COLUMBIA MEMORIAL HOSPITAL

SITE INFORMATION – HOSPITAL

Alternate contact: Dorothy M. Urschel
Email address: durschel@cmh-net.org

Type of Application: Establishment ☐ Construction ☐ Administrative ☐ Limited ☒

Total Project Cost: $500

Operator Information:
Columbia Memorial Hospital
71 Prospect Avenue, Hudson (Columbia County), New York 12534
PFI: 146

Project Site Information:
Columbia Memorial Hospital
71 Prospect Avenue, Hudson (Columbia County), New York 12534
PFI: 146

Site Proposal Summary (maximum of 1,000 characters):
Columbia Memorial Hospital ("CMH") is a 192-bed acute care hospital and member of Albany Med Health System, located at 71 Prospect Avenue, Hudson (Columbia County), New York 12534. CMH is submitting this Limited Review Application for approval to decertify beds for a total of 25 beds. With 25 certified beds, CMH will pursue federal designation as a Critical Access Hospital (CAH) to preserve essential hospital services for the residents of Columbia and Greene Counties.

Modify Name/Address: N/A

Beds:
Please provide table of existing and proposed bed numbers (similar to Schedule 18).

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30		☐	☐	
BONE MARROW TRANSPLANT	21		☐	☐	
BURNS CARE	09		☐	☐	
CHEMICAL DEPENDENCE-DETOX *	12		☐	☐	
CHEMICAL DEPENDENCE-REHAB *	13		☐	☐	
COMA RECOVERY	26		☐	☐	
CORONARY CARE	03		☐	☐	
INTENSIVE CARE	02	9	☐	☐	9

MATERNITY	05	10	☐	☒	0
MEDICAL/SURGICAL	01	147	☐	☒	16
NEONATAL CONTINUING CARE	27		☐	☐	
NEONATAL INTENSIVE CARE	28		☐	☐	
NEONATAL INTERMEDIATE CARE	29		☐	☐	
PEDIATRIC	04	4	☐	☒	0
PEDIATRIC ICU	10		☐	☐	
PHYSICAL MEDICINE & REHABILITATION	07		☐	☐	
PRISONER			☐	☐	
PSYCHIATRIC	08	22	☐	☒	0
RESPIRATORY			☐	☐	
SPECIAL USE			☐	☐	
TRANSITIONAL CARE	33		☐	☐	
TRAUMATIC BRAIN INJURY	11		☐	☐	
TOTAL		192	☐	☒	25

Services: N/A

Remove Site: N/A

COLUMBIA MEMORIAL HOSPITAL

EXECUTIVE SUMMARY

Columbia Memorial Hospital ("CMH") is a 192-bed acute care hospital and member of Albany Med Health System, located at 71 Prospect Avenue, Hudson (Columbia County), New York 12534. CMH is submitting this Limited Review Application for approval to decertify beds for a total of 25 beds. With 25 certified beds, CMH will pursue federal designation as a Critical Access Hospital (CAH) to preserve essential hospital services for the residents of Columbia and Greene Counties.

Columbia Memorial Hospital is submitting this Limited Review Application to enable the Hospital to convert from a 192-bed general acute care hospital model to a 25-bed Critical Access Hospital. CMH will achieve this through the following initiatives: 1) transferring 49 medical/surgical beds to Albany Medical Center Hospital; 2) converting 20 medical/surgical beds to 20 psychiatric beds for a total of 42 inpatient psychiatric beds under Project No. 251193; 3) operating the 42-bed inpatient psychiatric program under its own Office of Mental Health license; and lastly 4) through this project, decertifying 76 beds, resulting in a total of 25 beds. Upon conversion to a 25-bed CAH, CMH will operate 16 medical/surgical beds on the fourth floor and nine (9) ICU beds on the third floor. Under the CAH model, CMH will also continue to provide emergency department services including observation beds. Importantly, while CMH is right-sizing its number of certified beds, it will continue to have the flexibility to increase bed capacity during emergencies or unforeseen surges.

Following the COVID-19 pandemic, CMH experienced a significant decline in acute care inpatient volumes with a consistent average daily census less than 25% of its certified bed capacity. Surgical admissions have also decreased with over 90% of surgeries being ambulatory-based procedures that do not require an inpatient admission. Inpatient discharges, emergency room visits and clinic visits have also declined significantly and have not returned to pre-pandemic historical averages. In addition, changes in the labor market have exacerbated the need for temporary staffing while inflation has increased the cost of supplies and contracted services. The combined impact of reduced volumes and rising operating expenses has negatively affected CMH's operating margin and prompted the need for long-term strategies to preserve essential hospital services. With a 25-bed Critical Access Hospital, CMH will ensure long-term financial sustainability and most importantly, will preserve essential inpatient services for the communities it serves.

Conversion to a Critical Access Hospital is a central component of a broader transformation plan; additional ongoing initiatives under this plan include: 1) expanding inpatient psychiatric services under Project No. 251193, which is currently under review by the Department; and 2) establishing an ambulatory hub in Greene County that will offer an expanded range of surgical and cardiac services under Project No. 241220, which has received Department approval and is under construction. Together, these initiatives will enable Columbia Memorial Hospital and Albany Med Health System to preserve essential hospital services, strengthen long-term operational sustainability, and ensure that high-quality care remains accessible to the residents of Columbia and Greene Counties.

New York State Department of Health
Health Equity Impact Assessment Requirement Criteria

Effective June 22, 2023, a Health Equity Impact Assessment (HEIA) will be required as part of Certificate of Need (CON) applications submitted by facilities (Applicant), pursuant to Public Health Law (PHL) § 2802-b and corresponding regulations at Title 10 New York Codes, Rules and Regulations (NYCRR) § 400.26. This form must be used by the Applicant to determine if a HEIA is required as part of a CON application.

Section A. Diagnostic and Treatment Centers (D&TC) - ***This section should only be completed by D&TCs, all other Applicants continue to Section B.*** **N/A**

Table A.

Diagnostic and Treatment Centers for HEIA Requirement	Yes	No
Is the Diagnostic and Treatment Center's patient population less than 50% patients enrolled in Medicaid and/or uninsured (combined)?	☐	☐
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?	☐	☐

- ***If you checked "no" for both questions in Table A,*** you do not have to complete Section B - this CON application is considered exempt from the HEIA requirement. This form with the completed Section A is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section A, along with the CON application to acknowledge that a HEIA is not required.

- ***If you checked "yes" for either question in Table A,*** proceed to Section B.

Section B. All Article 28 Facilities

Table B.

Construction or equipment	Yes	No
Is the project minor construction or the purchase of equipment, subject to Limited Review, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours? *Per the Limited Review Application Instructions: Pursuant to 10 NYCRR 710.1(c)(5), minor construction projects with a total project cost of less than or equal $15,000,000 for general hospitals and less than or equal to $6,000 for all other facilities are eligible for a Limited Review.*	☐	☒

Establishment of an operator (new or change in ownership)	**Yes**	**No**
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, <u>AND</u> will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?	☐	☒
Mergers, consolidations, and creation of, or changes in ownership of, an active parent entity	**Yes**	**No**
Is the project a transfer of ownership in the facility that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?	☐	☒
Acquisitions	**Yes**	**No**
Is the project to purchase a facility that provides a new or similar range of services or care, that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?	☐	☒
All Other Changes to the Operating Certificate	**Yes**	**No**
Is the project a request to amend the operating certificate that will result in one or more of the following: a. Elimination of services or care; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours, and/or; d. Change in location of services or care?	☒	☐

*Calculate the percentage change from the number of certified/authorized beds and/or certified/authorized services (as indicated on the facility's operating certificate) specific to the category of service or care. For example, if a residential health care facility adds two ventilator-dependent beds and the facility had none previously, this would exceed the 10% threshold. If a hospital removes 5 out of 50 maternity certified/authorized beds, this would meet the 10% threshold.

- ***If you checked "yes" for one or more questions in Table B,*** the following HEIA documents are required to be completed and submitted along with the CON application:
  - HEIA Requirement Criteria with Section B completed
  - HEIA Conflict-of-Interest
  - HEIA Contract with Independent Entity
  - HEIA Template
  - HEIA Data Tables

  - Full version of the CON Application with redactions, to be shared publicly

- *If **you checked "no" for all questions in Table B,*** this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.

COLUMBIA MEMORIAL HOSPITAL

Health Equity Impact Assessment (HEIA) Attachments

1) HEIA Conflict-of-Interest
2) HEIA Contract with Independent Entity
3) HEIA Template
4) HEIA Data Tables

New York State Department of Health

Health Equity Impact Assessment Conflict-of-Interest

This Conflict-of-Interest form must be completed in full, signed by the Independent Entity, and submitted with the Health Equity Impact Assessment.

Section 1 – Definitions

Independent Entity means individual or organization with demonstrated expertise and experience in the study of health equity, anti-racism, and community and stakeholder engagement, and with preferred expertise and experience in the study of health care access or delivery of health care services, able to produce an objective written assessment using a standard format of whether, and if so how, the facility's proposed project will impact access to and delivery of health care services, particularly for members of medically underserved groups.

Conflict of Interest shall mean having a financial interest in the approval of an application or assisting in drafting any part of the application on behalf of the facility, other than the health equity assessment.

Section 2 – Independent Entity

What does it mean for the Independent Entity to have a conflict of interest? For the purpose of the Health Equity Impact Assessment, if one or a combination of the following apply to the Independent Entity, the Independent Entity **HAS** a conflict of interest and must **NOT** perform the Health Equity Impact Assessment:

- The Independent Entity helped compile or write any part of the Certificate of Need (CON) application being submitted for this specific project, other than the Health Equity Impact Assessment (for example, individual(s) hired to compile the Certificate of Need application for the facility's project cannot be the same individual(s) conducting the Health Equity Impact Assessment);
- The Independent Entity has a financial interest in the outcome of this specific project's Certificate of Need application (i.e. individual is a member of the facility's Board of Directors or advisory board); or
- The Independent Entity has accepted or will accept a financial gift or incentive from the Applicant above fair market value for the cost of performing the Health Equity Impact Assessment.

Section 3 – General Information

A. About the Independent Entity

1. Name of Independent Entity: Sachs Policy Group (SPG)
2. Is the Independent Entity a division/unit/branch/associate of an organization (**Y**/N)?
   - ❑ If yes, indicate the name of the organization: Ankura Consulting Group

3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (**Y**/N)? ________________

4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years?

   Sachs Policy Group conducted one Health Equity Impact Assessment for Columbia Memorial Health prior to this engagement.

Section 4 – Attestation

I, David Gross (individual name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of Sachs Policy Group (INDEPENDENT ENTITY), do hereby attest that the Health Equity Impact Assessment for project Critical Access Hospital Designation Application (PROJECT NAME) provided for Columbia Memorial Health (APPLICANT) has been conducted in an independent manner and without a conflict of interest as defined in Title 10 NYCRR § 400.26.

I further attest that the information provided by the INDEPENDENT ENTITY in the Health Equity Impact Assessment is true and accurate to the best of my knowledge, and fulfills the intent of the Health Equity Impact Assessment requirement.

Signature of Independent Entity: David Gross

Date: 11/24/2025

SPG SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

August 20, 2025

Dorothy M. Urschel, DNP
President and Chief Executive Officer
Columbia Memorial Health

Dear Ms. Urschel,

Ankura Consulting Group, operating through its Sachs Policy Group ("Ankura" or "SPG") is pleased to submit this proposal for the completion of a Health Equity Impact Assessment ("HEIA") for Columbia Memorial Health.

This proposal outlines the key components and processes SPG will use to execute the HEIA, drawing upon the expertise of SPG's consultant team, inclusive of individuals with extensive experience in health equity, stakeholder/community engagement, and health policy.

BACKGROUND

Starting June 22, 2023, New York State law (S1451/A191) mandates a HEIA along with certificate of need (CON) applications for Article 28 healthcare facilities. This assessment evaluates if a project affects service access, enhances health equity, and reduces disparities for medically underserved groups, involving meaningful community input and independent analysis. The HEIA requirement ensures that community voices are considered and provides an objective, independent assessment of the anticipated impact of the project on the public health of, service delivery of, or access to hospital and health services for historically medically underserved groups.

The proposed project involves the designation of the facility as a Critical Access Hospital (CAH).

SPG RELEVANT EXPERIENCE

The HEIA team at SPG is a diverse and experienced group dedicated to addressing health disparities and promoting equitable access to care. The team has been deeply involved in the HEIA process since it was rolled out by New York State, having already been engaged on numerous HEIAs for a variety of stakeholders, including hospitals, Article 28 outpatient facilities, and nursing homes.

The team comprises experts with extensive backgrounds in health policy, population health, data analysis, community engagement, and anti-racism. We are committed to understanding and improving how social, environmental, and policy factors impact health equity, particularly for historically marginalized communities.

The team collaborates with a wide range of health care organizations, government agencies, and communities to provide strategic support with an overarching goal of advancing diversity, equity, and inclusion. Our work encompasses research and evaluation of health programs and initiatives, stakeholder engagement, policy analysis, and development of mitigation and monitoring strategies.

In particular, the team has experience analyzing policy proposals that impact medically underserved groups, such as Medicaid programs serving children and maternal health initiatives that aim to reduce

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pre- and post-partum health disparities. We are dedicated to supporting organizations that serve vulnerable populations, including safety net hospitals, community health centers, long-term care organizations, behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities.

SPG is well-positioned to provide the required HEIA services for Columbia Memorial Health. Our approach includes a comprehensive demographic profile of the facility's primary service area, meaningful stakeholder engagement, and a detailed analysis of the project's potential impacts on community residents, focusing on medically underserved groups. We will complete the HEIA process and provide all required documentation, ensuring compliance with the State's guidelines and conflict-of-interest requirements.

SCOPE OF WORK

The following generally outlines the activities necessary to conduct and successfully complete the HEIA as required by the State Department of Health (DOH). The expected duration of this engagement is 8 weeks.

1. Comprehensive Review and Analysis

SPG will use both publicly available data and data requested from Columbia Memorial Health to conduct a comprehensive review of the service area and to identify populations, specifically medically underserved groups, that may be impacted by the proposed project. Using descriptive statistics and data visualizations, SPG will efficiently paint a picture of the community and its patient profiles. Examples of data may include, but are not limited to, the following:

- Data provided by Columbia Memorial Health
- New York State DOH
- Statewide Planning and Research Cooperative System (SPARCS)
- US Census Bureau Data
- Community Health and Community Service Needs Assessments
- Health Facilities Information System (HFIS)
- Health Resources and Services Administration (HRSA) shortage area data
- Area Deprivation Index
- Supplemental claims data as needed/by request
- Publicly available medical literature, grey literature, publications, and reports
- Stakeholder interviews and surveys
- Additional sources as identified/available such as RWJ, Kaiser Family Foundation, etc.

2. Meaningful Stakeholder and Community Engagement

SPG will perform meaningful, culturally competent, and sensitive engagement to obtain diverse stakeholder and community feedback on how the project impacts the unique health needs or quality of life of historically medically underserved group(s). From our experience, SPG understands that meaningful engagement with the community and stakeholders is crucial for a successful HEIA. We recognize that this process requires thoughtful planning, dedicated time, and resources to ensure an inclusive and impactful approach that effectively captures the diverse perspectives, experiences, and

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needs of those most affected by the proposed project. The types of activities that may be performed include, but are not limited to:

- Create culturally appropriate and engaging communications materials to promote participation in the HEIA stakeholder engagement process, including translation services to ensure access for individuals with limited English proficiency.
- Develop culturally competent community surveys and/or host community forms to gather input on the potential impacts of the project related to health equity.
- Conduct interviews or focus groups with key stakeholders, including the local health department, community members, health care professionals, and public health experts.

SPG will work closely with Columbia Memorial Health staff and its community partners to promote these engagement opportunities, with a focus on reaching historically underserved and marginalized groups. SPG will carefully review and synthesize all feedback, looking for common themes, concerns, and recommendations that can inform the project's planning and implementation. We will also prepare a summary of the engagement conducted and feedback received, which will be included in the HEIA data tables and final report.

The final community engagement plan will reflect the needs of the underlying project.

3. Health Equity Impact and Mitigation Strategy with Recommendations

SPG will utilize the insights gathered from our research/data analysis and stakeholder/community outreach to support the development of a mitigation strategy for any impacts identified. We will also provide recommendations to support programs and interventions that support health equity and quality of care for the impacted medically underserved group(s). This strategy will include:

- Data-informed interventions and new or expanded collaborations with health-related and/or community-based organizations.
- Evidence-based ways to reduce potential negative impacts as a result of the project, as applicable.
- Specific changes to the project to better meet the needs of medically underserved groups, as applicable.
- Approaches for monitoring and tracking progress on health equity, including the use of performance and quality measures such as access to screenings for historically medically underserved groups, timely to access care, processes and referrals with partner organizations, and general health outcomes for impacted groups.

4. Support of Delivery of Required HEIA Documents

SPG will organize and summarize findings in a final health equity impact assessment report that supports the completion of the following documents for Columbia Memorial Health:

- HEIA Template
- HEIA Data Tables

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- HEIA Conflict of Interest
- HEIA Contract (Independent Entity and Facility)

The following forms will need to be completed by Columbia Memorial Health, and SPG will be available to advise in complying with these requirements according to DOH:

- HEIA Requirement Criteria
- HEIA Template SECTION C: Acknowledgement and Mitigation Plan
- Dissemination of Results and Recommendations: Public Posting of Redacted full CON Application and HEIA Online and NYSE-CON System

5. Additional Services Performed During the Course of the Engagement

During the engagement, SPG will monitor the availability of, and offer strategic guidance, regarding any updates in HEIA policy and requirements for Columbia Memorial Health.

Notwithstanding any other engagements between SPG and Columbia Memorial Health, SPG will have no formal or informal involvement with any CON (or the related underlying project) for which SPG is performing a HEIA.

PROJECT COST

The project cost of completing the HEIA activities and required documents as required by the New York State DOH will be $32,000 – paid in two installments: $12,000 at the start of the project and $20,000 upon delivery of the required HEIA documents.

OTHER TERMS AND CONDITIONS

Except in the event of gross negligence, neither you nor anyone acting on your behalf shall hold Ankura liable for (i) an aggregate amount (including interest and legal fees) in excess of the amount of Fees actually received by Ankura from you pursuant to this agreement, (ii) loss of profit, goodwill, business opportunity, anticipated savings or benefits, or (iii) special, consequential, exemplary, incidental, punitive or indirect damages.

This letter agreement may be executed in counterparts (and by facsimile or other electronic means), each of which shall constitute an original and all of which together will be deemed to be one and the same document.

(Remainder of page intentionally left blank.)

SACHS POLICY GROUP
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If this letter correctly sets forth our understanding, please indicate your acceptance in the space provided below, and your acceptance shall constitute a binding agreement.

Sincerely,

ANKURA CONSULTING GROUP, LLC

DocuSigned by:

By: F8820DB34B21404...
Jeffrey A. Sachs
Senior Managing Director

AGREED AND ACCEPTED BY:

COLUMBIA MEMORIAL HOSPITAL

By: ______________________
Dorothy M. Urschel
President and CEO

New York State Department of Health

Health Equity Impact Assessment Template

Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

SECTION A. SUMMARY

1. Title of project	Critical Access Hospital Designation Application
2. Name of Applicant	Columbia Memorial Health
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Sachs Policy Group (SPG) – 212-827-0660 • Aisha King, MPH aking@sachspolicy.com • Anita Appel, LCSW - AnitaAppel@sachspolicy.com • Maxine Legall, MSW, MBA - mlegall@sachspolicy.com Qualifications: • Health equity – 6 years • Anti-racism – 6 years • Community engagement – 25+ years • Health care access and delivery – 10+ years
4. Description of the Independent Entity's qualifications	The Health Equity Impact Assessment (HEIA) Team at Sachs Policy Group (SPG) is a diverse and experienced group dedicated to addressing health disparities and promoting equitable access to care. The team comprises experts with extensive backgrounds in health policy, population health, data analysis, community engagement, and anti-racism. They are committed to understanding and improving how social, environmental, and policy factors impact health equity, particularly for historically marginalized communities. The team collaborates with a wide range of health care organizations, government agencies, and communities to provide strategic support with an overarching goal of advancing diversity, equity, and inclusion. Their work encompasses research and evaluation of health programs and initiatives, stakeholder engagement, policy analysis, and development of mitigation and monitoring strategies. In particular, the team has experience analyzing policy proposals that impact medically underserved groups, such as Medicaid programs serving low-income individuals and maternal health initiatives that aim to reduce pre- and post-partum health disparities. They are dedicated to supporting organizations that serve vulnerable populations, including safety net hospitals,

	community health centers, long-term care organizations, behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities. The HEIA team is deeply passionate about improving the health care delivery system, especially for underserved populations. The team is unwavering in its commitment to promoting equity through rigorous research, insightful consulting, and strategic advisory work.
5. Date the Health Equity Impact Assessment (HEIA) started	August 20, 2025
6. Date the HEIA concluded	November 25, 2025

7. Executive summary of project (250 words max)
Columbia Memorial Hospital (CMH; dba Columbia Memorial Health) is a multi-campus health care system and member of the Albany Med Health System (AMHS), the largest not-for profit health system in northeastern New York and western New England. CMH is certified as a 192-bed acute care hospital and 38 primary and specialty care centers.[1] CMH operates the only hospital in Columbia County and the closest hospital to Greene County. CMH is experiencing significant operating deficits, requiring cash flow relief of approximately $1 million/month from AMHS. CMH has a three-pronged approach to regain financial stability and remain operational: 1. Expand inpatient behavioral health services with separate licensure; 2. Develop a renovated and expanded ambulatory surgical center; and 3. Seek Critical Access Hospital (CAH) designation. The current HEIA addresses the third prong. CAH designation requires hospitals to have a maximum of 25 inpatient medical/surgical beds (excluding psychiatric beds) and an annual average length of stay of 4 days. Inpatient and emergency services will not be impacted. CMH's average daily census for medical/surgical beds is 30-50, or ~21% of capacity. Census reduction will be achieved through improved discharge and a shift to ambulatory same-day surgeries.

[1] Although CMH is certified for 192 beds, the hospital does not and has never operated the 192 beds. They have a current operational capacity of approximately 75 beds. CMH merged with Greene County Hospital in the 1990s and all certified beds were consolidated at the time, leaving CMH with 192 certified beds.

CAH designation will give CMH access to a new reimbursement model that will reimburse based on the cost of care provided, with the goal of regaining financial solvency and reinvesting across the care continuum.
8. Executive summary of HEIA findings (500 words max)
Background research for this HEIA utilized data provided by the Applicant, census data, information and data from the Columbia and Greene Counties Community Health Needs Assessment/Community Service Plan, county and state reports, academic literature, and grey literature. As part of our meaningful engagement, we conducted interviews and focus groups with 41 individuals, including leadership and staff from CMH and AMHS, local community-based organizations, government officials, and community leaders. A survey sent to over 10,000 CMH patients and employees received 308 responses. We also attended three in person town halls held for employees, physicians, and community members. The HEIA found that CMH's hospital is viewed as a critical asset to the community. While not everyone who participated in meaningful engagement supported the transition to a critical access hospital (CAH) designation, everyone was united in wanting to retain the hospital and critical healthcare services in the community. All stakeholders wanted the hospital to remain in the community, and CAH designation is expected to achieve that goal. Given the scale of the project, all medically underserved groups are expected to be impacted by this project. Majority of stakeholders, particularly those who were familiar with the project, viewed this project as a necessary change that would allow the hospital to stay open and financially viable, while enabling CMH to reinvest in the healthcare system across the care continuum. Stakeholders raised concerns about job security, reduced local healthcare access, strained EMS and regional hospital capacity, care quality and patient safety, family visitation burdens, increased patient costs, and widespread misinformation. We believe that these concerns highlight the need for transparent and proactive communication and that they can be addressed appropriately by the Applicant. Our assessment recommends that the Applicant address transportation barriers that this project may cause for patients, families, and staff; develop and implement comprehensive communication plans for staff and the general public; establish contingency plans for ED holding and seasonal census increases; and implement workforce retention strategies. The project would additionally benefit from the Applicant leveraging existing relationships to proactively communicate plans, changes, and updates to employees, local providers, community leaders, and community members, emphasizing the need for this project, the hospital's overall goals, and projected positive impacts of the project.

Lastly, the Applicant should use existing metrics and mechanisms to track how the project impacts local health disparities. By systematically monitoring patient demographics, outcomes, and service utilization trends, the Applicant can continue to tailor services to meet the needs of its patient population.

SECTION B: ASSESSMENT

For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.

STEP 1 – SCOPING

1. **Demographics of service area: Complete the "Scoping Table Sheets 1 and 2" in the document "HEIA Data Tables". Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.**

   Please see attached spreadsheet titled "heia_data_tables_CMH_CAH.xlsx"

   Columbia Memorial Health's (CMH's) primary service area includes Columbia and Greene Counties.

2. **Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:**

Due to the scale of this project, all medically underserved groups may be impacted:

- Low-income people
- Racial and ethnic minorities
- Immigrants
- Women
- Lesbian, gay, bisexual, transgender, or other-than-cisgender people
- People with disabilities
- Older adults
- Persons living with a prevalent infectious disease or condition
- Persons living in rural areas
- People who are eligible for or receive public health benefits
- People who do not have third-party health coverage or have inadequate third-party health coverage
- Other people who are unable to obtain health care

3. **For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?**

We utilized data provided by the Applicant, census data, information and data from the Columbia and Greene Counties Community Health Needs Assessment/Community Service Plan, county and state reports, academic literature, grey literature, and interviews and surveys with leadership, staff, clinical experts, community providers, community members, and community-based organizations.

4. How does the project impact the unique health needs or quality of life of each medically underserved group (identified above)?

This project involves transitioning CMH's 192-bed acute care hospital into a 25-bed Critical Access Hospital (CAH) with separately licensed inpatient psychiatric beds. Notably, although CMH is certified for 192 beds, only 70 beds are fully staffed and in use. The Emergency Department (ED) will remain as is and continue to provide 24/7 care.

Concurrently, the Applicant plans to open an outpatient surgery center at Greene Medical Arts in 2027, expand Cardiac Care services at Greene Medical Arts, and add new psychiatric inpatient beds for adult and geriatric patients within the hospital campus. These projects have been addressed in prior HEIAs.

We expect the Applicant's proposal to become a CAH to impact all individuals in the service area in the following ways:

- Access to local inpatient medical/surgical beds will be reduced.
- ED wait times may increase.
- Travel times to receive care external to CMH may increase.
- Families of patients transferred to AMC may have a more difficult time visiting their family members.

However, we expect the increased reimbursement rate of the CAH designation to allow the hospital to remain open, maintain access to core services, reinvest in the community, and increase availability of primary care and key outpatient services.

The following section describes the medically underserved groups in the Applicant's service area and how the project may impact those populations specifically.

Older Adults[2]

Age Group	New York State	Greene County	Columbia County
<18	20.7%	16.4% ↓	16.3% ↓
18-64	61.9%	60.2% ↓	58.3% ↓
65+	17.4%	23.4% ↑	25.4% ↑

Columbia and Greene Counties both have aging populations, with the 65+ age cohort forecasted to grow 10% over the next 5 years.[3] Older individuals typically require more

[2] U.S. Census Bureau. (2023). https://data.census.gov
[3] Data provided by the Applicant

inpatient services than younger individuals and may face barriers navigating transportation systems, telehealth and digital health platforms, and the geographic complexity of Albany Med Health System's (AMHS) multiple locations. These challenges may result in delayed care-seeking, difficulty attending follow-up appointments, and complications coordinating transfers between facilities - concerns that are particularly acute for older individuals living alone who lack transportation or caregiver support.

Low-income people, individuals who are eligible for or receive public health benefits, and individuals who are under- or uninsured[4]

	New York State	Greene County	Columbia County
Median household income	$84,578	$74,011 ↓	$83,619 ↓
Poverty rate	13.7%	11.6% ↓	11.4% ↓
% on public insurance	41.4%	46.5% ↑	46.3% ↑
% Uninsured	5.2%	3.5% ↓	3.8% ↓

Greene and Columbia Counties both have lower median household incomes than NYS, and higher proportions of the population receiving public health insurance. Although the poverty rates of both counties are lower than that of NYS as a whole, they are higher than that of NYS when excluding New York City (NYC); 11.1%[5]. Notably, the city of Hudson has the largest non-White population (21.2%) and also the highest neighborhood poverty rate (17.4%) in the county.[9] Multiple stakeholders noted that the region's demographic changes (i.e., gentrification and second-home purchases by individuals from NYC) have negatively impacted local families' ability to purchase homes, afford rent, and access healthcare. In Columbia County, the percentage of children aged 5-17 years living in poverty ranges from 8.3% in Chatham Central School District to 21.5% in Hudson City School District. In Greene County, the percentage of children aged 5-17 years living in poverty ranges from 10.5% in the Greenville Central School District to 19.8% in the Windham-Ashland-Jewett Central School District.[6]

Individuals with lower incomes often face difficulties accessing healthcare due to cost-related barriers such as high out-of-pocket expenses, lack of healthcare providers who accept public insurance, and transportation challenges. This project may impact individuals with lower incomes or those with public insurance if they fear seeking care due to perceived emergency medical transportation costs or beliefs that they will be transferred to Albany Medical Center (AMC). They may also be impacted by limited ability to access transportation services to receive care.

Racial and ethnic minorities and immigrant populations[7]

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[4] U.S. Census Bureau. (2023). https://data.census.gov

[5] Columbia-Greene Planning Partners. (2022). *Community Health Needs Assessment Implementation Strategy Community Health Improvement Plan and Community Service Plan for Columbia and Greene Counties, NY and their Hospital 2022-2024.* https://www.columbiacountynyhealth.com/wp-content/uploads/2022/12/2022-2024-CHIP-CSP_Columbia-Greene.pdf

[6] U.S. Census Bureau. (2022). https://data.census.gov

[7] U.S. Census Bureau. (2023). https://data.census.gov

	New York	Greene County	Columbia County
White	55.2%	84.8% ↑	83.7% ↑
Black/African American	14.8%	5.0% ↓	4.2% ↓
Asian	9.6%	1.0% ↓	2.3% ↓
Hispanic/Latino	19.5%	6.5% ↓	5.8% ↓
Foreign born	23.1%	4.9% ↓	6.8% ↓
Speak English less than very well (2018-2022)	6.7%	1.0% ↓	1.2% ↓

While the Applicant's service area is majority White, racial and ethnic minorities face disproportionate socioeconomic challenges that may increase their need for specialized health services. In Columbia County, 32% of Black Americans live in poverty compared to 10.5% of White residents, highlighting significant racial disparities in financial security and access to resources.[8] The city of Hudson, which has both the largest non-White population (21.2%) and the highest neighborhood poverty rate (17.4%), exemplifies the intersection of racial and economic disparities in the region. Barriers related to transportation and costs may particularly impact racial and ethnic minority individuals.

Local stakeholders identified several key immigrant populations in the area, including predominantly Hispanic seasonal migrant farmworkers, Haitian communities, and Bengali communities. The transition to CAH designation may create additional challenges for immigrant populations and individuals with limited English proficiency. Increased reliance on transfers to Albany Medical Center for specialized services may compound existing barriers related to navigating unfamiliar healthcare systems, coordinating transportation across greater distances, and communicating with multiple provider teams. For immigrant communities, particularly undocumented individuals, concerns about immigration enforcement during transfers or at larger hospital systems may deter care-seeking behavior or cause delays in accepting necessary transfers.

People with disabilities and/or prevalent infectious disease or condition[9,10]

	New York State	Greene County	Columbia County
% Living with disability	13.0%	14.8% ↑	13.9% ↑
Percentage of deaths that are premature (< 75 years)	42.9%	44.0% ↑	42.5% ↓
Diabetes mortality per 100,000 population, age-adjusted	19.5	25.0 ↑	26.8 ↑
Diseases of the heart mortality per 100,000 population, age-adjusted	170.6	195.2 ↑	163.7 ↓
Lung cancer incidence per 100,000 population, age-adjusted (2019-2021)	51.1	78.3 ↑	65.6 ↑

[8] PolicyMap. (n.d.). *Community Health Report: Columbia County, NY.* PolicyMap. Retrieved April 9, 2025, from https://www.policymap.com/

[9] U.S. Census Bureau. (2023). https://data.census.gov

[10] New York State Department of Health. (2023). https://apps.health.ny.gov

The percentages of Columbia and Green County residents living with a disability both exceed the state average of 13.0%. Many of these individuals are also older people over the age of 75. The most common types of disabilities are hearing difficulties, cognitive difficulties, ambulatory difficulties, self-care difficulties, and independent living difficulties.[11]

People with disabilities can face significant barriers to accessing health care services due to physical accessibility issues, transportation limitations, communication challenges (such as for those with hearing or cognitive impairments), and a lack of providers trained in disability-sensitive care. Additionally, individuals with cognitive impairments or mobility limitations may experience greater difficulty in navigating complex healthcare systems, leading to delayed or inadequate treatment.

Populations with disabilities, infectious diseases, and chronic conditions are at increased risk for needing intensive healthcare services. Therefore, these individuals may be impacted by the conversion to CAH if they are unable to be cared for at CMH and require transfer to another hospital.

People living in rural areas

Access to health care is particularly challenging in rural areas due to provider shortages, far distances between healthcare facilities, and limited public transportation.[12] Both Greene and Columbia Counties are predominantly rural, with many residents living in areas where health services are scarce or difficult to access. In Columbia County, 82.8% of the population lives in a low population density area, and Greene County has the lowest overall population and population density in the Hudson Valley region.

