ORANGE REGIONAL MEDICAL CENTER

Consolidated Financial Statements

December 31, 2017 and 2016

(With Independent Auditors' Report Thereon)

ORANGE REGIONAL MEDICAL CENTER

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KPMG LLP
345 Park Avenue
New York, NY 10154-0102

Independent Auditors' Report

The Board of Directors
Orange Regional Medical Center:

We have audited the accompanying consolidated financial statements of Orange Regional Medical Center, which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Orange Regional Medical Center as of December 31, 2017 and 2016, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

New York, New York
May 25, 2018

ORANGE REGIONAL MEDICAL CENTER

Consolidated Balance Sheets

December 31, 2017 and 2016

(In thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	47,483	26,093
Patient accounts receivable, less allowance for doubtful accounts of $75,586 in 2017 and $78,649 in 2016		52,017	51,003
Investments		—	48,059
Inventories		9,965	10,039
Assets limited or restricted as to use		9,477	11,760
Due from third-party payors		6,912	3,494
Other current assets		11,824	9,326
Total current assets		137,678	159,774
Long-term investments		79,243	27,202
Assets limited or restricted as to use, net of current portion		20,137	28,017
Interest in net assets of Orange Regional Medical Center Foundation, Inc., net		7,281	7,196
Due from third-party payors, net of current portion		2,899	5,005
Estimated malpractice insurance receivable		13,558	20,689
Other assets, net		9,405	9,097
Property and equipment, net		303,291	320,737
Total assets	$	573,492	577,717
Liabilities and Net Assets			
Current liabilities:			
Current installments of long-term debt and capital lease obligations	$	10,852	7,714
Accounts payable and accrued expenses		66,085	60,070
Estimated malpractice liabilities		4,498	—
Current portion of estimated third-party payor settlements		11,119	832
Total current liabilities		92,554	68,616
Long-term debt and capital lease obligations, net of current installments		303,404	293,646
Estimated third-party payor liabilities, net of current portion		11,652	23,057
Estimated malpractice liabilities, net of current portion		17,351	24,387
Accrued retirement benefits, net of current portion		46,602	53,805
Other liabilities		12,483	10,869
Total liabilities		484,046	474,380
Commitments and contingencies			
Net assets:			
Unrestricted		79,690	93,669
Temporarily restricted		7,498	7,674
Permanently restricted		2,258	1,994
Total net assets		89,446	103,337
Total liabilities and net assets	$	573,492	577,717

See accompanying notes to consolidated financial statements.

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Consolidated Statements of Operations

Years ended December 31, 2017 and 2016

(In thousands)

	2017	2016
Operating revenue:		
Net patient service revenue	$ 486,910	458,071
Less provision for doubtful accounts	(19,578)	(13,809)
Net patient service revenue, less provision for doubtful accounts	467,332	444,262
Other revenue	6,923	4,811
Net assets released from restrictions used for operations	11	7
Total operating revenue	474,266	449,080
Operating expenses:		
Salaries and wages	173,229	162,793
Employee benefits	66,539	67,670
Supplies	91,719	81,132
Purchased services	58,465	51,728
Insurance	5,041	5,432
Interest	14,525	16,166
Depreciation and amortization	26,929	26,359
Other	32,794	36,399
Total operating expenses	469,241	447,679
Income from operations	5,025	1,401
Nonoperating gains (losses):		
Investment income	5,473	2,888
Income from unconsolidated joint ventures	1,046	1,465
Unrestricted contributions	483	745
Loss on extinguishment of debt	(27,347)	—
(Deficiency) excess of revenue and gains over expenses and losses	(15,320)	6,499
Other changes in unrestricted net assets:		
Net assets released from restrictions, used for property and equipment	—	82
Transfer (to) from Greater Hudson Valley Health Systems, Inc., net	(605)	1,955
Contributions for property and equipment	689	1,851
Pension-related changes, other than net periodic pension costs	816	(5,491)
Postretirement-related changes, other than net benefit cost	441	118
(Decrease) increase in unrestricted net assets	$ (13,979)	5,014

See accompanying notes to consolidated financial statements.

ORANGE REGIONAL MEDICAL CENTER

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2017 and 2016

(In thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Net assets at December 31, 2015	$ 88,655	7,118	1,994	97,767
Excess of revenue and gains over expenses and losses	6,499	—	—	6,499
Net assets released from restrictions, used for operations	—	(7)	—	(7)
Net assets released from restrictions used, for property and equipment	82	(82)	—	—
Transfer from Greater Hudson Valley Health System, Inc., net	1,955	—	—	1,955
Contributions for property and equipment	1,851	—	—	1,851
Pension-related changes, other than net periodic pension cost	(5,491)	—	—	(5,491)
Postretirement-related changes other than net periodic benefit cost	118	—	—	118
Change in interest in net assets of Orange Regional Medical Center Foundation, Inc.	—	644	—	644
Investment income, net	—	1	—	1
Total changes in net assets	5,014	556	—	5,570
Net assets at December 31, 2016	93,669	7,674	1,994	103,337
Deficiency of revenue and gains over expenses and losses	(15,320)	—	—	(15,320)
Net assets released from restrictions, used for operations	—	(11)	—	(11)
Transfer to Greater Hudson Valley Health System, Inc., net	(605)	—	—	(605)
Contributions for property and equipment	689	—	—	689
Pension-related changes, other than net periodic pension cost	816	—	—	816
Postretirement-related changes, other than net periodic benefit cost	441	—	—	441
Change in interest in net assets of Orange Regional Medical Center Foundation, Inc.	—	(179)	264	85
Contributions and investment income, net	—	14	—	14
Total changes in net assets	(13,979)	(176)	264	(13,891)
Net assets at December 31, 2017	$ 79,690	7,498	2,258	89,446

See accompanying notes to consolidated financial statements.

ORANGE REGIONAL MEDICAL CENTER

Consolidated Statements of Cash Flows

Years ended December 31, 2017 and 2016

(In thousands)

	2017	2016
Cash flows from operating activities:		
Changes in net assets	$ (13,891)	5,570
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Depreciation and amortization	26,929	26,359
Loss on extinguishment of debt	27,347	—
Amortization of deferred financing fees	400	497
Amortization of deferred revenue	—	(628)
Contributions for property and equipment	(689)	(1,851)
Contributions and restricted income, net	(14)	(1)
Provision for doubtful accounts, net of recoveries	19,578	13,809
Loss on sale of property and equipment	—	447
Net realized and unrealized gains on investments	(3,457)	(1,037)
Transfer to (from) Greater Hudson Valley Health System, Inc., net	605	(1,955)
Change in interest in net assets of Orange Regional Medical Center Foundation, Inc.	(85)	(644)
Pension-related changes, other than net periodic pension cost	(816)	5,491
Postretirement-related changes, other than net periodic benefit cost	(441)	(118)
Changes in operating assets and liabilities:		
Patient accounts receivable	(20,592)	(24,956)
Other current assets and inventories	(2,424)	3,127
Due from third-party payors	(1,312)	(2,969)
Insurance receivable	7,131	(2,147)
Other assets, net	(308)	(1,501)
Accounts payable and accrued expenses	11,498	525
Estimated third-party payor settlements	(1,118)	(2,617)
Other liabilities	1,614	1,300
Estimated malpractice liabilities	(2,538)	2,494
Accrued retirement benefits	(5,946)	(4,502)
Net cash provided by operating activities	41,471	14,693
Cash flows from investing activities:		
Purchase of property and equipment	(9,483)	(22,558)
Cash paid for capital expenditures related to construction project	(5,483)	(45,682)
Purchases of investments and assets limited or restricted as to use	(234,427)	(243,494)
Sales of investments and assets limited or restricted as to use	244,065	283,473
Net cash used in investing activities	(5,328)	(28,261)
Cash flows from financing activities:		
Payment of long-term debt and capital lease obligations	(265,100)	(7,226)
Proceeds from long-term debt	253,825	—
Payment of debt issuance costs	(3,576)	—
Transfer (to) from Greater Hudson Valley Health System, Inc.	(605)	1,955
Contributions for property and equipment	689	1,851
Contributions and restricted income, net	14	1
Net cash used in financing activities	(14,753)	(3,419)
Net increase (decrease) in cash and cash equivalents	21,390	(16,987)
Cash and cash equivalents at beginning of year	26,093	43,080
Cash and cash equivalents at end of year	$ 47,483	26,093
Supplemental cash flow information:		
Cash paid during the year for interest, including capitalized interest	$ 12,194	18,262
Capital lease obligations incurred	—	7,500
Capital expenditures related to construction project included in accounts payable and accrued expenses	—	5,483

See accompanying notes to consolidated financial statements.

