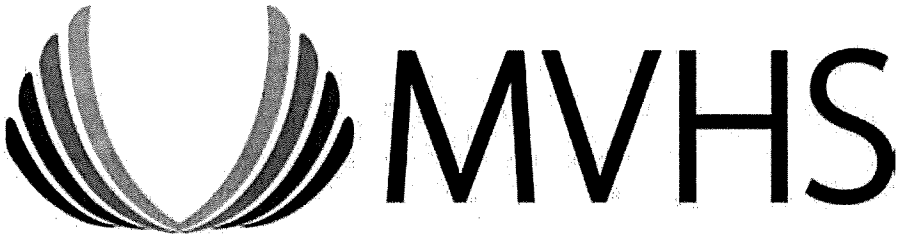
APPENDIX A
CERTAIN INFORMATION CONCERNING



MOHAWK VALLEY HEALTH SYSTEM

All information in this Appendix A has been provided by Mohawk Valley Health System unless otherwise noted. This Appendix A includes "forward looking statements;" please see "REGARDING USE OF THIS OFFICIAL STATEMENT – CAUTIONARY STATEMENTS REGARDING FORWARD LOOKING STATEMENTS IN THIS OFFICIAL STATEMENT" concerning such statements in the forepart of this Official Statement.

Each capitalized word or term used as a defined term but not otherwise defined in this Appendix A has the meaning assigned to it in the forepart of this Official Statement.

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INTRODUCTION

Mohawk Valley Health System ("MVHS" or "the System") is a fully integrated healthcare system that serves the residents of Utica, New York and parts of the surrounding counties including Oneida, Herkimer, and Madison. The 2018 total population of MVHS's service area was estimated at 388,652. In 2018, MVHS had over 22,600 inpatient admissions, over 80,000 total emergency department ("ED") visits, and over 295,700 other outpatient visits. The System includes two acute care hospitals on three campuses with 571 licensed beds, 20 primary care offices, 11 specialty offices, seven dialysis locations, one long-term care facility, one home care agency, an ambulatory surgery center joint venture, counseling services, social services, inpatient and outpatient substance abuse addiction management services, and a Medicaid managed care health plan. The System has 30 locations across Oneida, Herkimer and Madison Counties, where it maintains a leading market share and is the region's largest provider of healthcare services. The System captures approximately 65% of the inpatient market in its primary service area. The System employs more than 4,100 full-time equivalent employees and has a medical staff of 419 physicians.

ORGANIZATION

MVHS is a not-for-profit healthcare system, providing care to the residents of Central New York. The System is organized as an active parent model with much of the management responsibilities performed by the parent, MVHS. Each hospital within the System, Faxton St. Luke's Healthcare ("FSLH") and St. Elizabeth Medical Center ("SEMC"), retains its own corporate existence but is governed by the same Board of Directors with the exception of SEMC that has one additional member appointed by Partners in Franciscan Ministries, Inc. ("PFM"). The Board of Directors operates in a joint model to ensure consistency across the organization.

MVHS and its predecessors have been providing medical care to the residents of Utica and the surrounding communities for approximately 190 years. The formation of MVHS is one that evolved over many decades and has a rich history of affiliation and collaboration among healthcare facilities within the Utica community. MVHS was created in March 2014, through the affiliation of SEMC and the former Mohawk Valley Network ("MVN"), which included the affiliates of FSLH, St. Luke's Home, Senior Network Health and Visiting Nurses Association of Utica.

Faxton St. Luke's Healthcare – 370 Licensed Beds

FSLH began as two hospitals, Faxton Hospital and St. Luke's Memorial Hospital Center. These two hospitals affiliated in 1992 under the MVN umbrella and consolidated all services in 2000 under one organization. FSLH currently maintains two separate campuses in Utica, New York: FSLH – St. Luke's Division ("St. Luke's") and FSLH – Faxton Division ("Faxton").

FSLH – St. Luke's Division

St. Luke's originally opened its doors in 1872 and moved to its current location in 1957. St. Luke's ED provides 24-hour emergency care with nearly 41,000 visits annually. Comprehensive medical and surgical specialties at St. Luke's include coronary care, pediatrics, psychiatry, maternity, neonatal care and general surgical services. St Luke's is currently designated by the New York State Department of Health as a Level II Perinatal Center and a Stroke Center.

Included within the 370 beds of FSLH is a 24-bed inpatient rehabilitation unit that is located within the MVHS Rehabilitation and Nursing Center on the St. Luke's Campus.

FSLH – Faxton Division

Faxton has maintained a presence at its current location since 1873. Following the merger with St. Luke's, the Faxton campus was transitioned to an outpatient facility. In addition to the outpatient services provided at Faxton, the site also houses the regional cancer center and an urgent care center. Faxton also services as the System's primary site for outpatient imaging services and outpatient dialysis.

St. Elizabeth Medical Center – 201 Licensed Beds

SEMC was established in 1866 by the Sisters of St. Francis. Since its inception, SEMC has moved three times with the present location having opened in 1917.

MVHS and PFM are currently co-members of SEMC. PFM is sponsored by the Sisters of St. Francis of the Neumann Communities and has reserved powers related to the mission of SEMC only. PFM does not provide any financial support or guarantees to SEMC or the Obligated Group and will not be obligated to make any debt service payment with respect to the Series 2019 Bonds.

SEMC's ED provides 24-hour emergency care with nearly 39,000 visits annually. Comprehensive medical and surgical specialties at SEMC include cardiology, orthopedics, pediatrics, psychiatry and general surgical services. SEMC is currently designated by the New York State Department of Health as a Level III Adult Trauma Center.

SEMC's cardiac program includes adult open heart surgery, diagnostic cardiac catheterization, interventional cardiology (Angioplasty) and Electrophysiology.

In addition to the two acute care hospitals, MVHS is also the active parent and co-operator of the following:

- *St. Luke's Home Residential Healthcare Facility, Inc. d/b/a MVHS Rehabilitation and Nursing Center ("MVHS RNC")* – MVHS RNC is a 202-bed residential home with a 40-bed subacute rehabilitation unit located on the St. Luke's campus;
- *Senior Network Health, LLC ("SNH")* – SNH is a Medicaid managed care health plan that provides and arranges for health and long-term care services on a capitated basis (with New York State) for residents located in Oneida and Herkimer counties. It is a program designed to maintain the health and safety of MVHS's adult population as well as to delay, and if possible avoid, the need for nursing home placement. Through a collaboration with community agencies, SNH develops individualized care plans for each member that strives to provide the optimal setting for a healthy and safe environment in one's own home;
- *Visiting Nursing Association of Utica and Oneida County, Inc. ("VNA")* –VNA was founded in 1915 and provides healthcare through professional nurses, therapists and aides primarily in Oneida County. VNA is a certified home health agency in New York State and is licensed to sponsor a long-term home healthcare program; and
- *Mohawk Valley Health System Foundation ("MVHS Foundation")* – MVHS Foundation is a not-for-profit, tax-exempt corporation that carries out fundraising activities which benefit MVHS and its affiliates.

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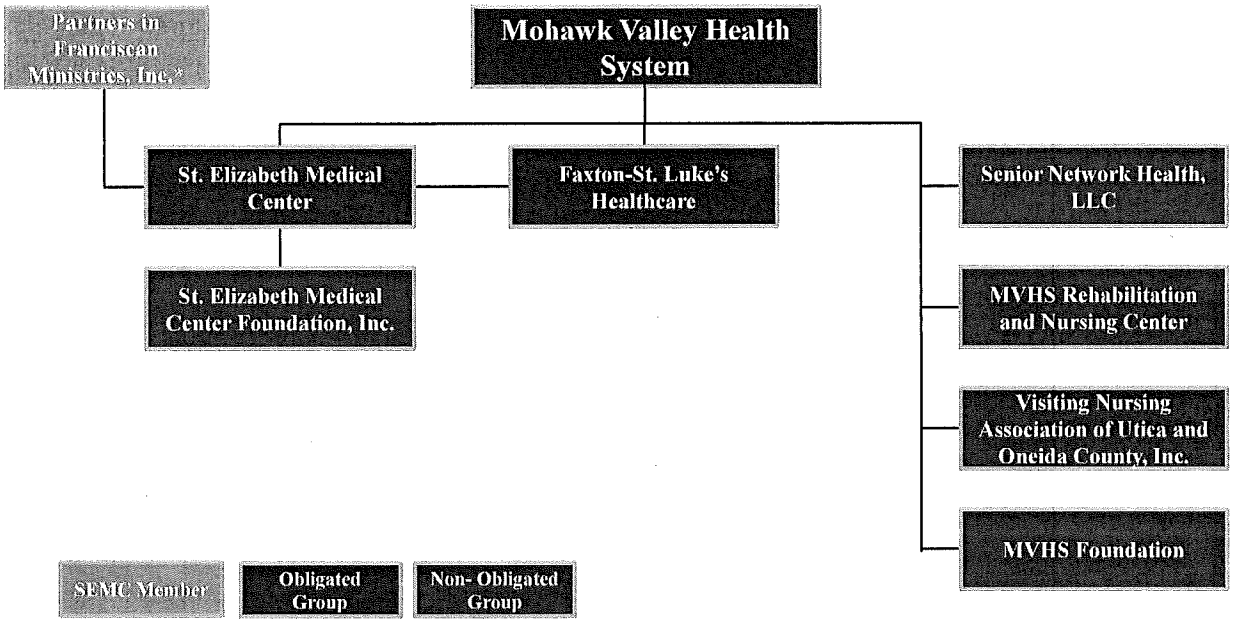
Organizational Structure

The table below sets forth the corporate membership of MVHS and certain of its consolidated affiliates, as well as the composition of the Obligated Group.



*Partners in Franciscan Ministries, Inc., which is sponsored by the Sisters of St. Francis of the Neumann Communities, is a co-member of SEMC with MVHS.

Obligated Group

The existing MVHS Obligated Group consists of MVHS, FSLH, and SEMC. The Obligated Group will represent approximately 92.3% of the assets of the System and 94.4% of its operating revenue.

No affiliate of MVHS, other than the current Members of the Obligated Group, will be obligated for amounts due under the Series 2019 Bonds, which are being secured on parity under the Master Indenture with other existing debt of the Obligated Group.

Licensure and Accreditation

FSLH and SEMC are accredited and deemed to be in compliance with the Medicare Conditions of Participation for Hospitals through July and August, 2020, respectively. Both hospitals are accredited by DNV GL – Healthcare, which conducts an annual survey for reaccreditation.

The System's hospitals and long-term care facilities are also fully licensed and regulated by the New York State Department of Health.

Awards and Honors

MVHS and its individual hospitals have received numerous awards and honors for quality, safety, and innovation.

SEMC was recognized among U.S. News & World Report's Best Hospitals for 2019 as a high performing hospital for Heart Failure, COPD, Knee Replacement and Hip Replacement.

FSLH received the Excellence in Labor and Delivery Award for the superior care of women during and after childbirth from Healthgrades. FSLH was one of only 16 hospitals in New York State to receive this award and the only one in Central New York.

Other MVHS awards and distinctions are highlighted below:

- *Cancer Services.* The FSLH Cancer Center operates in partnership with Upstate Cancer Center and has been nationally accredited by the Commission on Cancer since September 1991 and was reaccredited in 2019 for three years.

- *Cardiac Services.* SEMC is recognized as one of the first hospitals in the nation to receive a Blue Distinction Center+SM designation in the area of cardiac care, as part of the Blue Distinction Centers for Specialty Care® program through Excellus BlueCross BlueShield. SEMC also received the highest ratings possible in quality and cost efficiency from the United Health Premium Cardiac Services Specialty Center.

- *Orthopedic Program.* In May 2019, SEMC has achieved accreditation as a Center of Excellence in Orthopedic Surgery by Surgical Review Corporation. SEMC was selected by Excellus BlueCross BlueShield as a Blue Distinction Center+ for Knee and Hip Replacement, part of the Blue Distinction Specialty Care program, which will go into effect on January 1, 2020.

- *Stroke Program.* In July 2019, the FSLH Stroke Center received the ninth consecutive American Heart Association/American Stroke Association's (AHA/ASA) Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award with Target: StrokeSM Honor Roll Elite Plus. The Gold Plus and Target: Stroke Honor Roll awards are the highest award status given, making MVHS one of the top stroke centers in the United States.

- *Bariatric Surgery.* The FSLH Bariatric Surgery Program has been reaccredited as a Comprehensive Center under the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery. The program has also been recognized by Excellus BlueCross BlueShield as Blue Distinction® Center+ for Bariatric Surgery.

- *Maternal Child Services.* Maternal Child Services at FSLH welcomes more than 2,000 newborns into the world every year and has the only Level II Special Care Nursery in the Mohawk Valley. In 2019, FSLH received an award for Excellence in Labor and Delivery from Healthgrades.

- *Trauma.* SEMC was re-verified as a Level III Trauma Center by the American College of Surgeons in June 2019.

Medical Education

MVHS offers a wide selection of medical education opportunities for all levels of students through the St. Elizabeth College of Nursing, Family Medicine Residency and Dental Residency Programs. Other education opportunities for Nurse Practitioners, Physician Assistants and other Allied Health professionals are also offered within the System. The New Regional Medical Center (as defined herein) initiative, will focus on expanding these programs to meet the regional need for care in the Mohawk Valley.

SEMC's College of Nursing was established in 1904. The College of Nursing is a two year Associate Degree Nursing program affiliated with the State University of New York Institute of Technology. The nursing courses include hands on patient care that is planned and supervised by a qualified faculty member with expertise in a particular nursing area. The College of Nursing is accredited by the Accreditation Commission for Education in Nursing, Middle States Commission on Higher Education and the New York State Department of Education. Since its inception, the College of Nursing has graduated approximately 3,861 individuals.

St. Elizabeth Family Medicine Residency Program has a history of providing family medicine graduate medical education that spans more than three decades. It has earned the designation of being a New York State Priority Program due to the emphasis placed on primary care education. It is accredited through both the Accreditation Council for Graduate Medical Education and through the American Osteopathic Association. The curriculum is designed to emphasize both longitudinal and rotational exposure to continuity of care across various healthcare settings. As the Family Medicine Center is located only blocks from the Refugee Resettlement Center in Utica, New York, residents experience a wide array of cultural backgrounds and medical conditions.

The Dental Residency Program at FSLH is a one-year post-doctoral professional education program which offers special opportunity for advanced comprehensive clinical experiences in the hospital setting, additional training in the sciences basic to general dental practice, and a supervised clinical dentistry program. Five dental residents are accepted into the dental program each year.

MVHS also offers fellowship programs in Gynecological Surgery and Hospitalist Medicine, and MVHS's hospitals and outpatient locations are used to train students in allied health programs from local colleges. MVHS, along with community partners, also offers programs to high school students to acquaint them with healthcare careers.

As part of the New Regional Medical Center, MVHS is currently seeking a partner which will help to expand the medical residency programs to meet regional medical needs. Primary care, psychiatry, obstetrics/gynecology, emergency medicine, general surgery and podiatry are the focus of the expanded graduate medical education program.

MVHS GOVERNANCE AND CORPORATE STRUCTURE

Governance

MVHS is governed by a Board of Directors (the "Board"), composed of 16 elected members of the Board (the "Elected Directors") as well as the President and Chief Executive Officer of MVHS, who serves coterminous with his/her position, and the President of the Medical Staffs of SEMC and FSLH (the "Non-Elected Directors" and together with the "Elected Directors" the "Directors"), coterminous with holding their respective positions. Elected Directors are selected for their experience, expertise and skills; their ability and willingness to devote time and effort to fulfilling the Board's responsibilities; their commitment to the community and healthcare needs of its residents; and their personal and professional ethical values. The Board is divided into four equal "classes" and a new class is elected annually to a four (4)-year term expiring in successive years; Directors serve without compensation. The Board seeks to exhibit diverse backgrounds, including banking, investment management, healthcare, accounting, technology and community business leaders, among other groups. Extensive ties to the community provide the Board with a particularly keen insight into the needs of the communities the System serves.

The Board, which is required to hold at least nine regular meetings annually, is responsible for governing the affairs of the System, establishing policies, assuring quality patient care, and providing for institutional management and planning. Directors are chosen based on their ability to participate and be effective in fulfilling the Board's responsibilities and supporting the objectives of the System. The Officers of the Board are (a) Chairperson, (b) Vice Chairperson, (c) Chair Emeritus, (d) Secretary, (e) Treasurer and (f) President. The President and Chief Executive Officer of MVHS is appointed by the Board and, by virtue of the position, is a voting member of the Board as long as he/she holds that office.

There are seven (7) Standing Committees of the MVHS Board: Executive Committee, Finance Committee, Quality and Patient Safety Committee, Governance Affairs and Ethics Committee, Executive Compensation Committee, Investment Committee and Audit and Compliance Committee. The Executive Committee is able to transact any regular business of the Board during the period between meetings of the Board, subject to any prior limitation imposed by the Board, and with the understanding that all actions taken will be reported to the Board.

The current members of the Board are as follows:

BOARD MEMBERS

Member	Occupation	Initial Appointment	Term Expiration
Domenic Aiello, MD	Physician - Private Practice	March 2014	December 2023
Waleed Albert, MD	Physician, Mohawk Valley Health System, FSLH Medical Staff President		Ex-Officio
Barbara Brodock	Owner, Brodock Press	March 2014	December 2023
Catherine Brownell, PhD	Chair and Professor of Nursing, Leymone College	January 2018	December 2021
Larry Bull	Owner, Bull Brothers	June 2016	December 2023
Catherine Cominsky	Manager, Cathedral Corporation	March 2014	December 2021
Joan Compson [5]	Retired - Chief Financial Officer, Carbone Auto Group	March 2014	December 2020
Alicia DeTraglia, MD [3]	Physician, Mohawk Valley Health System	January 2018	December 2020
Robert Dicks [6]	President, Dicks Financial Services and Insurance		
Gregory Evans [2]	President/CEO, Indium Corporation of America	March 2014	December 2022
Sushma Kaul, MD	Physician - SEMC Medical Staff President		Ex-Officio
Andrew Kowalczyk III, Esq.	Attorney - Private Practice	March 2014	December 2020
Karen Leach	Vice President, Administration and Finance, Hamilton College	February 2018	December 2023
Gregory McLean	President, Caruso McLean & Co, Investment Advisors	March 2014	December 2021
Darlene Stromstad	President & CEO Mohawk Valley Health System		Ex-Officio
Honorable Norman Siegel [5]	Retired - New York State Supreme Court Judge	March 2014	December 2020
Richard Tantillo	Senior Philanthropic Advisor, Hamilton College	March 2014	December 2022
Symeon Tsoupelis	Owner, Symeon's Restaurant	March 2014	December 2021
Bonnie Woods [1]	Managing Director, Bank of America	March 2014	December 2022
Richard Zweifel [4]	Partner, The Bonadio Group, CPAs	March 2014	December 2022

[1] Chair
[2] Vice-Chair
[3] Secretary
[4] Treasurer
[5] Chair Emeritus
[6] St. Elizabeth Medical Center Board

Conflicts of Interest Policy

MVHS adheres to a formal conflict of interest policy requiring that any Director, Officer or Key Person of the health system with respect to any transaction or arrangement involving MVHS and its member organizations exercise the utmost good faith, care and diligence in all transactions involving MVHS. This policy also requires that Directors will not use their positions or knowledge gained there from in any transaction or activity, nor shall they engage in any activities which might involve interests in conflict with those of MVHS or its affiliates. This policy also requires an affirmative duty to disclose immediately to the Directors, the President of MVHS or the Corporate Compliance Officer of MVHS, all knowledge of situations involving potential or actual conflicts of interests.

The Board or its authorized committee is responsible for overseeing the implementation of and compliance with this conflicts of interest policy. The Directors are required annually to review the aforementioned conflict of interest policy and file a statement indicating their familiarity therewith. Each incoming Director is also advised of the policy.

Executive Management

A senior management team, including the current President and Chief Executive Officer of MVHS, supports and complements the governance activities of the Board, ensuring that policies, plans and programs are implemented. The management team's major responsibilities are:

- Implementing the organization's strategic vision;
- Monitoring and improving quality of care, patient safety and outcomes;
- Coordinating and engaging the medical staff;
- Ensuring well-trained employees;
- Ensuring efficient and effective daily operations of the System;
- Developing the System's budget and consistent management and oversight of its financial position;
- Developing and implementing actionable, measurable marketing and promotion plans to help drive MVHS growth strategies; and
- Creating and implementing a robust philanthropic program to meet the organization's goals, in particular a comprehensive campaign for the building of a New Regional Medical Center.

The President and Chief Executive Officer reports to the Board and is supported by the other members of the System's senior management. Biographical information regarding the President and Chief Executive Officer and the other key members of the System's senior management follows:

Darlene Stromstad, FACHE, President and Chief Executive Officer, Age 63

Darlene Stromstad was appointed President and CEO in January of 2019. Prior to her current appointment, she served as interim Chief Executive Officer of Fenway Health, a large federally qualified health center in Boston. She also served as President/CEO of Waterbury Hospital and the Greater Waterbury Health Network (now known as Waterbury HEALTH) in Connecticut and President/CEO of Goodall Hospital in Sanford, ME. Ms. Stromstad is nationally recognized for her leadership and active engagement in organizations such as the American College of Healthcare Executives where she served as a member of the Board of Governors. She also served on the American Hospital Association's Metropolitan Advisory Council. She served at the statewide level on the Board of Directors of the Connecticut Hospital Association and the Maine Hospital Association, and at the local and regional levels as a Board member for the Greater Waterbury United Way, Greater Waterbury Chamber of Commerce, Naugatuck Community College, and Sanford Downtown Legacy. Ms. Stromstad received her Master of Business Administration from Rivier College in Nashua, New Hampshire, and her Bachelor of Arts in Journalism from the University of North Dakota in Grand Forks, North Dakota.