Rural communities experience higher rates of social isolation and economic hardship, which can contribute to untreated or worsening health conditions if untreated.[13] As mentioned above, the older adults who make up a significant portion of the rural population in these counties may face compounding barriers related to living in a rural area, such as mobility limitations, lack of internet, limited skills to access telehealth services, and challenges navigating complexity of novel and larger healthcare systems.

Transportation was the most commonly mentioned impact of this project by local stakeholders. There is significant concern that individuals in rural areas will have increased transportation times both to CMH's ED and to external hospitals, particularly if EMS systems face increased burden. There are not currently any public transportation systems that individuals in the local community can utilize to get to Albany.

Women & Lesbian, gay, bisexual, transgender, or other-than-cisgender people[14,15]

[11] American Community Survey 2015-2019

[12] Edwards A, Hung R, Levin JB, Forthun L, Sajatovic M, McVoy M. Health Disparities among Rural Individuals with Mental Health Conditions: A Systematic Literature Review. Rural Ment Health. 2023 Jul;47(3):163-178. doi: 10.1037/rmh0000228. Epub 2023 May 11. PMID: 37638091; PMCID: PMC10449379.

[13] Warshaw, R. (2017). Health disparities affect millions in rural US communities. Association of American medical colleges, 31. Accessed on [April 2, 2025] from https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities

[14] U.S. Census Bureau. (2023). https://data.census.gov

[15] The Williams Institute. (n.d.). *LGBT statistics: Social services in ZIP code 36101 — economic*. University of California, Los Angeles. Retrieved August 24, 2025, from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=SS&area=36101#economic

	New York State	Greene County	Columbia County
Cisgender women as % of total population	51.0%	48.0% ↓	49.0% ↓
Fertility (%) *(women who gave birth past year)*	4.9%	2.8% ↓	4.6% ↓
Marital status (%): Married	44.6%	47.6% ↑	53.0% ↑
Same-sex couples per 1,000 households	16.7	7.6 ↓	13.6 ↓

The transition to CAH designation may disproportionately impact women with cardiac and stroke emergencies, who face lower survival rates from out-of-hospital events compared to men. While emergency services will remain available, potential challenges with timely transfers to higher-level care facilities or diversions that increase time to specialized treatment could compound existing gender disparities in outcomes and recovery.[16] However, the planned development of an enhanced cardiac care center could help mitigate these concerns and improve prevention options and outcomes for women (and all patients) with cardiac care needs. Additionally, women are more likely to be primary caregivers and may face barriers accessing care due to caregiving responsibilities, transportation limitations, and financial constraints. The need to travel to more distant facilities for specialized care may create additional logistical and financial burdens for this population.

For lesbian, gay, bisexual, transgender, queer, or other-than-cisgender people (LGBTQ+), the transition could impact quality of care if there is inconsistent staff cultural competency across hospitals or reductions in on-site specialty services that LGBTQ+ patients disproportionately rely on.

All groups

Importantly, all medically-underserved groups will be positively impacted by the hospital remaining open and providing vital acute care services. The CAH model has proven viable for many hospitals across the state.

5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

The tables below outline utilization across all CMH services among key medically underserved groups between November 1, 2023 and October 31, 2024.[17] The total number of individuals accessing inpatient med/surg services is expected to decrease with transition to CAH designation; however, the proportion of individuals across medically underserved groups who access services is not expected to change, as the

[16] Mody, P., Pandey, A., Slutsky, A. S., Segar, M. W., Kiss, A., Dorian, P., Parsons, J., … Morrison, L. (2021). Gender-based differences in outcomes among resuscitated patients with out-of-hospital cardiac arrest. *Circulation, 143*(7), 641-649. https://doi.org/10.1161/CIRCULATIONAHA.120.050427
[17] Data provided by Applicant

location and all other components of the service (e.g., accepted insurance) are expected to remain the same.

Race/Ethnicity

Race	% of Patients
Black	4.1%
White	77.7%
Other	17.3%
Asian	0.8%
American Indian/Alaska Native	0.1%
Native Hawaiian/Pacific Islander	0.0%

Ethnicity	% of Patients
Hispanic or Latino (any race)	10.0%
Not Hispanic or Latino	81.1%
Declined to Answer	8.9%

Payor Mix

Payor	% of Patients
Medicaid	25.1%
Medicare	25.3%
Dual Eligible (Medicaid & Medicare)	12.2%
Commercial	32.7%
Uninsured	3.3%
Other (NF/Comp)	1.5%

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

CMH is the only hospital in Columbia and Greene Counties. According to NYS DOH, there are 29 hospitals including CMH in the Capital District. The table below shows these hospitals and their distance to the Applicant.

Additionally, some hospitals in the Southern regions, including HealthAlliance Hospital and Northern Dutchess Hospital, are located 20 to 40 miles from the Applicant.

Name	Region/County	Distance from CMH
Columbia Memorial Hospital	Columbia	-
Samaritan Hospital - Albany Memorial Campus	Albany	34.7 miles
Albany Medical Center Hospital	Albany	36.1 miles
Albany Medical Center - South Clinical Campus	Albany	39.1 miles
Samaritan Hospital	Rensselaer	40.3 miles

St. Peter's Hospital	Albany	40.5 miles
St. Peter's Addiction Recovery Center	Albany	43.8 miles
Sunnyview Hospital and Rehabilitation Center	Schenectady	50.2 miles
St. Peter's Hospital - SPARC	Rensselaer	51.1 miles
Ellis Hospital - Bellevue Woman's Care Center Division	Schenectady	54.4 miles
Ellis Hospital	Schenectady	54.9 miles
Cobleskill Regional Hospital	Schoharie	57.2 miles
Margaretville Hospital	Delaware	59.5 miles
Saratoga Hospital	Saratoga	69.5 miles
St. Mary's Healthcare - Amsterdam Memorial Campus	Montgomery	72.4 miles
St. Mary's Healthcare	Montgomery	72.7 miles
O'Connor Hospital	Delaware	77.1 miles
A.O. Fox Memorial Hospital	Otsego	81.9 miles
Mary Imogene Bassett Hospital	Otsego	82.6 miles
Glens Falls Hospital	Warren	83.6 miles
Nathan Littauer Hospital	Fulton	85.9 miles
Delaware Valley Hospital Inc	Delaware	98.3 miles
A.O. Fox Memorial Hospital - Tri-Town Campus	Delaware	116 miles
The University of Vermont Health Network - Elizabethtown Community Hospital Moses Ludington	Essex	135 miles
The University of Vermont Health Network - Elizabethtown Community Hospital	Essex	153 miles
Adirondack Medical Center-Lake Placid Site	Essex	170 miles
Adirondack Medical Center-Saranac Lake Site	Franklin	181 miles
The University of Vermont Health Network - Champlain Valley Physicians Hospital	Clinton	191 miles
The University of Vermont Health Network - Alice Hyde Medical Center	Franklin	238 miles

7. **What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?**

   The Applicant is the only hospital in Columbia and Greene Counties.

8. **Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.**

   The Applicant is committed to providing comprehensive care and support to individuals who are uninsured or underinsured, in accordance with current financial assistance policies and federal/state regulations. This commitment is not expected to be impacted by the proposed project. The Applicant's current policy states that the hospital will not discriminate based on race, color, religion, creed, sex, national origin, marital status, sexual orientation, transgender status, gender identity, veteran status, or any other characteristic as protected by applicable law.

The Applicant participates in efforts to support the Prevention Agenda, New York State's Health Improvement Plan, which serves as a blueprint for state and local action to improve the health and wellbeing of all New Yorkers and promote health equity across any population that is experiencing a health disparity. The Applicant also implements community service activities and conducts a Community Health Assessment (CHA) every three years.[9]

The Columbia Memorial Hospital Health Affairs Committee, which replaced the Board of Trustees when the Applicant joined AMHS, is representative of the community, and all members either live, work, or have family ties to Columbia and Greene Counties.[18]

CMH is compliant with New York State's Public Health Law 2807-k, which requires hospitals to establish financial aid policies and procedures for reducing charges to low-income individuals without health insurance or who have exhausted their health insurance benefits and demonstrate an inability to pay full charges. As part of AMHS, CMH has a financial assistance policy that provides medically necessary care at no charge or reduced charge for patients who meet eligibility requirements.[19] Patients are provided with a financial counselor who provides assistance in the patient's language or via qualified telephonic interpreters through each phase of the application process.

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

The Applicant has stated that there will be limited, if any, impact on current staff. They note that agency staff and Per Diem employees are currently needed to fill vacancies throughout the organization, and that this would no longer be necessary if CMH is approved for CAH designation. Remaining employees would either 1) not be impacted or 2) have the opportunity to work elsewhere in the organization.

Stakeholders identified staffing concerns including potential workforce attrition, logistical barriers, and pipeline disruption. Despite assurances to the contrary, anxiety regarding potential layoffs may prompt employees to seek alternative employment, exacerbating existing staffing challenges. If staff are relocated or assigned to work at sites outside of the main Hudson campus, transportation barriers and/or retraining/credentialing requirements present significant retention risks, particularly for employees without personal vehicles or those facing increased commuting costs. Lastly, reduced acute care volume may jeopardize clinical placement partnerships with local nursing programs

[18] Data provided by the Applicant
[19]Albany Med Health System. (n.d.). *Financial Assistance Programs*. Retrieved [April 2, 2025], from https://www.albanymed.org/patients-visitors/billing-insurance/financial-assistance-programs/

and limit internship and training opportunities, compromising the long-term staffing pipeline.

The Applicant is deliberate when hiring, retaining, and developing diverse talent. Specific steps taken to ensure diversity among staff are as follows:

- Diverse and inclusive job advertisements
- Inclusive language in their job postings
- A culture that welcomes all candidates
- Recruiting from a wide variety of sources; high schools, universities and a variety of job posting websites
- Partnering with local minority groups to help promote job opportunities.

CMH staff currently self-identify as the following:[20]

- American/Alaska Indian: 2
- Asian: 68
- Black/African American: 105
- Hispanic/Latino: 45
- White: 1,012
- Two or more races: 63

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.

There are no civil rights access complaints against the Applicant.[21] Over the past 10 years, two cases have been filed under the jurisdiction of the Employment Opportunity Commission and one case under the Division of Human Rights, all three by employees.

11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.

The Applicant has not undertaken similar work in the las five years. However, this project is related to the organization's broader efforts to regain financial viability and maintain and expand access to vital services in the region. As mentioned in the executive summary, CMH's three-pronged strategy to return to financial stability includes: (1) the conversion of the hospital to Medicare's Critical Access Hospital designation, which will provide additional reimbursement for acute care services; (2) the expansion of inpatient behavioral health services and transition of licensure for these services; and (3) the development of an ambulatory surgery center to provide renewed surgical facilities and increase capacity in the region.

[20] Data provided by the Applicant
[21] Data provided by the Applicant

STEP 2 – POTENTIAL IMPACTS

1. **For each medically underserved group identified in Step 1 Question 2, describe how the project will:**
    a. **Improve access to services and health care**
    b. **Improve health equity**
    c. **Reduce health disparities**

The transition of CMH to a CAH will enhance access to services, advance health equity, and reduce health disparities in the following ways:

1. Preserving acute inpatient care in the community. Without CAH designation and the associated reimbursement rates, the hospital would continue to run a significant deficit and be unable to continue services. The CAH designation will enable the hospital to achieve financial viability while continuing to provide vital emergency and acute care services to the community. All medically underserved groups will benefit from retaining these services locally; both Columbia and Greene Counties are designated by HRSA as Medically Underserved Areas. In particular, older individuals, individuals with public health insurance, and individuals in rural areas - the Applicant's primary patient population - will benefit from having a nearby hospital with a fully functional ED, 25 inpatient med/surg beds, and separately licensed inpatient psychiatric beds. These services prevent the need for longer-distance travel to access emergency and acute care, which disproportionately burdens elderly patients, those without reliable transportation, and individuals with mobility limitations. Additionally, increased visibility surrounding this transition could enhance community awareness of CMH's outpatient and ambulatory services and improve access to wraparound health services such as primary care, chronic disease management, and support programs.

2. Enabling strategic reinvestment in hospital infrastructure and outpatient services. Financial stability will allow CMH to focus resources on services with demonstrated community need (emergency care, medical-surgical services, behavioral health, cardiac care). Increasing the kinds and quality of services available locally will benefit all medically underserved groups. Planned developments include the 2027 opening of Greene Medical Arts, a state-of-the-art ambulatory surgical center that will expand access to outpatient procedures closer to home, and a specialty cardiac care center designed to address cardiovascular health needs - a leading cause of morbidity and mortality in the region. Modern equipment and technologies will improve diagnostic capabilities and treatment quality, particularly benefiting patients with complex chronic conditions who require ongoing specialized care. Enhanced outpatient services will also reduce reliance on emergency department visits for non-emergent conditions, improving care coordination and health outcomes for vulnerable populations including those with diabetes, hypertension, and behavioral health needs.

3. Focusing resources on services that best meet community needs. By concentrating on services where CMH has demonstrated community demand, the CMH can reduce health disparities through improved quality and outcomes. CMH will be able to provide higher-quality care in specialty areas rather than spreading resources thinly across services that may be better delivered at tertiary care centers. For example, establishing formal transfer protocols and partnerships with specialty facilities ensures patients requiring complex interventions receive timely access to care at appropriate levels, while CMH maintains excellence in services most relevant to daily community health needs. This approach benefits rural residents, older individuals, and those with limited mobility who gain access to high-quality local care for most of their health needs, with clear pathways to specialized care when necessary.

2. **For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.**

Potential unintended negative impacts of the project are as follows:

Community perception and utilization:

- **Public misconception about hospital closure:** The transition has generated confusion in the community, with misinformation circulating on social media platforms and in the news suggesting that the hospital is closing entirely. The misconception could lead to decreased utilization of available services (e.g., currently thriving orthopedic surgery practices), worsening the hospital's financial position.
- **Political opposition:** Public criticism from local political figures may amplify negative perceptions and contribute to community mistrust of the hospital, potentially deterring patients from seeking care at CMH.
- **Population outmigration concerns:** Community fear that the hospital is diminishing could accelerate population loss, particularly among young people and healthcare workers, straining the local economy and tax base.

Workforce impacts:

- **Staff attrition:** Healthcare workers may leave due to concerns about job security, reduced clinical variety, relocation requirements, or feelings of being misled by hospital administration. Staff without reliable transportation or unwillingness to commute longer distances may be disproportionately affected. Loss of experienced staff would directly impact care quality for all patients.
- **Clinical skill degradation:** Reduction in acute care volume, particularly ICU beds, may lead to fewer opportunities for staff to maintain and develop critical care skills.
- **Reduced training opportunities:** Local nursing programs and healthcare training institutions may lose clinical placement sites for students needing acute and critical care experience. This could make local educational programs less competitive and reduce healthcare workforce pipeline development.

Access and care coordination challenges:

- **Emergency department strain:** Increased transfers could lead to ED overcrowding and increased ambulance wall times (i.e., when ambulances cannot unload patients due to lack of ED capacity), potentially delaying emergency response times for the broader community.
- **Burden on regional systems:** Increased patient transfers may overwhelm receiving facilities like AMC and Kingston Hospital and strain regional EMS systems transporting patients longer distances.
- **Family visitation barriers:** Patients transferred to Albany face significant visitation challenges for family members lacking transportation, financial resources, or ability to travel due to work or caregiving responsibilities. This particularly affects elderly patients, those with serious illnesses requiring family support, and immigrant communities with limited mobility.
- **Care fragmentation:** Patients transferred to Albany for surgical procedures may not return for post-operative follow-up due to transportation barriers or confusion about care coordination, leading to gaps in care and potentially avoidable complications.

Service reduction impacts:

- **Strain on community services:** Social service organizations, transportation providers, and community health programs may face increased demand as patients need more assistance navigating transfers and accessing care at farther locations.

Potential unintended positive impacts of the project are as follows:

Enhanced community awareness and engagement:

- **Improved awareness of available services:** With appropriate communication strategies, the increase in public attention caused by the proposal could serve as an opportunity to educate the community about the full range of services CMH provides beyond inpatient care, including primary care, behavioral health, and planned ambulatory services. Improved awareness could increase opportunity for health education and utilization of preventive and outpatient services, leading to reduced need for inpatient care. This may particularly impact underserved populations unaware of available resources.
- **Enhanced reputation:** Visible investments in hospital infrastructure and service quality could improve CMH's reputation, increasing community confidence and willingness to utilize available services. In addition, facilitating access to specialty services and clinicians through improved collaborative systems with AMHS could improve CMH's reputation as people access the care they need with increased ease.

Improved partnerships and regional systems:

- **Increased collaboration with community organizations:** With proper planning and communication, the transition could help CMH develop stronger partnerships with local social service providers, public health organizations, and community-based organizations. These collaborations could improve care transitions, discharge planning, and wraparound services for vulnerable populations, improving continuity of care.
- **Formalized transfer protocols:** Development of clear pathways between CMH and specialty facilities could improve care coordination and reduce delays for patients requiring higher levels of care, benefiting all patients and particularly those with complex needs or who experience difficulties navigating healthcare systems.

3. **How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.**

The current amount of indigent care is $9,916,126, which includes both bad debt and charity care activity only. Several services are reimbursed "below cost" (most Medicaid services and certain Medicare services) which are not included in this number.[22] Designation as a CAH will not change the Applicant's requirements to provide indigent care, although the total amount of indigent care provided may decrease if fewer patients overall are admitted.

4. **Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.**

Transportation options in the Applicant's service area include personal/private transit by car, contracted transportation services, and public transportation. The Applicant understands the transportation barriers that some members of the service area face and currently has partnerships and contracts in place to support individuals in need. These partnerships include a contract with The Healthcare Consortium's Children and Adults Rural Transportation Service (CARTS) program, which provides Columbia County residents with non-emergency medical transportation. The service retrieves individuals from any location in Columbia County and delivers them to locations throughout the county and beyond. Clients who are enrolled in Medicaid must call a company called MAS to confirm eligibility for Medicaid transportation and receive prior authorization for the trip. CARTS operates 8:00am-4:00pm Monday through Friday, excluding holidays. Ambulette services are available for individuals requiring additional assistance. As a result of a recently conducted HEIA on the construction of an ambulatory surgical center in Catskill, NY, the Applicant has partnered with local government to increase the number and frequency of stops at hospital-run locations.

Transportation to CMH within the Applicant's service area will remain unchanged. However, patients requiring care in Albany and their families may face transportation

[22] Data provided by Applicant

challenges. While emergency medical services will transport acute cases, families must rely predominantly on personal vehicles, creating potential barriers due to financial and time constraints. Public transportation options are limited to Amtrak service between Hudson and Albany and local bus routes within Albany, Columbia County, and Greene County.

5. **Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.**

   The project will not cause architectural barriers for people with mobility impairments.

6. **Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law § 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?**

   N/A

Meaningful Engagement

7. **List the local health department(s) located within the service area that will be impacted by the project.'**

   Columbia County Department of Health

   Greene County Department of Health

8. **Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?**

   Several Columbia and Greene County government officials, including representatives from both Counties' Health Departments, participated in the Meaningful Engagement portion of this assessment.

9. **Meaningful engagement of stakeholders: Complete the "Meaningful Engagement" table in the document titled "HEIA Data Table". Refer to the Instructions for more guidance.**

   Please refer to attached spreadsheet titled "heia_data_tables_CMH_CAH.xlsx"

10. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

Current CMH patients and residents of Greene and Columbia Counties will be affected by this project. In particular, individuals with estimated stays of longer than 4 days and those needing intensive care will be most affected. Importantly, a majority of current CMH patients with long length of stays do not require hospital-level care and would be better served in long-term care facilities. While individuals requiring acute inpatient care and their families may in some cases be transferred to Albany for care that they previously would have been able to receive locally, the entire service area will benefit from the retention of the hospital, including the Emergency Department and the remaining medical/surgical beds.

Without this project, the hospital might be forced to close. CMH has had significant operating deficits over the past several years: $18 million in 2023, $13 million in 2024, and projected to be $10 million in 2025. Additionally, the average daily census for CMH's medical/surgical beds is 40- 50 inpatients, or approximately 78% of the staffed bed capacity for inpatient medical/surgical services.

The Applicant's goal is to leverage the reimbursement rate provided by CAH designation to reinvest in critical infrastructure at the hospital and outpatient services to meet the evolving needs of the local community.

All stakeholders wanted CMH to remain open and within the community. Many stakeholders had positive reactions to the project and believed that this project is a necessary step for the organization. Several stakeholders, including those supportive and not supportive of the project, also expressed concerns.

Stakeholders expressed the following concerns:

- **Job security, staffing, and training opportunities.** As noted above, staff were concerned about job loss. There were many questions and concerns about layoffs and relocations due to the reduced hospital capacity. Staff also wanted to understand the process for deciding which staff would be asked to stay or relocate. Community and staff leaders expressed concern about staff attrition if they are asked to relocate to Green Medical Arts, particularly if they do not have cars or do not wish to pay the bridge toll.
- **Patient access & community healthcare.** Patients, staff, and community leaders expressed concern about the reduced availability of local healthcare services and negative impact on community members who cannot travel to Albany. There were concerns about what would happen to patients needing more than 4 days of inpatient care, in particular current patients who have been at the hospital for an extended period.
- **EMS and ED capacity. C**oncerns about insufficient ambulance/EMS capacity for additional transfers and lack of available beds at receiving hospitals were raised. Staff noted that it is already difficult to transfer patients to AMC, and that CMH patients transferred to AMC currently experience long wait times.

- **Quality of care & patient safety.** There were concerns that patient care would suffer, and about the ability to stabilize critical care patients if ICU is reduced.
- **Impact on families and visitors.** Concerns arose about increased hardships for families traveling to distant hospitals with limited access to public transportation. It was additionally noted the importance of being close to loved ones during hospitalization, and worries about confusion managing travel and navigating larger, more complex facilities.
- **Increased patient costs.** Stakeholders were concerned about potential for patients to incur additional costs if required to transfer to other facilities, including transportation costs and inconsistent insurance coverage across facilities.
- **Communication issues.** Communication was one of the most common concerns brought forward by stakeholders. There was some mistrust among clinical staff about the accuracy of patient numbers/data presented by administrative staff. In addition, significant misinformation has been spread among the community, leading many to believe that the hospital is closing. Community leaders were concerned that without a proactive and comprehensive communication plan, there would be increased division and mistrust between the community and the hospital.
- **Regulatory and process concerns.** Stakeholders were concerned about what would happen to the hospital if it were not approved for critical access designation.
- **Pandemic/ emergency preparedness.** Some staff were concerned about reduced capacity in the event of another pandemic.
- **Impact on other facilities.** Some stakeholders were worried about overtaxing other hospitals, noting an already insufficient hospital bed capacity regionally.

11. How has the Independent Entity's engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

As part of our stakeholder engagement, we conducted interviews and focus groups with 41 individuals, including among leadership and staff, government officials, healthcare professionals, service providers, and community leaders. We also interviewed representatives from community-based organizations and the local departments of health. Surveys were sent to CMH donors, board members, employees, community members, patients, and families of current or former patients. We also attended three in-person town hall meetings, where CMH leadership presented the proposal to staff, physicians, and community members and addressed questions.

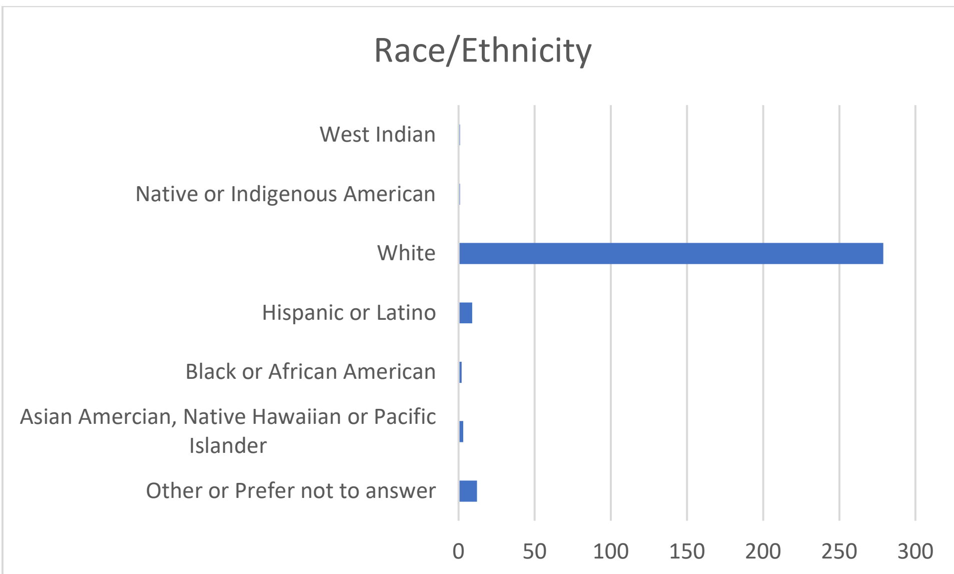
Interviews and survey responses helped us identify key considerations for the project, including motivation for the project, groups who would be most impacted, concerns, and suggestions. The town halls helped us identify key questions from community and staff, which indicated topics of most importance to these groups.

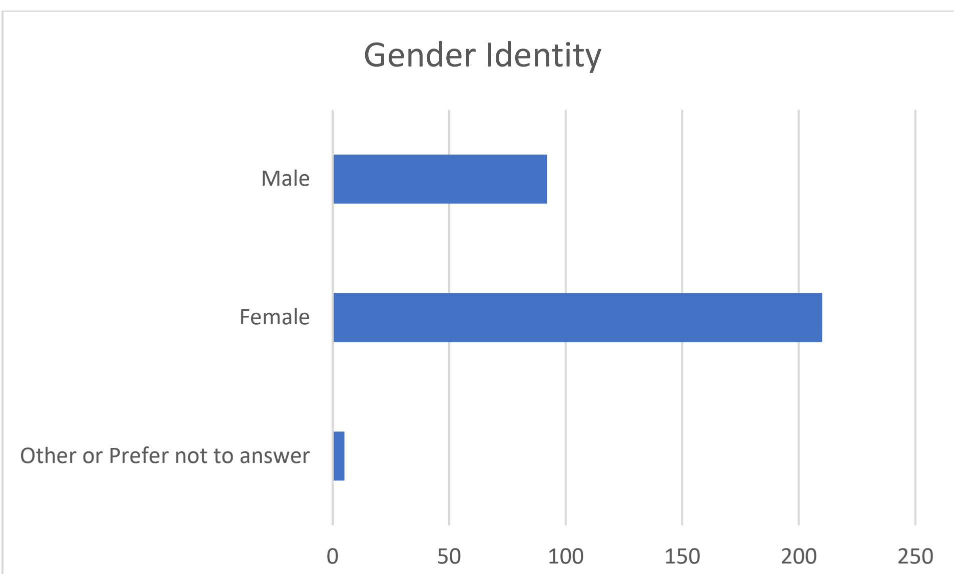
From the surveys, we received 185 responses from current or former patients and 123 responses from current CMH employees. Among the 308 responses we received, 44 (14%) were opposed to the project, 163 (53%) were supportive of the project, and 101 (33%) were neutral, unsure, or requested additional information.

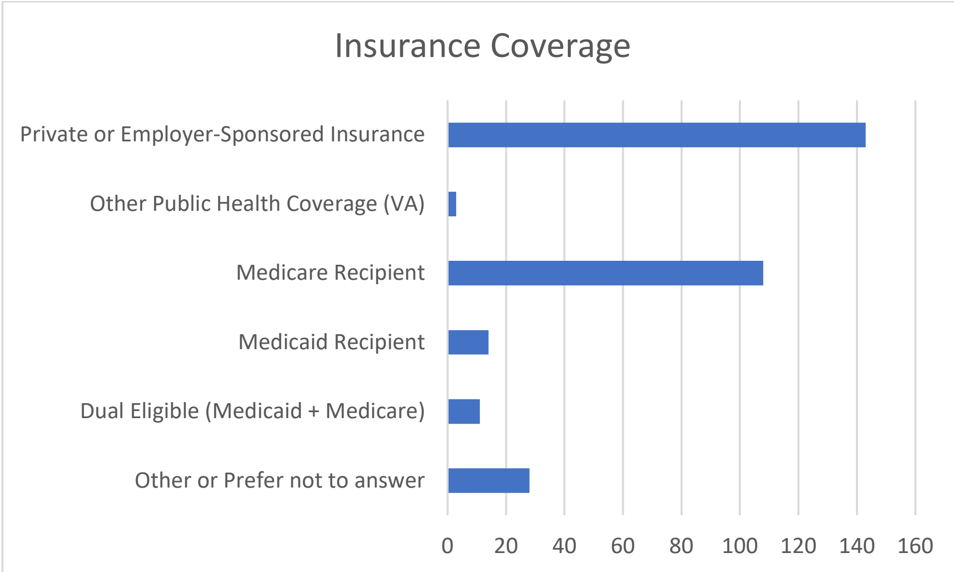
12. **Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.**

Our stakeholder engagement process involved working closely with CMH to identify and conduct comprehensive outreach to community-based organizations, staff, providers, and community members from which we sought feedback for the assessment. Among community survey respondents (N=185), more than 65% of were over 65 years of age, 5% identified as LGBTQIA+, and nearly 20% indicated that they were living with a disability and/or managing an infectious disease of chronic condition (e.g., diabetes).

Key demographics of all survey respondents (N=308):







STEP 3 – MITIGATION

1. **If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:**
    a. **People of limited English-speaking ability**
    b. **People with speech, hearing or visual impairments**
    c. **If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?**

The Applicant has strict policies and procedures in place to ensure that all patients have access to certified interpreters. Staff utilize the NYS Language Identification Tool to assist them in identifying interpretation needs. The primary method of providing interpretation services is via dual handset telephones, and video interpretation is available to support needs for American Sign Language. Any additional interpretation needs are escalated to the Language Access Coordinator to ensure timely access to communication services for patients. All staff are required to complete annual education on language access services, including the proper procedure for accessing interpreters and providing interpretation services to individuals in care.

The evaluation of language access services is ongoing and conducted annually at a minimum. Evaluations include review of mandatory staff education completion rates, review of event reports and patient grievances related to language access services, and confirmation that adequate and functional equipment is in place to meet patient needs.

Lastly, the Applicant conducts ongoing review of language needs within the community by 1) using county-level data to identify primary languages used in students' homes, 2) encouraging staff to alert the Language Access Coordinator to any newly identified interpretation or translation needs, and 3) identifying frequently used languages through review of translator service reports.

2. **What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?**

The Independent Entity suggests the following changes so the project better meets the needs of medically underserved groups.

- **Ensure that transportation barriers do not negatively impact care or health outcomes as a result of this project.** Transportation was the most commonly expressed concern among stakeholders and was noted as a particular barrier for medically underserved groups. The Applicant should work with community leaders, politicians, and AMHS to develop strategies to ensure that patients and family members can access appropriate care and visiting hours. In addition, the Applicant should ensure that staff asked to relocate have means of transportation and offer support if they do not (e.g., reimbursement of tolls or a shuttle between GMA and the hospital).
- **Transparently address staff concerns.** At town halls and in survey responses, staff expressed significant concerns and stress about continued employment. The Applicant should continue to engage actively with and solicit feedback from staff and employees to assuage concerns and ease tensions. Plans to communicate with staff should include addressing concerns such as fears of layoffs, plans for relocation, intensive care, observation beds, and flex-beds.
- **Develop plans for workforce retention.** Worries among the staff or expectations of forced relocation may lead to increased attrition of staff – even if beliefs are unfounded. In addition to developing trust among staff through transparent communication, the Applicant should create a concrete plan for retaining as many staff as possible. This could include collaborating with the Columbia-Greene Workforce Development Board.
- **Address public misinformation.** As noted above and seen in survey responses, there has been widespread misinformation about the project. The Applicant should liaise with key community leaders and staff to develop a strong and cohesive communication plan that can strengthen its reputation and continue to grow its positive presence in the community. This should include utilizing social media, as stakeholders highlighted widespread misinformation across social media platforms.
- **Address questions about current and future long-term patients.** Many patients currently exceed the 4-day limit required by CAH designation. It was noted that the majority of these patients do not require the acute level of care that hospitals provide, but they are not able to be transferred or discharged. The Applicant should create and communicate a plan for current and future patients who need inpatient stays of longer than four days. Planning should include key experts such as the Performance Improvement Committee and clinical staff currently caring for these patients.

- **Create contingency plans if the ED is overcrowded.** Stakeholders expressed significant concerns about long ED wait times, both at CMH and AMC. They also expressed concerns about meeting med/surg bed needs in winter months, when occupancy increases significantly. For example, winter census often reaches 35–50 patients, exceeding the CAH cap. A concrete contingency plan for current and future needs of the population should be created and clearly communicated to all staff. One stakeholder suggested increasing the size of the ED to prevent ambulance blockages.
- **Focus on improving access to services across the healthcare continuum.** The Applicant should play to its strengths by improving and expanding primary care practices, enhancing post-acute and transitional care, and building on current health education programs. By increasing and improving outpatient and community-based services, it may be possible to reduce hospital admissions and readmissions.

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?