(1) Organization

Orange Regional Medical Center (ORMC or the Hospital) is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal and state income taxes and other related income pursuant to Section 501(a) of the Code. ORMC is a 383-bed facility located in the town of Wallkill, New York and provides acute, psychiatric, and rehabilitative inpatient services, as well as ambulatory surgery, emergency care, and other outpatient services for residents of Orange County, New York, and surrounding areas.

The Greater Hudson Valley Health System, Inc. (GHVHS) is the parent of ORMC. During February 2010, GHVHS became the active parent of Catskill Regional Medical Center (Catskill Regional). Catskill Regional is located in Sullivan County and is licensed for a total of 181 beds maintained on two campuses in Harris, New York and Callicoon, New York. GHVHS has the same legal authority over, and responsibilities to, both ORMC and Catskill Regional. ORMC and Catskill Regional maintain independent financial operations and neither are liable for the other's obligations.

GHVHS is also the parent of the GHVHS Medical Group, P.C. (the PC), a not-for-profit corporation, which was formed in October 2013 for the purpose of engaging in the profession of medicine. The practice began operations in December 2014.

The Hospital is affiliated with Orange Regional Medical Center Foundation, Inc. (the Foundation) whose purpose is to raise funds for the Hospital and the health and welfare of the community. During October 2017, GHVHS became the sole corporate member of the Foundation.

(2) Summary of Significant Accounting Policies

(a) Basis of Accounting

The consolidated financial statements have been prepared on the accrual basis of accounting and include the activities of the Hospital. East Main Street Management Corporation, The Alpha Network, Inc., and Synera Corporation are all dormant corporations and therefore have no activities in the consolidated financial statements. All significant intercompany balances and transactions have been eliminated in preparation of the consolidated financial statements.

(b) Cash and Cash Equivalents

Cash and cash equivalents include certain highly liquid investments with original maturities of three months or less at the date of purchase. At December 31, 2017 and 2016, the Hospital had cash balances in financial institutions that exceeded federal depository insurance limits. The Hospital routinely invests its surplus operating funds in money market funds. These funds generally invest in highly liquid U.S. government and agency obligations. Investments in money market funds are not insured or guaranteed by the U.S. government.

(c) Investments and Assets Limited or Restricted as to Use

The Hospital classifies its debt and equity securities included in investments and assets limited or restricted as to use as trading securities. These investments are measured at fair value in the accompanying consolidated balance sheets.

Investment income (loss), net (including realized gains and losses on investments, interest, dividends, and unrealized gains and losses on trading investments) is included in (deficiency) excess of unrestricted revenue, gains, and other support over expenses unless the income or loss is restricted by donor or law.

The equity method of accounting is used for joint venture investments, included in other assets, net, in which the Hospital has significant influence but does not have control.

Assets limited or restricted as to use primarily include assets held by trustees under indenture agreements, and assets associated with the donor-restricted net assets.

(d) Patient Accounts Receivable and Net Patient Service Revenue

ORMC has agreements with third-party payors that provide for payment at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Management regularly reviews accounts and contracts and provides appropriate contractual allowances and discounts that are netted against patient accounts receivable in the consolidated balance sheets.

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, ORMC analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for doubtful accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, ORMC analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for doubtful accounts, if necessary (e.g., for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with uninsured patients, management records a significant provision for doubtful accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

ORMC wrote off approximately $22,700 and $6,200 for the years ended December 31, 2017 and 2016, respectively, of which a significant portion relate to uninsured patients.

(Dollars in thousands)

ORMC recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, ORMC recognizes revenue based on a discounted rate per the self-pay discount policy. On the basis of historical experience, a significant portion of ORMC's uninsured patients will be unable or unwilling to pay for the services provided. Thus, ORMC records a significant provision for doubtful accounts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances, and discounts (but before the provision for doubtful accounts) by primary payor, recognized in the period from these major payor sources, for the years ended December 31, 2017 and 2016 is as follows:

	December 31	
	2017	**2016**
Patient service revenue (net of contractual allowances and discounts):		
Medicare	$ 182,288	172,391
Medicaid	68,226	63,106
Managed care and other insurance	219,018	207,870
Uninsured patients	17,378	14,704
Total all payors	$ 486,910	458,071

The following table reflects the estimated percentages of patient service revenue by primary payor, net of provision for doubtful accounts, for the years ended December 31, 2017 and 2016:

	December 31	
	2017	**2016**
Medicare	39%	38%
Medicaid	14	14
Managed care and other insurance	46	46
Uninsured and other fee for service	1	2
	100%	100%

The following table reflects the estimated percentages of patient service revenue by inpatient and outpatient services for the years ended December 31, 2017 and 2016:

	December 31	
	2017	**2016**
Inpatient services	68%	69%
Outpatient services	32	31
	100%	100%

(Continued)

(Dollars in thousands)

Net operating revenue is recognized in the period services are performed and consists primarily of net patient service revenue that is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered, and adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

(e) Concentration of Credit Risk

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of patient accounts receivables, net of contractual allowances, by primary payor at December 31 is as follows:

	2017	2016
Medicare	34%	30%
Medicaid	14	15
Managed care and other insurance	45	45
Uninsured and other fee for service	7	10
	100%	100%

(f) Charity Care

ORMC provides charity care to patients who meet certain criteria under its charity care policy, to patients who are uninsured and to patients who are underinsured at amounts less than its established rates. Because ORMC does not pursue collection for patients who qualify, these amounts are not reported as revenue. The calculation of the cost of these services is done utilizing the ratio of patient care cost to charges based upon the prior year's Form 990 Return of Organization Exempt from Income Taxes, applied to the gross charity related allowances.

The amount of services related to charity care, uninsured, and underinsured, at cost, is $7,537 and $7,049 for the years ended December 31, 2017 and 2016, respectively. For the years ended December 31, 2017 and 2016, ORMC received $3,576 and $974, respectively from the indigent care pool.

(g) Impairment of Long-Lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. When the carrying value of an asset exceeds its estimated recoverability, an asset impairment charge is recognized for the difference between the fair value and carrying value of the asset. No impairment was recorded in 2017 or 2016.

(h) Net Assets

Unrestricted Net Assets – Unrestricted net assets are those whose use is not restricted by donors, even though their use may be limited in other respects, such as by contract, board designation, or under debt agreements.

Temporarily and Permanently Restricted Net Assets – Temporarily restricted net assets are those whose use by ORMC has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

(i) Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give are not recognized until they become unconditional, that is, when the conditions upon which they depend are substantially met. Fair value is estimated giving consideration to anticipated future cash receipts (after allowance is made for uncollectible contributions) and discounting such amounts at a risk-adjusted rate commensurate with the duration of the donor's payment plan. These inputs to the fair value estimate are considered Level 3 in the fair value hierarchy. The contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying consolidated statements of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

(j) Property and Equipment

Property and equipment (including equipment acquired under capital lease obligations) are recorded at cost or, if donated, at fair market value at date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the accompanying consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Estimated useful lives of the assets are as follows:

Land improvements	5 to 20 years
Buildings and building improvements	15 to 40 years
Equipment	5 to 15 years

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support, and are included in other changes in unrestricted net assets, unless explicit donor stipulations specify how the donated assets 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 support. Cash gifts restricted for investment in long-lived assets are released from restriction when the asset is placed in service or as costs are incurred for asset construction.