Robert Scholefield, MS, RN, Executive Vice President/Chief Operative Officer and Executive Vice President of Facilities and Real Estate, Age 59

Robert Scholefield has served as Executive Vice President/Chief Operating Officer since March, 2014 upon the affiliation of FSLH and SEMC.. Mr. Scholefield has been employed at MVHS and SEMC for over 30 years, having formerly served as the assistant director and director of nursing at SEMC and vice president of nursing at SEMC. In 2019, Mr. Scholefield was appointed to a new role at MVHS, Executive Vice President of Facilities and Real Estate. This is a newly created role which was established to ensure the necessary oversight of all aspects of the New Regional Medical Center project. While he is active in this new role, Mr. Scholefield continues to fulfill the responsibilities of COO as MVHS works to recruit his replacement. Mr. Scholefield holds a bachelor's degree in professional studies from the State University of New York at Utica/Rome, a Master of Science degree in health systems management from New School for Social Research in Utica, New York and is a graduate of the St. Elizabeth School of Nursing in Utica, New York. Mr. Scholefield is currently a member of the board of directors of the Greater Utica Chamber of Commerce and St. Elizabeth College of Nursing.

Louis Aiello, Senior Vice President and Chief Financial Officer, Age 50

Louis Aiello serves as the Senior Vice President and Chief Financial Officer at MVHS, a role he has served in since March 2014. In this position, Mr. Aiello is responsible for the finance and operations of the System while integrating accounting, budgeting, investing and financial reporting as well as providing the System with the managerial support necessary to administer the highest quality of care to all patients. Mr. Aiello is responsible for overseeing Patient Access Services, Patient Accounting, Financial Services, Cash Management, Health Information Management, Telecommunications, Purchasing, Mail Room/Print Shops and Home Care Services. Prior to the MVHS affiliation, Mr. Aiello served as the Chief Financial Officer and Vice President of Finance at SEMC. Mr. Aiello holds a bachelor's degree in accounting from Utica College of Syracuse University and passed his Uniform CPA Examination in 1996.

Linda McCormack-Miller, DNP, RN, NEA-BC, Senior Vice President and Chief Nursing Officer, Age 60

Linda McCormack-Miller, DNP, RN, NEA-BC, has served as the Senior Vice President and Chief Nursing Officer at MVHS since March 2017. In this position, she is responsible for nursing practice, policy and procedures across the System. Ms. McCormack-Miller has more than 25 years of progressive healthcare experience. After earning her Bachelor of Science in Nursing from Seton Hall University in South Orange, New Jersey, she was commissioned as a nurse in the United States Navy. She served at Portsmouth Naval Hospital in Portsmouth, Virginia; Camp Lejeune Naval Hospital in Jacksonville, North Carolina; and Oakland Naval Hospital in Oakland, California. Ms. McCormack-Miller completed her Master of Science in Nursing from Old Dominion University in Norfolk, Virginia, and her Doctorate in Nursing from Rush University in Chicago, Illinois. In 1993, Ms. McCormack-Miller began her post-naval career at Our Lady of Lourdes Memorial Hospital in Binghamton, New York, and held a variety of positions, most recently serving as the Senior Vice President of Operations/Chief Nursing Officer. Ms. McCormack-Miller is certified by the American Nurses Credentialing Center as a Nurse Executive, Advanced.

Eric Yoss, MD, FCCP, Senior Vice President, Interim Chief Medical Officer, Chief Quality Officer and Patient Safety Officer, Age 63

Eric Yoss, MD, FCCP, a specialist in Pulmonology and Critical Care Medicine, is Senior Vice President of Quality at MVHS. In this position, he is responsible for overseeing and coordinating the various quality programs at MVHS. Dr. Yoss has served on the SEMC medical staff since the early 1990s, including as its president and secretary/treasurer. He has been associated with Pulmonary and Critical Care Associates of New Hartford since 1988 and has served as medical director of Respiratory Care and the Intensive Care Unit at SEMC and as medical director of Critical Care services at FSLH. Dr. Yoss received his medical degree from New York Medical College in Valhalla, New York, and completed an internship/residency and fellowship at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania. Dr. Yoss is board certified in Internal Medicine, Pulmonary Diseases and Critical Care Medicine. Dr. Yoss is a member of the Society of Critical Care Medicine and a fellow in the American College of Chest Physicians.

Patricia Charvat, Senior Vice President of Marketing and Strategy, Age 57

Patricia Charvat is the Senior Vice President of Marketing and Strategy at MVHS. In this role, Ms. Charvat provides leadership and direction, in conjunction with the organization's senior executives, for establishing growth, business development and marketing strategies. She helps MVHS establish deep community relationships that target programs to demonstrably improve the health of the communities served by MVHS throughout the region. She develops advocacy strategies at the federal, state and local levels and manages the marketing and communications functions and staff. Ms. Charvat brings extensive experience to MVHS, as well as knowledge of New York healthcare and of Utica. Ms. Charvat served as vice president of Corporate Communications and Marketing for the Healthcare Association of New York State (HANYS) in Albany, New York. Ms. Charvat also served as a senior vice president at the Massachusetts Hospital Association, and for several years, ran her own consulting company which focused on healthcare marketing and strategy, advocacy, community health, as well as providing communications support to start-up companies. From 2013 to February 2019, she led the public affairs, communications and marketing function for the Greater Waterbury Health Network in Waterbury, Connecticut, where she was instrumental in navigating through regulatory processes, building community trust and grassroots advocacy. Her focus on rebranding also included a

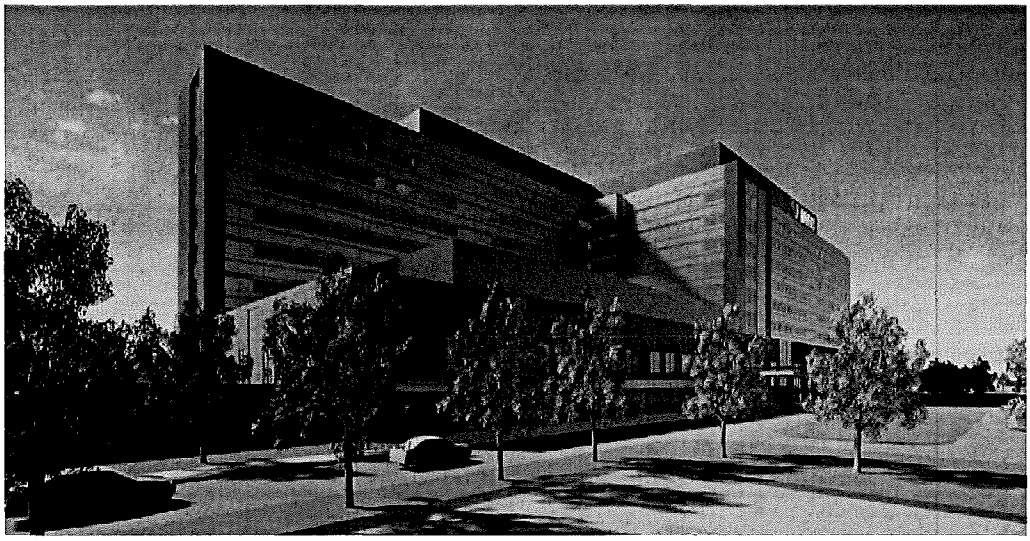
successful effort to improve awareness and referrals. Ms. Charvat graduated from Utica College with a dual bachelor's degree major in Journalism and Public Relations.

THE NEW REGIONAL HEALTHCARE CAMPUS

The Need for the New Regional Medical Center

The consolidation of healthcare services in the Utica region began in 1997 with the formation of the Mohawk Valley Heart Institute between FSLH and SEMC. Most recently, as noted above, MVHS was formed through the affiliation of FSLH and SEMC in 2014. Prior to the affiliation, FSLH and SEMC had a combined operating loss of $15 million for the fiscal year ended December 31, 2013. Following the approval of the affiliation by the State of New York in 2014, management was charged with the tasking of putting together a Business Plan of Efficiencies to neutralize the operating losses. The final plan consisted of over 124 initiatives phased over four years targeting $49.3 million in savings from fiscal years 2014-2018. Through the implementation of this plan, MVHS was able to achieve its target in less than three years resulting in $65.6 million of savings through fiscal year 2018. While MVHS was able to exceed the targeted savings, MVHS was limited from further operational improvement due to the combination of various IT systems across the multiple campuses.

MVHS's two existing acute care facilities were constructed over 60 and 100 years ago, respectively, and have been repaired, rehabilitated or replaced periodically. These facilities are limited in their ability to accommodate modern equipment and technology and adapt to changing models of patient care. New state initiatives for transforming healthcare in New York first provided the impetus in 2014 to explore the possibility of a new hospital in Central New York that could be sized, configured and equipped to more effectively, efficiently and reliably deliver clinical care in the 21st century. The New Regional Medical Center will enable MVHS to consolidate its two existing acute care hospitals into one integrated location and will create a structured delivery system that will serve to reduce gaps/inefficiencies in care coordination and duplication of services provided. **Through the consolidation of the existing campuses, MVHS projects approximately $15 million in annual savings through operating efficiencies.**



In November 2017, MVHS submitted a full review certificate of need ("CON") application to the New York State Department of Health ("NYSDOH") to transform the delivery of healthcare services within Oneida County and across the region with the construction of a new regional healthcare campus (the "New Regional Medical Center"). On April 16, 2018, NYSDOH approved the CON, with contingencies. To date, the original contingencies have been satisfied except for the submission of 60% architectural and engineering drawings, which are targeted for submission on October 23, 2019.

The New Regional Medical Center

The New Regional Medical Center, which will be located on a 25-acre parcel of land adjacent to the central business district of the City of Utica, is currently designed as a 9-story, approximately 672,000-square-foot building (a reduction in overall building square footage of approximately 28%). In total, MVHS will reduce its overall inpatient bed complement by 174 beds (30% reduction) to 373 beds. As part of the reduced bed count, MVHS intends to maintain 24 physical medicine and rehabilitation beds at its current St. Luke's campus. The following chart compares licensed beds at the existing facilities with the proposed licensed bed complement at the New Regional Medical Center and St. Luke's campus:

EXISTING AND PRO-FORMA LICENSED BEDS

	SEMC	FSLH	Existing Total	New Hospital Facility	Net Change
Medical/Surgical	149	238	387	232	-155
Intensive Care	20	22	42	42	0
Maternity	0	26	26	23	-3
Coronary Care	0	8	8	8	0
Neonatal Continuing Care	0	4	4	0	-4
Neonatal Intermediate Care	0	8	8	8	0
Pediatric	8	14	22	16	-6
Psychiatric	24	26	50	44	-6
Physical Medicine and Rehabilitation [1]	0	24	24	24	0
Total	**201**	**370**	**571**	**397**	**-174**

[1] MVHS will be retaining 24 beds at the FSLH-SL campus.

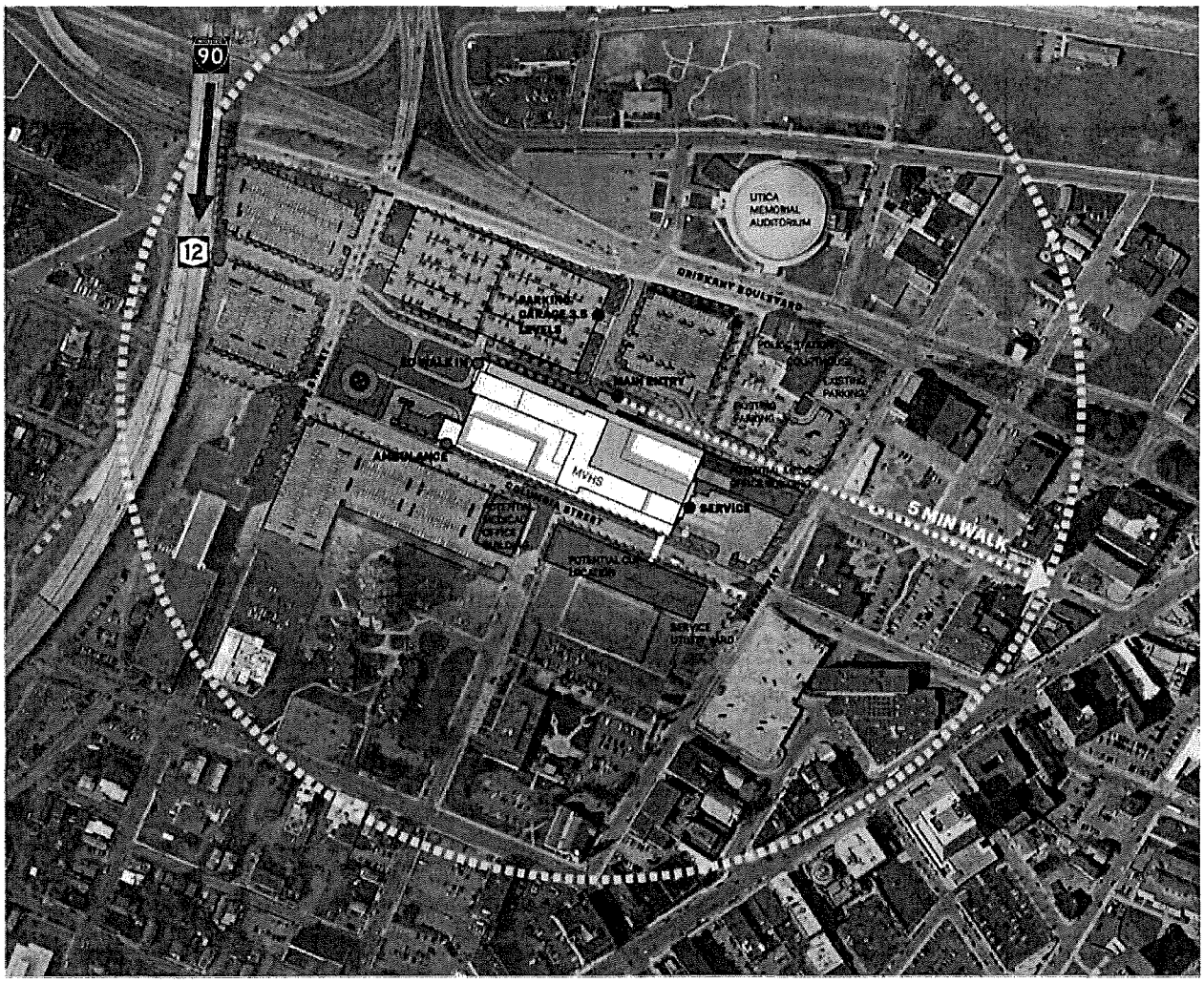
Based on the combined impatient utilization of SEMC and St. Luke's, the facilities had an overall occupancy rate of 56.1% as of December 31, 2018, based on licensed beds. Following the completion of the New Regional Medical Center, the overall occupancy rate when using 2018 utilization statistics would be 80.6%, which is more in-line with current hospital occupancy norms.

The inpatient units at the New Regional Medical Center will be almost entirely private. Approximately ten rooms will be constructed as semi-private rooms for use only during periods of high census. The new ED will include 47 treatment spaces (ED exam, quick turn, and trauma), six behavioral health treatment rooms and ten observation beds. The newly designed ED will support the care of 90,000 visits annually. For the year ended December 31, 2018, SEMC and FSLH had a combined total of 80,000 visits.

The New Regional Medical Center will have one primary entrance with easy drop-off, garage parking and building entry connections. The ED will contain separate walk-in, ambulance and decontamination entrances. The building is designed in an on-stage/off-stage configuration to aid in wayfinding, security controls and supporting patient dignity. There will be separate patient, service and visitor elevators providing for safe and efficient movements. A dedicated, rapid-access elevator will be able to be pulled from general use for quick movement of patients from the ED to interventional area, birthing center and behavioral health unit. A helistop will be located at the ED's ambulance entrance.

Utica Parking Garage

In conjunction with the New Regional Medical Center, Oneida County, the City of Utica and MVHS are collaborating on a new 1,550 car parking structure that will be adjacent to the new MVHS Regional Medical Center. The parking structure will be funded by the City of Utica and Oneida County, and not by proceeds of the Bonds. As part of the parking project, MVHS will have a parking agreement that allots 1,150 spaces for hospital needs and MVHS will be responsible for operation and maintenance costs estimated at $1 million/year. The remaining 400 spaces will be reserved for public use with additional space available for nighttime non-hospital events at the Utica Auditorium and surrounding areas.



The Design Team for the New Regional Medical Center

MVHS has hired NBBJ to serve as the architect for the New Regional Medical Center. Founded in 1943, NBBJ is a leader in designing healthcare, corporate office, commercial, civic, science, education and sports facilities. Since 2000, NBBJ has designed more than 250 projects in the State of New York. NBBJ's clients include Brigham & Women's Hospital, Cleveland Clinic, Massachusetts General Hospital, NYU Langone Medical Center, Providence Health, Medical University of South Carolina, and OhioHealth.

Gilbane Building Company ("Gilbane") will serve as the construction manager on the New Regional Medical Center project. Founded in 1873, it is one of the largest privately held family-owned construction and real estate development firms in the industry. Gilbane, headquartered in Providence, Rhode Island, is a national leader in healthcare facilities with experience in the Upstate New York market. Gilbane has completed more than 156 major healthcare projects in the past five years, totaling $4.5 billion.

Hammes Company is an industry leader in the development of healthcare facilities and provides a full services approach including strategic planning, project management and ownership on a national platform. They are assisting MVHS with the programming, budgeting, scheduling and land acquisition for the New Regional Medical Center project and will oversee the completion through occupancy. Hammes Company has also provided expertise in assembling the other team members including architects, engineers and construction managers who have the experience and expertise in planning and implementing the scope of the project in New York State.

Anticipated Schedule

Site acquisition for the New Regional Medical Center's building footprint was substantially completed in October 2019. MVHS's construction partners are scheduled to begin the abatement of hazardous materials within all of the acquired properties and demolition of the buildings in October in order to prepare the site. Construction on the New Regional Medical Center is anticipated to commence in March 2020 with completion scheduled to occur in February 2023.

Estimated Costs and Funding

The total cost of the New Regional Medical Center is anticipated to be approximately $520 million and will be funded with a combination of a state grant, proceeds of the Bonds, fundraising, equity from MVHS and other miscellaneous sources. In anticipation of the project and in an effort to assist in transforming and revitalizing the Utica community, the State of New York awarded a $300 million grant to MVHS under the Health Care Facility Transformation Program ("HCFTP Grant") that will be utilized for MVHS's New Regional Medical Center. The HCFTP Grant was split into two phases: (1) $18 million Phase I, which was executed in October 2018 to fund portions of the pre-construction, including scoping and design, and (2) $282 million Phase II, which was executed in September 2019 to repay portions of amounts spent on the acquisition of the New Regional Medical Center site, fund portions of the construction and equipping of the New Regional Medical Center. Through September 2019, MVHS has received $11 million from the grant and expects to utilize the remainder throughout the construction period. In order to ensure timely payment of construction costs while the grant funds are requisitioned from the State of New York, MVHS will be executing concurrently with the issuance of the Bonds, a $25 million bridge line of credit that will be drawn upon and then repaid with proceeds of the grant.

Hammes Company has been assisting MVHS in establishing project cost estimates and projections. The budget includes substantial contingency amounts, aggregating $26 million, or approximately 5% of the budgeted $517 million costs of the New Regional Medical Center. MVHS expects to have in place a guaranteed maximum price contract for construction of the New Regional Medical Center by February 2020.

The following table outlines the categories of the estimated project costs associated with the New Regional Medical Center.

Estimated Project Cost Category	($, 000s)
Scoping and Pre-Development	$ 3,490
Project Design	22,910
Property Acquisition and Demolition	35,769
Building and Site Construction [1]	392,286
Administrative Expenses	8,738
Furniture, Equipment and Other [2][3]	56,725
Total	$ 519,918

(1) Includes $26.2 million construction contingency.
(2) Some equipment from the existing hospital facilities will be moved to the New Regional Medical Center, which will represent approximately 50% of the equipment at the New Regional Medical Center.
(3) The equipment budget is currently allocated in the following manner: $36 million for medical equipment; $10 million for technology; and $10 million for furnishings.

Plans for the Existing Hospital Facility Campuses

In anticipation of the transition of MVHS's acute care operations to the New Regional Medical Center by the end of February 2023, MVHS has engaged CHA Consulting, Inc., an Albany-based engineering consulting firm, to assist with a comprehensive evaluation of the potential reuse of all three of the existing campuses (SEMC, St. Luke's and Faxton). It is anticipated that the Faxton campus will continue to house the regional cancer center, urgent care, outpatient dialysis and other ancillary services. In addition, the St. Luke's campus will continue to house the 24 physical medicine and rehabilitation beds and 202-bed St. Luke's Home. CHA Consulting's evaluation and

recommendations are anticipated to be completed in 2020. These recommendations may range from repurposing the existing assets for outpatient and other non-inpatient related medical services to sale of the existing properties.

STRATEGIC DIRECTION

With a new President and CEO joining the organization in January 2019, a new, short-term growth plan was established for 2019, which is laying the foundation for the development of a new strategic plan that will lead up to the opening of the New Regional Medical Center in 2023.

Key strategic initiatives for the short-term growth plan include:

- The implementation of Epic as the organization's uniform Electronic Health Record ("EHR") and using the robust data and analytics to drive clinical excellence and strengthen key service lines
- Growing and strengthening key service lines through a strong dyad with a physician and an administrator in:
    - Cardiology & Cardiothoracic Surgery
    - Orthopedic Surgery
    - General and Robotic Surgery
    - Certified Stroke Center
    - Obstetrics
- Embarking on the journey to become a high reliability organization
- Engaging employees, Medical Staff and Board of Directors in redefining the organizational mission
- Expanding graduate medical education programs by creating new residency programs to meet community/regional need for primary care, psychiatry, OB/GYN, emergency medicine, general surgery, and podiatry
- Actively recruiting highly skilled, talented physicians to the region
- Improving care coordination and reducing avoidable hospitalizations through the State's Delivery System Reform Incentive Payment ("DSRIP") Initiatives Program

These key initiatives form the core of MVHS's strategic plan moving forward.