The Applicant has a strong and positive presence among the community services network within Columbia and Greene Counties and the surrounding catchment area, which can be leveraged to gain important feedback on the implementation of this project moving forward. The Applicant has existing collaborative relationships with a large network of community leaders, including healthcare providers, community services providers, political leaders, and local departments of health. Key partners include (but are not limited to) the Department(s) of Human Services, the Chamber of Commerce, the Columbia County Healthcare Consortium, the Columbia County Economic Development Corporation, the Columbia County Emergency Medical Services, and Greene County Legislature. These relationships can be leveraged to consult impacted stakeholders on forthcoming changes to the project.

The Applicant has held multiple Town Halls, which were accessible both in person and virtually, for employees and community members. The Applicant is planning to continue holding Town Halls throughout the application and implementation process, which will enable them to gather invaluable feedback from key stakeholders.

The Applicant has several mechanisms in place to consult patients and family members:

- Leaders aim to develop committees and workgroups which are representative of prevalent cultural groups within the service area. Participation by individuals with lived experience is viewed as a valuable resource, and as such current or previous service recipients are encouraged and invited to participate in workgroups when possible.
- Patient experience surveys are utilized to identify opportunities for improvement across service offerings.
- The Applicant convenes inpatient and outpatient Family Advisory Committees, which encourage open dialogue regarding the experiences of patients or families who have received services at CMH.

In addition to established methods of engagement, the Applicant could utilize social media platforms to communicate with the public and address misinformation.

4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

Across the organization, the Applicant has shown a dedication to ensuring equitable access to care:

- AMHS has a governance workgroup focused on reducing disparities in access, quality, and treatment outcomes. The workgroup is multidisciplinary and diverse with robust participation from each entity from the health system, including the CEO of CMH.
- The CMH Diversity, Equity, and Inclusion Leadership Committee plans to develop learning materials to educate managers and leadership on how to promote equitable access to care and engage employees in the continued development of a cultural environment that is inclusive for the CMH workforce and patients.

This project addresses systemic barriers to equitable access to services in the following ways:

- **Financial sustainability of essential local services.** The most fundamental barrier to healthcare access is absence of available services. Without CAH designation, CMH faces potential closure. Hospital closure would be devastating for the local community and would eliminate emergency and acute care access for a medically underserved, rural population. CAH designation addresses the systemic barrier of healthcare facility financial unsustainability in rural areas by providing Medicare and Medicaid reimbursement rates that reflect the cost of delivering care in low-volume settings. As such, this project will ensure the continued availability of acute, emergency, and behavioral health services within the local community.
- **Formalized access to specialized services.** Rural healthcare systems face systemic barriers to recruiting and retaining specialists for a variety of reasons. This project, by continuing to formalize CMH's affiliation with AMHS, will improve CMH patients' access to specialty care across multiple disciplines. If this project is leveraged to establish clear transfer protocols, care coordination pathways, and collaborative relationships with AMHS specialists, it can create a systematic approach to ensuring rural patients receive appropriate and high-quality care. Additionally, the planned specialty cardiac care center represents a strategic investment in a high-need specialty service that can be delivered locally, reducing the need for patients to be transferred for common cardiovascular conditions - while maintaining pathways to higher levels of care as needed.
- **Increased community awareness of available services.** The public attention generated by this proposal creates an opportunity to increase awareness of available services in the local community. Residents may not be fully aware of the primary care, preventive services, behavioral health programs, and planned ambulatory services CMH offers. Strategic community education efforts during the

implementation of this project may be able to increase the utilization of preventive and outpatient services, particularly among medically underserved populations. The project also has the potential to highlight transportation gaps in the region and encourage local and state governments to prioritize improvements in public transportation infrastructure.

STEP 4 – MONITORING

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?

The Applicant has several mechanisms in place that can be leveraged to monitor the potential impacts of the proposed project.

- **Community Health Assessment (CHA).** Every three years, CMH staff work with community groups conduct a comprehensive Community Health Assessment to actively engage community members and assess local health and social needs. This process involves rigorous research, stakeholder engagement, and data collection, ensuring a thorough understanding of the community's evolving health care challenges. CMH can leverage the findings from this assessment to evaluate whether the organization’s services are effectively meeting community needs. By analyzing trends in service utilization, access barriers, and patient outcomes, CMH can make data-driven adjustments to enhance service delivery, address gaps, and ensure that the organization continues to align with community priorities.
- **Key metrics**. CMH currently tracks several quantitative measures that can be used to monitor impacts, such as
    - Average length of stay
    - Readmission statistics
    - Occupancy rate
    - Average daily census
    - Discharge outcomes, including linkage to outpatient services
    - Transfer rates
    - Patient outmigration
- **Performance Improvement Committee (PIC).** The PIC committee oversees all performance improvement initiatives, recommends allocation of resources, and coordinates communication of organization-wide performance improvement initiatives between medical staff, various departments, and the Board. The committee also assesses performance improvement activities annually.
- Patient feedback mechanisms are described in Step 3, Question 3.

2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

The Applicant can consider the following:

Data Monitoring and Analysis

- Develop a dashboard to easily compare patient demographics, referral patterns, transfers, service use, and outcomes.
- Analyze wait times, lengths of stay, outcomes, and readmission rates by demographic indicators and whether patients were treated exclusively at CMH or transferred to another hospital.
- Stratify reports by race, ethnicity, language, zip code, and social needs; include sexual orientation and gender identity when available.
- Continue to review patient demographics to ensure they are reflective of the service area.
- Use findings to refine policies promoting health equity and care quality.

Communication and Engagement
- Maintain open channels of communication between leadership, staff, and community partners, including sharing key findings.
- Engage community members to discuss experiences and evaluate needs.
- Monitor external partnerships (e.g., AMHS, transportation services, and local healthcare providers) for alignment and efficiency.

Training and Staff Support
- Ensure DEI training includes systemic racism and health equity impacts.
- Train staff on compassionate, culturally appropriate care and data collection practices, including trauma-informed and culturally sensitive approaches.

STEP 5 – DISSEMINATION

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

OPTIONAL: Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

------------ SECTION BELOW TO BE COMPLETED BY THE APPLICANT ------------

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.

I. Acknowledgement

I, (APPLICANT), attest that I have reviewed the Health Equity Impact Assessment for the (PROJECT TITLE) that has been prepared by the Independent Entity, (NAME OF INDEPENDENT ENTITY).

Dorothy M. Urschel

Name

President & CEO

Title

Dorothy M Urschel

Signature

December 5, 2025

Date

II. Mitigation Plan

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.

Columbia Memorial Hospital (CMH), the cornerstone sole provider of healthcare in Columbia and Greene counties, is undertaking an innovative transformation to preserve essential healthcare services while ensuring long-term financial sustainability. CMH intends to transition from its current rural referring hospital to a Critical Access Hospital (CAH) designation.

The HEIA process revealed several key concerns among stakeholders, including transportation, emergency department (ED) boarding, ICU reduction, seasonal surges, discharge delays, and misinformation.

Transportation

Transportation emerged as the most consistent concern, especially for the elderly, low-income and those without personal vehicles. This is not a new concern for our residents as many currently utilize several modes of transportation. Contracted transportation through CMH, public transportation, and EMS are used. CMH is evaluating how to expand partnerships to mitigate any future challenges. CMH has agreements with local County EMS for interfacility medical transportation. Columbia County EMS (CCEMS) will provide 24/7 Transportation Services for CMH patients. CCEMS responds to the facilities for pre-transport activities, care and treatment during transport, and one-way transportation to the patient's destination. CMH is working within the two counties, with government and EMS on transportation. CMH also contracts with the Healthcare Consortium, which provides non-emergency services. CMH patients utilize public transport systems and residents can access NYSDOT website for public transportation. To mitigate concerns of family visitation, CMH is evaluating a shuttle service for staff and patient visitations and evaluating a new position, transportation navigator. Creating dedicated transport routes between hospitals for periods of surge.

ED Holding

Emergency department holding patients was a concern. CMH has committed to ongoing efforts to eliminate holding. To address this, CMH can expand its current fast-track and low-acuity zones in the ED and create additional overflow spaces. We have also implemented Virtual provider in triage which is a robust use of a provider who utilizes telemedicine triage; this has already been trialed and has improved our throughput. The AMHS logistics center prioritizes patients by acuity and patient navigators work with AMHS to streamline patient flow. A surge plan for winter surges will be developed for seasonal increases in demand.

ICU Transition

Concerns were raised about the potential removal of ICU beds and the need for higher-acuity transfers. CMH currently sends the majority of its critical care patients to Albany Med, a tertiary care center. Our ICU provides level 1 support, which is basic life support, ventilation, and stabilization. CMH does not have in-house ICU coverage. This is why we send patients to tertiary care today. Our ICU average daily census is 2-4 patients. Given that CMH is remarkably close to a tertiary care center it is much safer to transfer patients with less than an hour away transport to the appropriate level of care. We are currently transferring to AMC with success. There are established critical care protocols, to manage patients requiring critical care. Our clinical staff will continue training in stabilization and code management. We will provide a formal step-down care model; this will provide the necessary care for our emergency patients appropriate for a critical access hospital.

Seasonal Surges

Seasonal surges and increase in census will be managed as we do today. We will continue to utilize our surge management policies and protocols to address concerns. AMHS will continue to collaborate with us on load-balancing to absorb future seasonal volume surges, which would help manage capacity. Additionally, pandemic-scenario modeling and contingency surge plans will provide preparedness for unexpected emergencies.

Discharge Delays

Today, inpatients at CMH face barriers to discharge due to guardianship delays and/or difficulty finding skilled nursing facility (SNF) placements. To reduce bottlenecks, CMH has begun a SNF coalition to address these issues, including behavioral health. We currently have a legal team working on our guardianship patients and we plan to hire a BH liaison to manage the flow of medically complex patients with behavioral health needs. CMH will continue to work with its outpatient centers, which include eighteen primary care services. CMH will provide access points for scheduling appointments, communicating with the healthcare team, language support, and health education. CMH's focus on primary care, ambulatory care and mental health management is key to caring for our communities.

Employee Recruitment and Retention

We will continue to work with CMH employees to review current plans and processes. To alleviate concerns about layoffs and relocation, we will continue to follow our collective bargaining agreement and be very transparent with our team. We will need more employees in the future; we need over thirty employees for geropsychiatry and over fifty employees for the expansion of our ambulatory surgery center. We will continue to recruit all clinical and non-clinical employees. CMH has legal agreements with colleges and engaged them in our plans for future clinical rotations, which will remain the same. We have developed a robust recruitment plan along with a retention planning; fostering a positive work culture, supporting professional growth, and adding more recognition programs.

Communication and Addressing Misinformation

The hospital is not closing and addressing that common misconception is key. This is a change in design that allows CMH to reinvest in our services. To rebuild trust we have a page on our website to improve transparent communication as well as ongoing media outreach, public forums, and collaborating closely with community leaders. The CMH current community advisory board will be expanded to advise on this change. CMH will continue to offer language services to multilingual patients. CMH will provide access points for scheduling appointments, communicating with the healthcare team, language support, and health education. Project communications will occur through various channels to ensure the communities stay informed including utilizing various visual and hearing impairment technology, and language preferences. Communication plan is attached.

CMH will continue to evaluate our quality indicators and ensure improvement in hospital and patient care outcomes. This is of utmost importance.

Columbia Memorial continues to focus on providing excellent access and care to the residents we serve in Columbia and Greene Counties we are committed to serving and this transformation will allow us to preserve services.

APPENDIX

ALBANY MED Health System

COLUMBIA MEMORIAL HEALTH

Critical Access Hospital
CMH Communications and Marketing Plan 2025-2026

SITUATION

Columbia Memorial Health (CMH) is the only hospital located within Columbia and Greene counties. The hospital and its thirty-seven outpatient- community locations are the primary source of care for the region's 111,000 residents. As the first affiliate of the Albany Med Health System, CMH and Albany Med have each made significant investments in operations in the CMH service area and expanded access to specialty care not previously available in this region.

Nevertheless, a cascade of factors has impacted CMH viability. The hospital's average daily census is between 40 and 50 patients; it is licensed for 192 beds. Medicare and Medicaid represent an overwhelming majority of the inpatient payer mix, which results in weaker reimbursement rates. Proximity to large cities has strained recruitment and retention efforts. Other health systems have lured away patients with higher financial means despite any investment in the two counties.
It also leaves CMH anticipating continued losses too great to overcome without significant reinvention.

CMH remains vital to the communities it serves. Without it, Columbia and Greene counties would become a health care desert. With the Albany Med Health System, CMH proposes a bold and innovative approach to maintaining an invaluable lifeline now and in the future. The plan calls for a reinvention of the main CMH campus as a critical access hospital (CAH) focused on the most critical services its patients require. To support this, CMH and Albany Med have also begun plans to create a new surgical center for same-day treatment at Greene Medical Arts (GMA), as well as investing in the burgeoning demand for behavioral health care in Hudson. A focus on primary care will also strengthen CMH's already solid presence in the market.

Crisis and community communications will focus on the evolution of the main CMH campus and the entire transformation plan—with access, respect for the community, and transparency as the guiding principles.

The following Communications and Marketing Plan addresses:

1. Strategy
2. Audiences
3. Objectives
4. Messaging
5. Tactics
6. Timeline and Tactics by Audience

OBJECTIVES

1. **KEY OBJECTIVE #1:** Positively convey the plan as fact based, data driven, and community focused. In other words, this is a very good thing for Columbia and Greene counties.
2. **KEY OBJECTIVE #2:** Transparently describe our commitment to the region.

3. **KEY OBJECTIVE #3:** Explain what a critical access hospital is and how services will continue.
4. **KEY OBJECTIVE #4:** Emphasize that the System is the regions only regionally governed, not-for-profit health system to underscore dedication and responsiveness to the region.
5. **KEY OBJECTIVE #5:** Highlight the net-new benefits to the southern market, i.e. an ambulatory surgery center and investment to mental health inpatient services and serve community need.

[redacted]

[redacted]

December 2023

[redacted]

December 2023

[redacted]

[redacted]

Limited Review Application

State of New York Department of Health
Office of Primary Care and Health Systems Management

LRA Cover Sheet

Project to be Proposed/Applicant Information

This application is for those projects subject to a limited review pursuant to 10 NYCRR 710.1(c)(5)-(7). Please check the appropriate box(es) reflective of the project being proposed by your facility (**NOTE** – Some projects may involve requisite "Construction". If so, and ***total*** project costs are below designated thresholds, then **both boxes** must be checked and necessary LRA Schedules submitted). ***Please read the LRA Instructions to ensure submission of an appropriate and complete application:***

☐ **Minor Construction** – Minor construction project with total project costs of up to $30,000,000 for general hospitals and up to $8,000,000 for all other facilities, if not relating to clinical space – check "Non-Clinical" box below).

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, and 6.

☐ **Equipment –** Project related to the acquisition, relocation, installation or modification of certain medical equipment, with total project costs of up to $30,000,000 for general hospitals and up to $8,000,000 for all other facilities. (**NOT** necessary for "1-for-1" replacement of existing equipment without construction, pursuant to Chapter 174 of the Laws of 2011 amending Article 28 of the Public Health law to eliminate limited review and CON review for one for one equipment replacement)

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, and 5.

☒ **Service Delivery –** Project to decertify a facility's beds/services; add services which involve a total project cost up to $30,000,000 for general hospitals and up to $8,000,000 for all other facilities; or convert beds within approved categories. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 6, 7, 8, 10, and 12. **If proposing to decertify beds within a nursing home, provide a description of the proposed alternative use of the space including a detailed sketch (unless the decertification is being accomplished by eliminating beds in multiple-bedded rooms). If proposing to convert beds within approved categories, an LRA Schedule 6 and all supporting documentation are required to confirm appropriate space for the new use.*

☐ **Mobile Vans –** Project to certify a new mobile van extension clinic or replace a previously certified mobile extension clinic van.

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, and 6.

☐ **Relocation of Extension Clinic** – Project to relocate an extension clinic within the same service area which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, 6 and 7. Also include a Closure Plan for vacating extension clinic.

☐ **Part-Time Clinic –** Project to operate, change services offered, change hours of operation or relocate a part-time clinic site – for applicants already certified for "part-time clinic". (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 8, 10, 11, and 12.

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
1001000H	Columbia Memorial Hospital	Hospital

OPERATOR ADDRESS – STREET & NUMBER 71 Prospect Avenue		PFI 0146	NAME AND TITLE OF CONTACT PERSON Frank M. Cicero, Consultant		
CITY Hudson	COUNTY Columbia	ZIP 12534	STREET AND NUMBER 925 Westchester Avenue, Suite 201		
PROJECT SITE ADDRESS – STREET & NUMBER 71 Prospect Avenue		PFI 0146	CITY White Plains	STATE New York	ZIP 10604
CITY Hudson	COUNTY Columbia	ZIP 12534	TELEPHONE NUMBER 914-682-8657	FAX NUMBER 914-682-8895	
TOTAL PROJECT COST: $ 500			CONTACT E-MAIL: Conadmin@ciceroassociates.com		

(Rev 09/2019)

COLUMBIA MEMORIAL HOSPITAL

SCHEDULE LRA COVER SHEET ATTACHMENTS

DRAFT Closure Plan

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Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 2

Total Project Cost

ITEM	ESTIMATED PROJECT COST	
1.1 Land Acquisition (*attach documentation*)	$	
1.2 Building Acquisition	$	
1.1-1.2 Subtotal:		0.00
2.1 New Construction		
2.2 Renovation and Demolition		
2.3 Site Development		
2.4 Temporary Power		
2.1-2.4 Subtotal:		**0.00**
3.1 Design Contingency		
3.2 Construction Contingency		
3.1-3.2 Subtotal:		0.00
4.1 Fixed Equipment (NIC)		
4.2 Planning Consultant Fees		
4.3 Architect/Engineering Fees (incl. computer installation, design, etc.)		
4.4 Construction Manager Fees		
4.5 Capitalized Licensing Fees		
4.6 Health Information Technology Costs		
4.6.1 Computer Installation, Design, etc.		
4.6.2 Consultant, Construction Manager Fees, etc.		
4.6.3 Software Licensing, Support Fees		
4.6.4 Computer Hardware/Software Fees		
4.7 Other Project Fees (Consultant, etc.)		
4.1-4.7 Subtotal:		**0.00**
5.1 Movable Equipment		
6.1 Total Basic Cost of Construction		
7.1 Financing Cost (points, fees, etc.)		
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount $ @ % for months		
7.3 Application Fee	$	500.00
8.1 Estimated Total Project Cost (Total 6.1 – 7.3)	$	**500.00**

If this project involves construction enter the following anticipated construction dates on which your cost estimates are based.

Construction Start Date **N/A**

Construction Completion Date **N/A**

(Rev. 1/31/2013)

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

Schedule applies to all projects with construction, including Articles 28 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

Instructions

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Projects over $15 Million, or Projects Requiring a Waiver (PDF)
  - Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY. (PDF) (Not to Be Submitted with Self-Certification Projects)
  - Architect's Letter of Certification for Completed Projects (PDF)
  - Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings (PDF)
- Provide FEMA BFE Certificate. Applies only to Hospitals and Nursing Homes.
  - FEMA Elevation Certificate and Instructions.pdf
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - Physicist's Letter of Certification (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews
  - DSG-1.0 Schematic Design & Design Development Submission Requirements
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

Architecture/Engineering Narrative

Narrative shall include but not limited to the following information. Please address all items in the narrative including items located in the response column. Incomplete responses will not be accepted.

Project Description	
Schedule 6 submission date: 12/1/2025	Revised Schedule 6 submission date:
Does this project amend or supersede prior CON approvals or a pending application? No If so, what is the original CON number? N/A	
Intent/Purpose: Convert from a general Article 28 hospital to an Article 28 hospital with federal designation as a critical access hospital	
Site Location: Columbia Memorial Health, 71 Prospect Avenue, Hudson, N.Y.	

New York State Department of Health Certificate of Need Application

Schedule 6

Brief description of current facility, including facility type: Currently a 192 bed Article 28 general hospital	
Brief description of proposed facility: Proposed conversion would reduce our bed count to a 25 bed hospital with federal designation as a critical access hospital by means of re-utilizing existing additional bed spaces for other future needs	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. Entire Building is Healthcare Occupancy	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: N/A	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	No
Relationship of spaces conforming with Article 28 space and non-Article 28 space: Entire Facility is Article 28	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. None	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below.	No
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. 2-pipe fancoil HVAC system with ventilation RTU. •Existing original power distribution branches. •Existing medical oxygen and vacuum distribution •Partially sprinklered	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. N/A	
Describe existing and or new work for fire detection, alarm, and communication systems: Existing Central Fire Detection & Alarm System with audio	
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. N/A	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. N/A	
Does the project comply with ADA? If no, list all areas of noncompliance. Yes	
Other pertinent information: N/A	

[redacted]

Does the work area exceed more than 50% of the smoke compartment, floor or building?	Less than 50% of the smoke compartment
Sprinkler protection per NFPA 101 Life Safety Code	Partially Sprinklered
Construction Type per NFPA 101 Life Safety Code and NFPA 220 **N/A**	
Building Height	84'0"
Building Number of Stories	6 floors plus basement and sub-basement
Which edition of FGI is being used for this project? **N/A**	
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code? **N/A**	
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans.	No
Will the project construction be phased? If yes, how many phases and what is the duration for each phase?	Not Applicable
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be?	Not Applicable
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be?	Not Applicable
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Closing 167 of the current beds to 25 beds	Decrease
Changes in the number of occupants? If yes, what is the new number of occupants? 25	Yes
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Type 1	Yes
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Yes
Does the existing EES system have the capacity for the additional electrical loads?	Not Applicable
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. N/A	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. N/A	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	No

REQUIRED ATTACHMENT TABLE			
SCHEMATIC DESIGN SUBMISSION for **CONTINGENT APPROVAL**	DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for **CONTINGENCY SATISFACTION**	**Title of Attachment**	**File Name in PDF format**
•		Architectural/Engineering Narrative	A/E Narrative.PDF
•		Functional Space Program	FSP.PDF
•		Architect/Engineer Certification Form	A/E Cert Form. PDF
•		FEMA BFE Certificate	FEMA BFE Cert.PDF
•		Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Plans including level of exit discharge, and NFPA 101-2012 Code Analysis	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details. Illustrate FGI compliance on plans.	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
optional	•	Wall Sections and Partition Types	A500.PDF
optional	•	Interior Elevations, Enlarged Plans and Details	A600.PDF
	•	Fire Protection	FP100.PDF
	•	Mechanical Systems	M100.PDF
	•	Electrical Systems	E100.PDF
	•	Plumbing Systems	P100.PDF
	•	Physicist's Letter of Certification and Report	X100.PDF

COLUMBIA MEMORIAL HOSPITAL

SCHEDULE LRA 06 ATTACHMENTS

1) Floor Plans and Square Footage

Limited Review Application

Schedule LRA 7

State of New York Department of Health/Office of Health Systems Management

[redacted]

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 7

[redacted]

Limited Review Application

Schedule LRA 7

State of New York Department of Health/Office of Health Systems Management

[redacted]

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Please refer to Schedule LRA 07 Attachments	-
2. In an attachment, provide the basis for charity care.	Please note, this Application seeks approval to decertify beds for a total of 25-beds as a Critical Access Hospital. Charity Care visits are included within the payor breakdown above.	-

* Net Deductions from Revenue

COLUMBIA MEMORIAL HOSPITAL

SCHEDULE LRA 07 ATTACHMENTS

1) Basis for Revenues by Payor
2) 2025 October Internal Financial Report
3) 2024 Audited Financial Statements

[redacted]

FINANCIAL REPORT

Columbia Memorial Health

October 2025

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

KPMG

ALBANY MED HEALTH SYSTEM

Combined Financial Statements
and Supplementary Information

December 31, 2024 and 2023

(With Independent Auditors' Report Thereon)

ALBANY MED HEALTH SYSTEM

Table of Contents

KPMG LLP
515 Broadway
Albany, NY 12207-2974

Independent Auditors' Report

The Board of Directors
Albany Med Health System:

Report on the Audit of the Combined Financial Statements

Opinion

We have audited the combined financial statements of Albany Med Health System (the System), which comprise the combined balance sheets as of December 31, 2024 and 2023, and the related combined statements of operations and change in net assets, and cash flows for the years then ended, and the related notes to the combined financial statements.

In our opinion, the accompanying combined financial statements present fairly, in all material respects, the financial position of the System as of December 31, 2024 and 2023, and changes in its net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Combined Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Combined Financial Statements

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

In preparing the combined financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for one year after the date that the combined financial statements are issued.

Auditors' Responsibilities for the Audit of the Combined Financial Statements

Our objectives are to obtain reasonable assurance about whether the combined financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the combined financial statements.

KPMG

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the combined financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the combined financial statements.
- Obtain an understanding of internal control relevant to the audit 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 System's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the combined financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The combining information included on pages 61 through 92 is presented for purposes of additional analysis and is not a required part of the combined 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 combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

Albany, New York
April 25, 2025

ALBANY MED HEALTH SYSTEM

Combined Balance Sheets

December 31, 2024 and 2023
(Dollars in thousands)

Assets		**2024**	**2023**
Current assets:			
Cash and cash equivalents	$	349,694	480,302
Investments		393,057	327,140
Receivables, net:			
Patient service		322,466	292,109
Other		68,612	65,554
		391,078	357,663
Inventories		50,708	45,950
Prepaid expenses and other current assets		35,327	29,354
Total current assets		1,219,864	1,240,409
Assets whose use is limited:			
Under debt financed agreements		31,116	31,072
Self-insurance funds		86,460	81,260
Other investments		24,904	23,959
		142,480	136,291
Property and equipment, net of accumulated depreciation and amortization		987,564	979,200
Right-of-use assets – operating leases		65,278	74,934
Investments, long-term		228,298	201,381
Other assets:			
Deferred compensation agreements		98,979	83,453
Assets held in charitable trusts		2,728	2,605
Accrued pension assets		7,722	662
Other assets		34,012	34,076
		143,441	120,796
Total assets	$	2,786,925	2,753,011

(Continued)

ALBANY MED HEALTH SYSTEM

Combined Balance Sheets

December 31, 2024 and 2023
(Dollars in thousands)

Liabilities and Net Assets		**2024**	**2023**
Current liabilities:			
Current maturities of long-term debt	$	37,297	33,662
Current portion of lease liabilities – finance leases		14,345	13,185
Current portion of lease liabilities – operating leases		14,522	15,925
Accounts payable		189,753	203,053
Accrued expenses:			
Salaries and related items		111,889	96,685
Compensated absences		76,300	73,804
Deferred revenue		25,678	23,480
Other liabilities		56,532	82,775
Total current liabilities		526,316	542,569
Long-term debt, net of current maturities		435,369	464,293
Long-term lease liabilities – finance leases		33,300	21,183
Long-term lease liabilities – operating leases		55,450	63,331
Accrued pension obligations		—	757
Professional liability self-insurance reserves		176,589	172,968
Other liabilities, long-term		162,948	140,183
Total liabilities		1,389,972	1,405,284
Commitments and contingencies (notes 4, 8, 10 and 14)			
Net assets:			
Without donor restrictions		1,162,156	1,134,170
With donor restrictions		234,797	213,557
		1,396,953	1,347,727
Total liabilities and net assets	$	2,786,925	2,753,011

See accompanying notes to combined financial statements.

ALBANY MED HEALTH SYSTEM

Combined Statements of Operations and Changes in Net Assets

Years ended December 31, 2024 and 2023
(Dollars in thousands)

		2024	2023
Operating revenue:			
Net patient service revenue	$	2,616,133	2,507,667
Tuition and fees		43,036	41,967
Federal, state, and local grants and contracts		33,282	28,609
Private gifts, grants, and contracts		2,868	4,385
Interest and dividend income and realized gains		22,084	20,691
Other revenue		277,598	253,535
Net assets released from restrictions used for operations		18,727	18,592
Total operating revenue		3,013,728	2,875,446
Operating expenses:			
Salaries		1,547,212	1,501,641
Employee benefits		244,287	224,471
Supplies		743,616	714,255
Purchased services		307,674	315,327
Depreciation and amortization		123,506	119,770
Interest		27,123	27,815
Other expenses		62,708	49,053
Total operating expenses		3,056,126	2,952,332
Operating loss before COVID-19 grants		(42,398)	(76,886)
COVID-19-related grants		—	334
Operating loss		(42,398)	(76,552)
Nonoperating gains:			
Net realized gains on sales of investments		51,719	8,311
Other, net		10,558	13,623
Total nonoperating gains		62,277	21,934
Excess (deficiency) of revenue over expenses, before investment (losses) gains and other activities	$	19,879	(54,618)

(Continued)

ALBANY MED HEALTH SYSTEM

Combined Statements of Operations and Changes in Net Assets

Years ended December 31, 2024 and 2023
(Dollars in thousands)

	2024	2023
Investment (losses) gains and other activities:		
Net unrealized (losses) gains on investments	$ (6,336)	42,546
Pension annuitization	—	(5,444)
Total investment (losses) gains and other activities, net	(6,336)	37,102
Excess (deficiency) of revenue over expenses	13,543	(17,516)
Net assets without donor restrictions:		
Net assets released from restrictions used for purchase of property and equipment	5,417	2,399
Change in fair value of interest rate swaps	468	(801)
Pension-related changes other than net periodic pension costs	8,558	4,099
Increase (decrease) in net assets without donor restrictions	27,986	(11,819)
Net assets with donor restrictions:		
Private gifts, grants, contracts, and other, net	21,882	26,840
Investment interest, dividends, and net realized gains, net	29,885	3,353
Net assets released from restrictions for operations	(18,727)	(18,592)
Changes in net unrealized gains and losses on investments	(9,444)	16,969
Contributions for property and equipment	3,061	1,808
Net assets released from restrictions used for purchase of property and equipment	(5,417)	(2,399)
Increase in net assets with donor restrictions	21,240	27,979
Change in net assets	49,226	16,160
Net assets, beginning of year	1,347,727	1,331,567
Net assets, end of year	$ 1,396,953	1,347,727

See accompanying notes to combined financial statements.

ALBANY MED HEALTH SYSTEM

Combined Statements of Cash Flows

Years ended December 31, 2024 and 2023
(Dollars in thousands)

		2024	2023
Cash flows from operating activities:			
Change in net assets	$	49,226	16,160
Adjustments to reconcile change in net assets to net cash provided by operating activities:			
Restricted gifts and income		(6,825)	(4,777)
Gain on joint venture investment		(3,269)	(4,383)
Net realized and change in net unrealized gains and losses on investments		(57,865)	(61,376)
Pension-related changes other than net periodic pension costs		(8,558)	(4,099)
Change in fair value of interest rate swaps		(468)	801
Depreciation and amortization		123,506	119,770
Amortization expense of operating leases		17,401	19,595
Payments of right-of-use lease obligations – operating leases		(17,029)	(18,198)
Gain on disposal of property and equipment		26	61
Changes in operating assets and liabilities:			
Receivables, net		(33,765)	(69,016)
Inventories		(4,758)	3,205
Prepaid expenses and other assets		(5,716)	4,773
Professional liability self-insurance reserve		3,621	14,330
Accounts payable		(28,972)	40,672
Accrued expenses and other liabilities		939	30,873
Accrued pension asset		741	16,918
Net cash provided by operating activities		28,235	105,309
Cash flows from investing activities:			
Additions to property and equipment		(88,136)	(120,189)
Change debt financed agreements		(45)	531
Investment purchases		(137,437)	(99,360)
Proceeds from investment maturities and sales		96,034	121,533
Equity distributions		4,016	4,847
Net cash used in investing activities		(125,568)	(92,638)
Cash flows from financing activities:			
Principal payments on long-term debt		(28,351)	(27,655)
Advances on line of credit		9,155	5,000
Payments on line of credit		(6,150)	—
Restricted gifts and income		6,825	4,777
Issuance of long-term debt		—	13,848
Principal payments on finance lease obligations		(14,734)	(21,030)
Cash paid for financing costs		(20)	(20)
Net cash used in financing activities		(33,275)	(25,080)
Net decrease in cash and cash equivalents		(130,608)	(12,409)
Cash and cash equivalents, beginning of year		480,302	492,711
Cash and cash equivalents, end of year	$	349,694	480,302
Supplemental disclosures of cash flow information:			
Cash paid during the year for interest	$	25,980	27,598
Property and equipment acquired including amounts in accounts payable		15,672	1,769
Equipment acquired under finance lease obligations		27,785	6,121

See accompanying notes to combined financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

The Albany Med Health System (the System), formerly known as Albany Medical Center (the Center), was organized in 1982 as a not-for-profit corporation for the purpose of coordinating planning, financial management, resource utilization, fundraising, and policy direction for the Albany Medical Center Hospital (AMCH), the Albany Medical College (College), the Albany Medical Center Foundation, Inc. (AMC Foundation) and other related organizations.

In order to enhance existing clinical affiliations and to more effectively allow furtherance of common missions, to promote the health of the broader community served, the Center affiliated and became the sole corporate member of the following providers:

In June 2013, the AMCH and Saratoga Hospital (Saratoga or SH) opened a jointly owned and operated diagnostic and treatment center (DTC). The DTC is sited on a portion of a 140-acre parcel of land Saratoga owns in Malta, NY. The DTC was established and operates as a separate not-for-profit corporation, Healthcare Partners of Saratoga, Ltd. (HCP) (d/b/a Malta Med Emergent Care or MMEC), approved under Article 28 of New York State Public Health Law. Saratoga and AMCH are equal members of MMEC, with each entity able to appoint four members to the eight-member board of directors of MMEC.