The Hospital's policy is to capitalize interest cost incurred on debt during the construction of major projects. Total interest costs capitalized for the year ended December 31, 2016 was $2,557. No interest costs were capitalized for the year ended December 31, 2017.

(k) Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market (net realizable value).

(l) Use of Estimates

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

(m) (Deficiency) Excess of Revenue and Gains over Expenses and Losses

The consolidated statements of operations include (deficiency) excess of revenue and gains over expenses and losses. Changes in unrestricted net assets that are excluded from (deficiency) excess of revenue and gains over expenses and losses, consistent with industry practice, include pension and postretirement – related changes other than net periodic pension or benefit cost, net assets released from restrictions for property and equipment, contributions for property and equipment, and equity transfer of assets to/from related parties.

(n) Operating and Nonoperating Activities

ORMC's primary mission is to meet the healthcare needs in its market area through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities, which are peripheral to ORMC's primary mission, are considered to be nonoperating. Nonoperating activities include investment income, income attributable to unconsolidated joint ventures, unrestricted contributions, and loss on extinguishment of debt.

(o) Estimated Malpractice, Workers' Compensation Costs, and Health Insurance Costs

The provision for estimated medical malpractice, workers' compensation, and health insurance claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported (IBNR).

(p) Deferred Financing Fees

Deferred financing fees are reported as an offset to long-term debt in the accompanying consolidated balance sheets which, represent costs incurred in connection with the issuance of the Orange Regional Medical Center Obligated Group Revenue Bonds, Series 2008, Series 2015 and Series 2017, and are amortized based on the effective-interest method over the lives of the bonds.

(q) Other Revenue

Other operating revenue, reported as part of total operating revenue, includes cafeteria and coffee shop revenue, rent and allocated overhead charged to the physician practice, consulting and administrative services revenue for services provided to Catskill Regional, rental revenue, grants for operations, and other miscellaneous revenue items.

(r) Income Taxes

The Hospital and Synera, a dormant corporation, have been determined by the Internal Revenue Service to be organizations described in Internal Revenue Code (the Code) Section 501(c)(3) and 501(c)(2), respectively; therefore, are generally exempt from federal income.

East Main Street Management Corporation and The Alpha Network, Inc. are dormant taxable corporations. No provision for income taxes has been recorded.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount that is greater than 50% likely to be realized upon settlement. Changes in recognition or in measurement are reflected in the period in which the change in judgment occurs. The Corporation did not recognize the effect of any income tax positions in either 2017 or 2016.

H.R.1, originally known as the Tax Cuts and Jobs Act (the Act), was signed into law on December 22, 2017. The Act contains various provisions affecting not-for-profit entities. Tax-exempt entities are impacted in part by the inclusion of a new excise tax on excess compensation for covered employees and changes to unrelated business income. The Act's provisions may also impact donor incentives for charitable giving. ORMC's preliminary assessment is that there is no impact on the financial statements as of December 31, 2017, but management is currently assessing the overall impact of the Act and its impact on the financial statements, including the impact on 2018.

(s) Reclassifications

Certain amounts in the 2016 consolidated financial statements have been reclassified to conform to the current year presentation. Within the consolidated statement of operations, investment income, income from unconsolidated joint ventures and unrestricted contributions are shown as nonoperating, while grants for operations is reflected as part of other operating revenue. This change has been applied retrospectively and resulted in a reduction of income from operations for the year ended December 31, 2016 of $4,312. Management believes this presentation better represents income from hospital operations and is more useful to the users of the consolidated financial statements.

(t) Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers*, which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition criteria, including guidance specific to the healthcare industry. ASU 2014-09 requires an entity to recognize revenue to depict the transfer of promised goods or services to customer in an amount that reflects consideration to which the entity expects to be entitled for those goods or services. This ASU provides entities the option of applying a full or modified retrospective approach upon adoption. ASU 2014-09 is effective for ORMC for fiscal years beginning after December 15, 2017. ORMC plans to adopt ASU 2014-09 under the cumulative effect method in 2018.

In January 2016, the FASB issued ASU 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU 2016-01 makes targeted improvements to the accounting for, and presentation and disclosure of, financial instruments. ASU 2016-01 requires that most equity instruments be measured at fair value, with subsequent changes in fair value recognized in net income. ASU 2016-01 does not affect the accounting for investments that would otherwise be consolidated or accounted for under the equity method. The new standard also impacts financial liabilities under the fair value option. This ASU is effective for ORMC for fiscal years beginning after December 15, 2018. Early adoption is permitted and ORMC has adopted the fair value disclosure component of this standard as of January 1, 2017, the effect of which was to eliminate the disclosures of the fair value of its debt instruments. ORMC expects to adopt the remaining provisions on January 1, 2019.

In February 2016, the FASB issued ASU No. 2016-02, *Leases*, which supersedes FASB ASC Topic 840, *Leases*, and requires lessees to recognize most leases on the balance sheet via a right-of-use assets and a lease liability, and additional qualitative and quantitative disclosures. Leases will be classified as either finance or operating leases, which will impact the expense recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. The ASU is effective for ORMC for fiscal years beginning after December 15, 2018, with early adoption permitted, and mandates a modified transition period. ORMC is evaluating the impact of ASU 2016-02 on the consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities: Presentation of Financial Statements of Not-for-Profit Entities*. ASU 2016-14 changes how Not-for-Profit entities report net asset classes, expenses, and liquidity in their financial statements. The guidance is effective for fiscal years beginning after December 15, 2017. ORMC is evaluating the impact of ASU 2016-14 on the consolidated financial statements.

In March 2017, the FASB issued ASU No. 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. ASU 2017-07 is intended to improve the presentation of net periodic pension and postretirement benefit costs by requiring that, among other things, the service cost component be reported in the same line item as other compensation costs arising from services rendered by the pertinent employees during the period. Additionally, the other components of net benefit cost are required to be presented in the income statement separately from the service cost component and outside the subtotal of income from operations. Additionally, the service component will be the only component that can be capitalized. This guidance is effective for fiscal years beginning after December 15, 2018. ASU 2017-07 requires retrospective application for the amendments related to the presentation of the service cost component and other components of net benefit costs, and prospective application for the amendments related to the capitalization requirements for the service cost components of net benefit cost. ORMC does not expect the adoption of ASU 2017-07 to have a material impact on the consolidated financial statements.