Information Technology

With the System's formation occurring in stages in 2000 and 2014, the System has operated numerous technological platforms, including electronic medical record systems, financial and billing software.

In 2009, the Electronic Medical Record Adoption Model ("EMRAM") was introduced, updating the roadmap with standardized national application and advanced EHR components. EMRAM was created by Health Information and Management Systems Society Analytics to track EHR progress at hospitals and healthcare systeMs. There are 8 stages (0 to 7) of paperless record environment on which hospitals and healthcare systems are scored. Stage 0 indicates an entirely paper-based medical record, while Stage 7 indicates a fully electronic medical record. Today, the System stands at EMRAM Stage 6, and anticipates achieving Stage 7 over the next three years.

In advance of the construction of the New Regional Medical Center and consolidation of services onto one campus, MVHS embarked on a comprehensive strategy to transform clinical processes and technology to improve quality and patient safety. In 2016, MVHS began an investigation of alternative EHR solutions and after extensive due diligence, MVHS selected Epic as its replacement EHR platform in early 2018. Significant selection factors included Epic's fully integrated and interoperable enterprise-wide platform and its offering of advanced and innovative tools with exceptional service support. The System's development and implementation of the new Epic platform, which consolidated all of the hospital and physician practice systems, began in May 2018 and the system-wide "go-live" occurred at the end of June 2019. A portion of this project that was initially funded by a bridge loan will be refinanced with proceeds of the 2019 Bonds.

MVHS also recently consolidated many of its business management systems under one platform, Infor Lawson. This includes the key organizational functions of financial management (general ledger & financial reporting), human capital management (HR & payroll) and procurement (purchasing & payment processing).

Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment Program ("DSRIP") is the main mechanism by which New York State will implement the Medicaid Redesign Team Waiver Amendment. Through reducing avoidable hospital use, DSRIP's core purpose is to fundamentally transform the healthcare delivery system and reduce avoidable hospital use by 25%. In conjunction with other partners, FSLH formed in January 2015 the Central New York Care Collaborative ("CNYCC"), a Performing Provider System with the purpose to develop and implement DSRIP project plans focusing on outpatient clinical management and population health, integrated delivery systems, primary care and behavioral health access and coordination, care coordination and transitional care programs, clinical improvement projects relating to behavioral health and physical health needs identified in a community needs assessment, and population health. CNYCC's goal is to create and sustain an integrated, high performing healthcare delivery system that can effectively and efficiently meet the needs of Central New York Medicaid. CNYCC connects more than 2,000 healthcare and community-based service providers in six counties across Central New York – Cayuga, Lewis, Madison, Oneida, Onondaga and Oswego.

MVHS's DSRIP project work is aimed at reducing Potentially Preventable Emergency Room Visits ("PPVs"), Potentially Preventable Readmissions ("PPRs") and improving Prevention Quality Indicators for adult and pediatrics ("PQIs" and "PDIs", respectively). In addition, MVHS is implementing evidence-based strategies for disease management in high risk/affected populations aiming to improve the management of cardiovascular disease and its associated risk factors. This project addresses blood pressure control, cholesterol management, tobacco cessation, and prevention efforts for stroke and cardiovascular disease. MVHS is working to achieve these objectives through the implementation of eleven DSRIP projects. The new regional healthcare campus project will provide the physical infrastructure necessary to remove many of the barriers and challenges currently impeding improvements to these measures. As a result of MVHS's efforts, MVHS recorded approximately $4,082,000 and $7,125,000 in operating revenue from DSRIP in 2017 and 2018, respectively.

MEDICAL STAFF

As of May 31, 2019, the medical staff of the System included 419 physicians. The average age of the active medical staff is 53 years. As of May 31, 2019, over 85% of active physicians are board certified in their respective specialties. In addition, the medical staff includes Allied Health Professionals including nurse practitioners, physician assistants, nurse anesthesiologists, midwives, audiologists, chiropractors, dentists, ophthalmologists, doctors of pharmacy, doctors of psychology, nurse first assistants, radiology practitioner assistants and speech language pathologists.

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The active medical staff distribution as of May 2019 was as follows:

MEDICAL STAFF DISTRIBUTION

Department	Number of Active	Average Age	Department	Number of Active	Average Age
Adolescent Medicine	1	62	Neurosurgery	4	53
Allergy/Immunology	1	71	OB/Gyn	23	52
Anesthesia	29	59	Ophthalmology	4	55
Bariatric Surgery	3	51	Oral & Maxillofacial Surgery	3	58
Cardiac Anesthesia	2	63	Otolaryngology	4	62
Cardiology	21	58	Orthopedics	13	54
Cardiothoracic Surgery	2	59	Pallative Care	1	65
Community Medicine	20	53	Pathology	8	60
Cytopathology	1	41	Pediatrics	8	53
Dentistry	6	55	Perinatology/Neonatology	3	48
Emergency Medicine	35	43	Plastic Surgery	3	60
Endocrinology	5	63	PM&R (Pain Management)	7	54
Family Medicine	34	53	Podiatry	7	52
Gastroenterology	10	56	Psychiatry	3	58
General Practice	1	34	Pulmonary/Critical Care	10	52
General Surgery	13	57	Radiation Oncology	4	51
Geriatric Medicine	1	31	Radiology	21	55
Hematology/Oncology	7	48	Rheumatology	1	55
Hospitalist	19	39	Teleradiology	23	53
Infectious Disease	3	60	Urgent Care	5	56
Internal Medicine	18	56	Urology	11	52
Nephrology	5	56	Vascular Neurology	4	45
Neurology	11	43	Vascular Surgery	1	56
			Totals	**419**	**53**

Labor Relations

The System has 11 labor bargaining units and contracts with five different unions, which represent 56% of the overall workforce. To date, all current agreements have been negotiated without work interruptions or stoppages. The System prioritizes longer-term agreements to stabilize the labor environment, minimize the cost and disruption of more frequent negotiations, establish and aggressively institute labor/management committees, and address areas of operational improvement that have long-term sustainability.

Operational contract modifications have provided flexibility to contract out work based on operational needs, as well as management flexibility in staffing and attendance rules. Negotiated contract provisions are consistent with key organizational needs and initiatives being implemented for the non-union workforce. The MVHS labor relations staff directly handles all labor arbitration hearings and charges before the National Labor Relations Board. Management has good relationships with its unionized and non-unionized employees.

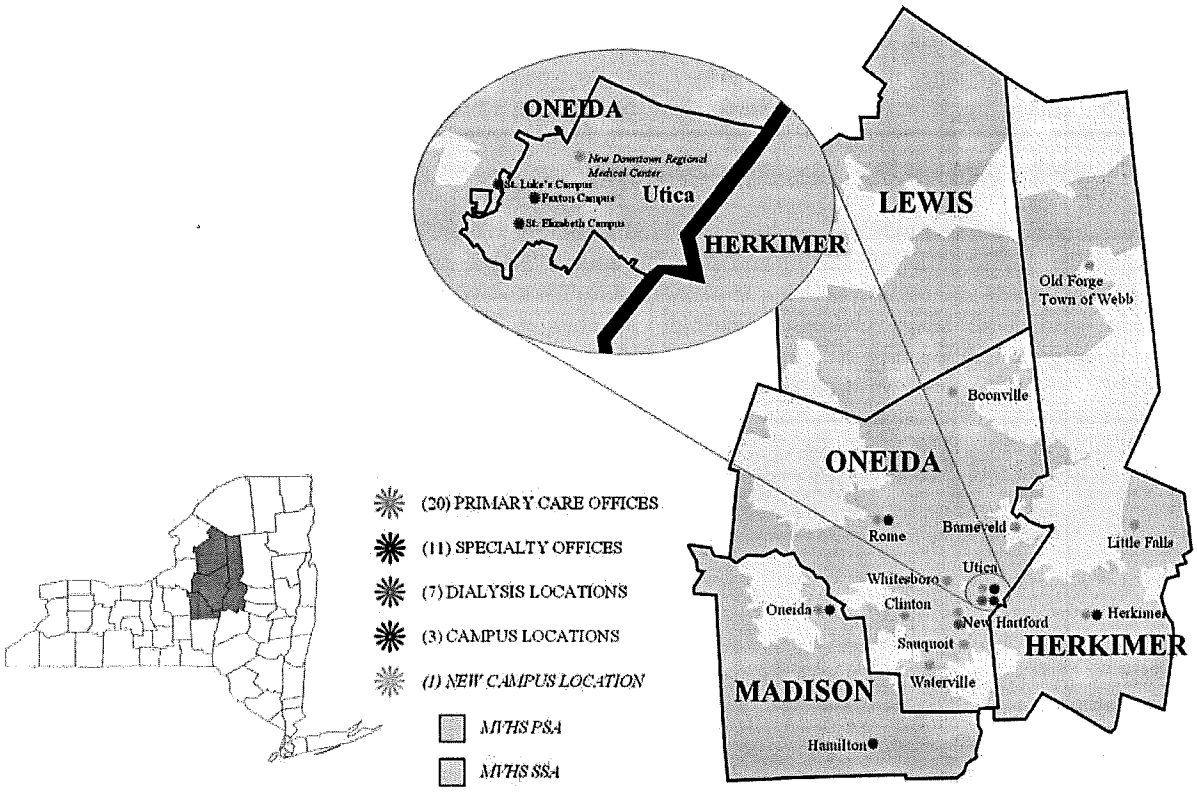
The following table illustrates the contract expiration terms of represented employees:

LABOR CONTRACT TERMS				
Facility	**# of Units**	**Job Classification**	**Contract Termination Date**	**Approximate Number of Associates**
FSLH	2	Registered Nurses ("RNs")	6/30/2020	657
	2	Licensed Practical Nurses and Technicians	6/30/2020	193
	1	Service and Maintenance	6/30/2020	696
SEMC	1	RNs	10/31/2019	471
	1	Licensed Practical Nurses and Technicians	9/7/2020	433
	1	Service and Maintenance	9/7/2020	152
VNA	1	RNs	4/30/2022	33
	1	Home Health Aides	7/31/2021	16
SNH	1	Care Manager Nurses	10/31/2019	9

SERVICE AREA AND COMPETITION

Service Area and Demographics

The System's primary and secondary service areas consist of portions of Oneida, Herkimer, Madison and Lewis Counties in New York. The map below depicts MVHS's service area footprint, the location of MVHS's facilities.



From a patient origin standpoint, Oneida County comprises 75.8% of total System discharges, with remaining discharges largely originating from the other bordering counties in central New York.

The four counties that MVHS primarily serves, which cover 4,667 square miles, are in the central portion of New York State with Syracuse to the west and Albany the east.

According to US Census Bureau website, the 2018 population for the four county region was estimated at 388,652. The 65+ age cohort in four counties represents approximately 19.0% of the current population, compared to 15.9% of the U.S. population.

TEN LARGEST EMPLOYERS IN ONEIDA COUNTY NEW YORK
Ranked by Number of Full-Time Equivalent Employees

Employer	Type of Activity	Number of Employees
Oneida Indian Nation	Tourism	4,750
Mohawk Valley Health System	Healthcare	4,279
Upstate Cerebral Palsy	Social Services	2,000
Metlife, Inc.	Insurance/Finance	1,368
Utica City School District	Education	1,302
Resource Center for Independent Living	Social Services	1,250
Air Force Research Lab	Research & Development	1,182
Utica National Insurance Group	Insurance/Finance	1,112
The Hartford	Insurance/Finance	1,080
Wal-Mart Stores Distribution Center	Warehousing/Transportation	1,011

Source: Mohawk Valley EDGE

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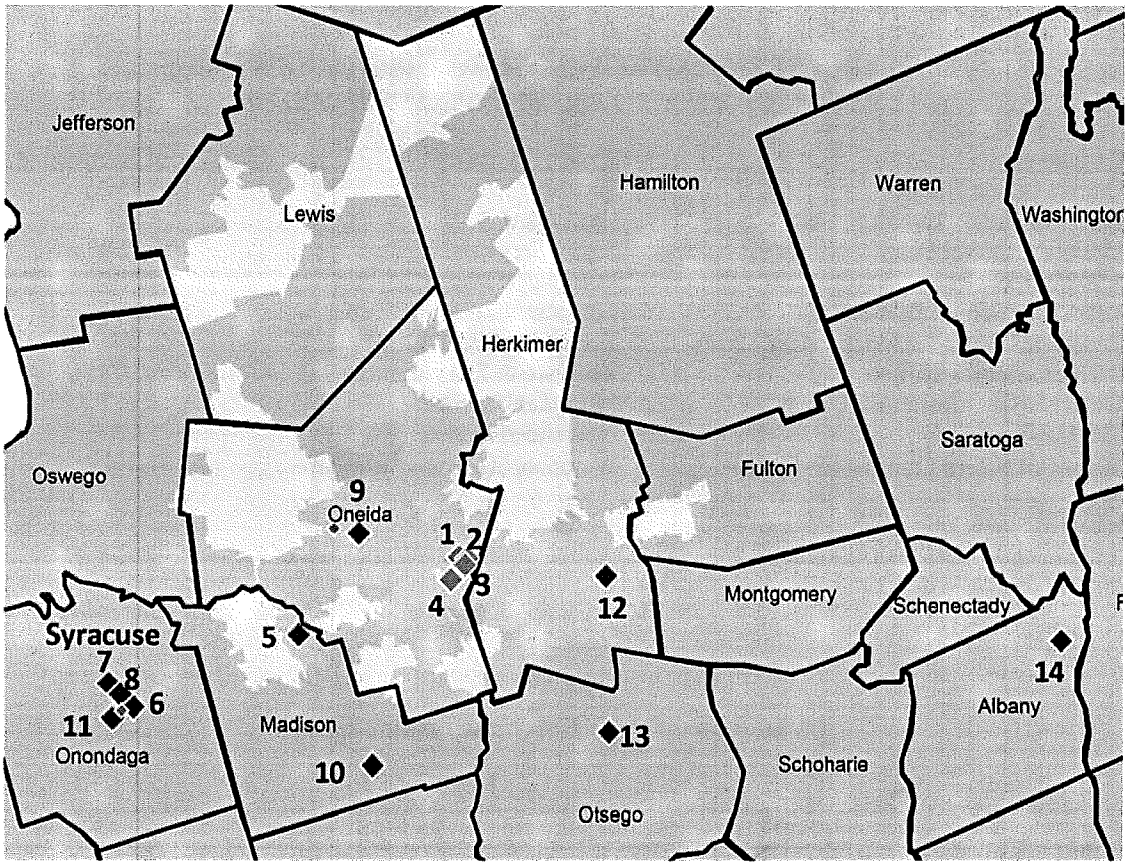
Competition

In its service area, the System's primary competitors include Rome Memorial Hospital ("Rome") (144 beds), Little Falls Hospital (25 beds – critical access hospital) and Oneida Healthcare (101 beds). In addition, there are four tertiary care providers approximately an hour away in Syracuse, NY.

The map below depicts MVHS's hospitals as well as those of its primary competitors.



Mohawk Valley Health

1. **New Downtown Regional Medical Center**
2. St. Luke's Campus
3. Faxton Campus
4. St. Elizabeth Campus

MVHS PSA

MVHS SSA

* Critical access hospital

Competitors

5. Oneida Healthcare Center
6. Crouse Health
7. St. Joseph's – *Trinity Health*
8. Upstate Medical Center – *SUNY*
9. Rome Memorial
10. Community Memorial*
11. Upstate University Hospital at Community Campus - *SUNY*
12. Little Falls Hospital* – *Bassett Healthcare*
13. Mary Imogene Bassett Hospital
14. Albany Medical Center

The following table presents the licensed beds by location for MVHS and its primary competitors in primary and secondary markets.

LICENSED BEDS BY LOCATION

Facility	Licensed Beds	City/Town	Approximate Distance (miles)
SEMC	201	Utica	N/A
FSLH	370	Utica	N/A
Mohawk Valley Health System	**571**		
Rome Memorial Hospital [1]	130	Rome	20
Oneida Healthcare [2]	101	Oneida	20
Little Falls Hospital [1]	25	Little Falls	25
Community Memorial [2]	25	Hamilton	30
Mary Imogene Bassett Hospital [2]	180	Cooperstown	50
St. Joseph's Hospital Health Center [3]	451	Syracuse	50
SUNY Health Services [3]	420	Syracuse	50
Crouse Hospital [3]	465	Syracuse	50
Upstate University Hospital at Community Campus [3]	314	Syracuse	55
Total Primary Service Market	**726**		
Total Secondary Service Area and Tertiary Care Market	**1,956**		
Total Market	**2,682**		

Source: New York State Department of Health website.
(1) Primary service area competitor.
(2) Secondary service area competitor.
(3) Tertiary care competitor.

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2016 Primary and Secondary Market Share

With a total of 571 acute care beds, MVHS experienced 20,168 inpatient admissions in 2016 representing a leading market share of 64.7% in its primary area and a leading market share of 36.7% in its secondary area.

The following tables present the most current inpatient admissions and market share available for the periods of 2014 through 2016 for MVHS and its competitors.

PRIMARY SERVICE AREA
(Accounts for 80% of MVHS Inpatients)

	2014		2015		2016	
	Inpatients	Market Share	Inpatients	Market Share	Inpatients	Market Share
Mohawk Valley Health System						
Faxton-St. Lukes Healthcare - St. Lukes Campus	12,973	42.0%	13,021	41.5%	12,221	39.2%
St. Elizabeth Medical Center	7,641	24.7%	7,790	24.8%	7,947	25.5%
Total MVHS	**20,614**	**66.7%**	**20,811**	**66.3%**	**20,168**	**64.7%**
Rome Memorial Hospital	3,018	9.8%	2,850	9.1%	3,002	9.6%
SUNY Upstate Medical University	1,364	4.4%	1,550	4.9%	1,733	5.6%
Mary Imogene Bassett Hospital	1,401	4.5%	1,537	4.9%	1,567	5.0%
Oneida Healthcare Center	1,116	3.6%	1,167	3.7%	1,122	3.6%
Crouse Hospital	845	2.7%	781	2.5%	817	2.6%
Little Falls Hospital	531	1.7%	505	1.6%	499	1.6%
St. Josephs Hospital Health Center	376	1.2%	399	1.3%	452	1.5%
Albany Medical Center	349	1.1%	413	1.3%	414	1.3%
Community Memorial Hospital	311	1.0%	325	1.0%	310	1.0%
Strong Memorial Hospital	165	0.5%	226	0.7%	205	0.7%
Upstate University Hospital at Community Campus	149	0.5%	171	0.5%	186	0.6%
Others	671	2.2%	670	2.1%	680	2.2%
Total	**30,910**	**100.0%**	**31,405**	**100.0%**	**31,155**	**100.0%**

Source: HANYS Market Expert using SPARCS data.

SECONDARY SERVICE AREA
(Accounts for 10% of MVHS Inpatients)

	2014		2015		2016	
	Inpatients	Market Share	Inpatients	Market Share	Inpatients	Market Share
Mohawk Valley Health System						
Faxton-St. Lukes Healthcare - St. Lukes Campus	1,561	24.6%	1,503	23.1%	1,384	21.3%
St. Elizabeth Medical Center	981	15.5%	990	15.2%	1,002	15.4%
Total MVHS	**2,542**	**40.1%**	**2,493**	**38.2%**	**2,386**	**36.7%**
Oneida Healthcare Center	1,215	19.1%	1,170	18.0%	1,173	18.1%
SUNY Upstate Medical University	491	7.7%	576	8.8%	689	10.6%
Rome Memorial Hospital	394	6.2%	529	8.1%	460	7.1%
Crouse Hospital	391	6.2%	440	6.8%	373	5.7%
Mary Imogene Bassett Hospital	357	5.6%	264	4.1%	358	5.5%
St. Josephs Hospital Health Center	334	5.3%	371	5.7%	394	6.1%
Other	621	9.8%	675	10.4%	660	10.2%
Total	**6,345**	**100.0%**	**6,518**	**100.0%**	**6,493**	**100.0%**

Source: HANYS Market Expert using SPARCS data.

FINANCIAL AND OPERATING INFORMATION

Utilization

The following is a summary of the System's inpatient and outpatient utilization for each of the fiscal years ended December 31, 2016, 2017 and 2018 and for the six-month period ended June 30, 2019.

UTILIZATION STATISTICS

	For the Years Ended December 31,			For the Period Ended June 30,
	2016	2017	2018	2019
Inpatient Admissions	23,452	23,462	22,683	11,398
Observation Stays	2,498	2,401	1,861	659
Total Patient Days	117,844	116,262	114,496	60,413
Average Length of Stay (days)	5.00	4.93	5.03	5.32
Occupancy Percentage [(1)]	75.6%	74.6%	73.5%	76.9%
Medicare Case Mix	1.59	1.55	1.59	1.62
Inpatient Surgeries	8,105	7,759	7,158	3,112
Outpatient Surgeries	14,050	11,532	11,030	5,050
Total Surgeries	18,721	19,291	18,188	8,162
Emergency Visits (net of admit)	72,017	65,051	63,504	30,876
Outpatient Visits	297,568	297,951	295,767	145,776
Unique Patients	183,173	186,911	186,688	125,945

(1) Occupancy percentage is based on operational beds.

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Payor Mix

The following table shows the System's payor mix, based on net patient service revenues, for each of the fiscal years ended December 31, 2016, 2017, and 2018.