In 2016, the Center entered into an affiliation agreement with Columbia Memorial Hospital (CMH), a voluntary not-for-profit charitable corporation incorporated in the State of New York that operates a 192-bed acute care facility located in Hudson, New York, Columbia Memorial Regional Medical (CMRM), a professional corporation incorporated in the state of New York for the sole purpose of employment of physicians and other licensed medical providers, a 21-unit apartment complex (Kaaterskill Commons, Inc. or KCI) located in Jefferson Heights, New York, and a charitable fundraising foundation (Columbia Memorial Health Foundation or the CMH Foundation). Under the affiliation agreement, the Center became the sole corporate member of CMH. The affiliation was executed to enhance an existing clinical affiliation and allow both institutions to further their common mission of promoting the health of the communities they serve. Effective June 5, 2024, the Columbia Memorial Board merged with the AMCH Board. Columbia Memorial will be overseen by the AMCH Board which ultimately is governed by the System Board.

In 2017, the Center entered into an affiliation agreement with Saratoga, a voluntary not-for-profit charitable corporation incorporated in the State of New York. Saratoga Hospital is the sole member of Saratoga Care, Inc., a not for profit organization established in the State of New York. The Saratoga Care Foundation is an operating division of Saratoga Care, Inc. established to raise funds to support the operations of Saratoga Hospital. Saratoga Regional Medical, P.C. (SRMPC) is a professional corporation incorporated in the State of New York for the sole purpose of employment of physicians and other licensed medical providers. SRMPC is controlled, organized, and operated to support the mission of the Hospital. Under the affiliation agreement, the Center became the sole corporate member of SH. The affiliation was executed to enhance an existing clinical affiliation and allow both institutions to further their common mission of promoting the health of the communities they serve.

On July 1, 2020, the Center entered into an affiliation agreement with Glens Falls Hospital (Glens Falls) a voluntary, not-for-profit charitable corporation, incorporated in the State of New York, which operates a comprehensive healthcare system serving Warren, Washington, Northern Saratoga, Essex, and Hamilton counties including a general medical and surgical hospital in Glens Falls, New York. Under the affiliation agreement, the Center became the sole corporate member of Glens Falls. The affiliation was consummated to enhance an existing clinical affiliation and allow both institutions to further their common mission of promoting the health of the communities they serve. Effective April 1, 2024, the Glens Falls Board merged with the AMCH Board. Glens Falls will be overseen by the AMCH Board which ultimately is governed by the System Board.

Albany Medical Center Hospital, Saratoga Hospital, and a nonrelated affiliate entity entered into an agreement on April 8, 2019, to establish an Ambulatory Surgery Center (Surgery Center) located in Malta, NY. The Surgery Center became operational in 2021. In addition to the Surgery Center, the three organizations also established a limited liability company to hold the realty of the new Surgery Center and medical office space.

Effective March 1, 2022, the System executed an affiliation agreement with Albany Visiting Nurse Home Care Services Group, Inc. (VNA) which made the Center the sole corporate member of VNA. Founded in 1880, the VNA is a certified home health agency that provides skilled nursing, medical social work, home health aide services, and cardiac, infusion, diabetes, and rehabilitation therapies. The Visiting Nurses Foundation, Inc. is a not-for-profit corporation incorporated in the State of New York established to raise funds for the VNA and its affiliates. The Visiting Nurse Association of Albany Home Care Corporation is a for-profit corporation providing private duty home health care services to individuals and other healthcare providers in the Capital District of New York State and surrounding counties. Albany Med Health System Staffing Alliance, LLC (the Alliance) was formed in December 2020 to provide contract staffing services to the AMCH, Saratoga, Glens Falls and CMH.

The Center also includes its subsidiaries, the Albany Medical Center Kidskeller, doing business as Albany Med Kids, a not-for-profit day-care facility, Albany Medical Park South I, LLC, a limited liability company, Albany Med Subs LLC, a limited liability company, and Madison Avenue Services Corporation, a taxable corporation. The combined financial statements of the Albany Med Health System (collectively referred to as the System and previously referred to as Albany Medical Center and Related Entities) are designed to present, in a summarized fashion, an aggregation of all the financial resources and activities of the discrete operating entities comprising the Center and the aforementioned related entities. For the purposes of these combined financial statements, the System, excluding CMH, Glens Falls, VNA and Saratoga, is referred to as AMC.

(b) Mission

The System's Mission, Vision, Values, and Purpose statement is written as follows:

(i) Our Mission

We are committed to improving health by attaining the highest standard of quality in care delivery, education, and research initiatives.

(ii) Our Vision

To best serve the needs of our communities, the Albany Med Health System will deliver its Mission by means of a structure that will be, and remain, autonomous and self-governing.

(iii) Our Values

- Excellence and continuous improvement
- Integrity in every decision we make
- Compassion and respect for the dignity of every person
- A diverse, equitable, inclusive and welcoming System
- Collaboration throughout our System
- Responsiveness to the people of our communities
- Fiscal accountability

(iv) Our Purpose

- Health care of the highest quality in a cost-effective and equitable manner;
- Education in the health sciences, allowing the region to have assured access to trained health professionals to deliver such care; and
- Biomedical and clinical research in order to contribute to the body of medical knowledge thus creating new ideas, procedures and drugs that advance the quality of such care.

(c) Basis of Presentation

The accompanying combined financial statements, which are presented on the accrual basis of accounting, have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 954, *Healthcare Entities* (ASC 954), which addresses the accounting for healthcare entities. In accordance with the provisions of the ASC 954, net assets and revenues, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. This is accomplished by classification of fund balances into two classes of net assets: without donor restrictions and with donor restrictions. Descriptions of the two net asset categories and the types of transactions affected in each category is as follow:

- Without donor restriction – Net assets that are not subject to donor stipulations restricting their use but may be designated for specific purposes by the System or may be limited by contractual agreements with outside parties.

- With donor restrictions – Net assets subject to donor stipulations that expire with the passage of time, can be fulfilled by actions pursuant to the stipulations, or which may be perpetual.

All significant interinstitutional transactions and accounts have been eliminated in combination.

(d) Use of Estimates

The preparation of the accompanying combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions about future events. These estimates and underlying assumptions affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Such estimates and assumptions are based on management's best estimate and judgment. Management evaluates its estimates and assumptions on an ongoing basis using historical experience and other factors, including current economic environment. Management adjusts such estimates and assumptions when facts and circumstances dictate. As future events and their effects cannot be determined with precision, actual results could differ from these estimates.

(e) Cash and Cash Equivalents

Cash and cash equivalents, as referred to in the combined statements of cash flows, consist of highly liquid investments with original maturities of less than three months, and excludes cash equivalents included in assets whose use is limited. As more fully discussed in note 1(i), cash equivalents available for operating purposes are stated at fair value using Level 1 measurement.

(f) Net Patient Service Revenue

Net patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care in accordance with FASB ASC Topic 606, *Revenue from Contracts with Customers* (ASC 606). These amounts are due from patients, third-party payors, and others and include variable consideration for retroactive revenue adjustments for favorable and unfavorable settlements. Generally, the System bills the patients and third-party payors several days after the services are performed or shortly after discharge. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the System. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The System believes that this method provides a faithful 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 in our System receiving inpatient acute care services. The System measures the performance obligation from admission into the System to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided, and the System does not believe it is required to provide additional goods or services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the System has elected to apply the optional exemption provided in 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 inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period. In certain circumstances, the System's hospitals may enter into agreements with patients that allow payments in excess of one year. For these instances, a financing component of the contract is deemed to be insignificant.

The System utilizes the portfolio approach practical expedient in ASC 606 for contracts related to net patient service revenue. The System accounts for contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio. As a result, the System has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

Generally, patients who are covered by third-party payors are responsible for patient responsibility balances, including deductibles and coinsurance, which vary in amount. The System estimates the transaction price for patients with deductibles and coinsurance 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 amounts and discounts (explicit price concessions) and routine uncollectible amounts (explicit 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. Adjustments arising from a change in transaction price were not significant in 2024 and 2023.

AMCH, CMH, Glens Falls, Saratoga, VNA and the College have agreements with third-party payors that provide for payments at amounts different from their established rates. Inpatient acute care services rendered are paid at prospectively determined rates per discharge in accordance with the Federal Prospective Payment System (PPS) for Medicare and generally at negotiated or otherwise predetermined amounts under the provisions of the New York Health Care Reform Act (HCRA) and related legislation for all other third-party payors. Reimbursement rates for Medicaid, Worker's Compensation, and No Fault are determined on a prospective basis defined by HCRA that is based on clinical, diagnostic, and other factors. These rates also vary according to a patient classification system defined by HCRA that is based on clinical, diagnostic, and other factors. Inpatient nonacute and outpatient services are paid at various rates under different arrangements with third-party payors, commercial insurance carriers and health maintenance organizations. The basis for payment under these agreements includes prospectively determined per diem rates, discounts from established charges, and fee schedules.

In addition, under HCRA, all non-Medicare payors are required to make surcharge payments for the subsidization of indigent care and other healthcare initiatives. The percentage amount of the surcharge varies by payor and applies to a broader array of healthcare services. Also, certain payors are required to make a covered lives payment to further fund the indigent care pools and other healthcare initiatives for inpatient services or through voluntary election to pay a covered lives assessment directly to the New York State Department of Health (DOH).

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation as well as significant regulatory action, and, in the normal course of business, the System is subject to contractual reviews and audits, including audits initiated by the Medicare Recovery Audit Contractor program. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term. The System believes it is compliant with applicable laws and regulations governing the Medicare and Medicaid programs and the adequate provisions have been made for any adjustments that may result from final settlements.

(g) Inventories

Inventories are stated at the lower of cost (weighted average) or net realizable value on a first-in, first-out (FIFO) method.

(h) Investments and Investment Income

Investments and defined benefit pension plan assets are reported at fair value or net asset value (NAV). Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between willing market participants at the measurement date. See notes 1(i) and 6 for a discussion of fair value and related measurements.

Investments represent funds available for operations (current) and endowed and other funds set aside for long-term planning and endowment purposes (long term).

Investment income or loss (including realized and certain unrealized gains and losses on investments, interest, and dividends) is included in excess of revenue over expenses (note 1(m)) unless the income or loss is restricted by donor or law.

(i) Fair Value Measurement of Financial Instruments

The System estimates fair value based on a valuation framework that uses a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of fair value hierarchy, as defined by ASC 820, *Fair Value Measurements and Disclosures*, are described below:

- Level 1 – Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.
- Level 2 – Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.
- Level 3 – Prices or valuation techniques that are both significant to the fair value measurement and unobservable and require significant management judgment or estimation or are investments with liquidity restrictions.

For investments that do not have a readily determinable fair value and meet the specifications of ASC 820, the System calculates a net asset value (NAV) per share (or its equivalent) that estimates the fair value of investments based on the investment's NAV per share or its equivalent as a practical expedient.

(j) Deferred Compensation Agreements

AMC sponsors a deferred compensation plan consistent with IRC §457(b)(6). Each eligible employee (participant) may elect to defer a portion of their compensation as an employee contribution. The employer contribution is 3% or 4% of excess compensation depending on the employee's employment date with AMC. Excess compensation represents the portion of an employee's gross compensation in excess of earnings as defined under the Albany Medical Center Retirement Plan (note 9(a)). The employer contribution for a plan year will be made if the employee remains in employment for 60 days after that calendar year-end to which the contribution relates. The obligation of AMC will not exceed the actual amount or value of the participant accounts. In addition, Saratoga and Glens Falls also sponsors an IRC §457(b)(6) plan. The value of the AMC, Saratoga, and Glens Falls participant accounts are included in other liabilities, long term at December 31, 2024 and 2023. The deferred compensation amounts are invested in mutual funds and common stocks, for which fair value is based on Level 1 and Level 2 measurements, respectively.

(k) Property and Equipment

Property and equipment are recorded at cost except in the case of gifts, which are recorded at fair value at the date of donation. Property and equipment under finance leases are stated at the present value of minimum lease payments. Costs include interest incurred on related indebtedness during periods of construction. Depreciation and amortization of property and equipment are computed by the straight-line method over the estimated useful lives of the assets ranging from 3 to 40 years. Leasehold improvements are depreciated over the shorter of the lease term or useful life of the asset.

The System monitors its long-lived assets for impairment indicators on an ongoing basis. If impairment indicators exist, the System performs the required analysis and records impairment charges. In conducting its analysis, the System compares the undiscounted cash flows expected to be generated from the long-lived assets to the related net book values. If the undiscounted cash flows exceed the net book value, the long-lived assets are considered not to be impaired. If the net book value exceeds the undiscounted cash flows, an impairment loss is measured and recognized based on the fair value of the asset, less costs to sell, or discounted cash flows compared to book value.

(l) Tuition Revenue Recognition and Deferred Revenue

College tuition revenue is recognized over the duration of the respective academic semester to which the revenue charges relate. Tuition revenue is billed and paid semiannually in advance of the academic period and such payments are due prior to the start of the academic semester. Deferred revenue represents payments received prior to the start of the academic semester or for academic services not yet provided. Students who adjust their course load or withdraw within a defined period may receive a full or partial refund in accordance with the College's refund policy. Historically, refunds have not been significant. The College applies the practical expedient in FASB ASC 606-10-50-14 and, therefore, does not disclose information about remaining performance obligations that have original expected durations of one year or less.

(m) Excess (Deficiency) of Revenue over Expenses

The combined statements of operations and changes in net assets include a performance indicator, the excess (deficiency) of revenue over expenses. In accordance with U.S. generally accepted accounting standards, changes in net assets without donor restrictions that are excluded from the determination of excess (deficiency) of revenue over expenses are net assets released from restrictions used for the purchase of property and equipment, net assets released from restriction for debt retirement, the effective portion of change in fair value of interest rate swaps, and changes in the funded status of the pension plan other than net periodic pension costs.

For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services, including interest and dividend income related to investments without donor restrictions are reported as operating revenue and expenses in the determination of the System's operating results. Activities, including contributions without donor restrictions associated with the furtherance of the System's mission are considered to be operating activities. Peripheral transactions including realized and unrealized gains and losses are reported as nonoperating activity.

Activities that are nonoperating in nature and otherwise not considered recurring peripheral transactions, such as settlements of swaps, gains on liquidation of investment portfolios, and pension annuitization are reported as other activities and are included in the performance indicator.

(n) Charity and Uncompensated Care

As part of its mission, the System's care is provided to all patients regardless of their ability to pay for services rendered. Patients who meet established criteria of the System qualify for charity care. Charity care is defined as services for which patients have the obligation and willingness to pay but do not have the ability to do so. The System does not pursue collection of amounts determined to qualify as charity care, therefore, are not reported as net patient service revenue. The System maintains records to identify and monitor the level of charity care it provides. The cost of charity care provided was determined based on the application of a ratio of overall costs to patient charges.

(o) Insurance Programs

AMC, Saratoga (effective August 1, 2019), and CMH (effective April 1, 2020) are self-insured for losses arising from medical malpractice, general liability insurance, and worker's compensation claims. Glens Falls is self-insured for the primary portion of their medical malpractice and general insurance liability. The provision for self-insured losses includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. Independent actuaries have been retained to assist the System with determining the provision for self-insured losses. AMC, Glens Falls, and Saratoga also provide self-insured health benefits to employees and have recorded a provision for estimated claims based on experience. The provision for self-insured losses includes estimates of the ultimate costs for both reported claims and claims incurred but not yet reported. VNA insures its malpractice risk on an occurrence basis. Under the policy, claims based on occurrences during its term but reported subsequently are insured should the policy not be renewed or replaced with other coverage. VNA intends to renew coverage on an occurrence basis and anticipates that such coverage will be available. See note 10 for further discussion regarding professional liability and workers' compensation plans.

(p) Contributions and grants

Grants and contributions received, including unconditional promises to give cash and other assets to the System, are recognized as revenue generally in the period received, at fair value. Grants, contributions, and promises to give that include conditions in the form of both a barrier to entitlement and a refund of amounts paid (or a release from an obligation to make future payments) are not recognized until such conditions are satisfied and they become unconditional. Unconditional contributions may be restricted or without restrictions. Contributions, grants, and other gifts are classified as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets or are classified as net assets without donor restrictions if no such conditions exist. When a donor restriction expires, that is, when a stipulated time restriction ends, or purpose restriction is accomplished, the net assets subject to donor restrictions are reclassified to net assets without restrictions and reported in the combined statements of operations as net assets released from restriction. Donor restricted funds for capital assets are released when such assets are placed into service. The contributions receivable is collectible over future periods and have been recorded at their estimated present value.

(q) Income Taxes

With the exception of Madison Avenue Services Corporation, Albany Med Subs, LLC, Albany Medical Park South I, LLC, Columbia Regional, PLLC, Saratoga Partners North, LLC, Saratoga Partners North Realty, LLC, Better Health for Northeast New York, Inc. and Visiting Nurse Association of Albany Home Care Corporation, all entities comprising the System are not-for-profit corporations under Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes pursuant to Section 501(a) of the Code. Better Health for Northeast New York, Inc. is a 501(c)(6) not-for-profit corporation. Income taxes associated with Madison Avenue Services Corporation and Visiting Nurse Association of Albany Home Care Corporation are not significant to the combined financial statements. In addition, Albany Medical Park South I, LLC, Albany Med Subs, LLC, and Columbia Regional, PLLC are limited liability companies, which are disregarded entities for income tax purposes. Saratoga Partners North, LLC and Saratoga Partners North Realty, LLC are limited liability companies organized as partnerships and do not make any material provision for income taxes. The System recognizes income tax positions when it is more likely than not that the position will be sustainable based on the merits of the position. Management has concluded that there are no uncertain tax positions that need to be recorded as of December 31, 2024 and 2023.

(r) Leases

The System accounts for leases in accordance with Topic 842, *Leases*. The System determines if an arrangement contains a lease at contract inception. The System recognizes a right-of-use (ROU) asset and a lease liability at the lease commencement date.

For operating leases, the lease liability is initially and subsequently measured at the present value of the unpaid lease payments at the lease commencement date. For finance leases, the lease liability is initially measured in the same manner and date as for operating leases and is subsequently measured at amortized cost using the effective-interest method. Key estimates and judgments include how the System determines (1) the discount rate it uses to discount the unpaid lease payments to present value, (2) lease term, and (3) lease payments.

The System discounts its unpaid lease payments using the interest rate implicit in the lease or, if that rate cannot be readily determined, its incremental borrowing rate. The System generally uses its incremental borrowing rate as the discount rate for the lease because the lease's implicit rate cannot be determined. The System's incremental borrowing rate for a lease is the rate of interest it would have to pay on a collateralized basis to borrow an amount equal to the lease payments under similar terms. Because the System does not generally borrow on a collateralized basis, it uses the interest rate it pays on its noncollateralized borrowings as an input to derive an appropriate incremental borrowing rate, adjusted for the amount of the lease payments, the lease term, and the effect on that rate of designating specific collateral with a value equal to the unpaid lease payments for that lease.

The ROU asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for lease payments made at or before the lease commencement date, plus any initial direct costs incurred less any lease incentives received.

For operating leases, the ROU asset is subsequently measured throughout the lease term at the carrying amount of the lease liability, plus initial direct costs, plus (minus) any prepaid (accrued) lease payments, less the unamortized balance of lease incentives received. Lease expense for lease payments is recognized on a straight-line basis over the lease term.

For finance leases, the ROU asset is subsequently amortized using the straight-line method from the lease commencement date to the earlier of the end of its useful life or the end of the lease term unless the lease transfers ownership of the underlying asset to the System or the System is reasonably certain to exercise an option to purchase the underlying asset. In those cases, the ROU asset is amortized over the useful life of the underlying asset. Amortization of the ROU asset is recognized and presented separately from interest expense on the lease liability.

Operating lease ROU assets are presented as operating lease right of use assets on the combined balance sheets. The current portion of operating lease liabilities is included in other current liabilities and the long-term portion is presented separately as operating lease liabilities in the combined balance sheets.

Finance lease ROU assets are included in property, plant, and equipment. The current portion of finance lease liabilities is included in lease liabilities – finance leases, and the long-term portion is included in long-term lease liabilities – finance leases in the combined balance sheets.

The System does not recognize ROU assets and lease liabilities for short-term leases that have a lease term of 12 months or less. The System has elected not to apply the short-term lease recognition and measurement exemption for other classes of leased assets. The System recognizes the lease payments associated with its short-term leases as an expense on a straight-line basis over the lease term.

The System's leases generally include nonlease maintenance services (i.e., equipment maintenance or common area maintenance). The System allocates the consideration in the contract to the lease and nonlease maintenance component based on each component's relative stand-alone price.

(s) Derivative Instruments and Hedging Activities

The System accounts for derivatives and hedging activities in accordance with ASC 815, *Derivatives and Hedging*, which requires that all derivative instruments be recorded in other assets and other liabilities long-term in the combined balance sheets at their respective fair values.

On the date derivative contracts are executed, the System designates certain derivatives to the variability of cash flows to be received or paid related to a recognized asset or liability (cash flow hedge). For such designated hedging relationships, the System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedging instrument, the item, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring and recording ineffectiveness. This process includes linking all derivatives that are designated as cash flow hedges to specific assets and liabilities in the combined balance sheets.

The System formally assesses, both at a designated hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash flow hedge are recorded as a change in net assets without donor restrictions to the extent that the derivative is effective. Any ineffectiveness associated with the cash flow hedge is recorded in nonoperating gains (losses) in the combined statements of operations and changes in net assets.

The System will discontinue hedge accounting prospectively when it is determined that the derivative is no longer highly effective in offsetting changes in the cash flows of the hedged item, the derivative expires or is sold, terminated, or exercised, the derivative is undesignated as a hedging instrument, a hedged firm commitment no longer meets the definition of a firm commitment, or management determines that designation of the derivative as a hedging instrument is no longer appropriate.

(t) Endowment Funds

The System's net assets with donor restrictions includes individual endowment funds established by donors to support a variety of purposes, among other donor restricted funds.

The New York Prudent Management of Institutional Funds Act (NYPMIFA or Act) is New York State's version of the Uniform Prudent Management of Institutional Funds Act (UPMIFA), which provides standards of fund management for those charged with governance of institutional or endowment funds. The Act requires covered organizations to take specific actions with respect to appropriation from endowment funds and investment of institutional funds, including adoption of a written investment policy; diversification of investments; and adherence to a specified process to lift donor restrictions, which is only allowable in certain limited circumstances. The Act permits an institution to determine the appropriate level of endowment expenditure, subject to donor-imposed restrictions expressed in the gift instrument. However, it establishes a rebuttable presumption of imprudence if such expenditure in any year is greater than 7% of the fair market value of an endowment funds established by a gift instrument entered on or after the effective date of the Act.

The System classifies as net assets with donor restrictions (a) the original value of gifts donated to an endowment fund; (b) the original value of subsequent gifts to that fund, and (c) accumulations to the fund made in accordance with the direction, if any of the applicable donor gift instrument at the time the accumulation is added to the fund. Expendable portions of endowment gifts restricted by donors to specific purposes and any retained income and appreciation thereon is included as a component of net assets with donor restrictions. When the restrictions on these assets have been met, the assets are reclassified to net assets without donor restrictions pursuant to AMC, Saratoga, Glens Falls, and CMH's respective spending policy.

(u) Other Assets

Other assets consist of equity investments in joint ventures, recoverable reinsurance amounts related to workers compensation and professional liability claims, deferred compensation agreements and goodwill recognized in connection with physician practice acquisitions.

(v) Reclassifications

Certain amounts in the 2023 combined financial statements have been reclassified to conform to 2024 presentation.

(2) Community Benefit, Charity Care and Uncompensated Care

(a) Community Benefit

The System offers numerous community benefit programs and services in community-based settings in response to the needs of the communities it serves. They include community health fairs, health screenings, health education lectures and workshops for community groups and the general public, consumer health information, facilitated (insurance plan) enrollment services and clinical services such as outpatient clinics, adult and pediatric care services, neonatal intensive care services, and behavioral health services. Staff members of the System also participate in community leadership efforts by donating significant hours of board service to other not-for-profit organizations. The System supports graduate medical education and offers health professions education support for community members through continuing education programs and scholarships.

(Dollars in thousands)

(b) Charity and Uncompensated Care

The System's net cost of charity care, including payments to and receipts from the statewide pool for 2024 and 2023, was as follows:

		Year ended December 31	
		2024	2023
Charity care at cost	$	33,530	17,297
Payments to statewide pool		11,276	10,742
Receipts from statewide pool		(4,839)	(2,965)
Cost of charity care, net	$	39,967	25,074

The cost of charity care provided was determined using direct and indirect costs to provide services based on the application of the ratio of the System's overall cost to patient charges.

The System also subsidizes services to Medicaid patients, which are paid at reimbursement levels below the System's cost of rendering the related services. In addition, the System incurred approximately $48,000 and $44,000 in provisions for uncollectible accounts during each of the years ended December 31, 2024 and 2023, respectively.

(3) Liquidity

As of December 31, 2024 and 2023, combined financial assets and liquidity resources 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:

		2024	2023
Financial assets:			
Cash and cash equivalents	$	349,694	480,302
Short-term investments		370,290	304,875
Patient accounts receivable, net		322,466	292,109
Other receivables		68,612	65,554
Board designations:			
Long-term and other liquid investments available for operations		57,486	52,999
Total financial assets available within one year	$	1,168,548	1,195,839

The System's revenues and related operating activities are generally not seasonal in nature. Funds functioning as endowments may be made available for operations by action of the respective hospital's board. In addition, the System has access to unused lines of credit that may be used for operations of which $68,500 are available as of December 31, 2024 until the line of credit maturity date (see note 14(b)).

(Dollars in thousands)

(4) Net Patient Service Revenue

The composition of net patient service revenue by primary payor for the years ended December 31 is as follows:

	2024		2023	
Medicare	$ 465,083	18 %	$ 409,097	16 %
Medicaid	53,712	2	46,838	2
Medicare and Medicaid Managed Care	884,886	34	831,104	33
Commercial carriers	1,102,738	42	1,093,923	44
No fault and worker's compensation	34,156	1	37,882	2
Self pay and other	75,558	3	88,823	3
	$ 2,616,133	100 %	$ 2,507,667	100 %

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

The System's primary geographic areas are generally consistent with its hospital settings. The composition of net patient care service revenue based on each hospital's lines of business and method of reimbursement for the years ended December 31, 2024 and 2023 are as follows:

	2024				
	AMC	CMH	Glens Falls	SH	Total
Service lines:					
Hospital – inpatient	$ 894,531	41,757	154,761	140,320	1,231,369
Hospital – outpatient	366,940	64,069	236,356	232,200	899,565
Physician services	265,841	50,813	35,840	80,563	433,057
	$ 1,527,312	156,639	426,957	453,083	2,563,991
Method of reimbursement:					
Fee for service	$ 1,506,935	154,528	425,755	448,402	2,535,620
Capitation and risk sharing	—	2,111	1,202	4,681	7,994
Other	20,377	—	—	—	20,377
	$ 1,527,312	156,639	426,957	453,083	2,563,991

Healthcare services are generally recognized as the services are transferred over time. MMEC patient service revenue of $27,086 is primarily outpatient and fee for service based for 2024. VNA patient revenue of $25,056 is primarily Home Care Services.

(Dollars in thousands)

In addition to the above, other operating revenues and gains includes revenue recognized for various other System activities, including AMC and Glens Falls Retail and Specialty Pharmacy of approximately $93,803, which is recognized on a point in time basis; CMH, Glens Falls, and AMC pharmacy rebates (340B Program) of $135,329, which is recognized as cash rebates are received; and AMC, CMH, and Saratoga contracted health services of approximately $10,968, which are recognized over the period the services are provided. There are no material contract assets or liabilities associated with these activities.

	2023				
	AMC	**CMH**	**Glens Falls**	**SH**	**Total**
Service lines:					
Hospital – inpatient	$ 880,935	36,723	133,312	114,551	1,165,521
Hospital – outpatient	362,809	59,583	193,650	228,883	844,925
Physician services	276,340	50,387	36,374	87,525	450,626
	$ 1,520,084	146,693	363,336	430,959	2,461,072
Method of reimbursement:					
Fee for service	$ 1,499,131	143,961	361,472	424,449	2,429,013
Capitation and risk sharing	—	2,732	1,864	6,510	11,106
Other	20,953	—	—	—	20,953
	$ 1,520,084	146,693	363,336	430,959	2,461,072

Healthcare services are generally recognized as the services are transferred over time. MMEC patient service revenue of $25,215 is primarily outpatient and fee for service based for 2023. VNA patient revenue of $21,380 is primarily Home Care Services for March 2023 through December 2023.

In addition to the above, other operating revenues and gains includes revenue recognized for various other System activities, including AMC and Glens Falls Retail and Specialty Pharmacy of approximately $59,810, which is recognized on a point in time basis; CMH, Glens Falls, and AMC pharmacy rebates (340B Program) of $151,379, which is recognized as cash rebates are received; and AMC, CMH, and Saratoga contracted health services of approximately $10,628, which are recognized over the period the services are provided. There are no material contract assets or liabilities associated with these activities.

AMCH, Saratoga, Glens Falls, and CMH are required to prepare and file various reports of actual and allowable costs annually. Provisions have been made in the combined financial statements for prior and current years estimated final settlements by applying the expected value and most likely amount methods under ASC 606. The difference between the amount provided and the actual final settlement is recorded as an adjustment to net patient service revenue in the year the final settlement is determined. During 2024 and 2023, the AMCH, Saratoga, Glens Falls, and CMH recorded adjustments for estimated settlements with third-party payors, which resulted in an increase/(decrease) to net patient service revenue of approximately ($1,118) and $6,917, respectively. The laws and regulations governing the reimbursement for healthcare services are complex and subject to interpretation. Third-party payors retain the right to review and propose adjustments to amounts requested and recorded by the AMCH, Saratoga, CMH, Glens Falls, and College. In the opinion of management, retroactive adjustments, if any, would not be material to the combined financial position or results of operations of the collective System.

(Dollars in thousands)

Cost reports supporting third party service revenue have been audited and finalized through December 31, 2019 by the designated intermediaries. Cost reports 2020 through 2023 have been filed. The 2020 through 2023 Medicare cost reports have not been finalized. A provision for the estimated settlements for all open years has been recorded at December 31, 2024, 2023, 2022, 2021 and 2020. In the opinion of management, no significant adjustments are expected to result from the audit of 2020 through 2024 cost reports. The System has classified a portion of the accrual for estimated third-party payor settlements as other long-term liabilities because such amounts, by their nature or by virtue of regulations or legislation, will not be settled within one year.

As of December 31, 2024 and 2023, significant concentrations of patient accounts receivable are as follows:

	2024	2023
Medicare	15 %	14 %
Medicaid	3	3
Medicaid and Medicare managed care	33	33
Commercial carriers	41	41
No-fault and worker's compensation	4	4
Private pay	1	2
Other third-party payors	3	3
	100 %	100 %

(Dollars in thousands)

(5) Investments

Investments, stated at fair value, consist of the following as December 31:

		2024	2023
Assets whose use is limited:			
Cash equivalents	$	19,103	13,945
Equity securities		42,777	49,376
U.S. government and agency obligations		36,040	28,964
Fixed income securities		42,885	43,551
Corporate bonds		127	142
Common collective trust funds		1,232	—
Limited partnerships		316	313
	$	142,480	136,291
Investments:			
Cash equivalents	$	10,505	5,284
Equity securities		355,776	284,614
U.S. government and agency obligations		861	767
Fixed income securities		161,666	127,971
Corporate bonds		16,881	19,052
Common collective trust funds		2,197	4,943
Limited partnerships		73,469	85,890
		621,355	528,521
Less investments, current		393,057	327,140
	$	228,298	201,381

		2024	2023
Assets held in charitable trusts:			
Cash equivalents	$	530	136
Equity securities		1,509	1,726
Common collective trust funds		—	40
Fixed income securities		689	703
	$	2,728	2,605

(6) Fair Value Measurements

The following is a description of the valuation methodologies used by the System for its assets and liabilities measured at fair value on a recurring basis:

(a) Cash Equivalents

Cash equivalents are valued at $1.00 per unit, as reported by the financial institution.

(b) Equity, Fixed Income Securities, and Common Collective Trust Funds

The System's equity and fixed income portfolios consist of direct investment in individual equity and fixed income securities that are valued based on readily determinable quoted market prices (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 fixed income securities with similar coupons, ratings, and maturities, rather than on specific bids and offers for a designated security.

In addition, the System's equity and fixed income portfolios include investments in actively traded mutual funds valued at the closing price on the active market in which the individual funds are traded (Level 1 measurements) and pooled/commingled investment funds where the System owns shares, units, or interests of pooled funds rather than the underlying securities in the fund. The pooled/commingled funds are measured at fair value based on the nature of the underlying investments and have been determined to have a readily determinable fair value (Level 1).

(c) Limited Partnerships

Limited partnerships consist of real estate, hedge funds, and other investment strategies. Limited partnership investments are redeemable with the fund at NAV under the original terms of the partnership agreement and/or subscription agreements. The estimation of fair value of investments in limited partnerships for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The System owns interests in these funds, which in turn invest in related investment funds, rather than the System having direct ownership of the underlying securities held by the investment funds. The System uses NAV as a practical expedient to estimate the fair value of limited partnership investments and are therefore reported separately from those investments categorized as Level 1, 2, or 3 in the hierarchy table.

(d) Interest Rate Swaps

The fair value of interest rate swaps is determined based on future cash flows calculated through a projection of forward rates, which are then discounted at observable market rates to their present value (note 14).