(Dollars in thousands)

(3) Assets Limited or Restricted as to Use and Investments

The composition of investments and assets limited or restricted as to use as of December 31 is set forth in the following tables:

	2017	2016
Assets limited or restricted as to use:		
By Bond Indenture Agreement (primarily cash and cash equivalents and U.S. government securities):		
Construction fund	$ 237	8,128
Medicaid revenue fund	1,964	2,108
Debt service fund	2,011	2,434
Debt service reserve fund	22,927	24,635
	27,139	37,305
By donor:		
Cash and cash equivalents	523	594
Corporate bonds	—	737
Mutual funds – domestic equities	431	1,141
Mutual funds – foreign equities	826	—
Mutual funds – domestic bonds	695	—
	2,475	2,472
Total assets limited or restricted as to use	29,614	39,777
Less current portion	9,477	11,760
Assets limited or restricted as to use, net of current portion	$ 20,137	28,017

	2017	2016
Investments:		
Mutual funds – domestic equities	$ 9,002	5,081
Mutual funds – foreign equities	7,721	—
Mutual funds – domestic bonds	24,145	—
Equity securities	—	13,043
Corporate bonds	38,127	38,250
Government agencies securities	248	18,887
Total investments	79,243	75,261
Less current portion	—	48,059
Investments, net of current portion	$ 79,243	27,202

(Continued)

(Dollars in thousands)

The Master Trust Indenture (MTI) requires the creation of a Medicaid Revenue Account to receive all Medicaid reimbursement receipts. These funds are to be used to pay all monthly installments on all indebtedness secured by obligations outstanding under the MTI. This balance is reconciled on a monthly basis and any overage or shortage from the required amount is transferred to or from operating funds. The Master Trustee then transfers payment to the holder of each obligation. A debt service reserve fund is maintained with a required balance equal to the greatest amount required in the current year or any future year to pay principal and interest on the bonds. Moneys are deposited in the debt service fund on a monthly basis to meet the principal and interest requirements. Principal and interest as due are withdrawn from the debt service fund for payment to bondholders.

The current portion of assets limited or restricted as to use includes amounts due in 2018 and 2017, respectively, for principal and accrued interest on the ORMC Obligated Group Revenue Bonds, Series 2008, the ORMC Obligated Group Revenue Bonds, Series 2015, and the ORMC Obligated Group Revenue Bonds, Series 2017. The current portion of investments is determined based on the amounts of investments expected to be used during 2018 to fund operating activities.

Investment income (loss), net from investments, assets limited or restricted as to use, and cash equivalents comprise the following for the years ended December 31:

		2017	2016
Investment income (loss), net:			
Interest and dividend income	$	2,016	1,851
Realized gains (losses), net		3,437	(574)
Unrealized gains, net		20	1,611
	$	5,473	2,888

Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The fair value hierarchy requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. There are three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include cash and cash equivalents, equity securities, and certain debt securities that are traded in an active exchange market.

Level 2: Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted market prices that are traded less frequently than exchange-traded instruments. This category generally includes certain U.S. government and agency mortgage-backed debt securities, and corporate debt securities.

(Continued)

(Dollars in thousands)

Level 3: Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. Level 3 assets and liabilities include financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation. This category generally includes certain private debt and equity instruments.

The following tables present the Hospital's fair value measurements for assets measured at fair value on a recurring basis as of December 31, 2017 and 2016:

		December 31, 2017		
	Fair value	Level 1	Level 2
U.S. government obligations and mortgages	$ 2,168	—	2,168
Corporate bonds – domestic	38,127	—	38,127
Mutual funds – domestic equities	9,434	9,434	—
Mutual funds – foreign equities	8,547	8,547	—
Mutual funds – domestic bonds	24,840	24,840	—
Cash and cash equivalents (included in cash and cash equivalents and assets limited or restricted as to use)	73,224	73,224	—
Total	$ 156,340	116,045	40,295

		December 31, 2016		
	Fair value	Level 1	Level 2
Equity securities – domestic	$ 11,460	11,460	—
Equity securities – foreign	1,583	1,583	—
U.S. government obligations and mortgages	3,834	1,402	2,432
Corporate bonds – domestic	55,909	—	55,909
Corporate bonds – foreign	563	—	563
Mutual funds – domestic equities	2,024	2,024	—
Mutual funds – foreign equities	4,198	4,198	—
Cash and cash equivalents (included in cash and cash equivalents and assets limited or restricted as to use)	61,560	61,560	—
Total	$ 141,131	82,227	58,904

At December 31, 2017 and 2016, the Hospital did not have any Level 3 assets or liabilities measured at fair value. There were no significant transfers into or out of Level 1 or Level 2 for the years ended December 31, 2017 and 2016. There are no assets measured at fair value within the charts above at December 31, 2017 and 2016 that are measured based upon net asset value (NAV).

(Dollars in thousands)

(4) Property and Equipment

A summary of property and equipment at December 31 is as follows:

		2017	2016
Land	$	4,897	4,897
Land improvements		17,164	17,108
Buildings and building improvements		204,587	203,233
Equipment		264,629	256,273
Construction in progress		1,383	1,530
		492,660	483,041
Less accumulated depreciation		189,369	162,304
Property and equipment, net	$	303,291	320,737

Equipment under capitalized lease obligations, included in equipment on the table above, as of December 31 is as follows:

		2017	2016
Equipment	$	7,500	7,500
Less accumulated depreciation		1,927	489
	$	5,573	7,011

During 2016, ORMC completed construction of (i) a five-floor outpatient medical office building (MOB) and (ii) a dedicated cancer center that included renovation of existing space and new construction. The building opened on September 26, 2016.

(Dollars in thousands)

(5) Long-Term Debt and Capital Lease Obligations

A summary of long-term debt and capital lease obligations at December 31 is as follows:

	2017	2016
Series 2008 Bonds (a)	$ —	232,784
Series 2015 Bonds (b)	67,532	68,731
Series 2017 Bonds (c)	246,531	—
Lease lines of credit (d)	5,343	6,749
	319,406	308,264
Deferred financing costs, net	(5,150)	(6,904)
	314,256	301,360
Current installments	(10,852)	(7,714)
Long-term debt and capital lease obligations, net of current installments	$ 303,404	293,646

Orange Regional Medical Center maintains an “Obligated Group” for the purposes of issuing debt instruments under a Master Trust Indenture (MTI). ORMC is currently the sole member of the Obligated Group. Under the terms of the MTI, all obligations issued thereunder are joint and several obligations of the member.

(a) On May 7, 2008, Orange Regional Medical Center Obligated Group Revenue Bonds, Series 2008 (Series 2008 Bonds), were issued with a par value of $261,345 and a net original issue discount of $1,239. The issue is composed of serial bonds of $27,840 with maturity dates ranging from December 1, 2011 to 2016, term bonds of $32,170 maturing December 1, 2021, term bonds of $76,960 maturing December 1, 2029, and term bonds of $124,375 maturing December 1, 2037. The Series 2008 Bonds maturing after December 1, 2018 were subject to redemption prior to maturity, at the option of the Hospital and as provided for in the debt agreement. The Series 2008 Bonds were also subject to redemption upon the occurrence of certain events as discussed in the debt agreement.

The Hospital was required to maintain a long-term debt service coverage ratio of 1.25 measured on an annual basis, and a day’s-cash-on-hand ratio of 60 days calculated semiannually, as defined in the debt agreement.

Interest on the Series 2008 Bonds was payable on a semiannual basis beginning December 1, 2008. Principal was payable annually beginning December 1, 2011 in varying amounts from $4,020 in 2011 to $19,035 in 2037. The Series 2008 Bonds were issued with various stated interest rates ranging from 5.50% to 6.50%. The effective interest rate for this issue was 6.53%.

The Series 2008 Bonds were collateralized by the land and buildings that comprise the hospital facility.

The Series 2008 Bonds were advance refunded with the issuance of the Orange Regional Medical Center Obligated Group Revenue Bonds, Series 2017.

(b) On May 13, 2015, Orange Regional Medical Center Obligated Group Revenue Bonds, Series 2015 (Series 2015 Bonds), were issued with a par value of $66,100 and a net original issue premium of $3,960. The issue is composed of serial bonds with values of $1,000 to $2,500 with maturity dates ranging from December 1, 2016 to 2035, term bonds of $14,600 maturing December 1, 2040, and term bonds of $18,600 maturing December 1, 2045. The Series 2015 Bonds maturing after December 1, 2025 are subject to redemption prior to maturity, at the option of the Hospital and as provided for in the debt agreement, on or after June 1, 2025, at 100% of the principal amount plus accrued interest to the date of redemption. The Series 2015 Bonds are also subject to redemption upon the occurrence of certain events as discussed in the debt agreement.