PAYOR MIX

	For the Years Ended December 31,		
Payer	**2016**	**2017**	**2018**
Medicare (Inc. HMOs)	37.1%	37.4%	36.5%
Medicaid (Inc. HMOs)	20.5	21.5	21.2
Blue Cross	27.7	26.6	25.6
Commercial	11.4	10.9	12.8
Self-Pay and Other*	3.3	3.6	3.9
Total	**100%**	**100%**	**100%**

* Other Includes: Hospice,Worker's Compensation and No Fault, among others
Source: MVHS Records

Historical Financial Information

The following financial information reflects a summary of the operating results and financial condition of the consolidated System for each of the fiscal years ended December 31, 2016, 2017 and 2018 and the unaudited six-month period ended June 30, 2019. The results have been derived from the System's audited consolidated financial statements and unaudited interim statements. In addition to the following summarized financial information, the complete audited consolidated financial statements for MVHS and Subsidiaries for the year ended December 31, 2018, including the notes thereto, appear in Appendix B and should be reviewed in order to evaluate the System's operating results and financial condition. These audited consolidated financial statements of MVHS and Subsidiaries were audited by Fust Charles Chambers LLP, as certified public accountants.

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Balance Sheets

The following is a summary of the System's balance sheets for each of the years ended December 31, 2016, 2017 and 2018 and period ended June 30, 2019:

MOHAWK VALLEY HEALTH SYSTEM
BALANCE SHEETS

(Dollars in Thousands)	December 31, (Audited)			June 30, (Unaudited)
	2016	2017	2018	2019
Assets				
Current Assets				
Cash and cash equivalents	$ 17,537	$ 21,959	$ 25,273	$ 7,489
Investments and assets limited as to use	95,543	102,368	103,861	117,836
Patient accounts receivable, net	59,439	64,528	63,639	70,984
Other current assets	26,408	29,414	31,592	36,690
Total Current Assets	**198,927**	**218,269**	**224,365**	**232,999**
Assets limited as to use	5,594	5,388	2,485	2,549
Investments	4,528	4,528	4,528	4,528
Property and equipment, net	158,427	150,039	157,592	185,614
Right-of-use assets	-	-	-	6,914
Other assets	27,993	29,272	25,055	25,903
Total Assets	**$ 395,469**	**$ 407,496**	**$ 414,025**	**$ 458,507**
Liabilities and Net Assets				
Current Liabilities				
Current portion of long-term obligations	$ 9,226	$ 7,953	$6,903	$ 6,635
Revolving line of credit	-	-	-	5,420
Lease liability	-	-	-	1,908
Accounts payable and accrued expenses	54,833	62,181	63,285	67,399
Current portion of estimated self-insured liabilities	9,294	7,292	6,201	8,233
Estimated third-party payor settlements, net	3,279	4,038	5,143	6,598
Other current liabilities	5,159	6,493	6,491	6,771
Total Current Liabilities	**81,791**	**87,957**	**88,023**	**102,964**
Long-term obligations, net	50,374	43,621	55,483	67,962
Lease liability	-	-	-	5,006
Other long-term liabilities	95,206	100,463	95,858	92,864
Total Liabilities	**$ 227,371**	**$ 232,041**	**$239,364**	**$ 268,796**
Net Assets				
Without donor restrictions	$ 158,319	$165,231	$158,627	$ 167,182
With donor restrictions	9,779	10,224	16,034	22,529
Total Net Assets	168,098	175,455	174,661	189,711
Total Liabilities and Net Assets	**$ 395,469**	**$407,496**	**$414,025**	**$ 458,507**

Source: MVHS Audited Financial Statements and Internally Prepared Financial Statements

Statements of Operations

The following is a summary of the System's audited statements of operations for each of the years ended December 31, 2016, 2017 and 2018 and the six month periods ended June 30, 2018 and 2019:

MOHAWK VALLEY HEALTH SYSTEM
STATEMENTS OF OPERATIONS

(Dollars in Thousands)	For the Years Ended December 31, (Audited)			For the Six Month Period Ended June 30, (Unaudited)	
	2016	2017	2018	2018	2019
Revenues and other support without donor restrictions:					
Net patient/resident revenue less bad debts	$ 500,362	$ 500,557	$ 504,324	$ 252,822	$ 251,498
Premium revenue	12,959	17,905	20,832	10,006	11,562
Other revenue	22,697	27,053	32,070	16,836	16,518
Net assets released from restrictions	707	725	1,159	-	-
Total revenues and other support without donor restrictions	**$ 536,725**	**$ 546,240**	**$ 558,385**	**$ 279,664**	**$ 279,578**
Expenses					
Salaries, wages, and benefits	$ 311,600	$ 314,500	$ 319,225	$ 160,009	$ 162,049
Supplies and other expenses	194,959	203,919	217,561	105,279	107,960
New York State gross receipts taxes	2,605	2,473	2,484	1,370	1,367
Depreciation and amortization	26,513	25,827	23,633	12,123	10,772
Interest	3,170	2,975	2,506	1,286	985
Total Expenses	**$ 538,847**	**$ 549,694**	**$ 565,409**	**$ 280,067**	**$ 283,133**
Net loss from operations	(2,122)	(3,454)	(7,024)	(403)	(3,555)
Nonoperating revenues and expenses	1,451	3,497	13,406	834	1,653
Excess (Deficiency) of revenues over expenses	**$ (671)**	**$ 43**	**$ 6,382**	**$ 431**	**$ (1,902)**
Change in fair value of interest rate swaps	$ 634	$ 562	$ 643	$ 718	$ (502)
Change in net unrealized gains and losses on investments	4,249	11,481	(11,462)	(1,693)	12,337
Net assets released from restriction for capital acquisitions	1,592	865	205	-	-
Contributions used for capital acquisitions	42	-	355	-	122
Pension related changes other than net periodic pension cost	2,673	(3,609)	22	-	-
Other components of net periodic benefit cost	-	(2,430)	(2,749)	(1,362)	(1,500)
Increase (Decrease) in net assets without donor restrictions	**$ 8,519**	**$ 6,912**	**$ (6,604)**	**$ (1,906)**	**$ 8,555**

Source: MVHS Audited Financial Statements and Unaudited Internal Records

Management's Discussion of Operations

Six-Month Period Ended June 30, 2019

Total assets increased by $44.4 million primarily due to an increase of $28 million property and equipment, net for assets added related to the New Regional Medical Center and the implementation of Epic. A $17.8 million decrease in cash was offset by a $13.9 million increase in market value of investments and a $7.3 million increase in patient accounts receivable, net due to the implementation of Epic.

Total liabilities increased by $29.4 million due to the additional debt associated with the New Regional Medical Center and the Epic implementation.

Net loss from operations totaled $3.6 million mostly due to one-time strategic items related to the Epic installation, CEO transition costs and a wage index reclassification. This loss includes $2 million of one-time Epic operating costs, consisting mostly of one-time training costs. In addition, MVHS had a $700,000 one-time cost related to the transition of the CEO as the prior CEO retired on January 1, 2019.

Total operating revenues were flat from the six-months ended June 30, 2018 to the six-months ended June 30, 2019 as overall volume has declined but reimbursement rate increases from payers offset these declines.

Total expenses increased by $3 million from the six-months ended June 30, 2018 to the six-months ended June 30, 2019. This is due in part to a $2 million increase in salaries and benefits related to cost of living increase in wages. Supplies and other expenses has increased $2.7 million due in part to a $1.4 million increase in drug costs related to inflation and drug mix; in particular, an increase in outpatient infusion volume over the prior year. In addition, there was a $500,000 increase related to locum and agency staffing and $600,000 increase in service contracts attributed to the purchase of new equipment. These increases were offset by a $1.3 million decrease in depreciation as expenditures on the existing facilities have reduced due to the plans to build the replacement New Regional Medical Center.

Non-operating revenue increased by $800,000 due to an increase in realized gains on investments compared to the same period in 2018. Total deficiency of revenue over expenses was $1.9 million. After adjusting for the $3.3 million in one-time strategic investments discussed above, the adjusted excess of revenues over expenses was $1.4 million.

Fiscal Year Ended December 31, 2018

Total assets increased by $6.5 million primarily due to an increase of $3.3 million in cash related to proceeds received from the demutualization of MLMIC Insurance Company ("MLMIC") and a $7.6 million increase in property and equipment, net for assets added related to the New Regional Medical Center and the implementation of Epic.

Assets whose use is limited declined by $2.9 million due to the refinancing of certain SEMC debt that enabled the elimination of a debt service reserve fund.

Total liabilities increased by $7.3 million due to the $10.8 million increase in long-term debt primarily associated with the New Regional Medical Center and the Epic implementation.

Net loss from operations totaled $7 million partially due to the start-up of new programs coupled with a decrease in inpatient admissions and ED volume that was partially offset with DSRIP revenue described below.

Total operating revenue increased by $12.1 million from fiscal year 2017 as patient service revenue, net increased $3.7 million due to positive rate increases from payers, which were partially offset by a decline in volume from a reduction in readmissions and avoidable ED visits. Premium revenue increased by $2.9 million as enrollment in SNH's managed long-term care ("MLTC") plan increased. Other revenue increased by $5 million mostly due to an increase of $1.7 million in contract pharmacy revenue from the 340B Program and $3 million increase in DSRIP funds.

Total expenses increased by $15.7 million from 2017. This was due in part to a $4.7 million increase in salaries and benefits which was attributed primarily to an increase in provider salaries and benefits from an increase in FTE's as a result of successful recruitment and the addition of new primary care sites in Rome and Oneida, New York, as well as starting a new urology practice in Utica, New York. Supplies and other expenses increased $13.6 million due in part to a $4.3 million increase in drug cost related to inflation, drug mix and an increase in outpatient infusion volume over the prior year. In addition, there was an increase of $3.5 million related to locum physician cost and nursing agency staffing, increase of $1.6 million in medical supplies due to increases in Electrophysiology and Cardiac Cath volume. Depreciation decreased by $2.2 million as IT spending slowed due to the plans to implement Epic in 2019 and hospital campus infrastructure cost slowed due to the plans to build the replacement New Regional Medical Center.

Non-operating revenue increased by $9.9 million mostly due to $11.6 million of revenue received related to the demutualization of MLMIC. Total excess of revenue over expenses was $6.4 million compared to $40,000 in 2017.

Fiscal Year Ended December 31, 2017

Total assets increased by $12 million as a result of $4.4 million increase in cash from positive operating cash flow, a $6.8 million increase in the market value of investments, and a $5.1 million increase in patient accounts

receivable, net due to timing at year end. Other current assets increased by $3 million due primarily to $1 million in DSRIP receivables and $1.2 million related to professional liability receivable true-up, which was offset by a corresponding liability. Property and equipment, net decreased by $8.3 million as capital projects related to IT and hospital capital projects slowed due to the continuation of planning for the New Regional Medical Center and planning for a replacement IT system.

Total liabilities increased by $4.7 million primarily due to a $7.3 million increase in accounts payable and accrued expenses. $3.1 million of the $7.3 million increase in accrued expenses was related New Regional Medical Center costs and the remaining $4.2 million was due to timing of payroll and accounts payable disbursements. Self-insured liabilities decreased $2 million due mainly to a decrease in the self- insured workers' compensation program. Total debt decreased by $8 million due to the normal amortization of debt.

Net loss from operations was $3.5 million due to volume declines outlined below coupled with the start-up of a new pulmonary practice in Utica, New York, and a new neuro endovascular program at the St. Luke's campus.

Total operating revenue increased by $9.5 million from fiscal year 2016 primarily due to a $4.9 million increase in premium revenue as enrollment in SNH's MLTC plan increased. Other operating revenue increased by $4.4 million mostly due to a $1.7 million increase in contract pharmacy revenue from the 340B Program and $2.5 million increase in DSRIP funds. Net patient revenue was flat as increases in rates were offset by decreases in volume mostly in cardiac surgery and outpatient surgery.

Total expenses increased by $10.8 million from fiscal year 2016 as a result of a $2.9 million increase in labor costs due to cost of living increases and an $8.5 million increase in purchased services related to additional nursing agency costs, locum physicians and anesthesia service costs. Medical supplies decreased by $3.7 million due to lower volumes while drug costs increased mainly due to an increase in outpatient infusion volume. The retrospective adoption of ASU 2017-07 resulted in a reclassification of $2.4 million of pension benefit cost from employee benefits to other components of benefit cost and an increase of $2.4 million in operating margin but had no impact on net assets.

Non-operating revenue increased $2 million due to an increase in investment income. Excess of revenue over expenses was $40,000 after the changes to the pension accounting and investment income noted above.

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Historical/Pro Forma Capitalization

The following table sets forth the capitalization of the System as of December 31, 2016, 2017, 2018, June 30, 2019 and 2019 as adjusted assuming the Series 2019 Bonds transaction were issued in the amount of $257.2 million and outstanding as of June 30, 2019.

MOHAWK VALLEY HEALTH SYSTEM
HISTORICAL / PRO FORMA CAPITALIZATION

	For the Years Ended December 31,			For the Period Ended June 30,	
Type	**2016**	**2017**	**2018**	**2019**	**Pro Forma 2019**
Series 1999A	$ 11,475	$ 10,863	$ -	$ -	$ -
Series 1999B	5,647	5,174	-	-	-
Series 2006A	8,000	8,000	-	-	-
Series 2006E&F	15,120	14,520	13,780	13,045	-
2018 Bank Loan	-	-	21,179	21,179	-
2018 Bridge Loan [1]	-	-	13,653	23,097	-
Revolving Note Payable	-	-	-	5,420	-
Series 2019A	-	-	-	-	236,015
Series 2019B (Taxable)					18,655
Lease liability [2]	-	-	-	6,914	6,914
Mortgages and other	9,817	6,913	4,305	3,823	3,823
Capital leases	10,489	6,938	10,064	14,036	14,036
Deferred issuance costs	(948)	(834)	(595)	(583)	(583)
Total Debt	**$ 59,600**	**$ 51,574**	**$ 62,386**	**$ 86,931**	**$281,410**
Net assets without donor restrictions	158,319	165,231	158,627	167,182	167,182
Total Capitalization	**$ 217,919**	**$216,805**	**$ 221,013**	**$ 254,113**	**$448,592**
Total Debt as a percentage of Total Capitalization	**27.3%**	**23.8%**	**28.2%**	**34.2%**	**62.7%**

Source: MVHS Audited Financial Statements and Unaudited Internal Records

(1) The 2018 Barclays bridge loan was utilized to fund the implementation of Epic as well as a portion of the pre-construction and design development work. Upon the issuance of the Series 2019 Bonds, the balance of the Barclays bridge loan will be reduced to $12.3 million for a short period of time until MVHS receives the disbursement from the state grant related to these expenses.

(2) Lease liability included as of June 30, 2019 due to Financial Accounting Standards Board's Accounting Standards Update 2016 02, Leases (Topic 842).

In addition to the long-term detailed in the table above, MVHS, in conjunction with the issuance of the 2019 Bonds will be entering into two lines of credit that will with be secured by a note under the Master Trust Indenture.

The first line of credit will have an available credit limit of $30 million, which will be replacing two existing lines of credit that total $30.5 million. Approximately $15 million of the new $30 million working capital line of credit will be utilized as letters of credit to guarantee payment of workers' compensation claims, which are required by the State of New York Workers' Compensation Board.

The second line of credit will total $20 million and will be utilized to bridge the receipt of the $300 million state grant funds that will be disbursed as part of the construction of the New Regional Medical Campus. This line of credit will be replacing the Barclays' credit facility that has been utilized to fund a portion of the pre-construction and design development work related to the New Regional Medical Campus.

Debt Service Coverage

The following table sets forth coverage of Maximum Annual Debt Service Requirements of the System on long-term indebtedness for each of the fiscal years ended December 31, 2016, 2017 and 2018.

MOHAWK VALLEY HEALTH SYSTEM
DEBT SERVICE COVERAGE

	For the Years Ended December 31,		
(Dollars in Thousands)	**2016**	**2017**	**2018**
Excess/deficiencies of revenues over expenses	$ (671)	$ 43	$ 6,382
Plus: Depreciation and amortization	26,513	25,827	23,633
Plus: Interest expense	3,170	2,975	2,506
Income Available for Debt Service	**$ 29,012**	**$ 28,845**	**$ 32,521**
Current Maximum Annual Debt Service Requirements on All Long-term Debt [1][2][3]	$ 11,798	$ 10,121	$ 9,766
Coverage of Current Maximum Annual Debt Service Requirement	**2.5x**	**2.9x**	**3.3x**
Pro Forma of Current Maximum Annual Debt Service Requirement [4]	$ 16,273	$ 16,273	$ 16,273
Coverage of Pro Forma Maximum Annual Debt Service Requirement [4]	**1.8x**	**1.8x**	**2.0x**

Source: MVHS Audited Financial Statements and Unaudited Internal Records
(1) Unhedged variable rate bonds interest rate assumed at 4.35%
(2) Hedged variable rate bonds interest rate assumed at fixed payor swap rates.
(3) The interest rate on the $600,000 adjustable note payable, which is fixed at 4.00% through March 2021, has been assumed at 4.00% through maturity in March 2026.
(4) Preliminary, subject to change.

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Liquidity

The following table sets forth the System's days cash on hand for each of the fiscal years ended December 31, 2016, 2017 and 2018 and the six month period ended June 30, 2019.

MOHAWK VALLEY HEALTH SYSTEM
DAYS CASH ON HAND

	For the Years Ended December 31,			For the Period Ended June 30,
(Dollars in Thousands)	**2016**	**2017**	**2018**	**2019**
Cash and cash equivalents without donor restrictions	$ 112,60	$ 122,979	$ 127,328	$ 124,778
Total operating expenses	538,847	549,694	565,409	283,134
Less: Depreciation and amortization	26,513	25,827	23,633	10,772
Total operating expenses less depreciation and amortization	$ 512,334	$ 523,867	$ 541,776	$ 272,631
Days Cash on Hand	**80**	**86**	**86**	**83**

Source: MVHS Audited Financial Statements and Unaudited Internal Records

The following table sets forth the System's cash-to-debt ratios at December 31, 2016, 2017, 2018, June 30, 2019 and 2019 as adjusted assuming the Series 2019 Bonds transaction were issued and outstanding on June 30, 2019.

MOHAWK VALLEY HEALTH SYSTEM
CASH-TO-DEBT

	For the Years Ended December 31,			For the Period Ended June 30,	
(Dollars in Thousands)	**2016**	**2017**	**2018**	**2019**	**Pro Forma 2019**
Cash and cash equivalents without donor restrictions [1][2]	$ 112,606	$122,979	$127,328	$ 124,778	$ 124,778
Total Debt	59,600	51,575	62,386	86,931	281,410
Cash-to-Debt	**1.9x**	**2.4x**	**2.0x**	**1.4x**	**0.4x**

Source: MVHS Audited Financial Statements and Unaudited Internal Records
(1) Pro Forma 2019, preliminary, subject to change.
(2) Total debt includes lease liability as of June 30, 2019 due to Financial Accounting Standards Board's Accounting Standards Update 2016 02, Leases (Topic 842).

Investments and Investment Policy

The System's investment portfolios are centrally managed through the Investment Committee of the Board. The primary investment strategy is to preserve purchasing power while providing a continuing and stable funding source to support the current and future mission of the Mohawk Valley Health System. To accomplish this objective, the System seeks to generate a total return that will exceed not only its operating expenses, but also all expenses associated with managing the investments and the eroding effects of inflation. It is the intention that all total return (interest income, dividends, and realized gains) above and beyond the amount approved for expenditure or distribution will be reinvested. MVHS's investments are managed on a total return basis, consistent with the applicable standard of conduct set forth in the New York Prudent Management of Institutional Funds Act.

The following table sets forth the composition of the System's total cash and cash equivalents and investments (donor restricted and without donor restriction), excluding pension assets, as of June 30, 2019.

MOHAWK VALLEY HEALTH SYSTEM
INVESTMENTS & INVESTMENT POLICY

(Dollars in Thousands)	June 30, 2019
Cash and cash equivalents	$ 8,424
Government Bonds	2,005
Mutual funds	94,655
Other	28,636
Total cash and cash equivalents and investments	**$ 133,720**

Source: MVHS Unaudited Internal Records

Insurance Arrangements

The System's healthcare professional (medical malpractice) and general liability exposures are provided under a claims-made based policy for FSLH and SEMC and an occurrence based policy for the Home, VNA and SNH, which provide for $1,000,000 coverage for each claim, not to exceed $3,000,000 in aggregate annual coverage. The insurance policies for FSLH and SEMC include a per claim $50,000 uninsured deductible, not to exceed $250,000 in aggregate annual coverage. MVHS has accrued a liability included in other liabilities of approximately $21,185,000 and $25,325,000 at December 31, 2018 and 2017, respectively. A corresponding receivable included in other assets of approximately $19,313,000 and $23,015,000, respectively, has been recorded to record anticipated recoveries from insurance companies.

The System is self-insured for employee healthcare costs. MVHS has obtained a stop loss policy for healthcare costs to supplement its self-insurance coverage. Claims are accrued based upon the System's estimates of the aggregate liability for claims incurred using certain actuarial assumptions used in the insurance industry and based on the System's experience.

FSLH and certain other System affiliates are enrolled in a high deductible insurance plan for employee workers' compensation and disability claiMs. SEMC is self-insured for employee workers' compensation and disability claiMs. As required by the State of New York Workers' Compensation Board, FSLH and SSEMC have purchased letters of credit to guarantee payment of workers' compensation claiMs.

Pension

SEMC has a noncontributory defined benefit pension plan (the "Plan") covering substantially all of its full-time employees prior to April 1, 2013. Benefits are based on compensation and years of service. In 2003, SEMC applied for and received a favorable determination that its defined benefit plan is classified as a church-sponsored retirement plan under Section 410(d) of the Internal Revenue Code. Therefore, SEMC's Plan is not subject to ERISA funding requirements SEMC has elected to contribute the minimum amounts calculated as if the plan were subject to ERISA funding requirements. Effective December 31, 2010, SEMC's Plan was amended to freeze benefit accruals for non-bargaining unit members. Effective January 1, 2012, SEMC's Plan was amended to freeze benefit accruals for the employees of one of the collective bargaining units. Effective April 1, 2013, SEMC's Plan was amended to freeze benefit accruals for the final collective bargaining unit. Based on the actuarial valuation, SEMC's Plan was under-funded as of December 31, 2018 and 2017. The funded level as of December 31, 2018 and 2017 was 57.9% and 58.9%, respectively. In 2018, SEMC contributed $4.2 million to the Plan. SEMC's internal funding policy requires annual plan funding equal to annual benefit costs.