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the System 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. The inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments or a reflection on the liquidity of each fund's underlying assets and liabilities.

(Dollars in thousands)

The following tables present the System's assets and liabilities that are measured at fair value as of December 31, 2024 and 2023, on a recurring basis. Financial instruments are classified in their entirety or at NAV (or equivalent) based on the lowest level of input that is significant to the fair value measurement:

	2024					
	Level 1	Level 2	NAV or equivalent	Total	Redemption or liquidation	Days notice
Assets:						
Cash equivalents	$ 30,138	—	—	30,138		
U.S. government and agency obligations	7,374	29,527		36,901		
Equity mutual funds	400,062	—	—	400,062		
Fixed income mutual funds	205,240	—	—	205,240		
Corporate bonds	—	17,008	—	17,008		
Common collective trust funds	3,429	—	—	3,429		
Limited partnerships	—	—	73,785	73,785	Quarterly	45–365
Total	$ 646,243	46,535	73,785	766,563		
Interest rate swaps	$ —	3,179	—	3,179		

	2023					
	Level 1	Level 2	NAV or equivalent	Total	Redemption or liquidation	Days notice
Assets:						
Cash equivalents	$ 19,365	—	—	19,365		
U.S. government and agency obligations	—	29,731	—	29,731		
Equity mutual funds	335,716	—	—	335,716		
Fixed income mutual funds	172,225	—	—	172,225		
Corporate bonds	—	19,194	—	19,194		
Common collective trust funds	4,983	—	—	4,983		
Limited partnerships	—	—	86,203	86,203	Quarterly	45–365
Total	$ 532,289	48,925	86,203	667,417		
Interest rate swaps	$ —	2,546	—	2,546		

As of December 31, 2024, the System can redeem or sell its investments at fair value in accordance with the following terms: daily $598,330, monthly $115,789, quarterly $18,662, annually $4,258, greater than one year $29,524.

(Dollars in thousands)

As of December 31, 2023, the System can redeem or sell its investments at fair value in accordance with the following terms: daily $507,130, monthly $108,071, quarterly $15,971, annually $3,445, greater than one year $32,800.

The System had no financial instruments that are classified as Level 3 measurements as of December 31, 2024 and 2023. There were no significant transfers between Level 1 and Level 2 fair value measurements due to changes in valuation methodologies during the years ended December 31, 2024 and 2023.

(7) Property and Equipment

Property and equipment at December 31 consisted of:

		2024	2023
Land and land improvements	$	65,509	64,888
Buildings and fixed equipment		1,407,201	1,391,901
Moveable equipment		502,127	484,044
Projects in progress		63,756	61,531
		2,038,593	2,002,364
Property held under finance leases		132,042	129,239
		2,170,635	2,131,603
Less accumulated depreciation and amortization		1,183,071	1,152,403
	$	987,564	979,200

(Dollars in thousands)

(8) Long-Term Debt

Long-term debt at December 31 consisted of:

	2024					
	Center/ AMCH	CMH	Glens Falls	MMEC	Saratoga	Total
Mortgage Loans (FHA Insured) AMCH (a)	$ 270,439	—	—	—	—	270,439
Mortgage Loans (b) (c) (d) (e)	18,835	1,608	28,825	13,370	—	62,638
IDA/CRC Bonds (f) (g)	74,428	—	—	—	43,081	117,509
Installment Payable Loan (h)	—	—	—	—	862	862
Term Loans (i)(j)(k)	16,025	—	505	—	—	16,530
Lines of Credit-outstanding balance (l)	—	—	8,004	—	—	8,004
	379,727	1,608	37,334	13,370	43,943	475,982
Less current maturities of long-term debt	22,677	110	10,391	299	3,820	37,297
	357,050	1,498	26,943	13,071	40,123	438,685
Less deferred financing costs	2,808	—	185	—	323	3,316
	$ 354,242	1,498	26,758	13,071	39,800	435,369

(a) Mortgage Loans (FHA Insured) – AMCH

(i) In December 2010, AMCH closed on a $321,440 Mortgage Loan, (2010 Mortgage Loan), which was comprised of a "Refinance Loan" of $9,584 and a "Patient Tower" Loan of $311,856 (which was reduced by $50,220 to $261,636 at Final Endorsement). The 2010 Mortgage Loan is insured under the FHA-241 program, with Prudential Huntoon Paige Associates as the lender.

The 2010 Mortgage Loan is currently secured by a first lien mortgage on substantially all of AMCH's property, equipment, and gross receipts, and a first mortgage lien on the South Clinical Campus of AMCH.

The Refinance Loan was used to retire the Series 1999 Bonds, the original purpose of which was to acquire properties and rights of the former Child's Hospital and Samaritan Service Corporation. The interest rate is 4.66% on the Refinance Loan. Monthly principal and interest payments of approximately $65 are payable through May 1, 2029.

The Patient Tower Loan was used to finance AMCH's expansion project consisting of a six-story patient tower, which contains 96 beds, 20 operating rooms, and a cogeneration plant. Final endorsement occurred in September 2014 in the amount of $261,636. The Patient Tower Loan has an interest rate of 6.2% and a maturity date of July 2038, with monthly principal and interest payments of approximately $1,731.

(Dollars in thousands)

Future principal payments on both components of the 2010 Mortgage Loan for the next five years and thereafter are as follows:

Year ending December 31:		
2025	$	9,873
2026		10,492
2027		11,151
2028		11,850
2029		12,136
Thereafter		137,994
Total	$	193,496

(ii) On February 26, 2014, the Center transferred ownership of a campus parking garage to AMCH, and the existing ground lease with Albany Stratton VA Medical was assigned to AMCH. The associated mortgage loan (Garage Loan) in the original amount of $38,425 is insured under the FHA-241 Program, with Prudential Huntoon Paige Associates as the lender. It is secured by a leasehold mortgage on the parking garage, as well as a lien on substantially all the AMCH's property, equipment, and gross receipts. The Garage Loan has a fixed interest rate of 3.86% and a maturity date of May 2034, with monthly principal and interest payments of approximately $230.

Future principal payments on the Garage Loan for the next five years and thereafter are as follows:

2025	$	1,967
2026		2,044
2027		2,125
2028		2,208
2029		2,295
Thereafter		10,804
Total	$	21,443

(iii) In April 2017, AMCH closed on a $65,000 FHA insured construction loan (2017 Mortgage Loan) to finance the costs to construct a new Pediatric Emergency Department building and complete other renovations within the AMCH complex to increase patient care capacity. The 2017 Mortgage Loan is insured under the FHA-241 Program, with Prudential Huntoon Paige as the lender. It is secured by a lien on substantially all AMCH's property, equipment, and gross receipts. The loan has a fixed interest rate of 4.26% and had an interest only 23-month construction period. Interest costs during the construction period were included within the loan budget. Construction began in the spring of 2017 and was completed mid-2019. Principal payments commenced in April 2019 based on a 25-year schedule and the loan matures on March 1, 2044.

(Dollars in thousands)

Future principal payments on the 2017 Mortgage Loan for the next five years and thereafter are as follows:

Year ending December 31:		
2025	$	1,903
2026		1,985
2027		2,071
2028		2,161
2029		2,255
Thereafter		45,125
Total	$	55,500

The Regulatory Agreement for all the FHA 241 Mortgage Loans requires AMCH to provide specific financial information and to meet specific financial covenant requirements in order to undertake certain actions. In addition, HUD requires the maintenance of a Mortgage Reserve Fund (MRF) at a banking institution recorded in Assets whose Use is Limited, with required balances to be maintained in accordance with the MRF Schedule.

(b) Mortgage Loans – AMC

(i) On March 25, 2020, the Albany Medical Center closed on a $6,600 mortgage loan to finance the costs of a building acquisition, as well as costs related to renovation. Funds for the renovation were fully advanced by late 2020. The loan has an interest rate of Term SOFR plus 1.40%, with a fixed rate of 2.32% obtained through a one year forward starting interest rate swap arrangement. The loan has a term of 11 years, with a 25-year amortization schedule. Amortization commenced on April 1, 2021 and the loan will mature on April 1, 2031.

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	215
2026		220
2027		225
2028		230
2029		235
Thereafter		4,730
Total	$	5,855

(ii) On October 1, 2020, Albany Medical Center and Nathan Littauer Hospital closed on a $4,700 mortgage loan to finance land acquisition and the costs of constructing a medical office building in Amsterdam, NY. The principal amount of the loan was reduced to $4,300 in mid-2022 once the building construction was completed. The Albany Medical Center and Nathan Littauer Hospital own the building as Tenants in Common, with each entity having a 50% ownership interest. The two entities also are coborrowers of the loan, with an internal legal agreement limiting liability to 50% each. Each entity records a total debt obligation of 50% of the outstanding principal balance. The loan has a fixed interest rate of 3.575%. Amortization based on a 25-year schedule commenced on July 1, 2021 and the loan will mature on July 1, 2031.

(Dollars in thousands)

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	61
2026		63
2027		66
2028		68
2029		71
Thereafter		1,623
Total	$	1,952

(iii) On September 23, 2021, the Center closed on a $12,100 leasehold mortgage loan to finance the acquisition of property located at 50 New Scotland Ave, Albany. The mortgage loan has a 10-year term, with a maturity date of October 1, 2031 and a 25-year amortization schedule. The interest rate is 3.01%, fixed for the term.

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	361
2026		372
2027		384
2028		395
2029		408
Thereafter		9,108
Total	$	11,028

(c) Mortgage Loan – CMH

(i) In November 2021, CMH entered into a 15-year mortgage loan arrangement not to exceed $4,500 in order to fund the costs of the Green Medical Arts Building project. The loan, secured by a mortgage lien on the building and other borrower assets, had an 18-month draw period during which proceeds could be drawn to fund project costs. The project was also funded by a NYS grant of up to $1,900. The loan converted to a permanent term loan in May 2023 at the end of the 18 month draw period, with a principal balance of $1,775. As of the end of 2024, the principal balance was $1,608 and the interest rate was 3.5%.

(Dollars in thousands)

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	110
2026		114
2027		119
2028		123
2029		127
Thereafter		1,015
Total	$	1,608

(d) Mortgage Loan – Glens Falls

(i) Mortgage loan – Refinancing of Series 2015 Glens Falls Civic Tax-Exempt Bonds

During June 2022, Glens Falls prepaid the loan made by Glens Falls Civic Development Corporation using funds from a syndicate of Financial Institutions (including M&T Bank as Administrative Agent). The new mortgage loan facility in the original principal amount of $33,000 has a 14-year amortization and a 10-year term with a balloon payment of $12.2M in 2032. The loan is secured by the gross receipts of Glens Falls Hospital, a mortgage lien on Hospital property, with the Glens Falls Hospital Foundation as Guarantor.

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	1,882
2026		1,978
2027		2,080
2028		2,187
2029		2,300
Thereafter		18,398
Total	$	28,825

(e) Mortgage Loan – MMEC

On May 24, 2023, Healthcare Partners of Saratoga (also known as MMEC) closed on a $13,800 mortgage loan to finance the costs of a building acquisition. The loan has a fixed interest rate of 5.45% for the first 5 years of the loan. In June 2028, the rate will adjust to the prevailing 5 year Federal Home Loan Bank of NY rate plus a margin of 1.85%. The interest rate will adjust every 5 years based on this index and margin. The floor rate for the loan will be 4.5%. The loan will mature on May 24, 2048 and is on a 25 year amortization schedule.

(Dollars in thousands)

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	299
2026		316
2027		334
2028		355
2029		372
Thereafter		11,694
Total	$	13,370

(f) IDA/CRC Bonds Payable – Center/AMCH

(i) Series 2014A CRC Bonds – AMCH

On September 10, 2014, AMCH closed on Series 2014A CRC Tax-Exempt Revenue Bonds in the amount of $22,000 (Series 2014A Bonds). The proceeds of the bonds were utilized for the reconstruction and renovation of certain portions of the existing AMCH facility and the acquisition of certain machinery and equipment for these existing facilities. The Series 2014A Bonds mature on September 10, 2039. Subject to the terms of the Series 2014A Bond Indenture, the bonds were issued in the Bank Purchase Rate Mode and are privately held by a financial institution. Principal and interest are payable over a 25-year term. The mandatory tender date for the Bonds was extended by the financial institution from September 1, 2024 to September 1, 2031. The interest rate was adjusted at the time of this extension to a tax-exempt fixed rate of 4.379%.

Future principal payment amounts are set forth in the table below:

Year ending December 31:		
2025	$	795
2026		832
2027		869
2028		907
2029		950
Thereafter		11,704
Total	$	16,057

(ii) Series 2014A & 2014B CRC Parking Garage Bonds and Series 2014A & 2014B CRC Medical Office Building Bonds – Center (Amended 2019)

On December 4, 2014, the Center closed on Series 2014A and Series 2014B Bonds issued by the City of Albany CRC to be used to finance the construction of a parking garage and medical office building on property owned by the Center and adjacent to AMCH.

(Dollars in thousands)

The Parking Garage Series 2014A and 2014B Bonds (Parking Garage Bonds) were issued in the amounts of $20,000 and $5,000, respectively. The Medical Office Building Series 2014A and 2014B Bonds (MOB Bonds) were issued in the amounts of $8,400 and $19,600, respectively. The Parking Garage Bonds and MOB Bonds were both considered construction loans, with construction fully completed in mid-2016.

The Center Parking Garage Series 2014B Bond has a tax-exempt fixed interest rate of 5.5%.

On November 25, 2019, the Center closed on amendments to the 2014A Parking Garage bond and the 2014A & 2014B MOB Bonds. In connection with these amendments, $12,046 of the taxable MOB bond was reallocated to the tax-exempt MOB bond. The new balance of the tax-exempt MOB bond as of November 25, 2019 was $19,929 (an increase from $7,884), or 75% of the total bond financing relative to the Medical Office Building. Associated unamortized debt issuance costs to be written off were determined to not be material.

The tax-exempt factor for the two tax-exempt bonds increased from 70% to 79%, as a result of the change in the Corporate Tax Rate. The credit spreads for all three bonds were reduced to 1.70%, with the spread further reduced to 1.343% for the tax-exempt bonds (79% of 1.70%).

The repayment terms of the bonds remained the same based on an original 30-year schedule, as well as the bank mandatory redemption dates of June 1, 2026. The bonds still have a maturity date of July 1, 2046.

The three original swap transactions related to the financing were not changed, although two new swap transactions were executed to ensure that the interest rate risks relating to the increase in the tax-exempt factor and the reallocation of the MOB exposure were effectively hedged. The three original swap transactions were structured with 30-year terms, with an option for AMC to terminate in June 2026.

In March 2023, the bonds were amended to change the interest rate index from LIBOR to SOFR. The associated interest rate swaps were also amended as noted in Note 15. There was no material impact on interest rates.

Future principal payment amounts of the bonds are set forth in the table below:

Year ending December 31:		
2025	$	1,220
2026		1,279
2027		1,340
2028		1,400
2029		1,473
Thereafter		37,998
Total	$	44,710

(Dollars in thousands)

(iii) Series 2017 CRC Bonds – Center/AMCH

In November 2017, the Center and AMCH each closed on Series 2017A, 2017B, and 2017C City of Albany CRC Revenue Refunding Bonds. The proceeds of the 2017 Bonds in the total amount of $40,930 were used to redeem the outstanding bonds associated with the Center and AMCH Series 2005 Bonds, Series 2006 Bonds, and Series 2007 Bonds, as well as to pay associated transaction costs, and swap termination fees relating to the 2005 and 2006 interest rate swap arrangements. The original bonds had been used for the acquisition of certain properties, refinancing of certain loans, and financing renovations of existing facilities. The 2017 Bonds are privately held by a financial institution and collateralized by a pledge of College accounts receivable and other gross receipts. AMCH and the Center are guarantors of each other's bonds.

The interest on all the 2017 Bonds is payable monthly. A summary of the five remaining tax-exempt and taxable 2017 Bonds is set forth in the table below:

Borrower/series, tax status*	Interest rate as of December 31, 2024	Principal payment frequency	Maturity date		Original par amount
AMCH – 2017A, TE	Fixed at 2.80%	Monthly, interest only until 2020	May 1, 2027	$	13,200
AMCH – 2017C, TE	70% Adj SOFR + 0.90**	Annual	May 1, 2027		11,855
AMC – 2017A, TE	Fixed at 2.92%	Monthly, interest only until 2025	May 1, 2027		2,625
AMC – 2017B, TX	Adj SOFR + 1.40**	Monthly	September 1, 2025		7,750
AMC – 2017C, TE	70% Adj SOFR + 0.90**	Annual	May 1, 2027		1,750
Total				$	37,180

* TE represents tax exempt bonds and TX represents taxable bonds.

** Variable rate issuances above have interest rates based on a floating rate plus a defined spread.

The Center and AMCH are parties to interest rate swap agreements with respect to the 2017C bonds, as described in note 14.

Future principal payment amounts for the combined 2017 Bonds are set forth in the table below:

Year ending December 31:		
2025	$	4,423
2026		4,592
2027		4,646
Total	$	13,661

(Dollars in thousands)

The 2017B and 2017C bonds were amended in April 2023 in order to change the interest rate index from LIBOR to SOFR. The associated interest rate swaps were also amended as noted in Note 14. There was no material impact on interest rates.

(g) IDA/CRC Bonds Payable – Saratoga

(i) Series 2013A CRC Bond

In February 2013, the Saratoga County CRC issued tax-exempt Revenue Bonds, Series 2013A in the amount of $22,430 for the purpose of refinancing certain existing debt. The Series 2013A Bonds were issued pursuant to the terms of a Master Trust Indenture and Supplemental Master Trust Indenture (Indentures) by and between Saratoga Hospital and Saratoga Care, Inc., as members of the Saratoga Hospital Obligated Group (Obligated Group). The Series 2013 Bonds are special and limited obligations of the CRC payable solely from and secured by pledges of payments to be made under a separate Loan Agreement, dated January 1, 2013, between the Obligated Group and the CRC. As additional security for all the bonds, the Obligated Group issued Obligated Group Master Notes to the trustee pursuant to the Indentures. The Obligated Group Master Notes are a joint and several obligations of the Obligated Group members secured by a pledge of and lien on the gross receipts of the Obligated Group members and a first mortgage lien on and security interest in certain portions of Saratoga Hospital's real and personal property.

The Indentures permit the Obligated Group to incur additional long-term debt subject to the approval of the Trustee, and the ability of the Obligated Group to meet certain financial performance and reporting requirements. Further, the members of the Obligated Group must satisfy certain financial performance and reporting requirement covenants annually if the Bonds are outstanding.

Outstanding serial bonds, bearing interest at fixed rates ranging from 2.5% to 5.0%, mature each year on December 1 and require annual payments ranging from $1,090 to $1,290 through 2028. Outstanding term bonds, bearing interest at a fixed rate of 3.25%, require annual mandatory sinking fund payments prior to maturity in amounts ranging from $1,150 to $1,490 in the years 2029 through 2033.

Annual principal payments on the Series 2013A bonds are set forth in the table below:

Year ending December 31:		
2025	$	1,115
2026		1,170
2027		1,225
2028		1,290
2029		1,355
Thereafter		5,480
Total	$	11,635

(Dollars in thousands)

(ii) Series 2017A and 2017B CRC Bonds

On January 3, 2017, the CRC issued tax-exempt Revenue Bonds, Series 2017 A and B (The Saratoga Hospital Project), in the amounts of $24,170 and $25,700, respectively, for the purpose of refinancing certain existing debt (Series 2007A, 2007B, and 2014 Bonds). The Series 2017A and Series 2017B Bonds mature on December 1, 2040 and December 1, 2032, respectively. The Trust Indenture for the Series 2017A and Series 2017B Bonds was issued pursuant to the Indentures for the Series 2013A CRC Bonds. Both 2017 Series Bonds were initially issued in Bank Purchase Rate mode and are privately held by a financial institution (Initial Bonds). Principal and interest are payable monthly over the terms of the respective 2017 Bond Series. The Initial Series 2017A and Series 2017B Bonds bear interest at fixed rates of 2.47% and 2.63%, respectively, and the Initial Bonds have initial mandatory tender dates of January 1, 2027 and January 1, 2032, respectively.

Annual principal payments on the Series 2018A and B Bonds are set forth in the table below:

Year ending December 31:		
2025	$	2,617
2026		2,684
2027		2,745
2028		2,815
2029		2,880
Thereafter		17,705
Total	$	31,446

(h) *Installment Payable – Saratoga*

In March 2003, Saratoga Hospital entered into an unsecured $2,000 installment sale contract in order to finance the purchase of the building where its Wilton Medical Arts site is located. The contract requires Saratoga Hospital to make monthly payments of $11, including interest at 5%, through February 2033. Saratoga Hospital will continue to lease the parcel of land the building is constructed on under a ground lease that runs through February 2035, with the option to renew the ground lease for up to four five-year terms thereafter. Under the terms of the installment sale contract, the lessor retains the right to evict Saratoga Hospital from any buildings on the parcel subject to the ground lease, in the event that Saratoga Hospital defaults on the installment sale contract.

(Dollars in thousands)

Future principal payments on the installment payable for the next five years and thereafter are as follows:

Year ending December 31:		
2025	$	88
2026		92
2027		97
2028		102
2029		107
Thereafter		376
Total	$	862

(i) Term Loans – AMCH/Center

(i) In November 2008, AMCH and the Center each entered into five-year revolving loan agreements in the amount of $4,000 and $4,500, respectively. The loan proceeds were utilized for various renovations and equipment expenditures. AMCH and the Center are the guarantors of each other's loans. In conformance with the Loan Agreements, the revolving loans have been converted to amortizing term loans. In May 2021, the term loans were amended to provide for a new seven-year term and amortization schedule. The maturity date for both loans was extended to May 1, 2028. In addition, the interest rate for both loans was adjusted to 2.44%, fixed for the term.

Future principal payments are set forth in the following table:

Year ending December 31:		
2025	$	496
2026		509
2027		522
2028		218
Total	$	1,745

(ii) In May 2017, the Albany Medical Center closed on a $9,000 term loan arrangement to finance the costs of various renovation projects on the AMC and AMCH campuses. The term loan, which was advanced over a two-month period, has an amended fixed rate of 3.70%. The loan was interest only until April 1, 2018 when principal payments commenced based on a 10-year amortization schedule. The loan matures on March 1, 2028.

(Dollars in thousands)

Future principal payments for this term loan are set forth in the following table:

Year ending December 31:		
2025	$	978
2026		1,015
2027		1,054
2028		270
Total	$	3,317

(iii) In February 2019, the Albany Medical Center closed on a $12,900 term loan arrangement to finance the costs relating to the acquisition of property located at 22 New Scotland Ave. The term loan has an interest rate of Term SOFR plus 1.25%, with a fixed rate of 3.95% obtained through an interest rate swap. The loan and swap have a 10-year term, with a 25-year amortization schedule. The loan matures on March 1, 2029.

Future principal payments for this term loan are set forth in the following table:

Year ending December 31:		
2025	$	385
2026		401
2027		418
2028		434
2029		9,325
Total	$	10,963

(j) Term Loans – Glens Falls

(i) Pruyn Pavilion

During May 2022, Glens Falls partially paid down and refinanced the term loan previously utilized to acquire the Pruyn Pavilion building located on its Park Street Campus. The refinanced term loan has a 3-year amortization and payment term. The loan is unsecured.

Future principal payments for the term loan is set forth in the following table:

Year ending December 31:		
2025	$	505
Total	$	505

(Dollars in thousands)

(k) Line of Credit

Glens Falls Hospital has a balance of $8,004 and $5,000 on their lines of credit as of December 31, 2024 and 2023. See note 14(b).

(l) Reserve Accounts

The System has established certain bank trusteed accounts to meet the requirements of borrowing or leasing agreements related to several of the FHA insured Mortgage Loans, Bonds, and other debt and lease agreements. Included in the accompanying combined financial statements, classified as Assets whose Use is Limited, are balances in these accounts at December 31 as follows:

		2024	2023
AMC:			
Mortgage Loans (FHA Insured) – Mortgage Reserve Fund	$	28,800	28,885
VA Enhanced Use Lease – VA Maint. Reserves		212	207
CRC Bonds		245	120
		29,257	29,212
Saratoga:			
Third-party and debt agreements		1,749	1,749
CMH:			
Capital Replacement Account – Kaaterskill Commons		110	111
Total	$	31,116	31,072

(m) Reporting Requirements

Certain of AMC, Glens Falls, Saratoga, and CMH's bonds, mortgage loans, and term loans set forth provisions and requirements, including financial ratios and reporting requirements, with which each entity must comply. As of December 31, 2024, certain, but not all, of these borrowings required financial ratios or requirements were not met for Glens Falls, and Columbia Memorial. The associated financial institutions have subsequently waived instances of non-compliance as of December 31, 2024.

(9) Retirement Plans

AMC has a defined benefit plan and CMH has an elective contributory defined benefit plan.

(a) Albany Medical Center Retirement Plan

AMC participates in a defined-benefit pension plan for substantially all full-time employees (AMC Plan). The projected unit credit method is used in determining employees' benefits. Pension costs are funded to the minimum levels established by the Employee Retirement Income Security Act (ERISA) of 1974. The AMC Plan is a qualified plan under Section 401(a) of the Internal Revenue Code and has been determined by the Internal Revenue Service to be exempt from federal income taxes. In December 2011, the AMC Plan approved amending the AMC Plan to freeze average monthly earnings for grandfathered participants, effective April 1, 2012. In 2023, the AMC Plan opted to derisk a segment of the AMC Plan through a plan annuitization whereby a group annuity was purchased for a portion of the retiree population, which was accounted for as an AMC Plan settlement.

(Dollars in thousands)

The following table sets forth the AMC Plan's projected benefit obligation and fair value of the AMC Plan assets at December 31:

		2024	2023
Change in projected benefit obligation:			
Benefit obligations at beginning of year	$	287,139	294,197
Service cost		15,863	14,488
Interest cost		14,386	15,766
Actuarial (gain) loss		(17,819)	20,899
Benefits and settlements paid and expected expenses		(18,697)	(59,035)
Settlement		—	824
Benefit obligation at end of year	$	280,872	287,139
Change in plan assets:			
Fair value of plan at beginning of year	$	286,382	307,648
Employer contributions		12,257	—
Actual return on plan assets		9,039	39,689
Benefits and settlements paid and actual expenses		(20,692)	(60,955)
Fair value of plan assets at end of year	$	286,986	286,382

The funded status of the AMC Plan and amounts recognized in the combined balance sheets at December 31 are as follows:

		2024	2023
Funded status, end of year:			
Fair value of plan assets	$	286,986	286,382
Projected benefit obligation		280,872	287,139
Accrued pension asset (liability)	$	6,114	(757)

(Dollars in thousands)

Amounts recorded in net assets without donor restrictions, end of year:

		2024	2023
Unrecognized net actuarial loss	$	13,721	22,473
Unrecognized prior service credit		—	(991)
	$	13,721	21,482

The AMC Plan accumulated benefit obligation as of December 31, 2024, and 2023 was $274,423 and $278,801, respectively.

The components of the AMC Plan net periodic pension cost for the years ended December 31 is as follows:

		2024	2023
Service cost	$	15,863	14,488
Interest cost		14,386	15,766
Expected return on plan assets		(16,110)	(17,532)
Amortization of prior service credit		(992)	(1,655)
Amortization of actuarial loss		—	452
Net periodic pension cost	$	13,147	11,519

During 2024 and 2023, service costs of $15,863 and $14,488 were recorded in operating expenses respectively, and other net periodic pensions benefits of $2,716 and $2,989 were recorded in nonoperating gains, respectively.

The weighted average assumptions used to determine the AMC Plan pension cost and benefit obligations at the AMC Plan's measurement date (December 31):

	2024	2023
Discount rate for net periodic pension cost	5.14 %	5.38 %
Discount rate for benefit obligation	5.68	5.14
Expected long-term return on plan assets	6.25	6.25
Rate of compensation increase:		
Below age 35	4.00	4.00
Age 35–49	3.00	3.00
Age 50 and up	2.00	2.00

(Dollars in thousands)

In 2024 and 2023, AMC used Pri-2012 Base Morality Table projected with scale MP-2021 to measure its benefit obligation. The methodology utilized by AMC to determine the discount rate assumptions is a bond matching model, which uses individual AAA-rated bond yield data consistently applied and expected future benefit payments to develop a weighted discount rate specific to AMC.

Investment Policy – The AMC Plan's investment policy provides for a diversified portfolio to minimize risk to the extent possible. The asset allocation policy as of December 31, 2024 and 2023 is as follows:

	2024	
	Policy	Range
Public equity	38.3 %	32.8%-43.8%
Core fixed income	45.0	35.0-55.0
Non–core fixed income	5.5	2.7-8.3
Real assets	5.5	2.7-8.3
Alternative investments	5.7	0.1-11.2

	2023	
	Policy	Range
Public equity	38.3 %	32.8%-43.8%
Core fixed income	45.0	35.0-55.0
Non–core fixed income	5.5	2.7-8.3
Real assets	5.5	2.7-8.3
Alternative investments	5.7	0.1–11.2

(i) Basis for Determination of Long-Term Rate of Return

The expected long-term rate of return on the AMC Plan assets reflects long-term earnings expectations on existing plan assets and those contributions expected to be received during the current plan year. In estimating that rate, appropriate consideration was given to historical returns earned by the AMC Plan assets in the fund and the rates of return expected to be available for reinvestment. Rates of return are adjusted periodically to reflect capital market assumptions and changes in investment allocations.

(Continued)

(Dollars in thousands)

The following tables present the AMC Plan's assets at December 31, 2024 and 2023 that are measured at fair value on a recurring basis. The hierarchy and inputs to valuation techniques to measure fair value of the AMC Plan's assets are the same as outlined in the note 6.

	2024					
	Level 1	Level 2	NAV or equivalent	Total	Redemption or liquidation	Days notice
Investments:						
Cash and cash equivalents	$ 28,240	—	—	28,240		
Common/collective trust funds	167,813	—	—	167,813		
Mutual funds	22,065	—	—	22,065		
Fixed income	46,037	—	—	46,037		
Hedge funds	14,509	—	8,322	22,831	Daily-Quarterly	1-15
	$ 278,664	—	8,322	286,986		

	2023					
	Level 1	Level 2	NAV or equivalent	Total	Redemption or liquidation	Days notice
Investments:						
Cash and cash equivalents	$ 72,906	—	—	72,906		
Common/collective trust funds	117,348	—	—	117,348		
Mutual funds	59,704	—	—	59,704		
Hedge funds	—	—	36,424	36,424	Quarterly	15
	$ 249,958	—	36,424	286,382		

The AMC Plan had no financial instruments that are classified as Level 3 measurements as of December 31, 2024 and 2023. There were no significant transfers between Level 1 and Level 2 measurements due to changes in valuation methodologies during the years ended December 31, 2024 and 2023.

From time to time, certain investment vehicles require additional capital contributions to be made by the Plan. There are no outstanding capital requirements for investments held at December 31, 2023.

(ii) Contributions and Benefit Payments

Expected contributions for the plan year ending December 31, 2024 will be made at a level recommended by AMC's consulting actuary and in accordance with ERISA funding requirements.

(Dollars in thousands)

Estimated Future Benefit Payments – The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid by the AMC Plan:

Year		Pension benefits
2025	$	20,314
2026		20,940
2027		20,216
2028		21,361
2029		20,627
2030–2034		111,252

(b) Employee Retirement Plan of Columbia Memorial Hospital

CMH has an elective contributory defined benefit retirement plan (the CMH Plan) for all regular full-time employees. The CMH Plan benefits are based on years of service and the employees' average annual compensation for the five highest consecutive years of continuous service. The cost of the CMH Plan is accrued annually and funding is in accordance with actuarial requirements of the plan, subject to the Employee Retirement Income Security Act of 1974. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future. Effective October 31, 2007, an amendment was approved that closed the CMH Plan to nonunion employees who were not active participants in the CMH Plan as of that date and disallowed resumption of active participation for nonunion employees who cease active participation after October 31, 2007. In 2011, an amendment was approved that froze all future benefit accruals for active participants effective December 31, 2011.

The following table sets forth the CMH Plan's obligations and fair value of plan assets at December 31:

		2024	2023
Reconciliation of benefit obligation:			
Benefit obligation at beginning of year	$	13,130	13,463
Interest cost		643	682
Benefit payments		(1,031)	(1,020)
Actuarial (gain) loss		(567)	5
Benefit obligation at end of year	$	12,175	13,130
Reconciliation of fair value of plan assets:			
Fair value of plan assets at beginning of year	$	13,792	12,736
Benefit payments		(1,031)	(1,020)
Actual return on plan assets		1,022	2,076
Fair value of plan assets at end of year	$	13,783	13,792

(Dollars in thousands)

The funded status of the CMH Plan and amounts recognized in the combined balance sheets at December 31, 2024 and 2023 are as follows:

		2024	2023
Funded status, end of year:			
Fair value of plan assets	$	13,783	13,792
Projected benefit obligations		12,175	13,130
Accrued pension asset	$	1,608	662
Amounts recorded in net assets without donor restrictions, end of year:			
Net actuarial (gains)	$	(1,307)	(509)

The CMH Plan's accumulated and projected benefit obligation was $12,175 and $13,130 as of December 31, 2024 and 2023, respectively.