The Hospital is required to maintain a long-term debt service coverage ratio of 1.25 measured on an annual basis, and a day's-cash-on-hand ratio of 60 days calculated semiannually, as defined in the debt agreement. The Series 2015 Bonds are collateralized by the land and buildings that comprise the hospital facility.

Interest on the Series 2015 Bonds is payable on a semiannual basis beginning December 1, 2015. Principal is payable annually beginning December 1, 2016 in varying amounts from $1,000 in 2016 to $18,600 in 2045. The Series 2015 Bonds were issued with various stated interest rates ranging from 4.45% to 5.00%. The effective interest rate for this issue is 4.75%.

(c) On February 28, 2017, Orange Regional Medical Center Obligated Group Revenue Bonds, Series 2017 (Series 2017 Bonds), were issued with a par value of $237,100 and a net original issue premium of $16,725. The issue is composed of serial bonds with values of $6,200 to $17,600 with maturity dates ranging from December 1, 2017 to 2037. The Series 2017 Bonds maturing after December 1, 2037 are subject to redemption prior to maturity, at the option of the Hospital and as provided for in the debt agreement, on or after June 1, 2027, at 100% of the principal amount plus accrued interest to the date of redemption. The Series 2017 Bonds are also subject to redemption upon the occurrence of certain events as discussed in the debt agreement. The proceeds of the Series 2017 Bonds were applied to refund on an advance basis all of the Orange Regional Medical Center Obligated Group Revenue Bonds, Series 2008, to make a deposit to a Debt Service Reserve Fund in the amount of $18,520, and to pay costs of issuance of $3,576. As a result of the extinguishment of the Series 2008 bonds, the Hospital recorded a loss on extinguishment of debt in the amount of $27,347.

The Hospital is required to maintain a long-term debt service coverage ratio of 1.25 measured on an annual basis, and a day's-cash-on-hand ratio of 60 days calculated semiannually, as defined in the debt agreement. The Series 2017 Bonds are collateralized by the land and buildings that comprise the hospital facility.

Interest on the Series 2017 Bonds is payable on a semiannual basis beginning June 1, 2017. Principal is payable annually beginning December 1, 2017 in varying amounts from $6,200 in 2017 to $17,600 in 2037. The Series 2017 Bonds were issued with various stated interest rates ranging from 4.00% to 5.00%. The effective interest rate for this issue is 4.33%.

(Dollars in thousands)

(d) During 2016, the Hospital entered into a lease line of credit with a bank for a $3,750, with interest at 3.62%, maturing December 2021, as well as a lease line of credit with another entity for $3,750 with interest at 3.00%, maturing November 2020.

The Hospital has a $10,000 working capital line of credit under which no amounts were outstanding as of December 31, 2017 and 2016. Interest on borrowings under this line of credit would be floating at the one-month London Interbank Offered Rate interest rate plus 2.75%. This agreement expires on July 31, 2018 and is renewable annually. The Hospital expects to renew this line of credit.

Aggregate principal payments on long-term debt and capital lease obligations as of December 31, 2017 for the next five years and thereafter are as follows: 2018 – $10,852; 2019 – $11,178; 2020 – $11,605; 2021 – $11,213; 2022 – $10,777; and thereafter – $258,631.

(6) Commitments and Contingencies

(a) Professional Liability

ORMC and Catskill Regional's professional liability insurance programs were combined effective September 1, 2016. Coverage is written on a claims made, first dollar basis. Professional liability limits are $2,000 per medical incident subject to annual aggregate limits of $7,000. Under the excess liability program, there are limits of $35,000 per medical incident and in the annual aggregate subject to the policy's varying retroactive dates. Joint and several liability does not apply between ORMC and Catskill Regional.

Prior to September 1, 2016, ORMC and Catskill Regional's professional liability programs were written separately. Prior to September 1, 2016, ORMC had professional liability claims-made commercial insurance coverage for the first $1,000 per occurrence, $5,000 in the aggregate for malpractice claims effective September 1, 2009 (prior to that date it was $1,000/$3,000) and excess insurance for $5,000 per occurrence, $5,000 in the aggregate for claims made prior to September 1, 2008, and $10,000 per occurrence and $10,000 in the aggregate for claims through September 1, 2012, and $15,000 per occurrence and $15,000 in the aggregate for claims made subsequent to that date.

The Hospital has engaged an independent actuary to estimate the liability for both reported and IBNR claims. Based on estimates that incorporate the Hospital's past experience, as well as other considerations, including the nature of each claim or incident and relevant trend factors, management, with the assistance of an independent actuary, has recorded an accrual for ultimate undiscounted cost. As of December 31, 2017 and 2016, the Hospital has recorded the following:

	2017	2016
Estimated malpractice liabilities	$ 21,849	24,387
Insurance claims receivable – included in other current assets	(4,498)	—
Insurance claims receivable – net of current portion	(13,558)	(20,689)

(Continued)

(Dollars in thousands)

The Hospital has been named as a defendant in various malpractice cases. The outcome of these actions cannot be predicted at this time, but it is the opinion of management that any loss that may arise from these actions will not have a material adverse effect on the consolidated financial position, results of operations, or liquidity of ORMC. In addition, there are known, and possibly unknown, incidents occurring through December 31, 2017 that may result in the assertion of additional claims. In management's opinion, any liability that may arise from the settlement of such claims will be settled within insurance coverage or otherwise will not have any material adverse effect on the Hospital's financial position, results of operations, or liquidity.

(b) Workers' Compensation

Effective January 1, 2002, the Hospital became a participating member of the Hudson Healthcare Workers Compensation Group Trust (the Trust). The Hospital has entered into an indemnity agreement with the Trust to have the Trust provide risk management services and workers' compensation and employers' liability coverage. The agreement stipulates, among other things, that each member is jointly and severally liable for the workers' compensation and employers' liability obligations of the Trust, irrespective of the subsequent termination of a member's membership in the Trust, the insolvency or bankruptcy of another member of the Trust, or other facts or circumstances. However, recourse for any and all payments of workers' compensation and employers' liability benefits covered by the Trust's certificate of coverage to a member shall first be made by the Trust's assets.

The Trust provides workers' compensation insurance (medical, indemnity, and legal costs) to Trust members. Such coverage is provided up to the per occurrence New York State statutory limits. The Trust also provides employers' liability insurance with the following limits:

Bodily injury by accident	$ 100 each accident
Bodily injury by disease	100 each employee
Bodily injury by disease	500 policy limit

The Trust engaged an independent actuary to estimate the liability for uninsured claims for all workers' compensation occurrences beginning January 1, 2002 for both reported claims and IBNR claims.

The Hospital has a 33% member interest in this Trust; accordingly, the Hospital accounts for this investment on the equity basis of accounting, which is included in other assets, net in the accompanying consolidated balance sheets. The Hospital's equity investment is fully reserved for as of December 31, 2017 and 2016.

Effective January 1, 2011, the Trust was frozen and has ceased underwriting operations and will run off its unpaid loss and loss adjustment expenses. The Hospital is responsible for all claims occurring prior to January 1, 2011 through the Trust. The Hospital became self-insured for workers' compensation claims occurring January 1, 2011 or later. Pennsylvania Manufacturers Association Insurance Company (PMA) administers the plan. The Hospital has recorded $11,292 and $9,344 within other liabilities related to those claims including IBNR claims as actuarially determined as of December 31, 2017 and 2016, respectively. Interim premiums will be paid and final premiums will be retrospectively set, trued up to historical actual claims paid. Funding for the plan has exceeded claims resulting in a

(Dollars in thousands)

receivable of $6,342 and $5,710 at December 31, 2017 and 2016, respectively, and is included within other assets.