LITIGATION MATTERS

The System is involved in litigation and regulatory investigations arising in the ordinary course of business. The health care industry is highly regulated and subject to numerous state, federal and local laws and regulations. Compliance with these laws and regulations can be subject to future government review and interpretation. However, at this time MVHS management knows of no claims, which have not been asserted at this time, which could have a

material adverse effect on the System's future financial position or materially negatively impact the operations or cash flows.

Currently the System is involved in medical malpractice lawsuits as well as some employment law litigation, all of which are anticipated to be defensible or to result in losses covered by insurance.

The System is also involved in litigation involving the co-generation facility located on the Faxton-St. Luke's campus. Faxton-St. Luke's was sued by Burrstone Energy Center, LLC for alleged breach of contract in 2014 in connection with the Energy Services Agreement that the parties entered into in 2007. This breach of contract claim is not covered by insurance. While the System believes the case is defensible, it has entered into settlement negotiations to limit any potential exposures. MVHS does not anticipate that the case will have a material adverse effect on the System's future financial position.

In May, 2019, several local residents and businesses (the "Plaintiffs") filed a lawsuit against the City of Utica Planning Board, the New York State Office of Parks, Recreation and Historic Preservation, and the Dormitory Authority of the State of New York (collectively, the "Agencies") and the System challenging the Agencies' review of the historic/cultural, archeological and environmental impacts (the "Historic and Environmental Reviews") of the New Hospital Project. New York State law requires that these Historic and Environmental Reviews be completed before public agencies may approve the New Hospital Project. The Plaintiffs seek a judgment declaring that the Historic and Environmental Reviews are invalid and an order directing the Agencies and the System to resume the Historic and Environmental Review process including further testing, consideration of alternatives, and development of avoidance/mitigation plans.

In June, 2019, the Agencies and the System filed a motion to dismiss the Plaintiffs' lawsuit on the basis that the Historic and Environmental Reviews were not final when the Plaintiffs filed their lawsuit so the matter was not ripe for judicial review. The Court has not yet ruled on the Plaintiffs' request for a declaratory judgment or the Agencies' and the System's motion to dismiss.

The Historic and Environmental Reviews became reviewable by the courts on September 19, 2019, when the Utica Planning Board issued site plan approval for the New Hospital Project. If the Court were to dismiss the Plaintiffs' lawsuit on the basis that the matter was not ripe for judicial review, the Plaintiffs could commence another lawsuit challenging the Historic and Environmental Reviews now that a decision has been made that renders those reviews justiciable.

The System believes the Historic and Environmental Reviews were properly completed in accordance with all legal requirements and are therefore valid. In the unlikely event the Court declares the Historic and Environmental Reviews to be invalid, and this decision is upheld upon any appeal by the Agencies and the System, the Agencies and the System may be required to reopen their Historic and Environmental Reviews and proceed with further testing, consideration of alternatives, and/or development of additional avoidance/mitigation plans. If this were to occur the New Hospital Project may be delayed while the additional review process is completed, but the System believes the results of any further Historic and Environmental Review process would not materially affect the System's ability to complete the New Hospital Project.

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APPENDIX B

AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF MOHAWK VALLEY HEALTH SYSTEM AND ITS SUBSIDIARIES

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MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Financial Statements and Schedules

December 31, 2018 and 2017

Fust Charles Chambers LLP
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

The Board of Directors
Mohawk Valley Health System:

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

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the 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.

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Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mohawk Valley Health System and Subsidiaries as of December 31, 2018 and 2017 and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating schedules on pages 56 - 59 are 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 audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Fust Charles Chambers LLP

June 20, 2019

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Balance Sheets

December 31, 2018 and 2017

Assets	2018	2017
Current assets:		
Cash and cash equivalents	$ 25,272,835	21,959,220
Escrow deposit	1,101,612	590,222
Investments and assets limited as to use	102,759,571	101,778,128
Patient accounts receivable, net	63,639,471	64,527,574
Other current assets	13,406,637	11,969,951
Inventories	13,197,859	12,680,327
Prepaid expenses	4,461,851	4,433,079
Due from affiliates, net	525,215	330,248
Total current assets	224,365,051	218,268,749
Assets limited as to use	2,484,824	5,388,469
Investments	4,528,164	4,528,164
Property and equipment, net	157,592,357	150,039,058
Other assets	25,054,585	29,271,766
Total assets	$ 414,024,981	407,496,206

Liabilities and Net Assets	2018	2017
Current liabilities:		
Current portion of long-term debt	$ 4,325,626	4,927,527
Current portion of capital lease obligations	2,577,579	3,025,798
Accounts payable and accrued expenses	39,592,474	39,570,037
Accrued payroll, payroll taxes and benefits	23,692,657	22,610,695
Current portion of estimated self-insured liabilities	6,200,756	7,292,215
Estimated third-party payor settlements, net	5,142,798	4,037,874
Other current liabilities	6,491,054	6,492,640
Total current liabilities	88,022,944	87,956,786
Long-term debt, net of current portion:		
Notes payable	35,261,577	3,520,112
Civic facility revenue bonds	12,735,615	36,188,799
Capital lease obligations	7,486,079	3,912,426
Total long-term debt, net of current portion	55,483,271	43,621,337
Accrued pension liability	47,940,922	49,248,716
Other liabilities	36,684,123	39,881,629
Estimated self-insured liabilities, net of current portion	11,233,322	11,332,704
Total liabilities	239,364,582	232,041,172
Net assets:		
Without donor restrictions	158,626,770	165,230,990
With donor restrictions	16,033,629	10,224,044
Total net assets	174,660,399	175,455,034
Commitments and contingencies (notes 4, 8 and 11)		
Total liabilities and net assets	$ 414,024,981	407,496,206

See accompanying notes to consolidated financial statements.

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2018 and 2017

	2018	2017
Revenues, gains and other support without donor restrictions:		
Patient service revenue, net	$ 504,324,147	515,671,178
Provision for bad debts	-	(15,113,615)
Net patient service revenue less provision for bad debts	504,324,147	500,557,563
Premium revenue	20,832,327	17,905,012
Other operating revenue	32,070,139	27,052,852
Net assets released from restrictions used for operations	1,157,957	724,888
Total revenues, gains and other support without donor restrictions	558,384,570	546,240,315
Expenses:		
Salaries and wages	268,699,755	265,641,318
Employee benefits	50,525,016	48,858,112
Supplies and other	217,561,085	203,919,047
Depreciation and amortization	23,633,459	25,826,762
Interest	2,506,299	2,975,131
New York State gross receipts taxes	2,483,764	2,473,317
Total expenses	565,409,378	549,693,687
Net loss from operations	(7,024,808)	(3,453,372)
Other revenue (expense):		
Contributions and other	(437,679)	241,879
Investment income, net of fees	13,844,021	3,254,885
Total other revenue, net	13,406,342	3,496,764
Excess of revenues over expenses	$ 6,381,534	43,392

(Continued)

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets, Continued

	2018	2017
Changes in net assets without donor restrictions:		
Excess of revenues over expenses	$ 6,381,534	43,392
Change in fair value of interest rate swaps	643,411	561,675
Change in net unrealized gains and losses on investments	(11,462,015)	11,481,137
Net assets released from restrictions for capital acquisitions	205,103	864,779
Contributions used for capital acquisitions	354,953	-
Pension related changes other than net periodic pension cost	21,877	(3,608,969)
Other components of net periodic benefit cost	(2,749,083)	(2,429,633)
Increase (decrease) in net assets without donor restrictions	(6,604,220)	6,912,381
Changes in net assets with donor restrictions:		
Contributions	1,431,571	1,671,603
Change in net unrealized gains and losses on investments and assets limited as to use	(407,883)	134,268
Interest income and dividends, net of fees	16,519	15,581
Interest income on net assets with donor restrictions	-	172,994
Change in value of beneficial interest in charitable trusts	(3,038)	(7,109)
Net realized gains on investments and assets limited as to use	148,004	47,714
Grant for capital acquistions	5,987,472	-
Net assets released from restrictions	(1,363,060)	(1,589,667)
Increase in net assets with donor restrictions	5,809,585	445,384
Total increase (decrease) in net assets	(794,635)	7,357,765
Net assets at beginning of year	175,455,034	168,097,269
Net assets at end of year	$ 174,660,399	175,455,034

See accompanying notes to consolidated financial statements.

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2018 and 2017

	2018	2017
Cash flows from operating activities:		
Change in net assets	$ (794,635)	7,357,765
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	23,633,459	25,826,762
Amortization of debt issuance costs	91,881	113,991
Provision for bad debts	-	15,294,230
Change in net unrealized gains and losses on investments and assets limited as to use	11,869,898	(11,615,405)
Pension related changes other than net periodic pension cost	(21,877)	3,608,969
Other components of net periodic pension cost	2,749,083	2,429,633
Change in fair value of interest rate swaps	(643,411)	(561,675)
Amortization of unearned lease income	(149,409)	(149,409)
Net realized gains on sale of investments and assets limited as to use	(12,561,776)	(2,170,291)
Gain on disposition of property and equipment	(11,605)	(22,762)
Change in grants receivable	(1,092,972)	86,480
Contributions used for and of capital acquisitions	(560,056)	(101,367)
Loss on bond refunding	553,111	-
Restricted grants received	(4,894,500)	-
Changes in operating assets and liabilities:		
Patient receivables	888,103	(20,216,807)
Accrued pension liability	(4,035,000)	(3,605,200)
Due from affiliates, net	(194,967)	(79,379)
Inventories, prepaid expenses and other assets	(1,898,462)	(1,903,128)
Accounts payable, accrued expenses and other liabilities	1,011,099	4,143,046
Estimated self-insured liabilities	(1,190,841)	304,165
Estimated third-party payor settlements, net	1,104,924	758,934
Net cash provided by operating activities	13,852,047	19,498,552
Cash flows from investing activities:		
Purchases of property and equipment	(23,168,338)	(13,568,686)
Proceeds from sale of property and equipment	504,930	22,762
Changes in assets limited as to use, net	2,717,977	(122,060)
Changes in investments, net	(103,897)	7,300,421
Increase in escrow deposit	(511,390)	(12,255)
Change in other assets	962,288	(366,492)
Net cash used in investing activities	(19,598,430)	(6,746,310)

(Continued)

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statement of Cash Flows, Continued

	2018	2017
Cash flows from financing activities:		
Proceeds from long-term debt	34,005,755	-
Principal payments on long-term debt and capital lease obligations	(30,947,429)	(8,978,687)
Grant proceeds received for capital acquisitions	4,894,500	-
Minimum direct financing lease payments received	547,116	547,116
Contributions used for capital acquisitions	560,056	101,367
Net cash provided by (used in) financing activities	9,059,998	(8,330,204)
Increase in cash and cash equivalents	3,313,615	4,422,038
Cash and cash equivalents at beginning of year	21,959,220	17,537,182
Cash and cash equivalents at end of year	$ 25,272,835	21,959,220

See accompanying notes to consolidated financial statements.

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

(a) Organization

The consolidated financial statements include the accounts of Mohawk Valley Health System (MVHS) and subsidiaries (the Corporation). The Corporation is a not-for-profit health care delivery system providing inpatient, outpatient, emergency care, cancer treatment, rehabilitation, laboratory, dialysis, maternity, childcare, long term care, home care, surgical, psychiatric and community services to residents of the Mohawk Valley region.

MVHS is the sole corporate member of Faxton-St. Luke's Healthcare (Healthcare), St. Elizabeth Medical Center (Medical Center), St. Luke's Home Residential Health Care Facility, Inc. d/b/a MVHS Rehabilitation and Nursing Center (Home), Senior Network Health, LLC (SNH), Visiting Nurse Association of Utica and Oneida County, Inc. (VNA), Mohawk Valley Health System Foundation (MVHS Foundation) and Mohawk Valley Home Care, LLC (MVHC). The Corporation is governed by a self-perpetuating Board of Directors.

Effective December 31, 2018, Faxton-St. Luke's Healthcare Foundation's name was changed to Mohawk Valley Health System Foundation (MVHS Foundation) and MVHS became the sole corporate member. Prior to December 31, 2018, Healthcare was the sole corporate member. Therefore, the accompanying balance sheets, statements of operations and changes in net assets, and statements of cash flows are presented as if MVHS was the sole corporate member of MVHS Foundation for the periods presented.

The Medical Center includes the accounts of St. Elizabeth Medical Center Foundation, Inc. (SEMC Foundation), of which the Medical Center is the sole corporate member.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(b) New Accounting Guidance

On January 1, 2018, the Corporation adopted ASU 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*, which makes targeted changes to the not-for-profit financial reporting model and applied these changes retrospectively, as applicable. The existing three category classification of net assets has been replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property and equipment have also been simplified and clarified. New disclosures have been incorporated to highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. The ASU also imposes several new requirements related to reporting expenses. The ASU was effective for fiscal years beginning after December 15, 2017. As a result of adopting this standard, certain prior year amounts were reclassified to conform to the presentation requirements.

A summary of the net asset reclassifications resulting from the adoption of ASU 2016-14 to the December 31, 2017 consolidated financial statements is as follows:

Net assets classifications	Without donor restrictions	With donor restrictions	Total net assets
As previously presented:			
Unrestricted	$ 165,230,990	-	165,230,990
Temporarily restricted	-	4,668,327	4,668,327
Permanently restricted	-	5,555,717	5,555,717
Net assets as reclassified	$ 165,230,990	10,224,044	175,455,034

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(b) New Accounting Guidance, Continued

On January 1, 2018, the Corporation adopted ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance, and requires expanded disclosures about revenue recognition. The core principle of the revenue model is that an entity recognizes 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. The Corporation adopted ASU 2014-09 effective for the year ended December 31, 2018 following the modified retrospective method of application, and as such the prior period financial statements have not been adjusted for the adoption of ASU 2014-09. As a result of implementing ASU 2014-09, certain patient activity where collection is uncertain previously reported as patient service revenue and provision for bad debts in the Corporation's consolidated statement of operations and changes in net assets no longer meets the criteria for revenue recognition and, accordingly, provision for bad debts after the adoption date is significantly reduced with a corresponding reduction to patient service revenue. Such patient activity is classified as an implicit price concession. Additionally, provision for bad debts as applicable is now presented as an expense item (included as a component of supplies and other expenses) rather than a reduction to patient service revenue. Other aspects of the Corporation's implementation of ASU 2014-09 impacting patient service revenue include judgements regarding collection analyses and estimates of variable consideration and the addition of certain qualitative and quantitative disclosures. The adoption of ASU 2014-09 did not have a material impact in relation to other applicable revenue activity.

On January 1, 2018, the Corporation early adopted ASU 2017-07, *Compensation - Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost,* which requires an employer to 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 (i.e. employee benefits expense). The other components of net benefit cost are required to be presented in the consolidated statements of operations and changes in net assets separately from the service cost component and outside the performance indicator, excess of revenues over expenses. ASU 2017-07 is effective for financial statements issued for fiscal years beginning after December 15, 2018 and is to be applied on a retrospective basis for all previous periods presented with early adoption permissible. The retrospective adoption of ASU 2017-07 resulted in a reclassification of $2,429,633 of net benefit cost from employee benefits expense to other components of net periodic benefit cost and increase of $2,429,633 in excess of revenues over expenses on the consolidated statements of operations and changes in net assets for the year ended December 31, 2017, but had no effect on net assets without donor restrictions as of December 31, 2017.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(c) Basis of Accounting

The accompanying consolidated financial statements include the accounts of MVHS, Healthcare, Medical Center, Home, SNH, VNA, MVHS Foundation and MVHC. For financial statement reporting purposes, MVHS is considered the reporting entity. All significant intercompany balances and transactions have been eliminated in the consolidated financial statements.

(d) Use of Estimates

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

(e) Collective Bargaining Agreements

At December 31, 2018, the Corporation has approximately 58% of its employees working under collective bargaining agreements. Certain agreements expire in June 2019 and 2020.

(f) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturity of three months or less, excluding temporary investments included in escrow deposit, investments and assets limited as to use.

(g) Escrow Deposit and Contingent Reserve

SNH is required by the New York State Insurance Department to maintain an escrow deposit equal to the greater of five percent of the current year's projected medical expenses or $100,000. SNH must also maintain positive net worth (member's equity) equal to or in excess of at least twelve and one half percent and twelve and one quarter percent of its net premium revenue in 2018 and 2017, respectively. At December 31, 2018 and 2017, SNH was in compliance with both requirements.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(h) Investments and Assets Limited as to Use

Investments, assets limited as to use and pension plan assets are reported at fair value. FASB ASC 820, Fair Value Measurement (FASB ASC 820), defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See note 15 for discussion on fair value measurements.

Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses since none of the investments are classified as trading securities.

Certain investments that do not have readily determinable fair values are valued by using the net asset value (NAV) per share (or its equivalent), as a practical expedient permitted under FASB ASC 820.

The Corporation invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the Corporation's net assets.

The Corporation reviews investments for other-than-temporary impairment whenever the fair value of an investment is less than amortized cost and evidence indicates that an investment's carrying amount is not recoverable within a reasonable period of time. In the evaluation of whether an impairment is other-than-temporary, the Corporation considers the reasons for the impairment, its ability and intent to hold the investment until the market price recovers or the investment matures, compliance with its investment policy, the severity and duration of the impairment, and expected future performance.

The Corporation's investments in common stocks, mutual funds and pooled investment funds consist of investments diversified in several different industries. The Corporation evaluated the near-term prospects of the issuer in relation to the severity and duration of impairment. Based upon the evaluation and the Corporation's ability and intent to hold the securities for a reasonable period of time sufficient for a forecasted recovery of fair value, the Corporation does not consider the securities in an unrealized loss position to be other-than-temporarily impaired at December 31, 2018 and 2017.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(i) Inventories

Inventories are stated at the lower of average cost or net realizable value.

(j) Property and Equipment

Property and equipment acquisitions are recorded at cost, if purchased, or at fair value at the date of acquisition when acquired by gift. Depreciation is calculated over the estimated useful life of each class of depreciable asset ranging from 2 - 40 years using the straight-line method. Property and equipment under capital leases and leasehold improvements are amortized on the straight-line method over the lesser of the lease term or the estimated useful life of the asset. Amortization of equipment under capital leases and leasehold improvements is included in depreciation and amortization expense.

Gifts of long-lived assets, such as land, buildings or equipment are reported as contributions without donor restrictions and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated asset must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(k) Unamortized Debt Issuance Costs

Debt issuance costs are amortized using the straight-line method, which approximates the effective interest method over the terms of the related debt obligations. In connection with the refunding of the Oneida County Industrial Development Agency Civic Facility Revenue Bonds, Series 1999-A and Series 1999-B, and the Oneida County Industrial Development Agency Multi-Mode Variable Rate Civic Facility Revenue Bonds, Series 2006-A outlined in note 8, the Medical Center wrote off approximately $553,000 of unamortized debt issuance costs related to the refunded bonds. At December 31, 2018 and 2017, accumulated amortization on the debt issuance costs was approximately $386,000 and $1,638,000, respectively. Amortization expense amounted to approximately $92,000 and $114,000 in 2018 and 2017, respectively, and is included in interest expense within the consolidated statements of operations and changes in net assets.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(l) Insurance Claims and Related Recoveries

The Corporation recognizes liabilities associated with malpractice claims or similar contingent liabilities when the incidents that give rise to the claims occur. Further, the liability shall not be presented net of anticipated insurance recoveries. Any amounts expected to be reimbursed from an insurance company are presented in other assets.

(m) Contributions and Pledges Receivable

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional contributions or intents to give are recorded at fair value when donor-imposed stipulations have been substantially met. Such contributions are reported as net assets with donor contributions if they are received with donor stipulations that limit the use of the donated assets. When the donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as contributions with donor restrictions and net assets released from restrictions in the consolidated statements of operations and changes in net assets.

The Corporation records contributions that are due in future periods as pledge receivables. Contributions that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-adjusted interest rates applicable to the years in which the promises are received. In subsequent years, this discount is accreted and recorded as additional contribution revenue in accordance with donor imposed restrictions, if any.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(n) Classification of Net Assets

Net assets without donor restrictions are available for general use and not subject to donor-imposed restrictions. These net assets may be used at the discretion of the Corporation's management and board of directors and may be subject to self-imposed limits by action of the governing board. Board-designated net assets may be earmarked for future programs, investments, contingencies, purchases or other uses. Net assets without donor restrictions and without board-designation are known as undesignated net assets. The board of directors has designated certain net assets without donor restriction for the following uses:

Designated by the SEMC Foundation Board - Investments designated to provide financial support to the Medical Center for operational needs as they arise.

Net assets with donor restrictions are those that are subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature and are limited by donors to a specific time period or purpose. Other donor restrictions are perpetual in nature, as stipulated by the donor.

(o) Net Assets with Donor Restrictions (Endowment Funds)

The Corporation maintains various donor-restricted and board-designated funds whose purpose is to provide long-term support for its charitable programs. In classifying such funds for consolidated financial statement purposes as either with donor restrictions or without donor restrictions, the Board of Directors looks to the explicit directions of the donor where applicable and the provisions of the laws of the State of New York. To constitute an endowment under New York State law, the restriction must arise from a clearly expressed donor limitation, not a limitation from within the beneficiary organization. The Board of Directors has determined that, absent donor stipulations to the contrary, the provisions of New York State law do not impose donor restrictions on the income or capital appreciation derived from the original gift. Therefore, all income and appreciation derived from the original gift are transferred to net assets without donor restrictions absent any restrictions on the use made by the donor. Net assets with donor restrictions consist of endowment funds and are included in the consolidated balance sheets as assets limited as to use and long-term investments.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(o) Net Assets with Donor Restrictions (Endowment Funds), Continued

The Corporation utilizes an investment strategy that emphasizes preservation of principal and total return consistent with prudent levels of risk. Investments are allocated over a diversified portfolio of multiple asset classes.