Net periodic pension expense includes the following components recorded in nonoperating gains:

		2024	2023
Interest cost	$	643	682
Expected return on plan assets		(790)	(728)
Net periodic pension expense	$	(147)	(46)

The assumptions used to determine the CMH Plan's pension cost and benefit obligations at the CMH Plan's measurement date (December 31) are as follows:

	2024	2023
Discount rate for net pension cost	5.14 %	5.36 %
Discount rate for benefit obligation	5.60	5.14
Expected long-term rate of return on plan assets	6.00	6.00
Rate of compensation increase	N/A	N/A
Mortality assumption	MP-2024	MP-2024

(Continued)

(Dollars in thousands)

(i) Asset Allocations

CMH Plan assets consist of cash and cash equivalents, and funds invested in fixed income and marketable equity securities. The CMH Plan assets are allocated as follows at December 31:

	Target	2024	2023
Marketable equity securities	60 %	52 %	51 %
Fixed income	40	47	48
Cash and cash equivalents	—	1	1
	100 %	100 %	100 %

(ii) Basis for Determination of Long-Term Rate of Return

The expected long-term rate of return on CMH plan assets reflects long-term earnings expectations on existing CMH plan assets and those contributions expected to be received during the current plan year. In estimating that rate, appropriate consideration is given to historical returns earned by CMH plan assets and the rates of return expected to be available for reinvestment. Rates of return are adjusted to reflect current capital market assumptions and changes in investment allocations.

(iii) Investment Policy

The CMH Plan's investment strategy is to utilize broadly diversified vehicles where appropriate, with an investment mix and risk profile consistent with pension liabilities. Periodic reviews are undertaken to determine the asset mix that will meet pension obligations at a reasonable cost to the CMH Plan and are consistent with the fiduciary requirements of pension regulations.

(iv) Contributions

No contributions were required for 2023. Expected contributions for the plan year ending December 31, 2024 will be made at a level recommended by CMH's consulting actuary and in accordance with ERISA funding requirements.

(v) Estimated Future Benefit Payments

Estimated future benefit payments are as follows for the CMH Plan:

Year	Pension benefits
2025	$ 1,139
2026	1,129
2027	1,109
2028	1,088
2029	1,060
2030–2034	4,898

(Dollars in thousands)

Benefits expected to be paid in future years are based upon the same assumptions used to measure the CMH Plan benefit obligation at December 31, 2024.

The following table presents the CMH Plan's assets at December 31, 2024 and 2023, which are measured at fair value on a recurring basis. The hierarchy and inputs to valuation techniques used to measure fair value of the Plan's assets are the same as outlined above in note 6:

	2024		
	Level 1	**Level 2**	**Total**
Cash and cash equivalents	$ 119	—	119
Equity securities	6,475	—	6,475
Fixed income	—	7,189	7,189
Total	$ 6,594	7,189	13,783

	2023		
	Level 1	**Level 2**	**Total**
Cash and cash equivalents	$ 193	—	193
Equity securities	7,014	—	7,014
Fixed income	—	6,585	6,585
Total	$ 7,207	6,585	13,792

There were no Level 3 investments held by the CMH Plan at either December 31, 2024 or 2023, nor were there any transfers between Level 1 and Level 2 during 2024 or 2023.

(vi) Multiemployer Defined-Benefit Plan

In lieu of the CMH plan, certain CMH employees represented by a collective bargaining unit participate in a multiemployer defined-benefit plan in which the employer agrees to contribute a certain amount per hour for all compensated hours for each eligible employee, based upon the employees' category of profession.

(Dollars in thousands)

The following table provides additional information about the plan:

Legal name of plan	Service Employees Pension Fund of Upstate New York
Employer identification number of plan	16-0908576
Plan number	001
Most recent certified zone status	Safe- Green Zone
Expiration date of collective bargaining agreement	December 31, 2027
Rehabilitation plan	Adopted November 16, 2009 – updated annually
Approximate employer contributions	$1,926 for 2024 Contributions represent more than 5% of total contributions to the plan
Surcharges paid	None

(c) *Saratoga Hospital*

Saratoga Hospital participates in a defined contribution retirement plan that covers substantially all employees. Employees are automatically enrolled in the plan but may opt out. The basic contribution during 2024 and 2023 was 2.75% of gross annual compensation for each eligible employee, regardless of the amount the employee contributed, with an additional match of eligible employee contributions ranging from 0.8% to 3.0% of gross annual compensation, based on years of benefit service. Employee contributions to the retirement plan are funded after each biweekly payroll period.

Employer contributions to the retirement plan are funded after the end of the year in which the benefits are earned and accrued. Retirement plan expense for 2024 and 2023 was $9,676 and $9,120, respectively.

(d) *Glens Falls*

Glens Falls sponsors a defined contribution plan covering substantially all full-time employees. Through August 31, 2015, Glens Falls agreed to make contributions between 2% and 4% of a participant's gross earnings up to statutory levels based on years of service. The participant may elect to contribute a portion of their salary up to a federally determined limit. Glens Falls will match 50% of eligible employee contributions up to 2% of a participant's gross earnings. Effective September 1, 2015, Glens Falls has agreed to make contributions up to 4% of a participant's gross earnings up to statutory levels based on employee contributions. Glens Falls will match 1:1 of eligible employee contributions up to 4% of a participant's gross earnings, with a two-year vesting for employees that enroll in the plan after September 1, 2015. Total expense related to the defined-contribution plan for 2024 and 2023 amounted to approximately $6,100 and $5,767, respectively.

(e) *VNA*

VNA sponsors a defined contribution plan under Section 401(k) of the IRC. Contributions to the plan for 2024 and 2023 amounted to $44 and $36, respectively.

(10) Professional Liability Insurance and Workers' Compensation Program

AMC, Saratoga, and CMH, have a self-insurance program for professional and general liability insurance, which involves the combination of purchased excess coverage and the establishment of funded reserves. The purchased coverage includes an excess policy retroactive to January 1, 1990. AMC maintains a risk management department to monitor and estimate professional liability exposure for AMC, Saratoga, and CMH. Management accrues for professional and general liability reserves and the corresponding charge to operating expenses based on estimates of asserted and currently identifiable unasserted claims, if any, and a provision for unknown incidents. The total undiscounted liability for AMCH was $19,400 and $18,100 as of December 31, 2024 and 2023, respectively. The total undiscounted liability for AMC was $32,940 and $31,210 as of December 31, 2024 and 2023, respectively. Independent actuaries have been retained to assist AMC, Saratoga, and CMH. Professional and general liability reserves are recorded at their estimated undiscounted value as of December 31, 2024 and 2023 for AMC, Saratoga and CMH. These amounts are recorded to other liabilities on the combined balance sheets.

Management maintains a balance in a trusteed account for purposes of paying claims (self-insured funds). The separate trusteed funded reserve accounts are maintained in the name of the Albany Medical Center, Saratoga, and CMH.

Effective October 1, 1988, Glens Falls adopted a policy of self-insuring the primary portion of their professional liability insurance. An irrevocable trust was established for setting aside assets based on actuarial funding recommendations. The trust agreement was created to cover liability claims arising from incidents occurring after June 30, 1982 and reported on or after October 1, 1988. Glens Falls has purchased a claims made policy effective August 30, 1988, to cover claims in excess of the limits provided by the self-insured trust on a per claim basis and in the aggregate.

Effective October 1, 1995, Glens Falls also adopted a policy of self-insuring the primary portion of their general liability insurance on an occurrence basis. Similar to professional liability, Glens Falls has a claims made policy to cover claims in excess of the self-insured limits on a per claim basis and in the aggregate.

AMC has a self-insurance program for workers' compensation insurance, which involves the combination of purchased excess coverage and the establishment of reserves. Management accrues reserves and the corresponding charges to operating expenses based on estimates of asserted and currently identifiable unasserted claims, if any, and a provision for unknown incidents. Independent actuaries have been retained to assist AMC. AMCH, College, and the Center are obligors/guarantors on a letter of credit, which collateralizes approximately $5,500 and $6,000 of the self-insurance workers' compensation liability as of December 31, 2024 and 2023, respectively. The total undiscounted liability is included in other liabilities and was $13,095 and $13,297 as of December 31, 2024 and 2023, respectively.

CMH, Glens Falls, and Saratoga have programs for workers compensation. Saratoga and Glens Falls utilized retrospectively rated insurance policies. CMH utilizes a retrospective rating program based on actual losses, with stop loss coverage on a per claim basis.

VNA insures its malpractice risk on an occurrence basis. Under the policy, claims based on occurrences during its term but reported subsequently are insured should the policy not be renewed or replaced with other coverage. VNA intends to renew coverage on an occurrence basis and anticipates that such coverage will be available.

(Dollars in thousands)

(11) Net Assets with Donor Restrictions

Net assets with donor restrictions at December 31, 2024 and 2023, are as follows:

		2024	2023
Medicaid Delivery System Reform	$	600	600
Purchase of equipment/construction projects		37,878	33,544
Scholarships, prizes, and awards		55,926	49,368
Chairs and professorships		47,522	42,663
Research and education		20,199	19,116
Department/division support		40,260	35,707
Health education		6,470	6,390
Fellowship, lectureships, and other		25,942	26,169
Total	$	234,797	213,557

During 2024 and 2023, net assets were released from donor restrictions by satisfying the restricted purpose as follows:

		2024	2023
Construction projects and purchase of property and equipment	$	5,417	2,399
Department/division support		5,733	5,119
Scholarship, prizes, and awards		2,220	2,437
Fellowship, lectureships, and other		4,514	4,819
Chairs and professorships		1,912	1,980
Research		4,348	4,237
	$	24,144	20,991

(12) Endowment Funds

The System has donor restricted endowment fund net assets classified as net assets with donor restrictions and amounts classified as net assets without donor restrictions designated by the board to function as endowments (quasi endowments).

(Dollars in thousands)

Endowment funds consisted of the following at December 31, 2024 and 2023:

	2024		
	Original gift	Accumulated gains, net	Total
Quasi	$ 14,482	23,116	37,598
Donor restricted	107,801	54,441	162,242
Total	$ 122,283	77,557	199,840

	2023		
	Original gift	Accumulated gains, net	Total
Quasi	$ 13,251	19,284	32,535
Donor restricted	105,598	41,624	147,222
Total	$ 118,849	60,908	179,757

Changes in the endowment funds for the year ended December 31, 2024 are as follows:

	Without donor restrictions	With donor restrictions	Total
Endowment funds, beginning of year	$ 33,739	146,018	179,757
Investment return:			
Interest and dividend income	6,319	32,437	38,756
Net depreciation	(1,720)	(12,813)	(14,533)
Contributions	27	3,407	3,434
Appropriation of endowment assets for expenditures	(767)	(6,807)	(7,574)
Endowment funds, end of year	$ 37,598	162,242	199,840

(Continued)

(Dollars in thousands)

Changes in the endowment funds for the year ended December 31, 2023 are as follows:

		Without donor restrictions	With donor restrictions	Total
Endowment funds, beginning of year	$	28,947	130,165	159,112
Investment return:				
Interest and dividend income		2,327	4,498	6,825
Net appreciation		1,789	16,471	18,260
Contributions		233	2,867	3,100
Appropriation of endowment assets for expenditures		(761)	(6,779)	(7,540)
Endowment funds, end of year	$	32,535	147,222	179,757

The System has investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power.

(13) Functional Expenses

The combined statements of operations present expenses by natural classification. The System also summarizes its expenses by functional classification. The System's primary program service is healthcare services. Natural expenses attributed to more than one functional expense category are allocated using a variety of cost allocation techniques such as percentage of revenues, percentage of expenses, and square footage.

Expenses by functional classification for the year ended December 31, 2024 consist of the following:

	2024					
	Patient services	Academic support	Research	Mgmt and general	Fundraising efforts	Total
Operating expenses:						
Salaries	$ 1,282,402	9,900	22,639	229,035	3,236	1,547,212
Employee benefits	172,254	1,220	2,645	67,734	434	244,287
Supplies	702,607	413	2,850	37,201	545	743,616
Purchased services	196,860	1,116	2,947	105,083	1,668	307,674
Depreciation and amortization	65,939	293	—	57,270	4	123,506
Interest	17,027	—	—	10,096	—	27,123
Other expenses	15,360	2,879	2,234	41,571	664	62,708
Operating expenses	$ 2,452,449	15,821	33,315	547,990	6,551	3,056,126

(Dollars in thousands)

Expenses by functional classification for the year ended December 31, 2023 consist of the following:

	2023					
	Patient services	Academic support	Research	Mgmt and general	Fundraising efforts	Total
Operating expenses:						
Salaries	$ 1,264,235	9,314	21,303	203,542	3,247	1,501,641
Employee benefits	162,228	1,250	2,648	57,961	384	224,471
Supplies	679,973	571	3,870	29,049	792	714,255
Purchased services	216,017	1,314	2,520	94,394	1,082	315,327
Depreciation and amortization	66,260	96	42	53,364	8	119,770
Interest	17,686	—	—	10,129	—	27,815
Other expenses	14,651	2,575	2,179	29,151	497	49,053
Operating expenses	$ 2,421,050	15,120	32,562	477,590	6,010	2,952,332

(14) Commitments and Contingencies

(a) Interest Rate Swaps

AMCH and the Center uses derivative financial instruments for the purpose of hedging variability in cash flows associated with interest payments on long-term debt. They do not hold or issue derivative financial instruments for trading or speculative purposes.

AMCH and the Center have interest rate swap agreements with a duration of at least six years and with the following notional amounts to hedge against variability in cash flows associated with variable rate debt, as follows:

Debt series	Notional amount as of 12/24	Fixed rate swap	Hedge instrument
Center Series 2017C	$ 615	4.131	70% SOFR
AMCH Series 2017C	1,390	4.121	70% SOFR
AMCH Series 2017C	2,665	3.601	70% SOFR
Center Series 2014A (Parking Garage)	18,551	2.490	70% SOFR
Center Series 2014A (Parking Garage)	18,551	0.1310	9% SOFR
Center Series 2014A (MOB)	6,952	2.490	70% SOFR
Center Series 2014A (MOB)	1,675	1.437	100% SOFR
Center Series 2014B (MOB)	16,925	3.560	100% SOFR
Center Term Loan	10,964	3.950	100% SOFR
Center Mortgage Loan	5,855	2.320	100% SOFR

In 2024, AMCH and the Center entered into swap amendments in order to convert the index from LIBOR to SOFR. There was no material impact on interest rates.

(Dollars in thousands)

As of December 31, 2024 and 2023, the System recorded other long-term assets (liabilities) for the fair value of the interest rate swaps as follows:

Bond series/Debt	Maturity		2024	2023
AMCH Series 2017C (2007 A Amended)	May 1, 2027	$	(23)	(43)
AMCH Series 2017C (2007 C Amended)	May 1, 2027		(25)	(49)
Center Series 2017C (2007 A Amended)	May 1, 2027		(10)	(19)
Center Series 2014A (Parking Garage)	July 1, 2046		676	550
Center Series 2014A (MOB)	July 1, 2046		199	102
Center Series 2014B (MOB)	July 1, 2046		946	713
Center Term Loan	March 1, 2029		536	443
Center Mortgage Loan	April 1, 2031		880	849
		$	3,179	2,546

The portion of the change in fair value of the interest rate swaps that is considered highly effective is reflected in net assets without donor restrictions in the combined statements of operations and changes in net assets for the years ended December 31, 2024 and 2023. The ineffective portion of the change in fair value of the interest rate swaps was not material to the combined statements of operations and changes in net assets for the years ended December 31, 2024 and 2023.

(b) Lines of Credit

The Center is the borrower for a line of credit with KeyBank, which has an available limit as of December 31, 2024 of $36,000. Of the total credit limit, $6,000 is reserved for the Letter of Credit exposure with KeyBank. AMCH and the College are guarantors of this line commitment. There was no outstanding balance at December 31, 2024 and 2023. The maturity date of the line is June 30, 2027. The line bears interest at adjusted SOFR plus 2.00%. The borrower has executed a security agreement associated with this line of credit which grants KeyBank a first security interest in a portion of AMCH's gross receipts. This line commitment requires the borrower and AMCH to measure and report on certain financial benchmarks on a quarterly basis.

CMH has a line of credit on a demand basis with HSBC, with an available balance of $6,000. The line bears interest at SOFR plus 2.50%. There was no outstanding balance as of December 31, 2024 and 2023.

Saratoga obtained a line of credit from TD Bank in August 2020, with an available limit of $10,000. The line of credit bears interest at an adjusted SOFR-based rate plus 1.50%. During 2024, the line was renewed for a period of one year from the original maturity date, with options available for annual one-year renewals thereafter at the discretion of the financial institution. There were no advances taken against the line of credit during 2024 or 2023. Saratoga also has a $4,000 line of credit, on a demand basis, with Adirondack Trust Company. This line bears interest at the prime lending rate set by a large commercial bank. There were no advances taken against this line in 2024 or 2023.

Glens Falls has two unsecured lines of credit with M&T Bank and Glens Falls National Bank. Both lines of credit have available limits of $10,000 each. The M&T line is on a demand basis, while the Glens Falls National Bank line is reviewed and renewed on an annual basis each August 1. Interest on the line with M&T Bank is at One-Month SOFR, adjusted daily, plus 2.61%. Interest on the line of credit with Glens Falls National Bank is at the Wall Street Journal Prime rate minus 37.5 basis points. There were outstanding balances of $4,024 and $3,980 with Glens Falls National Bank and M&T Bank, respectively, as of December 31, 2024.

VNA Home Care Service entities have an available bank revolving line of credit totaling $500. The line of credit is available to and guaranteed by the VNA's subsidiaries. Borrowings on the line of credit are collateralized by investments and other tangible assets of the Association and bear interest at the prime rate. There was no outstanding balance on the line of credit as of December 31, 2024.

(c) Collective Bargaining Agreements

In April 2018, AMC nurses voted to unionize as part of the New York State Nurses Association (NYSNA). As a result, a substantial portion of AMC's employed nurses are represented by NYSNA. A final three-year contract between AMC and NYSNA was signed in July 2021 and expired in July 2024. Negotiations relating to the next contract began April 23, 2024.

A substantial portion of CMH's employees work under a collective bargaining agreement covered by 1199 Service Employees International Union (1199SEIU), which was set to expire on December 31, 2023 and was extended by a short term contract extension expiring on May 30, 2024. A Memorandum of Understanding (MOU) covering the period January 1, 2024 through December 31, 2027 was signed by both parties and ratified by the Union on February 4, 2025.

The VNA has two collective bargaining agreements, one with a nurses' union and one with a clerical union, which expire on January 31, 2026 and March 31, 2026, respectively. Approximately 3% of the Association's employees are covered by the two collective bargaining agreements as of December 31, 2024 and 2023.

(d) SPN/SPNR Debt Guarantees

Albany Medical Center/Hospital, Saratoga Hospital, and a nonrelated entity have entered into two partnerships relating to the development/operation of a medical facility containing an Ambulatory Surgery Center and medical office space. The building is owned by Saratoga Partners North Realty LLC (SPNR), a NY limited liability company. Albany Medical Center and Saratoga Hospital each have a 20.0% ownership interest in this entity. The Ambulatory Surgery Center is owned and operated by Saratoga Partners North, LLC (SPN), a NY limited liability company. Albany Medical Center Hospital and Saratoga Hospital each have a 25.5% ownership interest in this entity.

On January 21, 2020, SPNR obtained a $16.0 million first leasehold mortgage construction and permanent loan to finance the costs of the building. This loan has a fixed interest rate of 4.07% with a 25-year term and amortization period. Amortization began in May 2021. The loan is structured as a "bond net lease" transaction with no guarantees of the SPNR partners. However, there is a requirement for a Master Lease between the SPNR (as Owner) and various Co-Tenants, including Saratoga Hospital, Albany Medical Center, Albany Medical Center Hospital, Albany Medical College, Healthcare

(Dollars in thousands)

Partners of Saratoga, Ltd., and Capital Region North Realty, LLC (Capital Region North). The Master lease contains certain requirements, including lease payments sufficient to cover the debt service of the loan. Under a Co-Tenancy Agreement, the Co-Tenants share in the profits and losses of the co-tenancy in the same percentage as each has a membership interest in SPNR.

On February 14, 2020, SPN obtained a $9.325 million loan to finance working capital and equipment costs relating to the Ambulatory Surgery Center. The loan has a fixed interest rate of 3.85% with a seven-year amortization period. Saratoga Hospital, Albany Medical Center Hospital, and Capital Region North provide guarantees for this loan on a joint and several basis. Under a Contribution and Indemnity Agreement between the parties, each partner's liability relative to the loan is limited to its ownership interest in SPN.

(e) Letter of Credit- Workman's Compensation Policy

AMC has obtained a $5,500 letter of credit which collateralizes $5,500 of it's self-insurance workers' compensation policy. See note 10.

(15) Leases

Amounts reported for finance and operating leases in the combined balance sheets as of December 31 were as follows:

		2024	2023
Finance leases:			
Property under finance leases, net	$	41,480	30,689
Total lease liabilities		47,645	34,368
Operating leases:			
Right-of-use assets	$	65,278	74,934
Total lease liabilities		69,972	79,256

(Dollars in thousands)

The components of lease cost for the years ended December 31 were as follows:

		2024	2023
Finance lease cost:			
Amortization of right-of-use assets, within depreciation and amortization expense	$	10,479	7,851
Interest on lease liabilities, within interest expense		1,453	1,448
Total finance lease cost	$	11,932	9,299
Net operating lease cost:			
Operating lease cost	$	17,401	19,595
Total operating lease cost, net	$	17,401	19,595

		2024	2023
Other information related to leases as of December 31, 2024 and 2023 was as follows:			
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flow from operating leases	$	(17,029)	(18,198)
Financing cash flows from finance leases		(14,734)	(21,030)
Right-of-use assets obtained in exchange for new finance lease liabilities		27,785	6,121
Right-of-use assets obtained in exchange for new operating leases liabilities		1,992	17,853

	2024	2023
Weighted average remaining lease term – finance leases	5.03 years	4.56 years
Weighted average remaining lease term – operating leases	11.52 years	11.44 years
Weighted average discount rate – finance leases	4.76 %	4.44 %
Weighted average discount rate – operating leases	4.42	4.21

(Continued)

(Dollars in thousands)

Future lease payments at December 31, 2024 are as follows:

		Operating leases	Finance leases
Year ending December 31:			
2025	$	17,170	16,293
2026		13,260	11,483
2027		9,432	8,227
2028		6,828	5,401
2029		4,462	4,397
Thereafter		46,801	8,656
Total undiscounted lease payments		97,953	54,457
Less net present value adjustment		(27,981)	(6,812)
Lease liabilities	$	69,972	47,645

Future lease payments at December 31, 2023 are as follows:

		Operating leases	Finance leases
Year ending December 31:			
2024	$	17,112	24,149
2025		15,451	10,351
2026		11,718	6,548
2027		7,864	3,675
2028		5,333	1,023
Thereafter		48,113	1,276
Total undiscounted lease payments		105,591	47,022
Less net present value adjustment		(26,335)	(12,654)
Lease liabilities	$	79,256	34,368

(16) Subsequent Events

The System considers events or transactions that occur after the combined balance sheets date, but before the combined financial statements are issued, to provide additional evidence relative to certain estimates or to identify matters that require additional disclosure. These combined financial statements were issued on April 25, 2025, and subsequent events have been evaluated through that date.

(17) Related Parties

A description of related entities is included as part of Note (1)(a) Organization with the nature and amount of transactions among those entities reflected in the Eliminations columns of the various Combining Statements included as part of the Supplementary Information provided herein.

Oversight of potential conflicts of interest and review and approval of related party transactions is administered by the Albany Med Health System Committee on Audit and Compliance. Annual disclosures of significant financial interests, family relationships, significant management functions, or substantial business with entities doing business with AMHS by members of the AMHS Board of Directors, Board Committee Members, Officers and Key Employees (Interested Persons) are required annually. When such relationships exist, measures are taken to assess potential conflicts of interest to protect the best interests of AMHS and ensure compliance with relevant laws and policy. AMHS's conflict of interest policy also requires, among other things, that no member of the Board of Directors or Officer may participate in any decision in which they have (or an immediate family member has) a material financial interest.

No material related party transactions have been identified affecting these financial statements other than those included in the Supplementary Information described above.

ALBANY MED HEALTH SYSTEM

Combining Balance Sheet

December 31, 2024
(Dollars in thousands)

			2024 Combining information									
				Center								
Assets		Combined total	Eliminations	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Current assets:												
Cash and cash equivalents	$	349,694	—	30,507	6,989	1,843	79,470	9,319	8,261	138,478	51,331	23,496
Investments		393,057	—	—	7,484	55,534	151,440	—	—	152,580	26,019	—
Receivables, net:												
Patient service		322,466	—	—	14,635	57,132	44,351	2,578	4,597	176,534	22,639	—
Interinstitutional receivables		—	(35,065)	4,678	17	115	7,143	4,379	—	14,873	3,860	—
Other		68,612	—	11,639	40	7,296	7,282	—	—	10,083	29,189	3,083
		391,078	(35,065)	16,317	14,692	64,543	58,776	6,957	4,597	201,490	55,688	3,083
Inventories		50,708	—	5,040	2,223	11,989	9,563	—	231	21,151	511	—
Prepaid expenses and other current assets		35,327	—	11,868	2,698	3,255	6,260	390	67	6,354	4,185	250
Total current assets		1,219,864	(35,065)	63,732	34,086	137,164	305,509	16,666	13,156	520,053	137,734	26,829
Assets whose use is limited:												
Under debt financed agreements		31,116	—	212	110	—	1,749	—	—	29,045	—	—
Self-insurance funds		86,460	—	—	8,354	12,430	13,639	—	—	52,037	—	—
Other investments		24,904	—	247	13,275	5,643	4,409	464	—	—	866	—
		142,480	—	459	21,739	18,073	19,797	464	—	81,082	866	—
Property and equipment, net of accumulated depreciation and amortization		987,564	—	212,720	46,273	139,021	153,584	322	13,955	372,712	48,971	6
Right-of-use assets – operating leases		65,278	—	1,067	8,384	7,649	32,346	190	—	7,407	8,235	—
Investments, long term		228,298	—	4,107	—	—	29,882	1,764	—	32,225	160,045	275
Other assets:												
Deferred compensation agreements		98,979	—	76,112	—	10,389	12,476	—	—	—	—	—
Assets held in charitable trusts		2,728	—	—	—	—	328	—	—	—	—	2,400
Accrued pension asset		7,722	(45)	—	1,608	—	—	—	—	3,196	2,963	—
Other assets		34,012	(8,821)	3,470	1,091	3,823	9,245	168	—	13,852	7,524	3,660
Interinstitutional receivables, noncurrent		—	(387,419)	152,471	—	—	—	—	—	211,473	23,475	—
Total other assets		143,441	(396,285)	232,053	2,699	14,212	22,051	168	—	228,521	33,962	6,060
Total assets	$	2,786,925	(431,350)	514,138	113,181	316,119	563,169	19,574	27,111	1,242,000	389,813	33,170

(Continued)

ALBANY MED HEALTH SYSTEM

Combining Balance Sheet

December 31, 2024
(Dollars in thousands)

		2024 Combining information									
			Center								
Liabilities and Net Assets	Combined total	Eliminations	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Current liabilities:											
Current maturities of long-term debt	$ 37,297	—	4,778	110	10,391	3,820	—	299	17,899	—	—
Current portion of lease liabilities – finance leases	14,345	—	91	270	1,732	832	—	—	11,263	37	—
Current portion of lease liabilities – operating leases	14,522	—	763	2,133	2,134	3,069	78	—	3,091	3,254	—
Payables:											
Accounts payable	169,753	—	38,869	14,126	44,755	14,388	682	3,136	63,172	10,287	318
Interinstitutional payables	—	(29,606)	14,886	2,311	6,825	384	—	1,756	3,436	8	—
Accrued expenses:											
Salaries and related items	111,889	—	9,292	6,743	10,411	35,129	1,762	—	28,309	20,243	—
Compensated absences	76,300	—	7,155	5,401	10,122	13,910	—	—	21,237	18,475	—
Deferred revenue	25,678	—	46	403	52	—	—	—	535	24,642	—
Other liabilities	56,532	—	9,824	2,749	9,328	9,988	9	—	17,055	6,870	709
Total current liabilities	526,316	(29,606)	85,724	34,246	95,750	61,620	2,531	5,191	166,017	83,816	1,027
Long-term debt, net of current maturities	435,369	—	76,848	1,498	26,758	39,800	—	13,071	277,394	—	—
Long-term lease liabilities – finance leases	33,300	—	189	614	2,000	504	—	28	29,925	40	—
Long-term lease liabilities – operating leases	55,450	—	340	6,338	5,831	33,278	124	—	4,430	5,109	—
Interinstitutional payables, noncurrent	—	(382,615)	228,960	8,393	9,109	—	—	—	—	111,416	24,737
Accrued pension obligations	—	(45)	45	—	—	—	—	—	—	—	—
Professional liability self-insurance reserves	176,569	—	—	7,023	14,375	22,412	—	—	86,915	45,864	—
Other liabilities, long-term	162,948	—	81,503	4,488	10,961	18,044	—	—	23,971	11,161	12,820
Total liabilities	1,389,972	(412,266)	473,609	62,600	164,784	195,658	2,655	18,290	588,652	257,406	38,584
Net assets (deficit):											
Without donor restrictions	1,162,156	(8,821)	38,498	47,755	131,401	358,097	16,458	8,821	626,806	(33,384)	(23,475)
With donor restrictions	234,797	(10,263)	2,031	2,826	19,934	9,414	461	—	26,542	165,791	18,061
	1,396,953	(19,084)	40,529	50,581	151,335	367,511	16,919	8,821	653,348	132,407	(5,414)
Total liabilities and net assets	$ 2,786,925	(431,350)	514,138	113,181	316,119	563,169	19,574	27,111	1,242,000	389,813	33,170

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Combining Balance Sheet

December 31, 2023
(Dollars in thousands)

		2023 Combining information									
			Center								
Assets	Combined total	Eliminations	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Current assets:											
Cash and cash equivalents	$ 480,302	—	29,460	5,489	6,343	83,834	5,960	6,496	260,967	55,410	26,343
Investments	327,140	—	—	8,737	49,070	132,500	—	—	115,487	21,346	—
Receivables, net:											
Patient service	292,109	—	—	12,248	46,189	43,618	2,666	2,789	162,703	21,896	—
Interinstitutional receivables	—	(37,899)	16,689	14	1,819	3,781	3,389	5	8,069	4,133	—
Other	65,554	—	9,581	1,641	6,100	1,281	—	—	20,175	22,968	3,808
	357,663	(37,899)	26,270	13,903	54,108	48,680	6,055	2,794	190,947	48,997	3,808
Inventories	45,950	—	5,246	2,287	9,969	8,035	—	291	20,122	—	—
Prepaid expenses and other current assets	29,354	—	7,612	1,291	3,796	5,261	56	154	6,442	4,637	105
Total current assets	1,240,409	(37,899)	68,588	31,707	123,286	278,310	12,071	9,735	593,965	130,390	30,256
Assets whose use is limited:											
Under debt financed agreements	31,072	—	207	111	—	1,749	—	—	29,005	—	—
Self-insurance funds	81,260	—	—	7,925	10,813	11,664	—	—	50,858	—	—
Other investments	23,959	—	242	12,122	5,070	4,409	1,260	—	—	856	—
	136,291	—	449	20,158	15,883	17,822	1,260	—	79,863	856	—
Property and equipment, net of accumulated depreciation and amortization	979,200	—	191,801	46,073	131,202	152,515	346	14,565	388,873	53,816	9
Right-of-use assets – operating leases	74,934	—	1,814	5,241	9,726	35,459	255	—	10,515	11,924	—
Investments, long term	201,381	—	3,177	—	—	32,594	695	—	28,896	135,791	228
Other assets:											
Deferred compensation agreements	83,453	—	66,499	—	8,876	8,078	—	—	—	—	—
Assets held in charitable trusts	2,605	—	—	—	—	335	—	—	—	—	2,270
Accrued pension asset	662	(1,462)	—	662	—	—	—	—	—	1,462	—
Other assets	34,076	(6,643)	2,833	1,154	3,436	6,418	437	—	11,698	9,994	4,749
Interinstitutional receivables, noncurrent	—	(287,490)	110,653	850	618	2,149	—	—	148,345	24,875	—
Total other assets	120,796	(295,595)	179,985	2,666	12,930	16,980	437	—	160,043	36,331	7,019
Total assets	$ 2,753,011	(333,494)	445,814	105,845	293,027	533,680	15,064	24,300	1,262,155	369,108	37,512

(Continued)

ALBANY MED HEALTH SYSTEM

Combining Balance Sheet

December 31, 2023
(Dollars in thousands)

