, National Library of Medicine: Medical Library Assistance	93.879	1G08LM012702-01	18,883	1,042
Total Direct Agency Funded Programs			5,437,352	1,619,649

Continued

MEMORIAL HERMANN HEALTH SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

YEAR ENDED JUNE 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Grant Number		Federal Expenditures		Expenditures to Subrecipients
Pass - Through Programs:						
Passed - Through The Regents of the University of California:						
Transforming Research and Clinical Knowledge in Traumatic Brain Injury	93.853	5U01NS086090-05	$	105,620	$	-
Passed - Through The Trustees of Indiana University:						
Examining Determinants of Negative Attribution Bias in People with Traumatic Brain Injury	93.433	90IF0095-03-00		23,035		-
Passed - Through Regents of the University of Michigan:						
Quality of Life in Caregivers of Traumatic Brain Injury	93.361	R01NR013658		33,459		-
Passed – Through Washington State University:						
The Collaborative on Health Reform and Independent Living	93.433	90DP0075-03-00		103,011		24,837
Passed - Through Johns Hopkins University:						
Child Health and Human Development Extramural Research	93.865	5R01HD074944-03		17,427		-
Passed – Through National Association of Areas Agencies:						
Special Programs for the Aging, Title IV, and Title II, Discretionary Projects	93.048	90PPBA0001-02		10,094		-
Passed - Through University of Iowa:						
Medication Focused Outpatient Center for Underutilization of Secondary Prevention	93.837	5R18HL116259/ W000863685		6,876		-
Total Agency Pass Through Programs				299,522		24,837
Total U.S. Department of Health and Human Services				5,736,874		1,644,486
U.S. Department of Education						
Passed – Through The University of Texas Health Science Center at Houston:						
Enhancing Early Learning for Infants with Disabilities: A Responsive Parenting Intervention	84.324 A	R324A120363		72,240		-
Total U.S. Department of Education				72,240		-
Total Research and Development Cluster				5,809,114		1,644,486
Total Expenditures of Federal Awards			$	5,870,307	$	1,644,486

MEMORIAL HERMANN HEALTH SYSTEM

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

YEAR ENDED JUNE 30, 2018

1. ORGANIZATION AND BUSINESS

The Memorial Hermann Health System (MHHS), a Texas not-for-profit corporation, is exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code. MHHS owns and operates 13 nonsectarian general acute care hospitals (including Memorial Hermann Texas Medical Center, the primary teaching hospital for The University of Texas Medical School at Houston), a research and rehabilitation hospital (TIRR) in the Texas Medical Center, a Medicare-certified home health agency and a comprehensive ambulatory care network of facilities and services – all serving to position Memorial Hermann Health System as the market-share leader in the greater Houston, Texas area. MHHS includes one of the nation's largest Independent Practice Association (IPA) models, through which nearly 5,500 physicians are clinically integrated to MHHS for clinical practice standards, two insurance companies that underwrite group health coverage for employers and the Medicare Advantage program, a captive casualty and liability insurance company, and an Accountable Care Organization. Additionally, the Health System is supported by the Memorial Hermann Foundation (the Foundation).

2. CONSOLIDATED FINANCIAL STATEMENTS

The consolidated financial statements of MHHS were audited by another auditor, whose report dated October 1, 2018, except for the schedule of expenditures of federal awards (the "Schedule") for which the date is March 27, 2019, indicated that the Schedule has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and that the Schedule is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

3. BASIS OF PRESENTATION

The Schedule presents federal grant activities of MHHS and is reported on the accrual basis of accounting, in accordance with the generally accepted accounting principles in the United States of America. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance).

4. INDIRECT COST RATE

MHHS has not elected to use the 10% de minimis indirect cost rate as allowed under the Uniform Guidance.

5. SUBRECIPIENTS

MHHS engaged 19 subrecipients in the performance of research and development programs during the current fiscal year. The following amounts paid to the subrecipients are included as expenditures in the accompanying schedule of expenditures of federal awards:

Utah State University	$	247,328
National Council on Independent Living		123,149
University of Illinois		178,546
University of Texas Health Science Center		183,430
Syracuse University		110,906
American Institutes		64,248
Craig Hospital		102,155
Spaulding Rehabilitation		76,333
Albert Einstein Healthcare		92,061
University of Arkansas		14,873
Oklahoma State University		53,812
University of Montana		51,497
Public Health Institute		74,275
Indiana University		197,495
Meeting the Challenge, Inc.		25,065
Arc of Louisiana		30,397
Native American Disability Law		3,304
Baylor College of Medicine		3,225
University of Texas Medical Branch		12,387
Grand Total	$	1,644,486

MEMORIAL HERMANN HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

YEAR ENDED JUNE 30, 2018

PART I – SUMMARY OF AUDITOR'S RESULTS

Financial Statement Section

1. Type of auditor's report issued:	Unmodified
2. Internal control over financial reporting:	
a) Material weaknesses identified?	No
b) Significant deficiencies identified, which are not considered to be material weaknesses?	None reported
3. Noncompliance material to financial statements noted?	No

Federal Awards Section

1. Internal control over major programs:	
a) Material weaknesses identified?	No
b) Significant deficiencies identified, which are not considered to be material weaknesses?	No
2. Type of auditor's report issued on compliance for major programs:	Unmodified
3. Any audit findings disclosed, which are required to be reported in accordance with 2 CFR Section 200.516(a)?	No

4. Identification of major programs:

Federal CFDA Numbers	Names of Major Federal Programs
Research & Development Cluster of Programs:	
84.324A	Research in Special Education
93.048	Special Programs for the Aging, Title IV, and Title II, Discretionary Projects
93.361	Nursing Research
93.369	Statewide Independent Living Council Training & Technical Assistance Center
93.432	Centers for Independent Living
93.433	Disability and Rehabilitation Research Program
93.837	Cardiovascular Diseases Research
93.853	Extramural Research Programs in the Neurosciences and Neurological Disorders
93.865	Child Health and Human Development Extramural Research
93.879	Medical Library Assistance

5. Dollar threshold used to distinguish between type A and type B programs: $ 750,000

6. Auditee qualified as low-risk auditee under 2 CFR Section 200.520? Yes

MEMORIAL HERMANN HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

YEAR ENDED JUNE 30, 2018

PART II – FINANCIAL STATEMENT AUDIT

This section identifies the significant deficiencies, material weaknesses, and instances of fraud, illegal acts, violations of provisions of contracts and grant agreements, and abuse related to the financial statements for which *Government Auditing Standards* require reporting under 2 CFR Section 200.515(d)(2).

No findings were noted.

MEMORIAL HERMANN HEALTH SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

YEAR ENDED JUNE 30, 2018

PART III – FINDINGS AND QUESTIONED COSTS - MAJOR FEDERAL AWARD PROGRAMS

This section identifies the significant deficiencies, material weaknesses, and material instances of noncompliance, including questioned costs, as well as any abuse findings involving federal awards that are material to a major program.

No findings were noted.

MEMORIAL HERMANN HEALTH SYSTEM

SUMMARY SCHEDULE OF PRIOR YEAR AUDIT FINDINGS

YEAR ENDED JUNE 30, 2018

No findings were noted.