Interpretation of Relevant Law

The Corporation is subject to the New York Prudent Management of Institutional Funds Act (NYPMIFA) and, thus, classifies amounts in its donor-restricted endowment fund as net assets with donor restrictions because those net assets are time restricted until the Board of Directors appropriates such amounts for expenditure. Certain of these net assets are also subject to purpose restrictions that must be met before reclassifying those net assets to net assets without donor restrictions. The Board of Directors has interpreted NYPMIFA as requiring the maintenance of purchasing power of the original gift amount contributed to an endowment fund, unless a donor stipulates the contrary. As a result of this interpretation, when reviewing its donor-restricted endowment funds, the Corporation considers a fund to be underwater if the fair value of the fund is less than the sum of (a) the original value of initial and subsequent gift amounts donated to the fund, (b) the portion of investment return added to the fund to maintain its purchasing power and (c) any accumulations to the fund that are required to be maintained in perpetuity in accordance with the direction of the applicable donor gift instrument. The Corporation has interpreted NYPMIFA to permit spending from underwater funds in accordance with the prudent measures required under the law. Additionally, in accordance with NYPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

1. The duration and preservation of the endowment fund
2. The purposes of the organization and the donor-restricted endowment fund
3. General economic conditions
4. The possible effect of inflation and deflation
5. The expected total return from income and the appreciation of investments
6. Other resources of the organization
7. The investment policies of the organization
8. Where appropriate, alternatives to spending from the endowment fund and the possible effects of those alternatives on the organization

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(o) Net Assets with Donor Restrictions (Endowment Funds), Continued

Underwater Endowment Funds

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or NYPMIFA requires the Corporation to retain as a fund of perpetual duration. If the situation were to occur, the deficiency would be recorded in the Corporation's net assets with donor restrictions. A deficiency did not exist at December 31, 2018 or 2017.

Return Objectives, Strategies, Spending Policy and Investment Objectives

The Corporation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment. Under this policy, as approved by the Board of Directors, the endowment assets are to be invested in a well-diversified asset mix that can be expected to generate acceptable long-term returns at an acceptable level of risk. The Corporation targets a diversified asset allocation that places a greater emphasis on equity-based investments and bonds to achieve its long-term return objectives within prudent risk constraints.

The Corporation has a policy of immediately making available for expenditure and recording as without donor restrictions the current yield (interest and dividends) of donor-restricted endowments as earned during the year to purchase capital assets or to support health care services based on the donor's request and that preserves the endowments purchasing power through maintaining all capital appreciation (realized and unrealized) within the endowment funds.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(o) Net Assets with Donor Restrictions (Endowment Funds), Continued

Changes in Endowment Net Assets

	2018		
	Without donor restrictions	With donor restrictions	Total
Endowment net assets, January 1	$ 3,025,806	5,973,881	8,999,687
Contributions	-	38,974	38,974
Investment return:			
Investment income	79,279	151,832	231,111
Net loss (realized and unrealized)	(298,481)	(548,794)	(847,275)
Net assets released from restrictions	-	(119,411)	(119,411)
Endowment net assets, December 31	$ 2,806,604	5,496,482	8,303,086

	2017		
	Without donor restrictions	With donor restrictions	Total
Endowment net assets, January 1	$ 2,641,926	5,734,853	8,376,779
Contributions	-	82,797	82,797
Investment return:			
Investment income	76,555	112,264	188,819
Net gain (realized and unrealized)	307,325	547,426	854,751
Transfer of earnings over historical value	-	(490,359)	(490,359)
Net assets released from restrictions	-	(13,100)	(13,100)
Endowment net assets, December 31	$ 3,025,806	5,973,881	8,999,687

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Patient Service Revenue and Patient Accounts Receivable

Effective January 1, 2018 upon the adoption of ASU 2014-09, patient service revenue is reported at the amount that reflects the consideration to which the Corporation expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Corporation bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Corporation. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Corporation believes that this method provides a reasonable depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient care services, outpatient (physician practices, emergency department, home care, clinics and ambulatory care center) services or skilled nursing services. The Corporation measures the performance obligation from admission into an inpatient stay facility or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services. The Corporation measures the performance obligation when the service is provided for skilled nursing services.

As substantially all of its performance obligations relate to contracts with a duration of less than one year, the Corporation has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to in-house acute care at the end of the reporting period. The performance obligations for in-house acute care patients are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Patient Service Revenue and Patient Accounts Receivable, Continued

In assessing collectibility, the Corporation uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient, outpatient, and skilled nursing revenue. Based on historical collection trends and other analyses, the Corporation believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

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

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors are as follows:

Medicare - Generally, inpatient acute care and outpatient services are paid at prospectively determined rates per discharge, day or visit based on clinical, diagnostic, and other factors. Physician services are paid based upon established fee schedules.

Medicaid - Inpatient acute care and outpatient services are paid at prospectively determined rates promulgated by the New York State Department of Health.

Commercial and Other - Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Patient Service Revenue and Patient Accounts Receivable, Continued

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Corporation also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Corporation estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the year ended December 31, 2018, revenue due to changes in estimates of implicit price concessions, discounts, and contractual adjustments for performance obligations satisfied in prior years was not significantly impacted. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as provision for bad debts.

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

Settlements with third-party payors for retroactive adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor, and the Corporation's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in the estimated settlements increased patient service revenue by approximately $841,000 and $3,846,000 in 2018 and 2017, respectively.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Patient Service Revenue and Patient Accounts Receivable, Continued

Consistent with the Corporation's mission, care is provided to patients regardless of their ability to pay. Therefore, the Corporation has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Corporation expects to collect based on its collection history with those patients.

The Corporation determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors: payors and service lines. The following tables provide details of these factors.

The composition of patient service revenue by primary payor for the year ended December 31, 2018 is as follows:

	Government payors	Commercial insurance and others	Self-pay	Total
Patient service revenue	$ 319,441,436	176,674,969	8,207,742	504,324,147

Revenue from patient's deductibles and coinsurance are included in the categories presented above based on the primary payor.

The composition of patient service revenue based on line of business for the year ended December 31, 2018 is as follows:

Inpatient	$ 194,280,341
Outpatient	293,714,728
Skilled nursing facility	16,329,078
	$ 504,324,147

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Patient Service Revenue and Patient Accounts Receivable, Continued

Prior to the adoption of ASU 2014-09, the Corporation recognized patient service revenue at the estimated net realizable amounts associated with services provided to patients who have third-party payor coverage on the basis of contractual or formula-driven rates for the services rendered and included estimated retroactive revenue adjustments due to ongoing and future audits, reviews and investigations. Retroactive adjustments were considered in the recognition of revenue on an estimated basis in the period that related services were rendered, and such amounts adjusted in future periods as adjustments became known or as years were no longer subject to such audits, reviews and investigations.

The composition of patient service revenue by primary payor for the year ended December 31, 2017 is as follows:

	Government payors	Commercial insurance and others	Self-pay	Total
Patient service revenue (net of contractual allowances and discounts)	$ 322,368,792	180,870,605	12,431,781	515,671,178
Provision for bad debts				(15,113,615)
Patient service revenue				$ 500,557,563

Patient Accounts Receivable

At December 31, 2018, patient accounts receivable is comprised of the following components:

Patient receivables	$ 59,997,466
Contract assets	3,642,005
	$ 63,639,471

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

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Patient Service Revenue and Patient Accounts Receivable, Continued

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

The Corporation grants unsecured credit to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31 was as follows:

	2018	2017
Medicare	41%	44%
Medicaid	19%	20%
Private payors	11%	7%
Insurance and all others	29%	29%
	100%	100%

The Corporation's allowance for doubtful accounts was not significant at December 31, 2018. The allowance for doubtful accounts was approximately $15,497,000 at December 31, 2017.

(q) Premium Revenue

SNH administers an agreement with New York State to provide a long-term care services benefit package to dually-eligible Medicare/Medicaid recipients under a partial risk contract. Under this agreement, SNH receives monthly capitation payments based on the number of enrollees, regardless of services actually performed. The agreement allows for retroactive adjustments to the monthly capitation rate.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(r) Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Corporation does not pursue collection of such amounts, they are not reported as net patient service revenue. During 2018 and 2017, costs incurred by the Corporation in the provision of charity care were based on the ratio of the Corporation's costs to gross charges and approximated $897,000 and $1,296,000, respectively.

(s) Delivery System Reform Incentive Payment Program

In April 2014, the Governor of the State of New York announced federal approval of a Medicaid 1115 waiver amendment that enabled the State to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms into the State's health care system. The Delivery System Reform Incentive Payment (DSRIP) program promotes community-level collaborations and focus on systems reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years.

Certain members of the Corporation are members in the CNY Care Collaborative (CNYCC) organized under the DSRIP program. The involvement with the CNYCC is to implement care transformation in patient care services. Funding for CNYCC is based on the members' collective success in reporting and achieving predefined results in system transformation, clinical management, and population health. Certain payments under the DSRIP program are subject to meeting specified performance criteria and other requirements which may be evaluated in future periods. The Corporation recorded approximately $7,125,000 and $4,082,000 during 2018 and 2017, respectively, as other operating revenue on the consolidated statements of operations and changes in net assets.

(t) MLMIC Distribution

On October 2, 2018, the demutualization of MLMIC Insurance Company and ownership transfer to National Indemnity Company, a Berkshire Hathaway Company, was finalized for consideration of approximately $2.5 billion. The transaction resulted in cash payments to eligible policyholders, or their designees, with policies in effect from July 15, 2013 through July 14, 2016. In connection with this transaction and their MLMIC policy during this period, the Corporation's portion was approximately $13,512,000, of which approximately $11,630,000 was received as a cash distribution and is recorded as investment income on the consolidated statement of operations and changes in net assets. As part of the transaction, the Corporation erroneously had tax withholdings of approximately $1,200,000, which is recorded in other current assets in the consolidated balance sheet at December 31, 2018. The Corporation expects to receive payment during 2019. At December 31, 2018, approximately $1,882,000 is recorded as a liability for payment related to certain physician policies under review.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(u) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in net assets with donor restrictions which are excluded from excess of revenues over expenses, consistent with industry practice, include changes in unrealized gains and losses on investments other than trading securities, the effective portion of gains and losses on derivative instruments, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension liability adjustments in accordance with FASB ASC Subtopic 715-30, Compensation- Retirement Benefits, Defined Benefit Plans - Pension.

(v) Income Taxes

The Corporation, except SNH and MVHC, are not-for-profit corporations and have been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

MVHC and SNH are single member New York State limited liability companies. Accordingly, they are treated as disregarded entities for tax purposes and are considered divisions of MVHS.

As of December 31, 2018 and 2017, the Corporation did not have any unrecognized tax benefits or any related accrued interest or penalties. The tax years open to examination by federal and state taxing authorities are 2015 through 2018. The Corporation does not anticipate the total unrecognized tax benefits will change in the next twelve months.

(w) Concentration of Credit Risk

The Corporation invests cash and cash equivalents with financial institutions, and has determined that the amount of credit exposure at any one financial institution is immaterial to the Corporation's financial position.

(x) Reclassifications

Certain 2017 amounts have been reclassified to conform to the 2018 consolidated financial statement presentation.

(y) Subsequent Events

Subsequent events have been evaluated through June 20, 2019, which is the date consolidated financial statements were issued.

(2) Liquidity and Availability of Financial Assets

As of December 31, 2018, financial assets available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, were as follows:

Cash and cash equivalents	$ 25,272,835
Investments and assets limited as to use	102,759,571
Patient accounts receivable, net	63,639,471
Pledges receivable	106,231
Other current assets	13,300,406
Due from affiliates, net	525,215
Total financial assets	205,603,729
Less amounts not available to be used within one year:	
Assets limited as to use - held in escrow	(704,792)
Other assets	(4,983,903)
Financial assets not available to be used within one year	(5,688,695)
Financial assets available to meet general expenditures within one year	$ 199,915,034

Included above within investments and assets limited as to use is approximately $2,807,000 in board-designated funds as of December 31, 2018. These funds could be drawn upon if the governing board approves such action.

As part of the Corporation's liquidity management, it has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations become due.

In the event of an unanticipated liquidity need, the Corporation could draw upon a revolving note payable or lines-of-credit (note 7).

(Continued)

(3) Investments and Assets Limited as to Use

At December 31, investments and assets limited as to use, at fair value, are comprised of the following:

		2018	2017
Assets limited as to use:			
Held in escrow - cash and cash equivalents	$	704,792	703,258
Under bond indenture agreements:			
Commercial paper	$	-	2,487,357
Less current portion for bond interest fund		-	55,316
Debt service reserve fund - long-term		-	2,432,041
Restricted by donors:			
Cash and cash equivalents		564,266	804,650
Common stock		1,177,198	1,053,293
Exchange traded funds		-	253,955
Mutual funds		535,918	813,373
Government and agency obligations		19,163	31,157
Domestic corporate bonds		188,279	-
Total restricted by donors		2,484,824	2,956,428
Total assets limited as to use - long-term	$	2,484,824	5,388,469

		2018	2017
Investments:			
Cash and cash equivalents	$	2,129,501	5,142,551
Certificates of deposit		-	19,994
Common stock		2,780,235	3,331,205
Exchange traded funds		1,041,468	601,122
Mutual funds		73,992,930	71,043,196
Pooled investment funds		25,156,827	28,291,893
Domestic corporate bonds		3,805,937	1,911,874
Government and agency obligations		12,356	320,510
Total investments	$	108,849,254	110,662,345

(Continued)

(3) Investments and Assets Limited as to Use, Continued

The above amounts are included in the accompanying consolidated financial statements as follows:

	2018	2017
Cash and cash equivalents	$ 1,164,699	4,524,405
Escrow deposit	1,101,612	590,222
Investments and assets limited as to use - current assets	102,759,571	101,778,128
Assets limited as to use - long term	2,484,824	5,388,469
Investments - long term	4,528,164	4,528,164
	$ 112,038,870	116,809,388

(4) Property and Equipment

Property and equipment is comprised of the following at December 31:

	2018	2017
Land and land improvements	$ 17,081,815	17,715,158
Buildings and improvements	226,915,552	227,872,651
Fixed equipment	101,189,345	108,991,580
Movable equipment	149,582,652	195,967,563
Property and equipment under capitalized leases	44,471,079	21,834,224
	539,240,443	572,381,176
Less accumulated depreciation and amortization	(410,681,516)	(431,007,517)
	128,558,927	141,373,659
Construction-in-progress	29,033,430	8,665,399
Property and equipment, net	$ 157,592,357	150,039,058

In April 2017, MVHS was notified by the New York State Department of Health of an award of $300 million granted under the Statewide Healthcare Facility Transformation Program. This award will be used by MVHS to consolidate inpatient care from Healthcare and the Medical Center into one, new integrated health campus. The cost projection for the new campus is estimated to be $498 million for a 670,000 square foot facility. The remaining $198 million will come from MVHS capital, bonds and fundraising. The planning and construction for this project is expected to take approximately five years. Approximately $15,912,000 and $6,431,000 is included within construction-in-progress related to the new integrated healthcare facility at December 31, 2018 and 2017, respectively. MVHS has signed certain contracts related to the project, which include commitments of approximately $17.3 million at December 31, 2018.

Depreciation and amortization expense amounted to approximately $23,633,000 and $25,827,000 for the years ended December 31, 2018 and 2017, respectively.

(Continued)

(5) Direct Financing Lease

In 2001, Healthcare completed construction of a medical office building with a cost of approximately $5 million on land owned by an affiliate of Slocum-Dickson Medical Group, P.C. (SDMG). The building is leased to SDMG under a direct financing lease for minimum lease payments of approximately $45,000 per month through November 2021.

The direct financing lease, included in other assets in the consolidated balance sheets, at December 31 is as follows:

	2018	2017
Minimum lease payments receivable	$ 1,576,783	2,123,899
Unearned lease income	(168,128)	(286,933)
Net investment in direct financing lease	1,408,655	1,836,966
Less current portion, included in other current assets	547,116	547,116
Long-term net investment in direct financing lease, included in other assets	$ 861,539	1,289,850

(6) Extended Sick Leave

Certain Corporation employees are permitted to accumulate unused extended sick leave time up to specified maximum amounts. The Corporation accrues the estimated expense related to extended sick leave based on pay rates currently in effect. Upon retirement, employees who have met certain criteria shall have the option to receive payment or receive sick leave credits to pay for post-employment health insurance payments based upon the formula in place. The Corporation has accrued an estimated liability of approximately $11,519,000 and $11,495,000 at December 31, 2018 and 2017, respectively, for these anticipated termination payments.

Amounts are included in the accompanying consolidated financial statements as follows at December 31:

	2018	2017
Accrued payroll, payroll taxes and benefits	$ 752,000	660,000
Other liabilities - long-term	10,767,000	10,835,000
	$ 11,519,000	11,495,000

(Continued)

(7) Short-Term Borrowings

At December 31, 2018 and 2017, the Medical Center had a line of credit with a lender which provides for borrowings up to $6,000,000 secured by the Medical Center's College of Nursing building and up to $7,000,000 of eligible accounts receivable, as defined. Borrowings against this line of credit are payable on demand and bear interest at the lender's prime rate. There were no borrowings on the line as of December 31, 2018 and 2017.

At December 31, 2018 and 2017, Healthcare had a $24,500,000 revolving note payable with a bank, collateralized by certain investments. The revolving note payable on short-term borrowings bears a daily interest rate at prime (5.50% at December 31, 2018). The revolving note payable on long-term borrowings bears a monthly interest rate at 1 month LIBOR plus 95 basis points (3.47% at December 31, 2018). The revolving note payable is available through July 2019. At December 31, 2018, a portion of the revolving note payable was reserved for four letters of credit totalling approximately $8,437,000 primarily related to self-insured liabilities. At December 31, 2018 and 2017, Healthcare had no amounts outstanding on the revolving note payable. The revolving note payable contains financial covenants including a debt service coverage ratio requirement, a days cash on hand requirement and a minimum unrestricted liquidity to funded debt ratio. At December 31, 2018 and 2017, Healthcare was in compliance with the covenants that are considered events of default.

(8) Long-Term Debt and Lease Obligations

Long-term debt consists of the following at December 31:

	2018	2017
Term loan (a)	$ 13,652,914	-
Term loan (b)	21,179,000	-
Series 1999-A Bonds ($10,920,000 principal amount less unamortized discount of $56,981 at December 31, 2017) (c)	-	10,863,019
Series 1999-B Bonds ($5,240,000 principal amount less unamortized discount of $65,836 at December 31, 2017) (d)	-	5,174,164
Series 2006-A Bonds (e)	-	8,000,000
Variable rate demand 2006 Civic Facility Revenue Bonds (f)	13,780,000	14,520,000

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

	2018	2017
Term loan (g)	158,286	389,924
Loans payable to Sisters (h)	732,065	1,081,748
Note payable in monthly installments of $65,617 at a fixed rate of 2.6% maturing May 2021 (i)	1,903,278	2,630,096
Mortgage payable in monthly installments of $41,253 at a fixed rate of 5.5%, maturing January 2020 and collateralized by the related building	656,118	1,201,317
Note payable in monthly installments of $9,223 at a fixed rate of 4.0% maturing July 2020	168,882	270,461
Note payable in monthly installments of $9,137 at an adjustable fixed rate of 4.0% (through March 2021), maturing March 2026	687,701	767,697
Note payable in monthly installments of $27,664 at a fixed rate of 4.0%, matured October 2018	-	271,650
Note payable satisfied in April 2018 in conjunction with related interest rate swap	-	300,000
Capital lease obligations (interest rates ranging from 2.6% to 10.61%)	10,063,658	6,938,224
	62,981,902	52,408,300
Less unamortized debt issuance costs	(595,426)	(833,638)
Less current portion:		
Debt	(4,325,626)	(4,927,527)
Capital lease obligations	(2,577,579)	(3,025,798)
Long-term debt, net of current portion	$ 55,483,271	43,621,337

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

(a) In September 2018, the Medical Center joined the initial obligated group of Healthcare and MVHS as established by the Master Trust Indenture and amended by the First Amendment to the Master Trust Indenture. Under these agreements a Revolving Credit Agreement (term loan) with a financial institution was established, for an amount up to $60,000,000 to be used to provide interim financing for the new hospital project and the implementation of the Electronic Health Records (EHR). At December 31, 2018 there was approximately $13,653,000 outstanding on the term loan.

The term loan is secured through the Mohawk Valley Health System Obligated Group Facilities Revenue Bond, Series 2018K as issued pursuant to the Seventh Series Indenture under the Master Trust Agreement. Interest is payable monthly at an annual variable rate based on one-month LIBOR that resets at various points in the agreement (4.02% at December 31, 2018). Principal payments commence at the earlier of September 23, 2022 or one year after permanent financing is finalized which is expected to occur by 2020.

(b) A loan agreement (term loan) with a financial institution was established, for an amount of $21,665,000 to be used to refund the entire outstanding principal balance of certain outstanding bonds (c) (d) (e).

The term loan is secured through the Mohawk Valley Health System Obligated Group Facilities Revenue Bond, Series 2018J as issued pursuant to the Sixth Series Indenture under the Master Trust Agreement. Interest is payable monthly at an annual variable rate equal to the lower of the one-month LIBOR + 1.35% or the prime rate (3.85% at December 31, 2018). Principal payments began in December 2018 and are payable through December 2029.

(c) In April 1999, the Medical Center obtained financing of $15,000,000 through the placement of Oneida County Industrial Development Agency Civic Facility Revenue Bonds, Series 1999-A (the Series 1999-A Bonds). In September 2018, the Series 1999-A Bonds were refunded in conjunction with the issuance of the term loan (b).

(d) In June 1999, the Medical Center obtained additional financing of $15,000,000 through the placement of Oneida County Industrial Development Agency Civic Facility Revenue Bonds, Series 1999-B (the Series 1999-B Bonds). In September 2018, the Series 1999-B Bonds were refunded in conjunction with the issuance of the term loan (b).