			2023 Combining information									
			Center									
Liabilities and Net Assets	Combined total	Eliminations	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Current liabilities:											
Current maturities of long-term debt	$ 33,662	—	4,598	107	7,955	3,705	—	289	17,008	—	—
Current portion of lease liabilities – finance leases	13,185	—	69	124	988	932	—	1	11,023	48	—
Current portion of lease liabilities – operating leases	15,925	—	956	2,594	2,350	3,156	84	—	3,137	3,648	—
Payables:											
Accounts payable	203,053	—	42,566	10,479	41,013	13,835	280	2,793	79,479	12,387	221
Interinstitutional payables	—	(32,103)	6,407	2,304	12,211	226	—	982	3,389	6,537	47
Accrued expenses:											
Salaries and related items	96,665	—	8,651	3,476	8,642	33,153	1,640	—	22,897	18,226	—
Compensated absences	73,804	—	7,065	5,419	9,655	12,222	—	—	21,122	18,321	—
Deferred revenue	23,480	—	189	998	—	—	—	—	238	22,055	—
Other liabilities	82,775	—	14,652	2,567	7,881	8,575	1,029	103	40,357	7,025	586
Total current liabilities	542,569	(32,103)	85,153	28,068	90,695	75,804	3,033	4,168	198,650	88,247	854
Long-term debt, net of current maturities	464,293	—	81,529	1,608	29,145	43,548	—	13,357	295,106	—	—
Long-term lease liabilities – finance leases	21,183	—	96	—	2,507	1,201	—	32	17,300	47	—
Long-term lease liabilities – operating leases	63,331	—	878	2,941	7,663	35,814	183	—	7,458	8,394	—
Interinstitutional payables, noncurrent	—	(282,359)	169,516	1,775	3,851	5,073	—	—	—	77,162	24,982
Accrued pension obligations	757	(1,462)	731	—	—	—	—	—	1,488	—	—
Professional liability self-insurance reserves	172,968	—	—	7,198	13,704	18,869	—	—	78,810	54,387	—
Other liabilities, long-term	140,183	—	70,871	4,444	9,458	12,719	—	100	17,722	11,488	13,381
Total liabilities	1,405,284	(315,924)	408,774	46,034	157,023	193,028	3,216	17,657	616,534	239,725	39,217
Net assets (deficit):											
Without donor restrictions	1,134,170	(6,643)	35,328	57,446	119,101	332,255	11,417	6,643	619,808	(20,794)	(20,391)
With donor restrictions	213,557	(10,927)	1,712	2,365	16,903	8,397	431	—	25,813	150,177	18,686
	1,347,727	(17,570)	37,040	59,811	136,004	340,652	11,848	6,643	645,621	129,383	(1,705)
Total liabilities and net assets	$ 2,753,011	(333,494)	445,814	105,845	293,027	533,680	15,064	24,300	1,262,155	369,108	37,512

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Combining Statement of Operations and Changes in Net Assets

Year ended December 31, 2024
(Dollars in thousands)

		2024 Combining information									
			Center								
	Combined total	Eliminations and reclassifications	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Operating revenue:											
Net patient service revenue	$ 2,616,133	—	—	156,639	426,957	453,083	25,056	27,086	1,261,471	265,841	—
Tuition and fees	43,036	—	1,620	—	—	—		—		41,216	—
Federal, state, and local grants and contracts	33,282	—	74	—	8,503	516	105	—	2,231	21,853	—
Private gifts, grants, and contracts	2,868	—	1	—	—	—	3	—	292	2,336	236
Interest and dividend income	22,084	—	1,971	—	—	—	187	—	16,069	3,221	636
Interinstitutional revenue	—	(471,647)	258,645	2,464	6,285	46,257	25,404	—	11,579	120,363	650
Other revenue	277,598	(5,178)	53,825	8,584	47,310	18,798	129	526	153,087	517	—
Net assets released from restrictions used for operations	18,727	—	134	312	907	438	22	—	2,416	13,052	1,446
Total operating revenue	3,013,728	(476,825)	316,470	167,999	489,962	519,092	50,906	27,612	1,447,145	468,399	2,968
Operating expenses:											
Salaries	1,547,212	—	120,315	91,113	199,537	294,621	33,015	43	472,155	333,695	2,718
Employee benefits	244,287	—	21,790	17,232	35,497	54,516	4,649	—	65,318	43,866	419
Supplies	743,616	—	56,822	24,558	166,008	77,405	—	1,917	397,902	18,571	433
Purchased services	307,674	—	45,104	25,480	39,142	45,258	—	1,964	108,576	40,634	1,516
Interinstitutional expense	—	(471,647)	19,241	14,348	23,808	16,461	—	16,576	310,928	69,672	613
Depreciation and amortization	123,506	—	27,669	6,558	14,275	19,267	76	963	46,453	8,241	4
Interest	27,123	—	3,169	91	2,306	1,479	243	745	19,040	50	—
Other expenses	62,708	—	20,870	1,815	3,509	5,312	7,521	226	5,919	17,189	347
Total operating expenses	3,056,126	(471,647)	314,980	181,195	484,082	514,319	45,504	22,434	1,427,291	531,918	6,050
Operating (loss) margin	(42,398)	(5,178)	1,490	(13,196)	5,880	4,773	5,402	5,178	19,854	(63,519)	(3,082)
Nonoperating gains (losses):											
Net realized gains on sales of investments	49,831	—	39	820	3,064	3,008	—	—	31,272	11,628	—
Other, net	12,446	—	892	1,888	1,031	5,825	(601)	—	1,369	2,042	—
Total nonoperating gains (losses)	62,277	—	931	2,708	4,095	8,833	(601)	—	32,641	13,670	—
Excess (deficiency) of revenue over expenses, before investment gains and other activities, net	$ 19,879	(5,178)	2,421	(10,488)	9,975	13,606	4,801	5,178	52,495	(49,849)	(3,082)

ALBANY MED HEALTH SYSTEM

Combining Statement of Operations and Changes in Net Assets

Year ended December 31, 2024

(Dollars in thousands)

		2024 Combining information									
		Eliminations	Center								
	Combined total	and reclassifications	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Investment (losses) gains and other activities:											
Net unrealized (losses) gains on investments	$ (6,336)	—	(28)	—	249	11,956	240	—	(10,992)	(7,759)	(2)
Total investment (losses) gains and other activities, net	(6,336)	—	(28)	—	249	11,956	240	—	(10,992)	(7,759)	(2)
Excess (deficiency) of revenue over expenses	13,543	(5,178)	2,393	(10,488)	10,224	25,562	5,041	5,178	41,503	(57,608)	(3,084)
Net assets without donor restrictions:											
Net assets released from restrictions used for purchase of property and equipment	5,417	—	27	—	2,076	280	—	—	1,800	1,234	—
Change in fair value of interest rate swaps	468	—	565	—	—	—	—	—	(97)	—	—
Pension-related changes other than net periodic pension costs	8,558	—	185	797	—	—	—	—	3,792	3,784	—
Equity distributions	—	3,000	—	—	—	—	—	(3,000)	(40,000)	40,000	—
Increase (decrease) in net assets without donor restrictions	27,986	(2,178)	3,170	(9,691)	12,300	25,842	5,041	2,178	6,998	(12,590)	(3,084)
Net assets with donor restrictions:											
Private gifts, grants, contracts, and other, net	21,882	(9,600)	193	760	5,577		—	—	1,766	12,101	11,085
Investment interest, dividends, and net realized gains (losses), net	29,885	(763)	398	13	—	1,735	—	—	(65)	27,804	763
Gift distributions	—	11,080	—	—	—	—	—	—	—	—	(11,080)
Net assets released from restrictions for operations	(18,727)	—	(134)	(312)	(907)	(438)	(22)	—	(2,416)	(13,052)	(1,446)
Changes in net unrealized gains and losses on investments	(9,444)	(53)	(138)	—	437	—	52	—	1,444	(11,239)	53
Contributions for property and equipment	3,061	—	27	—	—	—	—	—	1,800	1,234	—
Net assets released from restrictions used for purchase of property and equipment	(5,417)	—	(27)	—	(2,076)	(280)	—	—	(1,800)	(1,234)	—
Increase in net assets with donor restrictions	21,240	664	319	461	3,031	1,017	30	—	729	15,614	(625)
Change in net assets	49,226	(1,514)	3,489	(9,230)	15,331	26,859	5,071	2,178	7,727	3,024	(3,709)
Net assets (deficit), beginning of year	1,347,727	(17,570)	37,040	59,811	136,004	340,652	11,848	6,643	645,621	129,383	(1,705)
Net assets (deficit), end of year	$ 1,396,953	(19,084)	40,529	50,581	151,335	367,511	16,919	8,821	653,348	132,407	(5,414)

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Combining Statement of Operations and Changes in Net Assets

Year ended December 31, 2023
(Dollars in thousands)

		2023 Combining information									
			Center								
	Combined total	Eliminations and reclassifications	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Operating revenue:											
Net patient service revenue	$ 2,507,667	—	—	146,693	363,336	430,959	21,360	25,215	1,243,744	276,340	—
Tuition and fees	41,967	—	1,756	—	—	—	—	—	—	40,211	—
Federal, state, and local grants and contracts	28,609	—	149	324	6,305	1,450	482	—	2,108	17,791	—
Private gifts, grants, and contracts	4,385	—	6	—	—	—	7	—	177	4,043	152
Interest and dividend income	20,691	—	3,045	—	—	—	172	—	14,790	2,230	454
Interinstitutional revenue	—	(420,648)	240,673	1,752	4,601	38,826	19,807	—	12,064	102,275	650
Other revenue	253,535	(5,130)	46,935	8,029	26,375	11,425	21	362	164,862	656	—
Net assets released from restrictions used for operations	18,592	—	162	420	717	644	22	—	1,891	13,752	984
Total operating revenue	2,875,446	(425,778)	292,726	157,218	401,334	483,304	41,891	25,577	1,439,636	457,298	2,240
Operating expenses:											
Salaries	1,501,641	—	113,570	95,330	194,673	277,954	29,495	—	471,635	316,844	2,140
Employee benefits	224,471	—	16,292	16,457	35,148	51,023	4,356	—	63,958	36,946	289
Supplies	714,255	—	50,833	24,056	114,139	98,749	—	1,437	403,883	20,753	405
Purchased services	315,327	—	54,914	20,908	40,629	45,385	—	3,453	107,993	40,963	1,082
Interinstitutional expense	—	(420,648)	15,692	11,794	14,610	15,012	—	14,049	283,850	65,015	626
Depreciation and amortization	119,770	—	21,916	7,012	15,367	18,263	71	837	47,520	8,776	8
Interest	27,815	—	3,525	80	1,892	1,674	—	587	19,960	97	—
Other expenses	49,053	—	14,038	1,365	1,993	4,224	6,046	84	4,981	16,064	258
Total operating expenses	2,952,332	(420,648)	290,780	177,002	418,451	512,284	39,968	20,447	1,403,780	505,460	4,808
Operating (loss) margin before COVID-19 grants	(76,886)	(5,130)	1,946	(19,784)	(17,117)	(28,980)	1,923	5,130	35,856	(48,162)	(2,568)
COVID-19-related grants	334	—	334	—	—	—	—	—	—	—	—
Operating (loss) margin	(76,552)	(5,130)	2,280	(19,784)	(17,117)	(28,980)	1,923	5,130	35,856	(48,162)	(2,568)
Nonoperating gains (losses):											
Net realized gains on sales of investments	8,311	—	3	879	816	791	—	—	5,505	310	7
Other, net	13,623	—	1,048	3,296	1,485	4,165	(18)	—	1,596	2,051	—
Total nonoperating gains (losses)	21,934	—	1,051	4,175	2,301	4,956	(18)	—	7,101	2,361	7
(Deficiency) excess of revenue over expenses, before investment gains and other activities, net	$ (54,618)	(5,130)	3,331	(15,609)	(14,816)	(24,024)	1,905	5,130	42,957	(45,801)	(2,561)

(Continued)

ALBANY MED HEALTH SYSTEM

Combining Statement of Operations and Changes in Net Assets

Year ended December 31, 2023
(Dollars in thousands)

			2023 Combining Information								
		Eliminations	Center								
	Combined total	and reclassifications	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Investment gains and other activities											
Net unrealized gains on investments	$ 42,546	—	10	—	4,125	11,916	209	—	20 657	5 629	—
Pension annuitization	(5,444)	—	(604)	—	—	—	—	—	(3,447)	(1,393)	—
Total investment gains and other activities, net	37,102	—	(594)	—	4 125	11,916	209	—	17,210	4 236	—
(Deficiency) excess of revenue over expenses	(17,516)	(5,130)	2,737	(15,609)	(10,691)	(12,108)	2,114	5,130	60,167	(41,565)	(2,561)
Net assets without donor restrictions											
Net assets released from restrictions used for purchase of property and equipment	2,399	—	—	130	450	11	—	—	1,085	723	—
Change in fair value of interest rate swaps	(801)	—	(690)	—	—	—	—	—	(111)	—	—
Pension-related changes other than net periodic pension costs	4,099	—	156	1,344	—	—	—	—	568	2,011	—
Equity distributions	—	2,500	—	—	—	—	—	(2,500)	—	—	—
(Decrease) increase in net assets without donor restrictions	(11,819)	(2,630)	2,203	(14,135)	(10,241)	(12,097)	2,114	2,630	61,729	(38,831)	(2,561)
Net assets with donor restrictions											
Private gifts, grants, contracts, and other, net	26,840	(7,550)	445	594	5,740	2,830	—	—	1,372	10,963	12,446
Investment interest, dividends, and net realized gains (losses), net	3,353	(1,305)	60	—	—	—	—	—	(79)	3,372	1,305
Gift distributions	—	11,100	—	—	—	—	—	—	—	—	(11,100)
Net assets released from restrictions for operations	(18,592)	—	(162)	(420)	(717)	(644)	(22)	—	(1,891)	(13,752)	(984)
Changes in net unrealized gains and losses on investments	16,969	(264)	255	134	495	(5)	51	—	1,435	14,604	264
Contributions for property and equipment	1,808	—	—	—	—	—	—	—	1,085	723	—
Net assets released from restrictions used for purchase of property and equipment	(2,399)	—	—	(130)	(450)	(11)	—	—	(1,085)	(723)	—
Increase in net assets with donor restrictions	27,979	1,981	598	178	5,068	2,170	29	—	837	15,187	1,931
Change in net assets	16,160	(649)	2,801	(13,957)	(5,173)	(9,927)	2,143	2,630	62,566	(23,644)	(630)
Net assets (deficit), beginning of year	1,331,567	(16,921)	34,239	73,768	141,177	350,579	9,705	4,013	583,055	153,027	(1,075)
Net assets (deficit), end of year	$ 1,347,727	(17,570)	37,040	59,811	136,004	340,652	11,848	6,643	645,621	129,383	(1,705)

See accompanying independent auditors' report

ALBANY MED HEALTH SYSTEM

Combining Statement of Cash Flows

Year ended December 31, 2024
(Dollars in thousands)

	Combined total	2024 Combining information: Eliminations	Center: Center and other	Center: CMH	Center: Glens Falls	Center: Saratoga	VNA	MMEC	AMCH	College	Foundation
Cash flow from operations:											
Changes in net assets	$ 49,226	(1,514)	3,489	(9,230)	15,331	26,859	5,071	2,178	7,727	3,024	(3,709)
Adjustments to reconcile changes in net assets to net cash provided by operating activities:											
Restricted gifts and income	(6,825)		(127)	—	—	—	—		(1,850)	(4,848)	—
Gain on joint venture investment	(3,269)	2,178	(55)	—	411	(3,678)	—	3,000	(5,125)	—	—
Net realized and change in net unrealized gains and losses on investments	(57,865)	—	(223)	(585)	(3,313)	(14,962)	(291)	—	(20,914)	(17,295)	(282)
Pension-related changes other than net periodic pension costs	(8,558)	—	(185)	(797)	—	—	—	—	(3,792)	(3,784)	—
Changes resulting in reduction in interinstitutional receivable	—	—	—	—	—	—	—	—	40,000	(40,000)	
Change in fair value of interest rate swaps	(468)	—	(565)	—	—	—	—	—	97	—	—
Depreciation and amortization	123,506	—	27,669	6,558	14,275	19,267	76	963	46,453	8,241	4
Amortization expense of operating leases	17,401	—	944	2,331	2,478	4,846	—	—	3,130	3,672	—
Payments of right-of-use lease obligations – operating lease	(17,029)	—	(928)	(2,538)	(2,449)	(4,356)	—	—	(3,096)	(3,662)	—
Loss (gain) on disposal of property and equipment	26	—	—	—	(5)	—	—	—	—	31	—
Changes in operating assets and liabilities:											
Receivables, net	(33,765)	—	(2,058)	(786)	(12,529)	(7,836)	88	(1,808)	(3,739)	(6,908)	1,811
Inventories	(4,758)	—	206	64	(2,020)	(1,528)	—	60	(1,029)	(511)	—
Prepaid expenses and other assets	(5,716)	—	(4,292)	(1,344)	133	(2,554)	(65)	87	(405)	2,866	(142)
Professional liability self-insurance reserve	3,621	—	—	(175)	671	3,543	—	—	8,105	(8,523)	—
Accounts payable	(28,972)	—	(12,792)	2,727	1,779	268	402	330	(19,491)	(2,292)	97
Accrued expenses and other liabilities	939	—	(3,221)	2,880	3,725	6,002	(898)	(203)	(11,164)	4,276	(438)
Accrued pension asset	741	—	(501)	(149)	—	—	—	—	(892)	2,283	—
Net cash provided by (used in) operating activities	28,235	664	7,361	(1,044)	18,487	25,871	4,383	4,607	33,995	(63,430)	(2,659)
Cash flows from investing activities:											
Additions to property and equipment	(88,136)	—	(39,267)	(4,870)	(18,202)	(19,748)	(52)	(340)	(2,466)	(3,190)	(1)
Change in debt financed agreements	(45)	—	(5)	—	—	—	—	—	(40)	—	—
Investment purchases	(137,437)	—	(1,117)	(3,654)	(25,765)	(16,628)	(37)	—	(48,269)	(41,210)	(757)
Proceeds from investment maturities and sales	96,034	—	380	3,911	20,424	13,394	55	—	27,440	29,568	862
Equity distributions	4,016	—	44	—	—	3,508	—	(3,000)	3,464	—	—
Net transfers to affiliates	—	29,807	(29,807)	—	—	—	—	—	—	—	—
Net cash (used in) provided by investing activities	(125,568)	29,807	(69,772)	(4,613)	(23,543)	(19,474)	(34)	(3,340)	(19,871)	(14,832)	104
Cash flows from financing activities:											
Principal payments on long-term debt	(28,351)	—	(4,501)	(107)	(2,936)	(3,710)	—	(276)	(16,821)	—	—
Advances on line of credit	9,155	—	—	—	9,155	—	—	—	—	—	—
Payments on line of credit	(6,150)	—	—	—	(6,150)	—	—	—	—	—	—
Restricted gift and income	6,825	—	127	—	—	—	—	—	1,850	4,848	—
Issuance of long-term debt	—	—	—	—	—	—	—	—	—	—	—
Cash received under finance lease obligations	—	—	—	—	—	—	—	—	—	—	
Cash paid for financing costs	(20)	—	—	—	(20)	—	—	—	—	—	—
Cash receipts from related-party long-term finance lease	—	(1,614)		—	—	—	—	—	1,614	—	—
Payments of right-of-use lease obligations	(14,734)	—	(91)	(208)	(1,687)	(923)	—	(5)	(11,757)	(63)	—
Net transfers to affiliates	—	(28,857)	67,923	7,472	2,194	(6,126)	(990)	779	(111,499)	69,398	(292)
Net cash (used in) provided by financing activities	(33,275)	(30,471)	63,458	7,157	556	(10,761)	(990)	498	(136,613)	74,183	(292)
Net (decrease) increase in cash and cash equivalents	(130,608)	—	1,047	1,500	(4,500)	(4,364)	3,359	1,765	(122,489)	(4,079)	(2,847)
Cash and cash equivalents, beginning of year	480,302	—	29,460	5,489	6,343	83,834	5,960	6,496	260,967	55,410	26,343
Cash and cash equivalents, end of year	$ 349,694	—	30,507	6,989	1,843	79,470	9,319	8,261	138,478	51,331	23,496
Supplemental disclosure of cash flow information:											
Cash paid during the year for interest	$ 25,980	—	3,439	91	2,306	1,489	—	—	18,655	—	—
Property and equipment included in accounts payable	15,672	—	9,115	920	1,963	285	—	13	3,184	192	—
Equipment acquired under finance lease obligations	27,785	—	206	968	1,924	—	—	—	24,642	45	—

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Combining Statement of Cash Flows

Year ended December 31, 2023
(Dollars in thousands)

		2023 Combining information									
			Center								
	Combined total	Eliminations	Center and other	CMH	Glens Falls	Saratoga	VNA	MMEC	AMCH	College	Foundation
Cash flow from operations:											
Changes in net assets	$ 16,160	(649)	2,801	(13,957)	(5,173)	(9,927)	2,143	2,630	62,566	(23,644)	(630)
Adjustments to reconcile changes in net assets to net cash provided by (used in) operating activities:											
Restricted gifts and income	(4,777)	—	(300)	—	—	125	—	—	(1,090)	(3,512)	—
Gain on joint venture investment	(4,383)	2,630	(11)	—	(459)	(4,306)	—	2,500	(4,737)	—	—
Net realized and change in net unrealized gains and losses on investments	(61,376)	—	(303)	(3,110)	4,941	(12,707)	(260)	—	(27,716)	(21,903)	(318)
Pension-related changes other than net periodic pension costs	(4,099)	—	(156)	1,344	—	—		—	(3,276)	(2,011)	—
Change in fair value of interest rate swaps	801	—	690		—	—		—	111	—	—
Depreciation and amortization	119,770	—	21,916	7,012	15,367	18,263	71	837	47,520	8,776	8
Amortization expense of operating leases	19,595	—	980	2,443	2,799	5,618	12	—	3,772	3,971	—
Payments of right-of-use lease obligations – operating lease	(18,198)	—	(1,025)	(2,273)	(2,713)	(4,385)	—	—	(3,674)	(4,128)	—
(Gain) loss on disposal of property and equipment	61	—	—	—	(3)	—	—	—	—	64	—
Changes in operating assets and liabilities:											
Receivables, net	(69,016)	—	(1,777)	(2,852)	(11,628)	1,684	(337)	(148)	(44,224)	(9,261)	(473)
Inventories	3,205	—	(4,462)	747	(226)	3,169	—	(100)	4,063	14	—
Prepaid expenses and other assets	4,773	—	1,971	561	(650)	2,971	200	(108)	513	(240)	(445)
Professional liability self-insurance reserve	14,330	—	—	1,256	62	8,799	—	—	648	3,565	—
Accounts payable	40,672	—	23,868	(2,724)	2,947	1,198	60	950	7,953	6,422	(2)
Accrued expenses and other liabilities	30,873	—	4,354	(468)	1,839	8,866	(42)	203	7,053	7,757	1,311
Accrued pension asset	16,918	—	1,773	(2,733)	—	—		—	11,816	6,062	—
Net cash provided by (used in) operating activities	105,309	1,981	50,319	(14,754)	7,103	19,368	1,847	6,764	61,298	(28,068)	(549)
Cash flows from investing activities:											
Additions to property and equipment	(120,189)	—	(50,497)	(7,187)	(9,854)	(9,345)	(54)	(14,273)	(26,446)	(2,533)	—
Change in debt financed agreements	531	—	(5)		—	(73)	—	—	609	—	—
Investment purchases	(99,360)	—	(2,031)	(4,857)	(50,345)	(28,948)	(35)	—	(7,872)	(4,983)	(289)
Proceeds from investment maturities and sales	121,533	—	96	2,763	46,716	24,792	91	—	30,526	15,978	571
Equity distributions	4,847	—	—	—	—	3,674	—	(2,500)	3,673	—	—
Net transfers to affiliates	—	60,806	(60,808)	—	—	—	—	—	—	—	—
Net cash (used in) provided by investing activities	(92,638)	60,808	(113,245)	(9,281)	(13,483)	(9,900)	2	(16,773)	490	8,462	282
Cash flows from financing activities:											
Principal payments on long-term debt	(27,655)	—	(4,354)	(60)	(2,921)	(4,191)	—	(154)	(15,975)	—	—
Advances on Line of Credit	5,000	—	—	—	5,000	—	—	—	—	—	—
Restricted gift and income	4,777	—	300	—	—	(125)	—	—	1,090	3,512	—
Issuance of long-term debt	13,848	—	—	48	—	—	—	13,800	—	—	—
Cash paid for financing costs	(20)	—	—	—	(20)	—	—	—	—	—	—
Cash receipts from related-party long-term finance lease	—	(2,984)	—	—	—	—	—	—	2,984	—	—
Payments of right-of-use lease obligations	(21,030)	—	(146)	(153)	(1,490)	(4,140)	—	(160)	(14,896)	(45)	—
Net transfers to affiliates	—	(59,805)	55,622	(430)	10,232	(496)	(1,898)	(302)	(32,462)	30,740	(1,201)
Net cash (used in) provided by financing activities	(25,080)	(62,789)	51,422	(595)	10,801	(8,952)	(1,898)	13,184	(59,259)	34,207	(1,201)
Net (decrease) increase in cash and cash equivalents	(12,409)	—	(11,504)	(24,630)	4,421	516	(49)	3,175	2,529	14,601	(1,468)
Cash and cash equivalents, beginning of year	492,711	—	40,964	30,119	1,922	83,318	6,009	3,321	258,438	40,809	27,811
Cash and cash equivalents, end of year	$ 480,302	—	29,460	5,489	6,343	83,834	5,960	6,496	260,967	55,410	26,343
Supplemental disclosure of cash flow information:											
Cash paid during the year for interest	$ 27,598	—	3,672	60	1,892	1,678	—	587	19,689	—	—
Property and equipment included in accounts payable	1,769	—	—	—	1,769	—	—	—	—	—	—
Equipment acquired under finance lease obligations	6,121	—	218	—	—	555	—	—	5,305	43	—

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Balance Sheet

December 31, 2024
(Dollars in thousands)

	Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
Current assets:					
Cash and cash equivalents	$ 3,651	3	3,335	—	6,989
Investments	7,484	—	—	—	7,484
Receivables, net:					
Patient service	14,635	—	—	—	14,635
Institutional receivables	19	—	—	(2)	17
Other	—	10	30	—	40
	14,654	10	30	(2)	14,692
Inventories	2,223	—	—	—	2,223
Prepaid expenses and other current assets	2,684	6	8	—	2,698
Total current assets	30,696	19	3,373	(2)	34,086
Assets whose use is limited:					
Under debt financed agreements	—	110	—	—	110
Self-insurance funds	8,354	—	—	—	8,354
Other investments	12,184	—	1,091	—	13,275
	20,538	110	1,091	—	21,739
Property and equipment, net of accumulated depreciation and amortization	43,588	2,685	—	—	46,273
Right-of-use assets – operating leases	8,384	—	—	—	8,384
Interinstitutional receivables, long term	—	82	—	(82)	—
Accrued pension asset	1,608	—	—	—	1,608
Other assets	5,495	—	—	(4,404)	1,091
Total assets	$ 110,309	2,896	4,464	(4,488)	113,181

(Continued)

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Balance Sheet

December 31, 2024
(Dollars in thousands)

	Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
Current liabilities:					
Current maturities of long-term debt	$ 110	—	—	—	110
Current portion of lease liabilities – finance leases	270	—	—	—	270
Current portion of lease liabilities – operating leases	2,133	—	—	—	2,133
Payables:					
Accounts payable	14,066	39	21	—	14,126
Interinstitutional payables	2,311	2	—	(2)	2,311
Accrued expenses:					
Salaries and related items	6,743	—	—	—	6,743
Compensated absences	5,401	—	—	—	5,401
Deferred revenue	373	—	30	—	403
Other liabilities	2,740	—	9	—	2,749
Total current liabilities	34,147	41	60	(2)	34,246
Long-term debt, net of current maturities	1,498	—	—	—	1,498
Long-term lease liabilities – finance leases	614	—	—	—	614
Long-term lease liabilities – operating leases	6,338	—	—	—	6,338
Interinstitutional payables, long-term	8,475	—	—	(82)	8,393
Professional liability self-insurance reserve	7,023	—	—	—	7,023
Other liabilities, long-term	4,487	1	—	—	4,488
Total liabilities	62,582	42	60	(84)	62,600
Net assets (deficit):					
Without donor restrictions	44,901	2,854	2,874	(2,874)	47,755
With donor restrictions	2,826	—	1,530	(1,530)	2,826
	47,727	2,854	4,404	(4,404)	50,581
Total liabilities and net assets	$ 110,309	2,896	4,464	(4,488)	113,181

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Balance Sheet

December 31, 2023
(Dollars in thousands)

	Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
Current assets:					
Cash and cash equivalents	$ 2,558	9	2,922	—	5,489
Investments	8,737	—	—	—	8,737
Receivables, net:					
Patient service	12,248	—	—	—	12,248
Institutional receivables	37	—	—	(23)	14
Other	1,561	—	80	—	1,641
	13,846	—	80	(23)	13,903
Inventories	2,287	—	—	—	2,287
Prepaid expenses and other current assets	1,279	6	6	—	1,291
Total current assets	28,707	15	3,008	(23)	31,707
Assets whose use is limited:					
Under debt financed agreements	—	111	—	—	111
Self-insurance funds	7,925	—	—	—	7,925
Other investments	15,019	—	1,070	(3,967)	12,122
	22,944	111	1,070	(3,967)	20,158
Property and equipment, net of accumulated depreciation and amortization	43,268	2,805	—	—	46,073
Right-of-use assets – operating leases	5,241	—	—	—	5,241
Interinstitutional receivables, long term	850	—	—	—	850
Accrued pension asset	662	—	—	—	662
Other assets	1,154	82	—	(82)	1,154
Total assets	$ 102,826	3,013	4,078	(4,072)	105,845

(Continued)

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Balance Sheet

December 31, 2023
(Dollars in thousands)

	Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
Current liabilities:					
Current maturities of long-term debt	$ 107	—	—	—	107
Current portion of lease liabilities – finance leases	124	—	—	—	124
Current portion of lease liabilities – operating leases	2,594	—	—	—	2,594
Payables:					
Accounts payable	10,479	—	—	—	10,479
Interinstitutional payables	2,304	23	—	(23)	2,304
Accrued expenses:					
Salaries and related items	3,365	—	111	—	3,476
Compensated absences	5,419	—	—	—	5,419
Deferred revenue	998	—	—	—	998
Other liabilities	2,567	—	—	—	2,567
Total current liabilities	27,957	23	111	(23)	28,068
Long-term debt, net of current maturities	1,608	—	—	—	1,608
Long-term lease liabilities – operating leases	2,941	—	—	—	2,941
Interinstitutional payables, long-term	1,857	—	—	(82)	1,775
Professional liability self-insurance reserve	7,198	—	—	—	7,198
Other liabilities, long-term	4,436	8	—	—	4,444
Total liabilities	45,997	31	111	(105)	46,034
Net assets (deficit):					
Without donor restrictions	54,464	2,982	2,810	(2,810)	57,446
With donor restrictions	2,365	—	1,157	(1,157)	2,365
	56,829	2,982	3,967	(3,967)	59,811
Total liabilities and net assets	$ 102,826	3,013	4,078	(4,072)	105,845

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2024
(Dollars in thousands)

	Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
Operating revenue:					
Net patient service revenue	$ 156,639	—	—	—	156,639
Federal, state, and local grants and contracts	—	—	—	—	—
Interinstitutional revenue	2,464	—	—	—	2,464
Other revenue	7,622	162	800	—	8,584
Net assets released from restrictions used for operations	46	—	284	(18)	312
Total operating revenue	166,771	162	1,084	(18)	167,999
Operating expenses:					
Salaries	90,903	—	210	—	91,113
Employee benefits	17,217	—	15	—	17,232
Supplies	24,558	—	—	—	24,558
Purchased services	25,480	—	—	—	25,480
Interinstitutional expense	14,347	1	—	—	14,348
Depreciation and amortization	6,437	121	—	—	6,558
Interest	91	—	—	—	91
Other expenses	1,433	168	998	(784)	1,815
Total operating expenses	180,466	290	1,223	(784)	181,195
Operating (loss) margin	(13,695)	(128)	(139)	766	(13,196)
Nonoperating gains:					
Net realized gains on sales of investments	820	—	—	—	820
Other, net	1,689	—	199	—	1,888
Total nonoperating gains	2,509	—	199	—	2,708
(Deficiency) excess of revenue over expenses, before investment gains (losses) and other activities, net	$ (11,186)	(128)	60	766	(10,488)

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2024
(Dollars in thousands)

	Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
(Deficiency) excess of revenue over expenses	$ (11,186)	(128)	60	766	(10,488)
Net assets without donor restrictions:					
Net assets released from restrictions used for purchase of property and equipment	766	—	—	(766)	—
Pension-related changes other than net periodic pension costs	797	—	—	—	797
Changes in interest in net assets of Columbia-Greene Hospital Foundation	60	—	4	(64)	—
(Decrease) increase in net assets without donor restrictions	(9,563)	(128)	64	(64)	(9,691)
Net assets with donor restrictions:					
Private gifts, grants, contracts, and other	886	—	657	(783)	760
Investment interest, dividends, and net realized gains (losses), net	13	—	—	—	13
Net assets released from restrictions for operations	(46)	—	(284)	18	(312)
Net assets released from restrictions used for purchase of property and equipment	(766)	—	—	766	—
Changes in interest in net assets of Columbia-Greene Hospital Foundation	374	—	—	(374)	—
Increase (decrease) in net assets with donor restrictions	461	—	373	(373)	461
Change in net assets	(9,102)	(128)	437	(437)	(9,230)
Net assets, beginning of year	56,829	2,982	3,967	(3,967)	59,811
Net assets, end of year	$ 47,727	2,854	4,404	(4,404)	50,581

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2023
(Dollars in thousands)

		Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
Operating revenue:						
Net patient service revenue	$	146,693	—	—	—	146,693
Federal, state, and local grants and contracts		324	—	—	—	324
Interinstitutional revenue		1,752	—	—	—	1,752
Other revenue		6,945	152	933	(1)	8,029
Net assets released from restrictions used for operations		—	—	420	—	420
Total operating revenue		155,714	152	1,353	(1)	157,218
Operating expenses:						
Salaries		95,039	—	291	—	95,330
Employee benefits		16,433	—	24	—	16,457
Supplies		24,056	—	—	—	24,056
Purchased services		20,553	169	970	(784)	20,908
Interinstitutional expense		11,794	—	—	—	11,794
Depreciation and amortization		6,890	122	—	—	7,012
Interest		80	—	—	—	80
Other expenses		1,365	—	—	—	1,365
Total operating expenses		176,210	291	1,285	(784)	177,002
Operating (loss) margin		(20,496)	(139)	68	783	(19,784)
Nonoperating gains:						
Net realized gains on sales of investments		879	—	—	—	879
Other, net		3,296	—	—	—	3,296
Total nonoperating gains		4,175	—	—	—	4,175
(Deficiency) excess of revenue over expenses, before investment gains (losses) and other activities, net	$	(16,321)	(139)	68	783	(15,609)

(Continued)

ALBANY MED HEALTH SYSTEM

Columbia Memorial Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2023
(Dollars in thousands)

		Columbia Memorial Hospital	Kaaterskill Commons, Inc.	Columbia-Greene Hospital Foundation	Eliminations	Consolidated
(Deficiency) excess of revenue over expenses	$	(16,321)	(139)	68	783	(15,609)
Net assets without donor restrictions:						
Net assets released from restrictions used for purchase of property and equipment		913	—	—	(783)	130
Pension-related changes other than net periodic pension costs		1,344	—	—	—	1,344
Changes in interest in net assets of Columbia-Greene Hospital Foundation		69	—	—	(69)	—
(Decrease) increase in net assets without donor restrictions		(13,995)	(139)	68	(69)	(14,135)
Net assets with donor restrictions:						
Private gifts, grants, contracts, and other		921	—	456	(783)	594
Investment interest, dividends, and net realized gains (losses), net		—	—	—	—	—
Net assets released from restrictions for operations		—	—	(420)	—	(420)
Changes in net unrealized gains and losses on investments		2	—	132	—	134
Net assets released from restrictions used for purchase of property and equipment		(913)	—	—	783	(130)
Changes in interest in net assets of Columbia-Greene Hospital Foundation		167	—	—	(167)	—
Increase (decrease) in net assets with donor restrictions		177	—	168	(167)	178
Change in net assets		(13,818)	(139)	236	(236)	(13,957)
Net assets, beginning of year		70,647	3,121	3,731	(3,731)	73,768
Net assets, end of year	$	56,829	2,982	3,967	(3,967)	59,811

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Saratoga Hospital and Affiliates Consolidating Balance Sheet

December 31, 2024
(Dollars in thousands)

Assets	Saratoga Hospital	Saratoga Regional Medical, PC	Saratoga Care, Inc.	Obligated Group Eliminations	Obligated Group	Flower and Fruit	Eliminations	Combined
Current assets:								
Cash and cash equivalents	$ 71,484	1,758	6,096	—	79,338	132	—	79,470
Investments	151,430	—	—	—	151,430	10	—	151,440
Accounts receivable:						—	—	
Patient care	41,570	2,781	—	—	44,351	—	—	44,351
Interinstitutional receivables	7,143	—	—	—	7,143	—	—	7,143
Other	5,933	6	1,588	(200)	7,327	—	(45)	7,282
	54,646	2,787	1,588	(200)	58,821	—	(45)	58,776
Inventories	9,523	40	—	—	9,563	—	—	9,563
Prepaid expenses and other current assets	6,232	26	2	—	6,260	—	—	6,260
Total current assets	293,315	4,611	7,686	(200)	305,412	142	(45)	305,509
Assets whose use is limited:								
Under debt financed agreements	1,749	—	—	—	1,749	—	—	1,749
Self-insurance funds	13,639	—	—	—	13,639	—	—	13,639
Other investments	4,409	—	—	—	4,409	—	—	4,409
	19,797	—	—	—	19,797	—	—	19,797
Property and equipment, net of accumulated depreciation and amortization	151,616	1,968	—	—	153,584	—	—	153,584
Right-of-use assets – operating leases, net	32,208	138	—	—	32,346	—	—	32,346
Investments, long-term	29,882	—	—	—	29,882	—	—	29,882
Other assets:								
Interinstitutional receivables	23,184	—	—	(23,184)	—	—	—	—
Deferred compensation agreements	12,478	—	—	—	12,478	—	—	12,478
Assets held in charitable trusts	—	—	328	—	328	—	—	328
Interest in net assets of Saratoga Care Foundation	8,704	—	—	(8,704)	—	—	—	—
Other assets	9,290	—	—	—	9,290	—	(45)	9,245
	53,656	—	328	(31,888)	22,096	—	(45)	22,051
Total assets	$ 580,474	6,717	8,014	(32,088)	563,117	142	(90)	563,169

(Continued)

ALBANY MED HEALTH SYSTEM

Saratoga Hospital and Affiliates Consolidating Balance Sheet

December 31, 2024
(Dollars in thousands)

Liabilities and Net Assets	Saratoga Hospital	Saratoga Regional Medical, PC	Saratoga Care, Inc.	Obligated Group Eliminations	Obligated Group	Flower and Fruit	Eliminations	Combined
Current liabilities:								
Current portion of long-term debt	$ 3,820	—	—	—	3,820	—	—	3,820
Current portion of lease liabilities – finance leases	932	—	—	—	932	—	—	932
Current portion of lease liabilities – operating leases	3,038	31	—	—	3,069	—	—	3,069
Accounts payable and accrued expenses	14,385	—	3	—	14,388	—	—	14,388
Interinstitutional payables	384	—	2,318	(2,318)	384	—	—	384
Accrued salaries and related items	35,129	—	—	—	35,129	—	—	35,129
Compensated absences	13,910	—	—	—	13,910	—	—	13,910
Other liabilities	9,878	—	310	(200)	9,988	45	(45)	9,988
Total current liabilities	81,476	31	2,631	(2,518)	81,620	45	(45)	81,620
Long-term debt, net of current portion, and unamortized financing expenses	39,800	—	—	—	39,800	—	—	39,800
Long-term lease liabilities – finance leases	504	—	—	—	504	—	—	504
Long-term lease liabilities – operating leases	33,170	108	—	—	33,278	—	—	33,278
Due to affiliates	—	23,184	—	(23,184)	—	—	—	—
Professional liability self-insurance reserve	22,412	—	—	—	22,412	—	—	22,412
Other liabilities, long-term	18,004	—	40	—	18,044	45	(45)	18,044
Total liabilities	195,366	23,323	2,671	(25,702)	195,658	90	(90)	195,658
Net assets (deficit):								
Without donor restrictions	375,478	(16,606)	(1,043)	—	357,829	52	216	358,097
With donor restrictions	9,630	—	6,386	(6,386)	9,630	—	(216)	9,414
	385,108	(16,606)	5,343	(6,386)	367,459	52	—	367,511
Total liabilities and net assets	$ 580,474	6,717	8,014	(32,088)	563,117	142	(90)	563,169

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Saratoga Hospital and Affiliates Consolidating Balance Sheet

December 31, 2023
(Dollars in thousands)

Assets		Saratoga Hospital	Saratoga Regional Medical, PC	Saratoga Care, Inc.	Obligated Group Eliminations	Obligated Group	Flower and Fruit	Eliminations	Combined
Current assets:									
Cash and cash equivalents	$	78,797	1,501	3,458	—	83,756	78	—	83,834
Investments		132,490	—	—	—	132,490	10	—	132,500
Accounts receivable:									
Patient care		42,798	820	—	—	43,618	—	—	43,618
Interinstitutional receivables		5,107	—	—	(1,326)	3,781	—	—	3,781
Other		672	29	725	(100)	1,326	—	(45)	1,281
		48,577	849	725	(1,426)	48,725	—	(45)	48,680
Inventories		8,035	—	—	—	8,035	—	—	8,035
Prepaid expenses and other current assets		5,251	—	10	—	5,261	—	—	5,261
Total current assets		273,150	2,350	4,193	(1,426)	278,267	88	(45)	278,310
Assets whose use is limited:									
Under debt financed agreements		1,749	—	—	—	1,749	—	—	1,749
Self-insurance funds		11,664	—	—	—	11,664	—	—	11,664
Other investments		4,409	—	—	—	4,409	—	—	4,409
		17,822	—	—	—	17,822	—	—	17,822
Property and equipment, net of accumulated depreciation and amortization		150,371	2,144	—	—	152,515	—	—	152,515
Right-of-use assets – operating leases, net		35,308	151	—	—	35,459	—	—	35,459
Investments, long-term		32,594	—	—	—	32,594	—	—	32,594
Other assets:								—	
Interinstitutional receivables		21,439	—	—	(19,290)	2,149	—	—	2,149
Deferred compensation agreements		8,078	—	—	—	8,078	—	—	8,078
Assets held in charitable trusts		—	—	335	—	335	—	—	335
Interest in net assets of Saratoga Care Foundation		4,664	—	—	(4,664)	—	—	—	—
Other assets		5,932	—	976	(400)	6,508	—	(90)	6,418
		40,113	—	1,311	(24,354)	17,070	—	(90)	16,980
Total assets	$	549,358	4,645	5,504	(25,780)	533,727	88	(135)	533,680

(Continued)

ALBANY MED HEALTH SYSTEM

Saratoga Hospital and Affiliates Consolidating Balance Sheet

December 31, 2023
(Dollars in thousands)

Liabilities and Net Assets		Saratoga Hospital	Saratoga Regional Medical, PC	Saratoga Care, Inc.	Obligated Group Eliminations	Obligated Group	Flower and Fruit	Eliminations	Combined
Current liabilities:									
Current portion of long-term debt	$	3,705	—	—	—	3,705	—	—	3,705
Current portion of lease liabilities – finance leases		932	—	—	—	932	—	—	932
Current portion of lease liabilities – operating leases		3,156	—	—	—	3,156	—	—	3,156
Accounts payable and accrued expenses		13,935	—	—	(100)	13,835	45	(45)	13,835
Interinstitutional payables		226	—	1,326	(1,326)	226	—	—	226
Accrued salaries and related items		33,147	—	6	—	33,153	—	—	33,153
Compensated absences		12,222	—	—	—	12,222	—	—	12,222
Other liabilities		8,575	—	—	—	8,575	—	—	8,575
Total current liabilities		75,898	—	1,332	(1,426)	75,804	45	(45)	75,804
Long-term debt, net of current portion, and unamortized financing expenses		43,548	—	—	—	43,548	—	—	43,548
Long-term lease liabilities – finance leases		1,201	—	—	—	1,201	—	—	1,201
Long-term lease liabilities – operating leases		35,638	176	—	—	35,814	—	—	35,814
Due to affiliates		5,073	19,290	—	(19,290)	5,073	—	—	5,073
Professional liability self-insurance reserve		18,869	—	—	—	18,869	—	—	18,869
Other liabilities, long-term		12,650	—	469	(400)	12,719	90	(90)	12,719
Total liabilities		192,877	19,466	1,801	(21,116)	193,028	135	(135)	193,028
Net assets (deficit):									
Without donor restrictions		347,868	(14,821)	(961)	—	332,086	(47)	216	332,255
With donor restrictions		8,613	—	4,664	(4,664)	8,613	—	(216)	8,397
		356,481	(14,821)	3,703	(4,664)	340,699	(47)	—	340,652
Total liabilities and net assets	$	549,358	4,645	5,504	(25,780)	533,727	88	(135)	533,680

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Saratoga Hospital and Affiliates Consolidating Statement of Operations

Year ended December 31, 2024
(Dollars in thousands)

	Saratoga Hospital	Saratoga Regional Medical, PC	Saratoga Care, Inc.	Obligated Group Eliminations	Obligated Group	Flower and Fruit	Eliminations	Combined
Operating revenue:								
Net patient service revenue	$ 450,796	2,287	—	—	453,083	—	—	453,083
Interinstitutional revenue	46,257	—	—	—	46,257	—	—	46,257
Grants	516	—	—	—	516	—	—	516
Other revenue	18,612	—	—	—	18,612	186	—	18,798
Net assets released from restrictions	427	11	—	—	438	—	—	438
Total operating revenue	516,608	2,298	—	—	518,906	186	—	519,092
Operating expenses:								
Salaries and wages	291,763	2,858	—	—	294,621	—	—	294,621
Employee benefits	53,938	578		—	54,516	—	—	54,516
Supplies	77,181	137	—	—	77,318	87	—	77,405
Purchased services	44,928	330	—	—	45,258	—	—	45,258
Interinstitutional expense	16,461		—	—	16,461	—	—	16,461
Depreciation and amortization	19,090	177	—	—	19,267	—	—	19,267
Interest	1,479	—	—	—	1,479	—	—	1,479
Other expenses	5,309	3	—	—	5,312	—	—	5,312
Total operating expenses	510,149	4,083	—	—	514,232	87	—	514,319
Operating (loss) margin	6,459	(1,785)	—	—	4,674	99	—	4,773
Nonoperating gains:								
Net realized gains on sales of investments	3,008	—	—	—	3,008	—	—	3,008
Other, net	5,438	—	387	—	5,825	—	—	5,825
Total nonoperating gains	8,446	—	387	—	8,833	—	—	8,833
Excess (deficiency) of revenue over expenses, before investment gains and other activities, net	14,905	(1,785)	387	—	13,507	99	—	13,606
Investment gains and other activities:								
Net unrealized gains on investments	11,956	—	—	—	11,956	—	—	11,956
Total investment gains and other activities, net	11,956	—	—	—	11,956	—	—	11,956
Excess (deficiency) of revenue over expenses	26,861	(1,785)	387	—	25,463	99	—	25,562
Net assets released from restrictions used for purchase of property and equipment	280	—	—	—	280	—	—	280
Increase (decrease) in net assets without donor restrictions	$ 27,141	(1,785)	387	—	25,743	99	—	25,842

See accompanying independent auditors' report.

ALBANY MED HEALTH SYSTEM

Saratoga Hospital and Affiliates Consolidating Statement of Operations

Year ended December 31, 2023
(Dollars in thousands)

	Saratoga Hospital	Saratoga Regional Medical, PC	Saratoga Care, Inc.	Obligated Group Eliminations	Obligated Group	Flower and Fruit	Eliminations	Combined
Operating revenue:								
Net patient service revenue	$ 428,443	2,516	—	—	430,959	—	—	430,959
Interinstitutional revenue	38,826	—	—	—	38,826	—	—	38,826
Grants	1,450	—	—	—	1,450	—	—	1,450
Other revenue	11,275	—	—	—	11,275	150	—	11,425
Net assets released from restrictions	639	5	—	—	644	—	—	644
Total operating revenue	480,633	2,521	—	—	483,154	150	—	483,304
Operating expenses:								
Salaries and wages	275,146	2,378	430	—	277,954	—	—	277,954
Employee benefits	50,528	495	—	—	51,023	—	—	51,023
Supplies	98,354	203	91	—	98,648	101	—	98,749
Purchased services	45,039	346	—	—	45,385	—	—	45,385
Interinstitutional expense	15,012	—	—	—	15,012	—	—	15,012
Depreciation and amortization	18,175	88	—	—	18,263	—	—	18,263
Interest	1,674	—	—	—	1,674	—	—	1,674
Other expenses	4,207	17	—	—	4,224	—	—	4,224
Total operating expenses	508,135	3,527	521	—	512,183	101	—	512,284
Operating (loss) margin	(27,502)	(1,006)	(521)	—	(29,029)	49	—	(28,980)
Nonoperating gains:								
Net realized gains on sales of investments	791	—	—	—	791	—	—	791
Other, net	4,041	—	124	—	4,165	—	—	4,165
Total nonoperating gains	4,832	—	124	—	4,956	—	—	4,956
Excess of revenue over expenses, before investment gains and other activities, net	(22,670)	(1,006)	(397)	—	(24,073)	49	—	(24,024)
Investment gains and other activities:								
Net unrealized gains on investments	11,916	—	—	—	11,916	—	—	11,916
Total investment gains and other activities, net	11,916	—	—	—	11,916	—	—	11,916
(Deficiency) excess of revenue over expenses	(10,754)	(1,006)	(397)	—	(12,157)	49	—	(12,108)
Net assets released from restrictions used for purchase of property and equipment	11	—	—	—	11	—	—	11
(Decrease) increase in net assets without donor restrictions	$ (10,743)	(1,006)	(397)	—	(12,146)	49	—	(12,097)

See accompanying independent auditors' report

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidated Balance Sheet

December 31, 2024
(Dollars in thousands)

Assets	Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Current assets:				
Cash and cash equivalents	$ 1,178	665	—	1,843
Investments	44,976	10,558	—	55,534
Receivables, net:				
Patient service	57,132	—	—	57,132
Interinstitutional receivables	115	—	—	115
Other	5,964	1,332	—	7,296
	63,211	1,332	—	64,543
Inventories	11,989	—	—	11,989
Prepaid expenses and other current assets	3,255	—	—	3,255
Total current assets	124,609	12,555	—	137,164
Assets whose use is limited:				
Self-insurance funds	12,430	—	—	12,430
Other investments	5,643	—	—	5,643
	18,073	—	—	18,073
Property and equipment, net of accumulated depreciation and amortization	139,021	—	—	139,021
Right-of-use assets – operating leases	7,649	—	—	7,649
Other assets:				
Deferred compensation agreements	10,389	—	—	10,389
Other assets	16,378	3,110	(15,665)	3,823
Interinstitutional receivables, noncurrent	—	—	—	—
	26,767	3,110	(15,665)	14,212
Total assets	$ 316,119	15,665	(15,665)	316,119

(Continued)

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidated Balance Sheet

December 31, 2024
(Dollars in thousands)

Liabilities and Net Assets		Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Current liabilities:					
Current maturities of long-term debt	$	10,391	—	—	10,391
Current portion of lease liabilities – finance leases		1,732	—	—	1,732
Current portion of lease liabilities – operating leases		2,134	—	—	2,134
Payables:					
Accounts payable		44,755	—	—	44,755
Interinstitutional payables		6,825	—	—	6,825
Accrued expenses:					
Salaries and related items		10,411	—	—	10,411
Compensated absences		10,122	—	—	10,122
Other liabilities		9,380	—	—	9,380
Total current liabilities		95,750	—	—	95,750
Long-term debt, net of current maturities		26,758	—	—	26,758
Long-term lease liabilities – finance leases		2,000	—	—	2,000
Long-term lease liabilities – operating leases		5,831	—	—	5,831
Interinstitutional payables, noncurrent		9,109	—	—	9,109
Professional liability self-insurance reserve		14,375	—	—	14,375
Other liabilities, long-term		10,961	—	—	10,961
Total liabilities		164,784	—	—	164,784
Net assets:					
Without donor restrictions		131,401	1,311	(1,311)	131,401
With donor restrictions		19,934	14,354	(14,354)	19,934
		151,335	15,665	(15,665)	151,335
Total liabilities and net assets	$	316,119	15,665	(15,665)	316,119

See accompanying notes to combined financial statements.

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidated Balance Sheet

December 31, 2023
(Dollars in thousands)

Assets		Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Current assets:					
Cash and cash equivalents	$	3,846	2,497	—	6,343
Investments		41,289	7,781	—	49,070
Receivables, net:					
Patient service		46,189	—	—	46,189
Interinstitutional receivables		1,819	3	(3)	1,819
Other		6,029	71	—	6,100
		54,037	74	(3)	54,108
Inventories		9,969	—	—	9,969
Prepaid expenses and other current assets		3,796	—	—	3,796
Total current assets		112,937	10,352	(3)	123,286
Assets whose use is limited:					
Self-insurance funds		10,813	—	—	10,813
Other investments		5,070	—	—	5,070
		15,883	—	—	15,883
Property and equipment, net of accumulated depreciation and amortization		131,202	—	—	131,202
Right-of-use assets – operating leases		9,726	—	—	9,726
Other assets:					
Deferred compensation agreements		8,876	—	—	8,876
Other assets		13,785	2,720	(13,069)	3,436
Interinstitutional receivables, noncurrent		618	—	—	618
		23,279	2,720	(13,069)	12,930
Total assets	$	293,027	13,072	(13,072)	293,027

(Continued)

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidated Balance Sheet

December 31, 2023
(Dollars in thousands)

Liabilities and Net Assets		Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Current liabilities:					
Current maturities of long-term debt	$	7,955	—	—	7,955
Current portion of lease liabilities – finance leases		988	—	—	988
Current portion of lease liabilities – operating leases		2,350	—	—	2,350
Payables:					
Accounts payable		41,013	—	—	41,013
Interinstitutional payables		12,211	—	—	12,211
Accrued expenses:					
Salaries and related items		8,642	—	—	8,642
Compensated absences		9,655	—	—	9,655
Other liabilities		7,881	—	—	7,881
Total current liabilities		90,695	—	—	90,695
Long-term debt, net of current maturities		29,145	—	—	29,145
Long-term lease liabilities – finance leases		2,507	—	—	2,507
Long-term lease liabilities – operating leases		7,663	—	—	7,663
Interinstitutional payables, noncurrent		3,851	—	—	3,851
Professional liability self-insurance reserve		13,704	—	—	13,704
Other liabilities, long-term		9,458	—	—	9,458
Total liabilities		157,023	—	—	157,023
Net assets:					
Without donor restrictions		119,101	1,189	(1,189)	119,101
With donor restrictions		16,903	11,883	(11,883)	16,903
		136,004	13,072	(13,072)	136,004
Total liabilities and net assets	$	293,027	13,072	(13,072)	293,027

See accompanying notes to combined financial statements.

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2024
(Dollars in thousands)

		Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Operating revenue:					
Net patient service revenue	$	426,957	—	—	426,957
Federal, state, and local grants and contracts		3,049	5,454	—	8,503
Interinstitutional revenue		6,372	—	(87)	6,285
Other revenue		52,764	894	(6,348)	47,310
Net assets released from restrictions used for operations		907	—	—	907
Total operating revenue		490,049	6,348	(6,435)	489,962
Operating expenses:					
Salaries		199,537	421	(421)	199,537
Employee benefits		35,497	80	(80)	35,497
Supplies		166,008	415	(415)	166,008
Purchased services		39,142	—	—	39,142
Interinstitutional expense		23,808	87	(87)	23,808
Depreciation and amortization		14,275	—	—	14,275
Interest		2,306	—	—	2,306
Other expenses		3,596	6,479	(6,566)	3,509
Total operating expenses		484,169	7,482	(7,569)	484,082
Operating (loss) margin		5,880	(1,134)	1,134	5,880
Nonoperating gains:					
Net realized gains on sales of investments		3,064	445	(445)	3,064
Other, net		1,031	—	—	1,031
Total nonoperating gains		4,095	445	(445)	4,095
Excess (deficiency) excess of revenue over expenses, before investment gains and other activities, net	$	9,975	(689)	689	9,975

(Continued)

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2024
(Dollars in thousands)

	Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Investment gains and other activities:				
Net unrealized gain (losses) on investments	$ 249	811	(811)	249
Total investment gains (losses) and other activities, net	249	811	(811)	249
Excess (deficiency) of revenue over expenses	10,224	122	(122)	10,224
Net assets without donor restrictions:				
Net assets released from restrictions used for purchase of property and equipment	2,076	—	—	2,076
Increase (decrease) in net assets without donor restrictions	12,300	122	(122)	12,300
Net assets with donor restrictions:				
Private gifts, grants, contracts and other	5,577	1,580	(1,580)	5,577
Net assets released from restrictions for operations	(907)	907	(907)	(907)
Net provision for uncollectible accounts		(15)	15	—
Changes in net unrealized gains and losses on investments	437	—	—	437
Net assets released from restrictions used for purchase of property and equipment	(2,076)	—	—	(2,076)
Increase (decrease) in net assets with donor restrictions	3,031	2,472	(2,472)	3,031
Change in net assets	15,331	2,594	(2,594)	15,331
Net assets (deficit), beginning of year	136,004	13,071	(13,071)	136,004
Net assets (deficit), end of year	$ 151,335	15,665	(15,665)	151,335

See accompanying notes to combined financial statements

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2023
(Dollars in thousands)

		Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Operating revenue:					
Net patient service revenue	$	363,336	—	—	363,336
Federal, state, and local grants and contracts		988	5,317	—	6,305
Interinstitutional revenue		4,657	—	(56)	4,601
Other revenue		31,692	652	(5,969)	26,375
Net assets released from restrictions used for operations		717	—	—	717
Total operating revenue		401,390	5,969	(6,025)	401,334
Operating expenses:					
Salaries		194,673	386	(386)	194,673
Employee benefits		35,148	71	(71)	35,148
Supplies		114,139	195	(195)	114,139
Purchased services		40,629	—	—	40,629
Interinstitutional expense		14,610	56	(56)	14,610
Depreciation and amortization		15,367	—	—	15,367
Interest		1,892	—	—	1,892
Other expenses		2,049	5,357	(5,413)	1,993
Total operating expenses		418,507	6,065	(6,121)	418,451
Operating (loss) margin		(17,117)	(96)	96	(17,117)
Nonoperating gains:					
Net realized gains on sales of investments		816	209	(209)	816
Other, net		1,485	—	—	1,485
Total nonoperating gains		2,301	209	(209)	2,301
(Deficiency) excess of revenue over expenses, before investment gains and other activities, net	$	(14,816)	113	(113)	(14,816)

(Continued)

ALBANY MED HEALTH SYSTEM

Glens Falls Hospital Consolidating Statement of Operations and Changes in Net Assets

Year ended December 31, 2023
(Dollars in thousands)

	Glens Falls Hospital	Glens Falls Hospital Foundation	Eliminations	Consolidated
Investment gains and other activities:				
Net unrealized losses on investments	$ 4,125	988	(988)	4,125
Total investment gains and other activities, net	4,125	988	(988)	4,125
(Deficiency) excess of revenue over expenses	(10,691)	1,101	(1,101)	(10,691)
Net assets without donor restrictions:				
Net assets released from restrictions used for purchase of property and equipment	450	—	—	450
(Decrease) increase in net assets without donor restrictions	(10,241)	1,101	(1,101)	(10,241)
Net assets with donor restrictions:				
Private gifts, grants, contracts and other	5,740	4,692	(4,692)	5,740
Net assets released from restrictions for operations	(717)	(828)	828	(717)
Net provision for uncollectible accounts	—	(68)	68	—
Changes in net unrealized gains and losses on investments	495	—	—	495
Net assets released from restrictions used for purchase of property and equipment	(450)	—	—	(450)
Increase (decrease) in net assets with donor restrictions	5,068	3,796	(3,796)	5,068
Change in net assets	(5,173)	4,897	(4,897)	(5,173)
Net assets (deficit), beginning of year	141,177	8,174	(8,174)	141,177
Net assets (deficit), end of year	$ 136,004	13,071	(13,071)	136,004

See accompanying notes to combined financial statements.

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 8

[redacted]

PLEASE COMPLETE THE FOLLOWING:

1. Are staff paid and on payroll? ☒ Yes ☐ No

2. Provide copies of contracts for any independent contractor. **N/A**

3. Please attach the Medical Doctors C.V. **Please refer to Schedule LRA 08 Attachments**

4. Is this facility affiliated with any other facilities? (If yes, please describe affiliation and/or agreement.) ☒ Yes ☐ No **Please refer to Schedule LRA 08 Attachments**

(Rev. 7/7/2010)

COLUMBIA MEMORIAL HOSPITAL

SCHEDULE LRA 08 ATTACHMENTS

1) Medical Director Curriculum Vitae
2) Organizational Structure

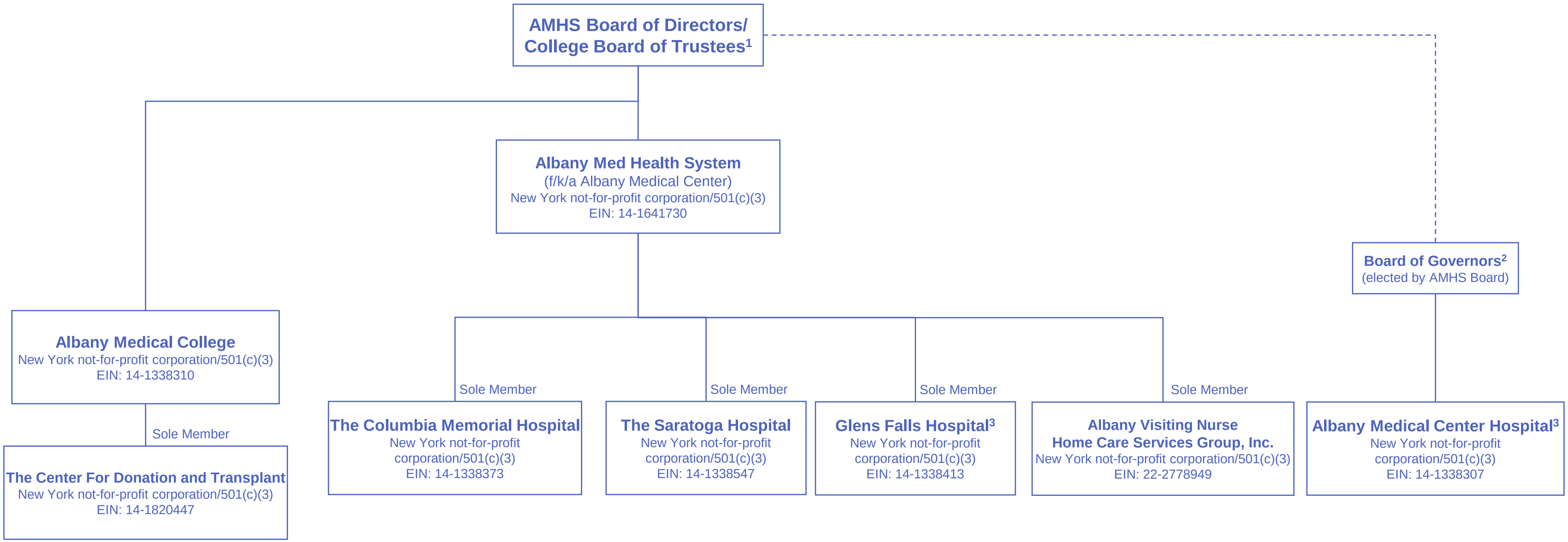
[redacted]

[redacted]

[redacted]

[redacted]

Albany Med Health System
Organizational Structure – April 1, 2024



[1] Per the Bylaws of Albany Medical College and the Omnibus Resolution of the Liaison Committee of Trustees and Governors adopted by the Board of Directors of AMHS on January 19, 1983, the responsibility for the conduct of the College is vested in the College Board of Trustees, subject to the direction and control of the directors of AMHS.

[2] Per the Bylaws of Albany Medical Center Hospital and the Omnibus Resolution of the Liaison Committee of Trustees and Governors adopted by the Board of Directors of AMHS on January 19, 1983, the responsibility for the conduct of AMCH is vested in the AMCH Board of Governors, subject to the direction and control of the directors of AMHS.

[3] The Boards of Glens Falls Hospital and Albany Medical Center Hospital consist of the same individuals.

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 10

The Sites Tab in NYSE-CON has replaced Schedule LRA 10. Schedule LRA 10 is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval. ***However, due to programming issues, you may still be required to upload a blank Schedule LRA 10 to submit a Service Delivery LRA application.***

Impact of Limited Review Application on Operating Certificate (services specific to the site)

Instructions:
"Current" Column: Mark "x" in the box only if the service currently appears on the operating certificate (OpCert) not including requested changes
"Add" Column: Mark "x" in the box this CON application seeks to add.
"Remove" Column: Mark "x" in the box this CON application seeks to decertify.
"Proposed" Column: Mark "x" in the box corresponding to all the services that will ultimately appear on the OpCert.

Category/Authorized Service	Code	Current	Add	Remove	Proposed
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
N/A – Please refer to Site Tab		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
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		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Does the applicant have any previously submitted Certificate of Need (CON) applications that have not been completed involving addition or decertification of beds?

☐ No

☐ Yes (*Enter CON numbers to the right)* ______ ______ ______

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 12

Assurances

The undersigned, as a duly authorized representative of the applicant, hereby gives the following assurances:

a) The applicant has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way, sufficient to assure use and possession for the purpose of the construction and operation of the facility.

b) The applicant will obtain the approval of the Commissioner of Health of all required submissions, which shall conform to the standards of construction and equipment in Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (Title 10).

c) The applicant will submit to the Commissioner of Health final working drawings and specifications, which shall conform to the standards of construction and equipment of Subchapter C of Title 10, prior to contracting for construction, unless otherwise provided for in Title 10.

d) The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.

e) The applicant will provide and maintain competent and adequate architectural and/or engineering inspection at the construction site to insure that the completed work conforms to the approved plans and specifications.

f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.

g) The facility will be operated and maintained in accordance with the standards prescribed by law.

h) The applicant will comply with the provisions of the Public Health Law and the applicable provisions of Title 10 with respect to the operation of all established, existing medical facilities in which the applicant has a controlling interest.

i) The applicant understands and recognizes that any approval of this application is not to be construed as an approval of, nor does it provide assurance of, reimbursement for any costs identified in the application. Reimbursement for all cost shall be in accordance with and subject to the provisions of Part 86 of Title 10.

12.10.2025

Date

Signature

Dorothy M. Urschel

Name (Please Type)

President and CEO

Title (Please Type)