(c) Employee Health

The Hospital is self-insured for employee health insurance for certain union and nonunion employees. Effective July 1, 2008, technical, service, and clerical employees who participate in collective-bargaining agreements became covered under the union's benefit plan. The Hospital records an estimate for IBNR claims based on information provided by its third-party administrator. The amount accrued was approximately $903 and $1,153 at December 31, 2017 and 2016, respectively, and is recorded in accounts payable and accrued expenses in the consolidated balance sheets.

(d) Operating Lease Obligations

During 2006, the Hospital sold the Medical Pavilion, a medical office building, with a net book value of $10,800 for $18,890. Simultaneously, the Hospital's Series 2002A Variable Rate Demand Civic Facility Revenue Bonds (Horton Medical Center West Hudson Facility Project) of $9,800 were defeased and the Hospital received cash proceeds of approximately $8,200 relating to the sale of the Medical Pavilion. As part of the transaction, the Hospital leased back the Medical Pavilion through 2016, and subsequently has leased a portion of that space through October 2019. Accordingly, the gain of $7,160 has been recorded in the accompanying consolidated balance sheets as deferred revenue and was amortized as an offset to rental expense over the life of the related leases. There was no deferred revenue related to this transaction as of December 31, 2017.

The following is a schedule of minimum lease payments under noncancelable operating lease agreements as of December 31, 2017:

	Lease obligations
Year ending December 31:	
2018	$ 2,441
2019	2,105
2020	956
2021	449
2022	116
Thereafter	—

Net rent expense was $3,213 and $4,040 for the years ended December 31, 2017 and 2016, respectively.

(e) General

Various suits and claims arising in the normal course of operations are pending. While the outcome of these suits cannot be determined at this time, management believes that such suits and claims are

either specifically covered by insurance or are not material to the Hospital's overall consolidated financial position, operating results, or liquidity.

(f) Collective-Bargaining Agreements

Approximately, 80% of the Hospital's employees are union employees covered under the terms of various collective-bargaining agreements. The collective-bargaining agreement with Local 1199 SEIU covering service, technical, professional, and clerical staffs was ratified in January 2016 and expired on April 30, 2018. This agreement covers approximately 49% of the total workforce. The collective-bargaining agreement with Local 1199 SEIU covering nursing staff was ratified in April 2016 and expires on September 30, 2018. This agreement covers approximately 30% of the total workforce. The collective-bargaining agreement with Law Enforcement Officers Professional Association covering security staff became effective on September 18, 2017 and expires September 18, 2022. The agreement shall successively renew itself annually and continue in full force unless written notice is served no more than ninety days and no less than thirty days prior to the expiration date.

(7) Pension and Other Postretirement Benefits

(a) ORMC's employees not covered by collective-bargaining agreements have a defined-contribution retirement plan that includes a base employer contribution to a 403(b) account equal to a percentage of compensation, to a maximum of 5% based on years of service. During 2017 and 2016, the base employer contribution was $1,357 and $1,365, respectively, which was included within employee benefits expense in the accompanying consolidated statements of operations.

In addition, there is an employer-matching component to the plan. As of January 1, 2008, ORMC makes a matching contribution equal to 100% of the employee's 403(b) contribution, up to 4% of the employee's compensation. During 2017 and 2016, the matching contribution was $1,195 and $1,092, respectively, which was included within employee benefits expense in the accompanying consolidated statements of operations.

ORMC maintains a fully frozen noncontributory defined-benefit pension plan for current and past employees not covered by a collective-bargaining agreement. Effective January 1, 2006, ORMC froze participation in the pension plan to any employees hired after December 31, 2005. Effective January 1, 2008, ORMC froze the pension plan for the remaining active participants in the plan by ceasing any future accrual of credited service and compensation under the plan.

(b) ORMC participates in a multiemployer Local 1199 defined-benefit pension plan for participating staff. The contribution percentages are defined in the collective-bargaining agreements. The risks of participation in this multiemployer plan are different from a single-employer plan in the following aspects: a) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers; b) if a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers; and c) if the Hospital chooses to stop participating in its multiemployer plan and if the plan is underfunded, ORMC may be required to pay the plan an amount based on the underfunded status of the plan, referred to as the withdrawal liability.

(Dollars in thousands)

The Hospital's participation in this plan for the years ended December 31, 2017 and 2016 is outlined in the table below. The "EIN/Pension Plan Number" column provides the Employer Identification Number (EIN) and the three-digit plan number, if applicable. Unless otherwise noted, the most recent Pension Protection Act (PPA) zone status available in 2017 and 2016 is for the plan's year-end at December 31, 2016 and 2015, respectively. The zone status is based on information received from the plan sponsor and, as required by the PPA, is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are less than 80% funded, and plans in the green zone are at least 80% funded.

The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The last column lists the expiration date of the collective-bargaining agreements requiring contributions to the plan:

Pension fund	EIN/Pension plan number	Pension Protection Act zone status		FIP/RP Status pending/ implemented	Contributions of ORMC		Surcharge imposed	Expiration date of collective-bargaining agreements
		January 1, 2017	January 1, 2016		2017	2016		
1199 SEIU Health Care Employees Pension Fund	13-3604862 Plan No. 001	Green	Green	No	$ 12,775	12,334	No	4/30/2018

Total amounts expensed under the union-sponsored multiemployer plans were $11,344 and $13,584 for the years ended December 31, 2017 and 2016, respectively. ORMC was not listed in the plan's most recent available annual report (Form 5500 for U.S. Plans) for providing more than five percent of the total contributions to the plan for the years ended December 31, 2016 and 2015. At the date the consolidated financial statements were issued, Form 5500 was not available for the plan year ended December 31, 2017.

(c) ORMC sponsors a defined-contribution healthcare plan that provides postretirement medical, dental, and life insurance benefits to employees who meet the eligibility requirements under the plan.

ORMC offers executives, who are at least age 55 with five years of service, subsidized medical coverage to age 65 based on years of service. Nonunion and security employees who were hired before January 1, 1988 receive a nominal monthly reimbursement. Employees in the nursing and professional unions who are at least age 62 with 20 years of service receive 100% subsidized medical benefits until age 65. Employees in the professional group who are age 62 with 20 years of service also receive fully subsidized dental coverage. A select group of grandfathered retirees receive dental coverage for life.

(Dollars in thousands)

The following table sets forth the benefit obligations and fair value of plan assets at December 31, 2017 and 2016:

	Pension benefits		Postretirement benefits	
	2017	2016	2017	2016
Change in benefit obligation:				
Benefit obligation at beginning of year	$ 130,430	127,848	3,249	3,429
Service cost	—	—	54	58
Interest cost	5,259	5,459	121	132
Actuarial loss (gain)	6,798	3,295	(43)	27
Plan participant contributions	—	—	33	47
Benefits paid and administrative expenses	(6,589)	(6,172)	(277)	(444)
Projected benefit obligation at end of year	$ 135,898	130,430	3,137	3,249
Change in plan assets:				
Fair value of plan assets at beginning of year	$ 79,463	77,793	—	—
Actual return on plan assets	11,089	1,842	—	—
Employer and participant contributions	8,050	6,000	277	444
Benefits paid and administrative expenses	(6,589)	(6,172)	(277)	(444)
Fair value of plan assets at end of year	$ 92,013	79,463	—	—

(Continued)

(Dollars in thousands)

The following table sets forth the plan's benefit obligations, fair value of plan assets, and funded status at December 31, 2017 and 2016:

	Pension benefits		Postretirement benefits	
	2017	2016	2017	2016
Benefit obligation	$ (135,898)	(130,430)	(3,137)	(3,249)
Fair value of plan assets	92,013	79,463	—	—
Funded status	$ (43,885)	(50,967)	(3,137)	(3,249)
Amounts recognized in the consolidated balance sheet consist of:				
Current liabilities	$ —	—	(420)	(410)
Noncurrent liabilities	(43,885)	(50,967)	(2,717)	(2,839)
	$ (43,885)	(50,967)	(3,137)	(3,249)

Amounts recognized in accumulated other changes in unrestricted net assets consist of the following:

	Pension benefits		Postretirement benefits	
	2017	2016	2017	2016
Prior service cost	$ —	—	(31)	(90)
Net actuarial loss	70,125	70,940	3,242	3,742
	$ 70,125	70,940	3,211	3,652

The estimated amount that will be amortized from unrestricted net assets into net periodic pension cost in 2018 is $2,294 for the pension plan and $399 for the postretirement plan related to actuarial gains and losses and prior service costs.