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

(e) In June 2006, the Medical Center obtained additional financing of $14,000,000 through the placement of Oneida County Industrial Development Agency Multi-Mode Variable Rate Civic Facility Revenue Bonds Series 2006-A (the Series 2006-A Bonds). In September 2018, the Series 2006-A Bonds were refunded in conjunction with the issuance of the term loan (b).

(f) Healthcare, through the Oneida County Industrial Development Agency (OCIDA), has issued serial and term Civic Facility Revenue Bonds as follows:

Series	Term	Annual principal payments
Faxton-St. Luke's Healthcare:		
2006E - tax-exempt	2031	$285,000 - $525,000
2006F - taxable	2031	$440,000 - $955,000

The bonds are insured and are collateralized by Healthcare's gross receipts (as defined), including all rights to receive such receipts whether in the form of accounts receivable, contract rights or other rights. Healthcare entered into a lease agreement with OCIDA, which also acts as security for payment of the revenue bonds. Additional security is provided by a Master Trust Indenture under which the Members of the Obligated Group (Healthcare, Medical Center and MVHS) are jointly and severally responsible for payment of the bonds. Various agreements relating to the bonds establish covenants with which Healthcare has agreed to comply, including provisions regarding liquidity ratio, minimum debt service coverage ratio and liquidity to funded debt. At December 31, 2018 and 2017, the Obligated Group was in compliance with the covenants that are considered events of default.

The bonds bear interest based on one of three modes - the weekly rate, the term rate, or the fixed rate - for periods selected by Healthcare. The interest rate for each mode will be the current market interest rate as determined by the remarketing agent of the bonds. Healthcare used the weekly rate during 2018 and 2017. At December 31, 2018, the bonds carried interest at rates of 1.75% (tax-exempt) and 2.50% (taxable). At December 31, 2017, the bonds carried interest at rates of 1.80% (tax-exempt) and 1.58% (taxable).

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

The bonds are remarketed by a remarketing agent in accordance with the terms of a remarketing agreement. The bonds will be remarketed whenever a new interest rate is in effect. If the bonds cannot be remarketed, they would be due and payable under the terms of the remarketing agreement; however, the bonds are credit-enhanced by an irrevocable letter of credit, which is set to expire July 31, 2020. In the event that the remarketing agent is unable to remarket the bonds, the bond trustee will make a draw on the letter of credit and the tendered variable rate bonds will become bank bonds.

As a result of the aforementioned 2006 bond issuances, Healthcare has entered into two interest rate swap contracts to reduce its risk of exposure to changes in interest rates. The interest rate swaps effectively convert the variable rates of the 2006 bonds to fixed rates of 5.938% and 4.216% through June 2031. The swaps have been designated as cash flow hedges of the variable interest rates and are recorded at fair value as a liability of approximately $2,761,000 and $3,403,000 in other long-term liabilities on the accompanying consolidated balance sheets as of December 31, 2018 and 2017, respectively. The amounts exchanged are based on the notional amounts whereby Healthcare pays the swap counter-party interest at a fixed rate (4.216% - tax-exempt, 5.938% - taxable) and the swap counter-party pays Healthcare a variable rate (based on 70% of 1 month LIBOR tax-exempt, BMA Rate - taxable). The notional amounts and fair values based on quoted market prices, of Healthcare's interest rate swaps are approximately as follows at December 31:

	2018		2017	
	Notional amount	Liability fair value	Notional amount	Liability fair value
Healthcare - Series E	$ 5,120,000	808,000	5,410,000	998,000
Healthcare - Series F	8,660,000	1,953,000	9,110,000	2,405,000
	$ 13,780,000	2,761,000	14,520,000	3,403,000

The mark-to-market adjustments resulted in an increase of approximately $641,000 and $562,000 in net assets without donor restrictions for the years ended December 31, 2018 and 2017, respectively. Changes in value of the swaps determined to arise from ineffectiveness of the instruments, as determined through the hypothetical derivative method, are recorded as a component of interest expense in the consolidated statements of operations and changes in net assets. For the years ended December 31, 2018 and 2017, there was no significant ineffectiveness. Healthcare expects that the loss existing in net assets without donor restrictions to be reclassified into net loss from operations within the next 12 months will not be significant.

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

(g) In September 2014, the Medical Center obtained financing through a term note, for equipment, with a bank in the amount of $1,100,000. The note is collateralized by the related equipment. The term note is payable in monthly installments including interest fixed at 3.95%. The term note matures in September 2019. The Medical Center is also required to maintain certain covenants including minimum debt service coverage. The Medical Center is in compliance with its covenants at December 31, 2018 and 2017.

(h) The Medical Center has loans outstanding with the Sisters of St. Francis of the Neumann Communities. All loans are interest free through 2022. Expected principal payments are approximately $183,000 annually. In the event that timely principal payments are not made, the Medical Center will be charged interest at 5%.

(i) In May 2016, a note payable, with principal balance of approximately $3,683,000 of which approximately $1,100,000 was already allocated and recorded by Healthcare, was assigned to Healthcare. In conjunction with the assignment, the bank agreed to extend the maturity date of the loan through May 2021. The note payable is collateralized by the building constructed with the original funds. The note payable agreement contains various covenants including provisions regarding minimum days cash on hand, minimum debt service coverage ratio, and minimum unrestricted liquidity to funded debt ratio. At December 31, 2018 and 2017, Healthcare was in compliance with the financial covenants that are considered events of default.

The Corporation leases certain equipment under capital leases. The Corporation also leases equipment and facilities under noncancellable operating leases. The net book value of the equipment capitalized under lease agreements at December 31, 2018 and 2017 amounted to approximately $13,738,000 and $10,111,000, respectively.

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

In March 2018, MVHS signed an agreement on behalf of Healthcare and the Medical Center for the purchase and implementation of a new EHR. In addition to the term loan, the EHR is financed by two separate capital leases. The new system will replace a number of clinical and billing systems currently used by Healthcare and the Medical Center into one system-wide EHR with clinical, billing and scheduling functionality. The rollout of the development and implementation began in 2018 with a system-wide go live target during 2019. The cost of the new system will be equally split between Healthcare and the Medical Center. At December 31, 2018, the Corporation recorded capital leases related to the new EHR of approximately $7,108,000 and has approximately $12,782,000 in EHR related construction-in-progress on the consolidated balance sheet.

Effective September 1, 2018, the Obligated Group under the Master Trust Indenture (Master Indenture), dated as of March 1, 1998, as supplemented and amended, members include MVHS, Healthcare and the Medical Center. Each member of the Obligated Group is jointly and severally liable for all the obligations of the members issued pursuant to the Master Indenture. Additionally, all members of the Obligated Group have granted an interest in their gross receipts. As of December 31, 2018, the aggregate outstanding balance of all obligations under the Master Indenture totalled approximately $49,412,000 and are included as long-term debt on the consolidated balance sheet. Additionally included under the Master Indenture is Healthcare's interest rate swap liabilities totalling approximately $2,761,000 at December 31, 2018.

Under the terms of the Master Indenture, the Obligated Group is required to meet certain covenant requirements. In addition, the indenture provides for restrictions on among other things, additional indebtedness. The Obligated Group was in compliance with these covenants at December 31, 2018.

(Continued)

(8) Long-Term Debt and Lease Obligations, Continued

The table below reflects principal payments and the present value of future minimum capital lease payments over the next five years and beyond and assumes that the letter of credit related to the Series 2006 E and F Bonds is renewed in 2020 and that the financial institution does not exercise its put option for the Series 2006 Bonds in 2020. If the letter of credit is not renewed, the outstanding Series 2006 Bonds would be due on demand, as described above, in 2019.

	Long-term debt	Capital lease obligations	Operating leases
Years ending December 31:			
2019	$ 4,325,626	2,863,135	1,447,000
2020	4,264,829	2,525,111	1,050,000
2021	4,037,153	1,495,212	1,046,000
2022	3,771,759	1,062,174	1,043,000
2023	3,870,654	773,828	1,043,000
Thereafter	32,648,223	2,603,809	
Total payments	$ 52,918,244	11,323,269	
Less amounts representing interest		(1,259,611)	
Present value of capital lease obligations		10,063,658	
Less current portion		(2,577,579)	
Capital lease obligations, net of current portion		$ 7,486,079	

Rent expense under operating leases amounted to approximately $6,411,000 and $5,353,000 in 2018 and 2017, respectively.

(Continued)

(9) Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes at December 31:

	2018	2017
Time or purpose:		
Funds held in trust by others (for capital)	$ 69,181	72,219
Children's Miracle Network	1,120,627	999,993
Continuous Learning Center	118,354	118,078
Scholarship assistance	169,875	229,482
Programs	610,122	454,749
Renovations	2,294,113	2,566,234
Donor-restricted endowments	70,540	227,572
New Integrated Health Campus	5,987,472	-
	10,440,284	4,668,327
Perpetual:		
The below perpetual amounts represent the corpus of the donor-restricted gifts. Income from these gifts is expendable for the following purposes:		
Investments, the income from which is to support charity care, health care services, scholarships and facility maintenance	5,593,345	5,555,717
	$ 16,033,629	10,224,044

(Continued)

(10) Pension Plans

Medical Center Pension Plan

The Medical Center has a noncontributory defined benefit plan covering substantially all of its full-time employees prior to April 1, 2013. Benefits are based on compensation and years of service. In 2003, the Medical Center applied for and received a favorable determination that its defined benefit plan is that of a nonelecting church plan under Section 410(d) of the Internal Revenue Code. Under status as a church plan, the Medical Center has elected to contribute the minimum amounts calculated as if the plan were subject to ERISA funding requirements.

Effective December 31, 2010, the Plan was amended to freeze benefit accruals for non-bargaining unit members. Effective January 1, 2012, the Plan was amended to freeze benefit accruals for the employees of one of the collective bargaining units. Effective April 1, 2013, the Plan was amended to freeze benefit accruals for the final collective bargaining unit.

The following table presents the changes in the Medical Center's benefit obligation and plan assets and funded status as of December 31:

	2018	2017
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 119,971,888	108,140,610
Interest cost	5,397,775	5,564,451
Actuarial (gain) loss	(7,539,750)	9,808,965
Benefits paid	(3,911,099)	(3,542,138)
Benefit obligation at end of year	$ 113,918,814	119,971,888
Change in plan assets:		
Fair value of plan assets at beginning of year	70,723,172	61,325,296
Actual return on plan assets, net	(4,860,825)	9,325,653
Employer contributions	4,160,000	3,739,200
Benefits and administrative expenses paid	(4,044,455)	(3,666,977)
Fair value of plan assets at end of year	65,977,892	70,723,172
Funded status and accrued pension liability	$ (47,940,922)	(49,248,716)

The Medical Center had $34,933,470 and $34,955,347 of actuarial net losses in net assets without donor restrictions as of December 31, 2018 and 2017, respectively, which have not yet been recognized as a component of net periodic pension cost. The estimated net loss expected to be amortized from net assets without donor restrictions into net periodic pension cost over the next fiscal year is $2,267,610.

(10) Pension Plans, Continued

Medical Center Pension Plan, Continued

The components of net periodic pension cost for the years ended December 31:

	2018	2017
Administrative costs	$ 125,000	134,000
Interest cost	5,397,775	5,564,451
Expected return on plan assets	(5,266,792)	(4,908,856)
Amortization of unrecognized net loss	2,618,100	1,774,038
Net periodic pension cost	$ 2,874,083	2,563,633

The components of net periodic benefit cost other than the administrative costs component are included in other components of net periodic benefit cost in the consolidated statements of operations and changes in net assets.

The weighted average assumptions used to determine projected benefit obligations at December 31 are as follows:

	2018	2017
Discount rate	5.06%	4.58%
Expected long-term return on plan assets	7.50%	7.50%

The weighted average assumptions used to determine net periodic benefit cost for the years ended December 31 are as follows:

	2018	2017
Discount rate	4.58%	5.24%
Expected long-term return on plan assets	7.50%	7.50%

The Medical Center's defined benefit plan's investment objectives are to emphasize total return specifically through long-term growth of capital while avoiding excessive risk, and to achieve a balanced return of current income and modest growth of principal. In order to achieve these objectives, the Medical Center has established the following asset allocation guidelines:

Asset Class	Minimum	Maximum	Preferred
Large cap equity	30%	50%	41%
Small cap equity	-	15%	5%
Mid cap equity	-	15%	6%
International equity	-	25%	16%
Fixed income	20%	80%	32%
Cash and cash equivalents	-	5%	-

(Continued)

(10) Pension Plans, Continued

Medical Center Pension Plan, Continued

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2018 or 2017.

Money market fund: Valued at amortized cost which approximates fair value.

Common stocks: Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end and closed-end mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Common trust: Valued based on the NAV per unit as a practical expedient, without further adjustment. NAV is based upon the fair value of the underlying investments.

Alternative investments: The investments consist of partnership and hedge funds. These securities are estimated using current information obtained from the general partner or investment manager for the respective funds. Investments in private equity partnerships are generally estimated using partner's capital balances, and their fair value of investments are generally estimated using the NAV as a practical expedient.

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

(10) Pension Plans, Continued

Medical Center Pension Plan, Continued

The following tables present by level, within the fair value hierarchy, the Plan's assets as of December 31:

	Assets at fair value as of December 31, 2018			
	Total	Level 1	Level 2	Level 3
Assets in fair value hierarchy:				
Money market fund	609,046	-	609,046	-
Mutual funds	47,677,396	47,677,396	-	-
Investments measured at NAV:				
Common trust	5,159,620	-	-	-
Alternative investments	12,531,830	-	-	-
	$ 65,977,892	47,677,396	609,046	-

	Assets at fair value as of December 31, 2017			
	Total	Level 1	Level 2	Level 3
Assets in fair value hierarchy:				
Cash and cash equivalents	$ 1,200,000	1,200,000	-	-
Money market fund	627,658	-	627,658	-
Mutual funds	50,373,206	50,373,206	-	-
Investments measured at NAV:				
Common trust	5,883,879	-	-	-
Alternative investments	12,638,429	-	-	-
	$ 70,723,172	51,573,206	627,658	-

The Medical Center expects to contribute $4,658,000 to its defined benefit plan in 2019.

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

	Benefit payments
2019	$ 4,658,166
2020	4,956,367
2021	5,279,529
2022	5,708,250
2023	6,027,082
2024 - 2028	33,451,153

(Continued)

(10) Pension Plans, Continued

Other Plans

The Medical Center also offers a 401(k) defined contribution retirement plan to substantially all of its non-union employees. Members of UFCW collective bargaining unit receive contributions equal to other participants, however their plan assets are administered by representatives selected by UFCW. Effective March 3, 2013, members of the New York State Nurses Association were admitted to the plan in conjunction with the freezing of the defined benefit plan as discussed above. Each year participants may contribute up to 75% of eligible pre-tax compensation, as defined in the Plan, subject to maximum annual additions allowed by law. Employees that are not covered by UFCW collective bargaining unit are eligible to receive a safe harbor contribution equal to 3% of compensation. Further, non-union employees are eligible for a discretionary match on their contributions based on years of service as detailed below:

Years of service	% of employer contribution (up to 4%)
1 - 9	50% (or 2% in most cases)
10 - 19	75% (or 3% in most cases)
20+	100% (or 4% in most cases)

The Medical Center also offers a 457(b) plan covering certain highly compensated employees. Participants may contribute amounts up to statutory limits on an annual basis. Under the plan the Medical Center contributes between 2% and 4% of earnings over the 401(k) annual maximum amount depending on the employee's years of service. An asset and liability representing the total amount invested in the 457(b) plan totalling approximately $733,000 and $677,000 has been recorded as an other long-term asset and other long-term liability at December 31, 2018 and 2017, respectively.

Healthcare sponsors a 401(k) plan that covers substantially all full-time non-union employees. Healthcare contributes 4% of eligible compensation to the plan (5% for employees hired before December 1, 2001). Healthcare also makes a matching contribution up to 100% of the first 4% of employee contributions to the 401(k) plan. Healthcare also sponsors a 403(b) plan that covers union and certain other employees. Healthcare contributes 5% of eligible compensation to the plan and also makes a matching contribution for employees with 5 years of service, up to 100% of the first 5% of employee contributions to the 403(b) plan.

(Continued)

(10) Pension Plans, Continued

Other Plans, Continued

The Home maintains defined contribution retirement plans which cover all employees who have completed one year of service and are age twenty-one or older. Participants may contribute a percentage of compensation, but not in excess of the maximum allowed under the Internal Revenue Code. The plans provide for matching contributions based on participant contributions at varying percentages of the participant's compensation for the year. In addition, under one plan, the Home will contribute a fixed amount up to 4% of the participant's compensation.

SNH maintains defined contribution retirement plans which cover all employees who have completed one year of service and are age twenty-one or older. Participants may contribute a percentage of compensation, but not in excess of the maximum allowed under the Internal Revenue Code. The plans provide for matching contributions based on participant contributions at varying percentages of the participant's compensation for the year. In addition, under one plan, SNH will contribute a fixed amount up to 5% of the participant's compensation.

VNA sponsors two defined contribution pension plans covering substantially all employees. VNA matches employee contributions up to specified limits.

Pension expense under all defined contribution plans aggregated approximately $11,177,000 and $11,344,000 for the Corporation in 2018 and 2017, respectively.

(Continued)

(11) Contingencies

Professional Liability Insurance

Malpractice insurance coverage is provided under a claims-made based policy for Healthcare and Medical Center and an occurrence-based policy for the Home, VNA and SNH, which provide for $1,000,000 coverage for each claim, not to exceed $3,000,000 in aggregate annual coverage. Healthcare and the Medical Center's insurance policy includes a per claim $50,000 uninsured deductible, not to exceed $250,000 in aggregate annual coverage. In addition, the Corporation has purchased excess insurance policies. Claims alleging malpractice have been asserted against the Corporation and are currently in various stages of litigation. There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted relating to services provided to patients. Accrued malpractice losses in management's opinion provide an adequate reserve for loss contingencies. The Corporation has accrued a liability included in other liabilities of approximately $21,185,000 and $25,325,000 at December 31, 2018 and 2017, respectively. A corresponding receivable included in other assets of approximately $19,313,000 and $23,015,000, respectively, has been recorded to record anticipated recoveries from the insurance company. If the claims-made policy is not renewed or replaced with equivalent insurance, claims based on occurrences during the claims-made coverage period but reported subsequent to such a change will be uninsured. Healthcare and the Medical Center have a right under their present policy to acquire extended coverage if they decide to terminate their claims-made coverage. Healthcare and the Medical Center intend to renew their coverage on a claims-made basis and do not expect any difficulty in renewing the policies as they become due.

Self-Insured Risks

The Corporation is self-insured for employee healthcare costs. The group has obtained a stop loss coverage policy for healthcare costs to supplement its self-insurance coverage. An accrual for healthcare claims, including those incurred but not reported, is included in the current portion of estimated self-insured liabilities.

(Continued)

(11) Contingencies, Continued

Workers' Compensation Insurance

The Corporation is primarily self-insured for employee workers' compensation and disability claims along with certain of its affiliates for certain years 2007 and prior. Beginning in 2015, Healthcare and certain of its affiliates enrolled in a high deductible plan with an insurance company with a deductible of $500,000 for each employee and occurrence, and an aggregate deductible of $7,900,000 for 2015 and 2016, $8,150,000 for 2017 and $15,000,000 for 2018. Self-insured and high deductible liabilities are based on claims filed and estimates for claims incurred but not reported. As required by the State of New York Workers' Compensation Board, the Corporation has purchased letters of credit to guarantee payment of workers' compensation claims. Stop loss insurance for losses exceeding certain amounts has been purchased for workers' compensation. Each affiliate is jointly and severally liable for the satisfaction of all obligations. These liabilities are recorded at discounted amounts using a 3% interest rate in 2018 and 2017. From 2010 to 2014, certain entities of the Corporation, excluding the Medical Center, were insured in a retrospectively rated workers' compensation and disability policy and premiums are accrued based on the ultimate cost of the experience to date of the entities. The Corporation has accrued a liability included in other liabilities and a corresponding receivable in other assets for anticipated recoveries from the insurance company of approximately $5,972,000 and $6,049,000 at December 31, 2018 and 2017, respectively.

Prior to January 1, 2012, the Medical Center obtained coverage for workers compensation insurance through the Healthcare Underwriters Mutual Risk Management Group (Group). The Medical Center is one of four members of the Group. The Group is an unincorporated association of healthcare providers in the upstate region of New York State and was organized under a trust agreement for the purpose of establishing a workers' compensation self-insurance group. The Group is governed by a board of trustees consisting of one trustee for each member. Members of the Trust are jointly and severally liable for Group activities and liabilities. The Group is no longer active and has been in the process of settling outstanding claims since December 31, 2011. During 2018, the Medical Center made approximately $696,000 in assessment payments to the Trust. In addition, management of the Medical Center monitors the financial stability of the Trust on an ongoing basis and have determined that any future assessment payments would not be significant. At December 31, 2018 and 2017, the Medical Center has not been notified of any assessments resulting from participation in the Trust however has accrued approximately $0 and $515,000, respectively, in long-term portion of estimated self-insured liabilities to cover any future assessments.

(Continued)

(11) Contingencies, Continued

Workers' Compensation Insurance, Continued

Since January 1, 2012, the Medical Center has been self-insured for these liabilities. Losses from asserted and unasserted workers compensation claims are accrued based on actuarial estimates that incorporate the Medical Center's past experience, the nature of each claim or incident, relevant trend factors, and estimated recoveries, if any, on unsettled claims. The Medical Center has accrued approximately $5,049,000 and $4,330,000 for the years ended December 31, 2018 and 2017, respectively. These accruals are part of estimated insurance liabilities on the consolidated balance sheets. In conjunction with the self-insurance program, the Medical Center is required to post a letter of credit with the State of New York Workers Compensation Board. This letter of credit totalled approximately $4,983,000 and $2,994,000 as of December 31, 2018 and 2017, respectively.