(Continued)

(Dollars in thousands)

Other changes recognized in unrestricted net assets consist of the following:

	Pension benefits		Postretirement benefits	
	2017	2016	2017	2016
Net (loss) gain	$ (1,484)	(7,463)	43	(27)
Amortization of net loss	2,300	1,972	457	491
Amortization of prior service credit	—	—	(59)	(346)
Prior service credit	—	—	—	—
Total recognized in unrestricted net assets	$ 816	(5,491)	441	118

The components of net periodic pension cost for the years ended December 31, 2017 and 2016 are included within employee benefits expense and are as follows:

	Pension benefits		Postretirement benefits	
	2017	2016	2017	2016
Service cost	$ —	—	54	58
Interest cost	5,259	5,459	121	132
Expected return on assets	(5,774)	(6,010)	—	—
Amortization of prior service cost	—	—	(59)	(346)
Recognized net actuarial loss	2,300	1,972	457	491
Net periodic benefit cost	$ 1,785	1,421	573	335

	Pension plan		Postretirement plans	
	2017	2016	2017	2016
Weighted average assumptions used to determine benefit obligations:				
Discount rate	3.65%	4.14%	3.56%	3.97%
Weighted average assumptions used to determine net benefit cost:				
Discount rate	4.14	4.38	3.97	4.18
Expected return on plan assets	7.25	7.75	—	—

(Continued)

(Dollars in thousands)

The discount rate is derived by identifying a theoretical settlement portfolio of high quality corporate bonds sufficient to provide for the plan's projected benefit payments. The returns from this portfolio are used to determine a single discount rate that results in a discounted value of the plan's benefit payments that equates to the market value of the selected bonds.

The expected long-term rate of return is based on the portfolio as a whole and not on the sum of the returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

Effective December 31, 2017, the annual rate of increase in the per capita cost of covered healthcare benefits was 7% and assumed to decrease to 4.5% by 2026.

(a) Plan Assets

The weighted average asset allocation of the plan assets, excluding cash at December 31, 2017 and 2016 was as follows:

	2017	2016
Asset category:		
Equity	59%	57%
Fixed income	29	28
Alternative investments	12	15
	100%	100%

The Hospital's financial and investment objectives are to meet present and future obligations to beneficiaries, while minimizing the Hospital's contributions over the long term, by earning an adequate return on assets with moderate volatility.

The following tables present the Hospital's fair value measurements for plan assets measured at fair value on a recurring basis as of December 31, 2017 and 2016:

		December 31, 2017		
		Total	Level 1	Level 2
Asset category:				
Cash	$	4,871	4,871	—
Mutual funds – domestic equity		27,788	27,788	—
Exchange traded funds – equity		23,485	23,485	—

(Continued)

(Dollars in thousands)

		December 31, 2017	
	Total	Level 1	Level 2
Exchange traded funds – fixed income	$ 25,471	25,471	—
Fixed-income securities – domestic	245	—	245
	81,860	$ 81,615	245
Investments measured at net asset value	10,153		
Total	$ 92,013		

		December 31, 2016	
	Total	Level 1	Level 2
Asset category:			
Cash	$ 2,801	2,801	—
Mutual funds – domestic fixed income	3,917	—	3,917
Mutual funds – global and foreign fixed income	5,800	—	5,800
Exchange traded funds – equity	10,329	10,329	—
Exchange traded funds – fixed income	10,990	6,148	4,842
U.S. Treasury obligations	727	—	727
Equity securities – domestic	16,791	16,791	—
Equity securities – foreign	16,002	16,002	—
Fixed-income securities – domestic	241	—	241
	67,598	$ 52,071	15,527
Investments measured at net asset value	11,865		
Total	$ 79,463		

Investments measured at NAV consist of shares or units in funds of funds and limited partnerships as opposed to direct interests in the funds' underlying holdings, which may be marketable. The NAV reported by each fund is used as a practical expedient to estimate the fair value of the Hospital's interest therein as the Hospital is able to redeem its interest at or near the date of the consolidated balance sheets. The Hospital has two and five alternative investments measured at NAV at December 31, 2017 and 2016, respectively; they can be redeemed on a quarterly basis with a written notification period ranging to 125 days. The Hospital has two investments in private equity funds at December 31, 2017 and 2016. Total funding commitment for these investments is a total of $6,000 of which $3,937 has been invested as of December 31, 2017. The Hospital receives 10 business days' notice of funding requests. Investment in these funds is expected to last the life of the fund without redemption. The classification of investments in the fair value hierarchy is not necessarily an indication of the risks, liquidity, or degree of difficulty in estimating the fair value of each investment's underlying assets and liabilities.

(Dollars in thousands)

There are no plan assets measured at fair value based upon Level 3 inputs as of December 31, 2017 and 2016.

Assumed healthcare cost trend rates have a significant effect on the amounts reported for the healthcare plan. A one-percentage-point change in assumed healthcare cost trend rates would have the following effects:

	One-percentage-point increase	One-percentage-point decrease
Effect on total of service and interest cost components	$ 9	(8)
Effect on postretirement benefit obligation	110	(98)

(b) Contributions

The Hospital expects to contribute $8,050 to the pension plan and $420 to its postretirement plans in 2018.

(c) Estimated Future Benefit Payments

The benefits expected to be paid in each year from 2018 to 2022 for the pension plan are $7,010, $7,230, $7,380, $7,500, and $7,710, respectively. The aggregate benefits expected to be paid in the five years from 2023 to 2027 are $40,200. The expected benefits are based on the same assumptions used to measure the Hospital's benefit obligation at December 31, 2017.

The benefits expected to be paid in each year from 2018 to 2022 for the postretirement plans are $420, $290, $230, $230, and $200, respectively. The aggregate benefits expected to be paid in the five years from 2023 to 2027 are $1,040. The expected benefits are based on the same assumptions used to measure the Hospital's benefit obligation at December 31, 2017.

(8) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31:

	2017	2016
Temporarily restricted:		
Programs, capital equipment, and improvements	$ 7,476	7,647
Health education	22	16
Scholarships	—	11
	$ 7,498	7,674

(Continued)

(Dollars in thousands)

	2017	2016
Permanently restricted:		
Investments held in perpetuity, with income restricted to equipment purchases	$ 2,130	1,866
Investments held in perpetuity, with income available for operations	128	128
	$ 2,258	1,994

(9) Related-Party Transactions

(a) Certain individuals serving on the board of the Hospital also serve on the board of the Foundation.

(b) The Hospital recognizes its interest in the net assets of the Foundation and the changes in net assets of the Foundation. During October 2017, GHVHS became the sole corporate member of the Foundation.

The following table sets forth a summary of the balance sheets of the Foundation at December 31, 2017 and 2016:

	2017	2016
Total assets	$ 7,281	7,196
Total liabilities	—	—
Total net assets	$ 7,281	7,196

The following table sets forth a summary of the statements of activities of the Foundation for the years ended December 31, 2017 and 2016:

	2017	2016
Total support and revenue	$ 1,816	3,320
Total expenses, distributions, and other	1,771	2,676
Change in net assets	$ 45	644

(c) The Hospital incurred and paid expenses on behalf of the Foundation in the amount of $806 and $727 for the years ended December 31, 2017 and 2016, respectively.