(12) Affiliated Entities

The following are approximate dollar amounts of significant transactions and balances with affiliated entities:

New Hartford Scanner Associates

New Hartford Scanner Associates (NHSA) is a joint venture between Healthcare and several radiologists to provide CT scan services. Healthcare receives income from NHSA, which amounted to approximately $548,000 and $631,000 in 2018 and 2017, respectively. Healthcare charges NHSA for equipment, which amounted to approximately $120,000 in 2018 and 2017.

Mohawk Valley EC, LLC

Healthcare, the Medical Center and Mohawk Valley EC Holdings, LLC entered into an agreement for the purpose of owning and operating a single-specialty ambulatory surgery center, exclusively providing gastroenterology services in Oneida County. As part of the agreement, the three members formed the Mohawk Valley EC, LLC (MVEC), a New York limited liability company. Healthcare and the Medical Center each maintain a 20% interest and sharing ratio in MVEC. The amount recognized as income based on the Corporation's share is approximately $122,000 and $480,000 for the years ended December 31, 2018 and 2017, respectively.

The Corporation recognizes income from these joint ventures in other operating revenue.

(Continued)

(12) Affiliated Entities, Continued

Receivables from the affiliates are approximated as follows as of December 31:

		2018	2017
New Hartford Scanner Associates	$	500,000	314,000
Other		25,000	16,000
	$	525,000	330,000

(13) Consolidated Statements of Cash Flows - Supplemental Disclosures

The Corporation's non-cash investing and financing activity and cash payments for interest as of or for the years ended December 31 were approximately as follows:

		2018	2017
Capital lease obligations issued for property and equipment	$	7,109,000	840,000
Cash paid for interest		2,523,000	2,831,000
Property and equipment acquisitions included in accounts payable		4,619,000	3,508,000

(Continued)

(14) Functional Expenses

The Corporation provides general healthcare services to residents of the Mohawk Valley Region. Expenses related to providing these services are as follows for the years ended December 31:

	2018			
	Healthcare services	General and administrative	Fundraising	Total
Salaries and wages	$ 241,092,166	27,607,589	-	268,699,755
Employee benefits	43,731,828	6,793,188	-	50,525,016
Supplies and other	193,122,005	24,349,703	89,377	217,561,085
Depreciation and amortization	14,913,515	8,719,944	-	23,633,459
Interest	1,089,694	1,416,605	-	2,506,299
New York State gross receipts taxes	1,836,239	647,525	-	2,483,764
Total expenses	$ 495,785,447	69,534,554	89,377	565,409,378

	2017			
	Healthcare services	General and administrative	Fundraising	Total
Total expenses	$ 488,762,242	60,863,886	67,559	549,693,687

The consolidated financial statements report certain categories of expenses that are attributable to more than one functional expense category. Therefore, these expenses require allocation on a reasonable basis that is consistently applied. The expenses that are allocated include depreciation and amortization on a combination of square footage utilized and moveable equipment utilized, as well as employee benefits which are allocated based on salary expense.

(15) Fair Value of Financial Instruments

The Fair Value Measurement Topic of the FASB Accounting Standards Codification requires disclosures that categorize assets and liabilities measured at fair value based on a fair value hierarchy. The hierarchy prioritizes the inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels which is determined by the lowest level input that is significant to the fair value measurement in its entirety.

(Continued)

(15) Fair Value of Financial Instruments, Continued

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

Cash and Cash Equivalents: The amount reported on the consolidated balance sheets for cash and cash equivalents approximates fair value and money market funds are valued at the net asset value (NAV) reported by the financial institutions.

Certificates of Deposit: consists of fixed-maturity certificates of deposit that are valued based on discounted future cash flows using the rates currently offered for deposits of similar remaining maturities.

Mutual Funds, Exchange Traded Funds, Commercial Paper and Common Stock: The fair values, which are the amounts reported on the consolidated balance sheets, are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

Pooled Investment Funds: Fair values are based on NAV per share as determined by the fund's investment manager or general partner.

U.S. Government and Agency Debt Securities, Domestic Corporate Bonds and Municipal Bonds: Consists of the Corporation's directly owned securities and the Corporation's investment in securities that are issued by the U.S. government or publicly owned government-sponsored enterprises. Securities owned directly by the Corporation and securities issued by the U.S. government or publicly owned government-sponsored enterprises are valued based on quoted market prices or dealer quotes where available (Level 1 measurements). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings, and maturities, rather than on specific bids and offers for the designated security.

Estimated Third-Party Payor Settlements: The amount reported on the consolidated balance sheets for estimated third-party payor settlements approximates its fair value.

Long-Term Debt: The fair value of fixed rate issues was determined by price quotes from a financial institution or estimated using discounted cash flow analysis, based on the current incremental borrowing rate of similar types of borrowing arrangements (considered a Level 2 input). The fair value of variable rate debt approximates its reported value on the consolidated balance sheets. Fixed rate long-term debt is the only financial instrument with a difference between recorded and fair value. The recorded value of fixed rate long-term debt on the consolidated balance sheets at December 31, 2018 and 2017 approximates its fair value.

(Continued)

(15) Fair Value of Financial Instruments, Continued

The following tables present information about assets and liabilities that are measured at fair value on a recurring basis as of December 31 and indicate the fair value hierarchy of the valuation techniques utilized to determine such fair value. In general, fair values determined by Level 1 inputs utilize quoted prices in active markets for identical assets or liabilities. The Corporation considers a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

		Fair value measurements at December 31, 2018		
	Total	Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 1,164,699	1,164,699	-	-
Assets limited as to use:				
Cash and cash equivalents	1,269,058	1,269,058	-	-
Common stock	1,177,198	1,177,198	-	-
Mutual funds	535,918	535,918	-	-
Domestic corporate bonds	188,279	188,279	-	-
Government agency obligations	19,163	-	19,163	-
Investments:				
Cash and cash equivalents	964,802	964,802	-	-
Common stock	2,780,235	2,780,235	-	-
Exchange traded funds	1,041,468	1,041,468	-	-
Mutual funds	73,922,930	73,922,930	-	-
Pooled investment funds:				
Hedge funds	5,133,976	-	-	-
Real estate funds	4,945,414	-	-	-
Bond funds	5,201,275	-	-	-
Foreign equity funds	9,876,162	-	-	-
Domestic corporate bonds	3,805,937	-	3,805,937	-
Government and agency obligations	12,356	-	12,356	-
Beneficial interest in charitable trusts	69,181	-	-	69,181
Total assets at fair value	$ 112,108,051	83,044,587	3,837,456	69,181
Liabilities:				
Interest rate swaps	$ 2,761,464	-	2,761,464	-

(Continued)

(15) Fair Value of Financial Instruments, Continued

	Total	Fair value measurements at December 31, 2017 Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 4,524,405	4,524,405	-	-
Assets limited as to use:				
Cash and cash equivalents	1,507,908	1,507,908	-	-
Commercial paper	2,487,357	2,487,357	-	-
Common stock	1,053,293	1,053,293	-	-
Exchange traded funds	253,955	253,955	-	-
Mutual funds	813,373	813,373	-	-
Government and agency obligations	31,157	-	31,157	-
Investments:				
Cash and cash equivalents	618,146	618,146	-	-
Certificates of deposit	19,994	-	19,994	-
Common stock	3,331,205	3,331,205	-	-
Exchange traded funds	601,122	601,122	-	-
Mutual funds	71,043,196	71,043,196	-	-
Pooled investment funds:				
Hedge funds	5,699,750	-	-	-
Real estate funds	5,541,039	-	-	-
Bond funds	4,931,910	-	-	-
Foreign equity funds	12,119,194	-	-	-
Domestic corporate bonds	1,911,874	-	1,911,874	-
Government and agency obligations	320,510	-	320,510	-
Beneficial interest in charitable trusts	72,219	-	-	72,219
Total assets at fair value	$ 116,881,607	86,233,960	2,283,535	72,219
Liabilities:				
Interest rate swaps	$ 3,404,875	-	3,404,875	-

(Continued)

(15) Fair Value of Financial Instruments, Continued

The following is a summary of the investments whose NAV approximates fair value and the related redemption restrictions associated with each major category at December 31:

	2018		
Pooled investment funds	Total fair value	Redemption frequency	Redemption notice periods
Hedge funds	$ 5,133,976	Monthly	90 days
Real estate funds	4,945,414	Monthly	None
Bond funds	5,201,275	Monthly	10 days
Foreign equity funds	9,876,162	Monthly	10 days
	$ 25,156,827		

	2017		
Pooled investment funds	Total fair value	Redemption frequency	Redemption notice periods
Hedge funds	$ 5,699,750	Monthly	90 days
Real estate funds	5,541,039	Monthly	None
Bond funds	4,931,910	Monthly	10 days
Foreign equity funds	12,119,194	Monthly	10 days
	$ 28,291,893		

Hedge Funds

Hedge fund strategies involve funds with investment managers who have the authority to invest in various asset classes at their discretion and who have the ability to employ multiple investments strategies within their respective portfolios. Investment strategies may include the following categories: merger arbitrage, distressed, long/short credit, fixed income arbitrage and convertible arbitrage. These funds attempt to reduce individual manager risk by allocating capital among multiple investment managers. Funds with hedged strategies generally hold securities or other financial instruments for which a ready market exists and may include stocks, bonds, put or call options, swaps, currency hedges, and other instruments, and are valued accordingly.

(Continued)

(15) Fair Value of Financial Instruments, Continued

Real Estate Funds

Real estate funds hold interests in publicly traded equity securities issued by real estate investment trusts ("REIT"), private real estate partnerships, and privately held REIT's. Strategies of these funds often require the estimation of fair values by the fund managers in the absence of readily determinable market values. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed, and the differences could be material. Such valuations are determined by fund managers and generally consider variables such as operating results, comparable earnings multiples, projected cash flows, recent sales prices, and other pertinent information, and may reflect discounts for the illiquid nature of certain investments held. Moreover, the fair values of the Corporation's interests in shares or units of these funds, because of the liquidity and capital commitment terms that vary depending on the specific fund or partnership agreement, may differ from the fair value of the funds' underlying net assets.

Bond Funds

Bond funds are invested in a globally diversified portfolio of primarily debt and debt-like securities. The funds are controlled by an investment manager. The investment manager generally will acquire positions in debt securities and currencies that are rated investment grade by Standard & Poor's Credit Market Services, or if unrated, an equivalent rating determined by the investment manager at its sole discretion.

Foreign Equity Funds

Foreign equity funds are invested in a diversified portfolio of equity securities of companies ordinarily located in any country other than the United States and Canada. The funds are controlled by an investment manager.

Various assets and liabilities are not required to be measured at fair value on a recurring basis. The carrying value of all remaining financial assets and liabilities not required to be measured at fair value on a recurring basis approximate fair value at December 31, 2018 and 2017.

Schedule 1

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Balance Sheet

December 31, 2018
with comparative consolidated totals for 2017

	Faxton-St. Luke's Healthcare	St. Elizabeth Medical Center and Affiliate	St. Luke's Home Residential Health Care Facility, Inc.	Mohawk Valley Health System Foundation	Senior Network Health, LLC	Visiting Nurse Association of Utica and Oneida County, Inc.	Mohawk Valley Health System	Mohawk Valley Home Care, LLC	Eliminations	Consolidated	Consolidated 2017
$	6,267,666	8,865,283	947,125	431,952	5,505,692	365,764	2,889,353	-	-	25,272,835	21,959,220
	-	-	-	-	1,101,612	-	-	-	-	1,101,612	590,222
	84,132,841	12,938,367	-	3,858,321	1,830,042	-	-	-	-	102,759,571	101,778,128
	37,676,435	22,054,067	3,304,535	-	111,569	492,865	-	-	-	63,639,471	64,527,574
	8,171,804	3,990,017	-	85,378	63,843	-	1,092,972	2,623	-	13,406,637	11,969,951
	6,513,672	6,582,114	98,610	-	-	-	-	3,463	-	13,197,859	12,680,327
	2,751,059	1,326,981	233,293	127,120	-	23,398	-	-	-	4,461,851	4,433,079
	7,896,009	-	212,704	13,106	-	302,559	11,833	-	(7,910,996)	525,215	330,248
	153,409,486	55,756,829	4,796,267	4,515,877	8,612,758	1,184,586	3,994,158	6,086	(7,910,996)	224,365,051	218,268,749
	2,969,767	-	-	-	-	-	-	-	(2,969,767)	-	-
	-	-	-	-	-	-	5,733,151	-	(5,733,151)	-	-
	-	-	3,917,233	-	-	-	-	-	(3,917,233)	-	-
	-	1,026,788	-	1,452,536	-	5,500	-	-	-	2,484,824	5,388,469
	4,528,164	-	-	-	-	-	-	-	-	4,528,164	4,528,164
	67,542,143	60,147,141	12,730,343	933,981	141,679	179,941	15,912,340	4,789	-	157,592,357	150,039,058
	22,241,166	1,460,315	949,179	69,181	40,179	-	270,000	24,565	-	25,054,585	29,271,766
$	250,690,726	118,391,073	22,393,022	6,971,575	8,794,616	1,370,027	25,909,649	35,440	(20,531,147)	414,024,981	407,496,206

(Continued)

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Balance Sheets, Continued

December 31, 2018
with comparative consolidated totals for 2017

	Faxton-St. Luke's Healthcare	St. Elizabeth Medical Center and Affiliate	St. Luke's Home Residential Health Care Facility, Inc.	Mohawk Valley Health System Foundation	Senior Network Health, LLC	Visiting Nurse Association of Utica and Oneida County, Inc.	Mohawk Valley Health System	Mohawk Valley Home Care, LLC	Eliminations	Consolidated	Consolidated 2017
$	2,264,308	2,061,318	-	-	-	-	-	-	-	4,325,626	4,927,527
	1,942,312	635,267	-	-	-	-	-	-	-	2,577,579	3,025,798
	18,287,751	16,103,250	575,068	47,243	1,696,448	70,600	2,777,991	33,977	146	39,592,474	39,570,037
	13,976,849	8,468,765	654,932	-	129,082	463,029	-		-	23,692,657	22,610,695
es	3,047,285	1,402,439	1,056,800	-	203,132	465,800	-	25,300	-	6,200,756	7,292,215
	(361,266)	2,811,125	1,889,765	-	795,051	8,123	-	-	-	5,142,798	4,037,874
	-	6,452,704	-	614,052	114,698	-	621,395	16,775	(7,819,624)	-	-
	4,821,523	1,472,780	183,961	10,167	-	-	-	2,623	-	6,491,054	6,492,640
	43,978,762	39,407,648	4,360,526	671,462	2,938,411	1,007,552	3,399,386	78,675	(7,819,478)	88,022,944	87,956,786
	3,032,547	21,044,151	-	-	-	-	11,184,879	-	-	35,261,577	3,520,112
	12,735,615	-	-	-	-	-	-	-	-	12,735,615	36,188,799
	4,559,399	2,926,680	-	-	-	-	-	-	-	7,486,079	3,912,426
on	20,327,561	23,970,831	-	-	-	-	11,184,879	-	-	55,483,271	43,621,337
	-	47,940,922	-	-	-	-	-	-	-	47,940,922	49,248,716
	1,058,928	-	-	-	-	5,939,823	-	-	(6,998,751)	-	-
	34,619,093	832,421	1,131,979	-	40,179	35,886	-	24,565	-	36,684,123	39,881,629
rtion	6,639,022	4,518,369	60,856	-	15,075	-	-	-	-	11,233,322	11,332,704
	106,623,366	116,670,191	5,553,361	671,462	2,993,665	6,983,261	14,584,265	103,240	(14,818,229)	239,364,582	232,041,172
	136,538,230	273,138	16,839,661	2,266,563	5,800,951	(5,618,734)	5,337,912	(67,800)	(2,743,151)	158,626,770	165,230,990
	7,529,130	1,447,744	-	4,033,550	-	5,500	5,987,472	-	(2,969,767)	16,033,629	10,224,044
	144,067,360	1,720,882	16,839,661	6,300,113	5,800,951	(5,613,234)	11,325,384	(67,800)	(5,712,918)	174,660,399	175,455,034
$	250,690,726	118,391,073	22,393,022	6,971,575	8,794,616	1,370,027	25,909,649	35,440	(20,531,147)	414,024,981	407,496,206

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Statements of Operations and Changes in Net Assets (Deficit)

Year ended December 31, 2018
with comparative consolidated totals for 2017

	Faxton-St. Luke's Healthcare	St. Elizabeth Medical Center and Affiliate	St. Luke's Home Residential Health Care Facility, Inc.	Mohawk Valley Health System Foundation	Senior Network Health, LLC	Visiting Nurse Association of Utica and Oneida County, Inc.	Mohawk Valley Health System	Mohawk Valley Home Care, LLC	Eliminations	Consolidated	Consolidated 2017
estrictions:											
	$ 278,838,298	204,691,870	18,933,674	-	261,880	5,619,559	-	-	(4,021,134)	504,324,147	515,671,178
	-	-	-	-	-	-	-	-	-	-	(15,113,615)
on	278,838,298	204,691,870	18,933,674	-	261,880	5,619,559	-	-	(4,021,134)	504,324,147	500,557,563
	-	-	-	-	20,832,327	-	-	-	-	20,832,327	17,905,012
	23,123,164	8,970,566	2,045,061	-	202,367	122,327	565,511	-	(2,958,857)	32,070,139	27,052,852
	-	13,000	-	1,144,957	-	-	-	-	-	1,157,957	724,888
t	301,961,462	213,675,436	20,978,735	1,144,957	21,296,574	5,741,886	565,511	-	(6,979,991)	558,384,570	546,240,315
	146,046,454	104,336,587	11,385,824	391,984	1,920,628	4,517,498	-	-	100,780	268,699,755	265,641,318
	25,558,020	20,476,188	3,013,244	49,320	428,447	999,797	-	-	-	50,525,016	48,858,112
	118,389,555	81,318,343	4,359,284	1,185,383	18,247,677	373,281	207,263	-	(6,519,701)	217,561,085	203,919,047
	13,003,039	9,078,120	1,431,256	418	72,698	47,928	-	-	-	23,633,459	25,826,762
	1,257,146	1,249,153	-	-	-	-	-	-	-	2,506,299	2,975,131
	1,092,389	647,525	743,850	-	-	-	-	-	-	2,483,764	2,473,317
	305,346,603	217,105,916	20,933,458	1,627,105	20,669,450	5,938,504	207,263	-	(6,418,921)	565,409,378	549,693,687
	(3,385,141)	(3,430,480)	45,277	(482,148)	627,124	(196,618)	358,248	-	(561,070)	(7,024,808)	(3,453,372)
	(607,218)	91,100	-	78,439	-	-	-	-	-	(437,679)	241,879
	8,412,012	4,894,550	364,757	172,702	-	-	-	-	-	13,844,021	3,254,885
	7,804,794	4,985,650	364,757	251,141	-	-	-	-	-	13,406,342	3,496,764
penses	$ 4,419,653	1,555,170	410,034	(231,007)	627,124	(196,618)	358,248	-	(561,070)	6,381,534	43,392

(Continued)

MOHAWK VALLEY HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Statements of Operations and Changes in Net Assets (Deficit), Continued

Year ended December 31, 2018
with comparative consolidated totals for 2017

	Faxton-St. Luke's Healthcare	St. Elizabeth Medical Center and Affiliate	St. Luke's Home Residential Health Care Facility, Inc.	Mohawk Valley Health System Foundation	Senior Network Health, LLC	Visiting Nurse Association of Utica and Oneida County, Inc.	Mohawk Valley Health System	Mohawk Valley Home Care, LLC	Eliminations	Consolidated	Consolidated 2017
ctions:											
$	4,419,653	1,555,170	410,034	(231,007)	627,124	(196,618)	358,248	-	(561,070)	6,381,534	43,392
	643,411	-	-	-	-	-	-	-	-	643,411	561,675
	(9,662,567)	(1,284,253)	-	(449,141)	(66,054)	-	-	-	-	(11,462,015)	11,481,137
	354,953	-	-	-	-	-	-	-	-	354,953	-
	-	21,877	-	-	-	-	-	-	-	21,877	(3,608,969)
	-	(2,749,083)	-	-	-	-	-	-	-	(2,749,083)	(2,429,633)
	-	205,103	-	-	-	-	-	-	-	205,103	864,779
	(4,244,550)	(2,251,186)	410,034	(680,148)	561,070	(196,618)	358,248	-	(561,070)	(6,604,220)	6,912,381
	-	126,871	-	1,304,700	-	-	-	-	-	1,431,571	1,671,603
estments	-	(70,607)	-	(337,276)	-	-	-	-	-	(407,883)	134,268
	-	(28,582)	-	45,101	-	-	-	-	-	16,519	15,581
ets	-	-	-	-	-	-	-	-	-	-	172,994
le trusts	-	-	-	(3,038)	-	-	-	-	-	(3,038)	(7,109)
ited											
	-	-	-	148,004	-	-	-	-	-	148,004	47,714
	-	-	-	-	-	-	5,987,472	-	-	5,987,472	-
	-	(218,103)	-	(1,144,957)	-	-	-	-	-	(1,363,060)	(1,589,667)
	(20,358)	-	-	-	-	-	-	-	20,358	-	-
ons	(20,358)	(190,421)	-	12,534	-	-	5,987,472	-	20,358	5,809,585	445,384
	(4,264,908)	(2,441,607)	410,034	(667,614)	561,070	(196,618)	6,345,720	-	(540,712)	(794,635)	7,357,765
	148,332,268	4,162,489	16,429,627	6,967,727	5,239,881	(5,416,616)	4,979,664	(67,800)	(5,172,206)	175,455,034	168,097,269
$	144,067,360	1,720,882	16,839,661	6,300,113	5,800,951	(5,613,234)	11,325,384	(67,800)	(5,712,918)	174,660,399	175,455,034

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