(d) As part of the affiliation agreement between GHVHS and Catskill Regional entered into in 2007, ORMC is providing consulting and administrative services to Catskill Regional. These services are billed at a base annual fee of $560 to be paid in monthly installments of approximately $47 and are included in other revenue in the accompanying consolidated statements of operations. Included within other

(Continued)

current assets is a receivable of $667 and $1,193 at December 31, 2017 and 2016, respectively, mainly pertaining to these management fees owed to ORMC from GHVHS.

(e) During 2017 and 2016, ORMC transferred to GHVHS funding and assets in the amount of $3,189 and $2,785, respectively, for the purpose of developing, implementing, and maintaining the EPIC system, an electronic health record system. This system is owned by GHVHS and will be utilized by ORMC, and GHVHS Medical Group PC (the PC). For the years ended December 31, 2017 and 2016, included in purchased services expense is an expense allocation from GHVHS in connection with ORMC's use of the EPIC system in the amount of $2,584 and $4,740, respectively, and a transfer from GHVHS to ORMC for the same amount.

(f) The PC furnishes services exclusively to GHVHS, ORMC, and CRMC, both to hospital inpatients and to members of the community in outpatient settings that are effectively hospital sites. All management and administrative services in connection with the operation of the PC are performed by GHVHS, ORMC, and CRMC. These services are governed by administrative and professional services agreements. Pursuant to the professional services agreement, at the direction of GHVHS, ORMC, and CRMC will provide payment to the PC for the amount by which the PC's expenses exceed its revenue. For the years ended December 31, 2017 and 2016, ORMC's share of $19,858 and $13,516, respectively, is recorded in purchased services expense in the accompanying consolidated statements of operations. Related to these agreements, at December 31, 2017 and 2016, a receivable from the PC in the amount of $932 and $4,035, respectively, is included in other current assets and a payable to the PC in the amount of $2,107 and $740, respectively, is included in accounts payable and accrued expenses in the accompanying consolidated financial statements.

(10) Joint Venture Agreements

Crystal Run Ambulatory Surgery Center of Middletown, LLC (CRASC)

The Hospital has an agreement with CRASC to operate an ambulatory surgical center. CRASC was organized as a for-profit corporation for income tax purposes. The Hospital has a 40% ownership interest in CRASC at December 31, 2017, and records its investment on the equity method. At December 31, 2017 and 2016, $1,397 and $1,475, respectively, has been recorded in other assets, net in the accompanying consolidated balance sheets. As of December 31, 2017, the Hospital has cumulatively invested $440 in CRASC.

Hudson Valley Ambulatory Surgery, LLC (HVAS)

The Hospital has an agreement with HVAS to operate an ambulatory surgical center. HVAS was organized as a limited liability company but is treated as a partnership for income tax purposes. The Hospital has a 26% ownership interest in HVAS at December 31, 2017, and records its investment on the equity method. At December 31, 2017 and 2016, $101 and $57, respectively, has been recorded in other assets, net in the accompanying consolidated balance sheets. As of December 31, 2017, the Hospital has cumulatively invested $570 in HVAS.

(11) Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts that are different from their established rates. Revenue from Medicare and Medicaid programs accounted

for approximately 39% and 14%, respectively, of the Hospital's patient service revenue for the year ended December 31, 2017, and 38% and 14%, respectively, for the year ended December 31, 2016. A summary of the payment arrangements with major third-party payors is as follows:

(a) Medicare

Inpatient acute and certain outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge or procedure. These rates vary according to patient classification systems based on clinical, diagnostic, and other factors. Certain items are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary.

(b) Medicaid

The New York Health Care Reform Act of 1996 (the Act), as amended, governs payments to hospitals in New York State and Medicaid, workers' compensation, and no-fault payors rates are promulgated by the New York State Department of Health. Reimbursement for services to Medicaid program beneficiaries includes prospectively determined rates per discharge and per visit amounts.

(c) Other Third-Party Payors

The Hospital has entered into payment arrangements with certain commercial carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, discounts from established charges, and per diem payment rates. If such rates are not negotiated, then the payors are billed at the Hospital's established charges.

(d) Healthcare Regulatory Environment

As a result of federal healthcare reform legislation, changes are anticipated in the U.S. healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers, and the legal obligation of health insurers, providers, and employers. The ultimate outcome of proposed legislation and other market changes cannot presently be determined and could be material to ORMC's future results of operations and cash flows.

The healthcare industry is subject to extensive governmental regulation through numerous and complex laws, some of which are ambiguous and subject to varying interpretation. The federal government and many states, including the State of New York, have aggressively increased enforcement under a number of such laws that are often referred to as Medicare and Medicaid "antifraud and abuse" legislation. For many years, ORMC has maintained a corporate compliance program to monitor the organization's compliance with applicable laws, including the so-called "antifraud and abuse" rules. Noncompliance with such rules could result in repayments of amounts improperly reimbursed, substantial monetary fines, civil and criminal penalties, and exclusion from the Medicare and Medicaid programs.

Both federal and New York State regulations provide for certain adjustments to current and prior years' payment rates and indigent care pool distributions based on industry-wide and hospital specific data.

(Dollars in thousands)

The Hospital has established estimates based on information presently available of the amounts due to or from Medicare, Medicaid, workers' compensation, and no-fault payors, and amounts due from the indigent care pool for such adjustments.

As a result of monitoring and review conducted under the ORMC Corporate Compliance Program, ORMC discovered and self-disclosed to the Medicare Administrative Contractor (MAC), a clerical error omission of certain Medicare charges from the 2013 Cost Report. During 2015, ORMC both refiled an Amended Cost Report per the MAC's instructions, and has recorded an estimated liability for this omission within third-party payor liabilities as of December 31, 2017 and 2016.

Net patient service revenue for the years ended December 31, 2017 and 2016 increased by approximately $3,552 and $3,058, respectively, due to changes in estimates to reflect the most recent information available.

(12) Delivery System Reform Incentive Payment (DSRIP) Program

New York State has embarked on an effort to address critical healthcare issues throughout the state and allow for comprehensive healthcare reform through a Delivery System Reform Incentive Payment (DSRIP) Program. The DSRIP Program will promote community-level collaborations and focus on health system reform, specifically a goal to achieve a 25% reduction in avoidable hospital admissions over five years for Medicaid patients. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement, and population health improvement. DSRIP funds will be based on performance linked to achievement of project milestones. DSRIP funding is expected to consist of, but not be limited to, a variety of grants and incentive payments.

The groups of providers who are responsible for creating and implementing DSRIP projects are called Performing Provider Systems (PPS). Following an application and approval process, New York State Department of Health approved the creation of 25 Preferred Provider Systems across New York State. The PPSs are comprised of various healthcare providers located within the same geographic region; providers represent different types across the care continuum, including hospitals, physician practices, nursing homes, and Federally Qualified Health Centers, among others. Orange Regional Medical Center, under the guise of the Greater Hudson Valley Health System, is participating in one PPSs – the WMCHealth Center for Regional Healthcare Innovation lead by Westchester Medical Center.

(13) Functional Expenses

The Hospital provides general healthcare services to residents within its geographic location, including acute and psychiatric inpatient services, as well as ambulatory surgery, emergency care, and other outpatient services. Expenses related to providing these services for the years ended December 31, 2017 and 2016 are as follows:

		2017	2016
Healthcare services	$	366,477	349,055
General and administrative		102,764	98,624
	$	469,241	447,679

(Continued)

(14) Subsequent Events

The Hospital has evaluated and disclosed subsequent events from the consolidated balance sheet date of December 31, 2017 through May 25, 2018, which is the date of the consolidated financial statements were issued.