Consolidated Financial Statements (Unaudited)

Montefiore Medical Center

For the Nine Months Ended September 30, 2022 and 2021

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Contents

Montefiore Medical Center

Consolidated Statements of Financial Position

	Unaudited September 30, 2022	Audited December 31, 2021
	(In Thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 113,858**	$ 36,113
Marketable and other securities	**1,292,599**	1,761,269
Assets limited as to use, current portion	**11,931**	16,239
Receivables for patient care, net	**259,101**	290,931
Other receivables	**89,404**	40,056
Estimated insurance claims receivable, current portion	**63,022**	63,022
Other current assets	**59,896**	70,676
Due from members, current portion	**338,760**	201,739
Total current assets	**2,228,571**	2,480,045
Assets limited as to use, net of current portion	**154,791**	166,023
Property, buildings and equipment, net	**1,181,185**	1,228,779
Right-of-use assets – operating leases	**330,176**	361,140
Estimated insurance claims receivable, net of current portion	**223,442**	223,442
Other noncurrent assets	**256,315**	226,503
Due from members, net of current portion	**343,765**	349,720
Total assets	**$ 4,718,245**	$ 5,035,652
Liabilities and net assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 334,733**	$ 343,421
Accrued salaries, wages and related items	**404,539**	317,971
Self-insured professional and other insured liabilities, current portion	**131,852**	118,523
Estimated insurance claims liabilities, current portion	**63,022**	63,022
Estimated third-party payer liabilities, current portion	**148,480**	285,378
Long-term debt, current portion	**14,082**	13,910
Finance lease liabilities, current portion	**17,241**	16,475
Operating lease liabilities, current portion	**37,870**	36,620
Total current liabilities	**1,151,819**	1,195,320
Long-term debt, net of current portion	**1,988,269**	1,999,258
Finance lease liabilities, net of current portion	**324,028**	334,198
Operating lease liabilities, net of current portion	**303,342**	335,237
Noncurrent defined benefit pension and other postretirement health plan liabilities	**216,460**	217,449
Self-insured professional and other insured liabilities, net of current portion	**199,385**	186,508
Employee deferred compensation	**82,197**	90,576
Estimated insurance claims liabilities, net of current portion	**223,442**	223,442
Estimated third-party payer liabilities, net of current portion	**255,295**	255,296
Other noncurrent liabilities	**38,702**	25,491
Total liabilities	**4,782,939**	4,862,775
Commitments and contingencies		
Net (deficiency) assets:		
Without donor restrictions	**(172,230)**	61,155
With donor restrictions	**107,536**	111,722
Total net deficiency	**(64,694)**	172,877
Total liabilities and net deficiency	**$ 4,718,245**	$ 5,035,652

See accompanying notes.

Montefiore Medical Center

Consolidated Statements of Operations

	Unaudited Nine Months Ended September 30, 2022	2021
	(In Thousands)	
Operating revenue		
Net patient service revenue	**$ 3,104,280**	$ 2,849,868
Grants and contracts	**164,986**	142,278
Other revenue	**138,566**	177,628
Total operating revenue	**3,407,832**	3,169,774
Operating expenses		
Salaries and wages	**1,562,284**	1,520,769
Employee benefits	**503,931**	488,273
Supplies and other expenses	**1,213,172**	1,142,596
Depreciation and amortization	**116,773**	121,968
Interest	**74,812**	74,056
Total operating expenses	**3,470,972**	3,347,662
Deficiency of operating revenue over operating expenses before other items	**(63,140)**	(177,888)
Net realized and changes in net unrealized gains and losses on marketable and other securities	**(87,738)**	32,731
Malpractice insurance program adjustments	**(6,525)**	144
Net periodic pension and other postretirement benefit costs (non-service related)	**(5,111)**	(7,687)
Other nonoperating gains and losses, net	**(5,987)**	(40,910)
Deficiency of revenues over expenses	**(168,501)**	(193,610)
Transfer of CMO The Care Management Company, LLC to Montefiore Consolidated Ventures, Inc. *(Note 1)*	**–**	(18,200)
Grants for the purchase of property, buildings and equipment	**10,116**	–
Transfers to members, net	**(75,000)**	(86,000)
Decrease in net assets without donor restrictions	**$ (233,385)**	$ (297,810)

See accompanying notes.

Montefiore Medical Center

Consolidated Statements of Changes in Net Assets

Unaudited Nine Months Ended September 30, 2022 and 2021

	Without Donor Restrictions	With Donor Restrictions	Total Net Assets
		(In Thousands)	
Net assets at January 1, 2021	$ 495,229	$ 111,895	$ 607,124
Decrease in net assets without donor restrictions	(297,810)	–	(297,810)
Restricted gifts, bequests, and similar items	–	3,586	3,586
Restricted investment income	–	536	536
Net assets released from restrictions	–	(2,254)	(2,254)
Total changes in net assets	(297,810)	1,868	(295,942)
Net assets at September 30, 2021	$ 197,419	$ 113,763	$ 311,182
Net assets at January 1, 2022	**$ 61,155**	**$ 111,722**	**$ 172,877**
Decrease in net assets without donor restrictions	**(233,385)**	**–**	**(233,385)**
Restricted gifts, bequests, and similar items	**–**	**1,019**	**1,019**
Restricted investment income	**–**	**(2,924)**	**(2,924)**
Net assets released from restrictions	**–**	**(2,281)**	**(2,281)**
Total changes in net assets	**(233,385)**	**(4,186)**	**(237,571)**
Net (deficiency) assets at September 30, 2022	**$ (172,230)**	**$ 107,536**	**$ (64,694)**

See accompanying notes.

Montefiore Medical Center

Consolidated Statements of Cash Flows

	Unaudited Nine Months Ended September 30, 2022	2021
	(In Thousands)	
Operating activities		
Decrease in net assets	**$ (237,571)**	$ (295,942)
Adjustments to reconcile decrease in net assets to net cash used in operating activities:		
Depreciation and amortization	**116,773**	121,968
Transfers to members, net	**75,000**	86,000
Transfer of CMO The Care Management Company, LLC to Montefiore Consolidated Ventures, Inc.	**–**	18,200
Net realized gains and losses on marketable and other securities	**(21,227)**	(2,198)
Change in net unrealized gains and losses on marketable and other securities	**108,965**	(30,533)
Equity earnings from investments	**(9,942)**	(37,320)
Amortization of long-term mortgage premium and debt discount	**(3,046)**	(2,913)
Amortization of deferred financing costs	**1,139**	1,120
Changes in operating assets and liabilities:		
Receivables for patient care	**31,830**	(92,308)
Other receivables	**(49,348)**	21,278
Accounts payable and accrued expenses	**(8,686)**	(39,302)
Accrued salaries, wages and related items	**86,568**	65,181
Estimated third-party payer liabilities	**(136,900)**	(31,558)
Net change in all other operating assets and liabilities	**(85,079)**	(63,984)
Net cash used in operating activities	**(131,524)**	(282,311)
Investing activities		
Acquisition of property, buildings and equipment, net	**(65,424)**	(22,540)
Funding of self-insurance trust	**(36,888)**	(31,261)
Payments from Montefiore Health System, Inc. on MHS Note	**12,915**	4,791
Decrease in marketable and other securities, net	**112,401**	157,468
Decrease in assets limited to use, net	**15,540**	102,407
Net cash provided by investing activities	**38,544**	210,865
Financing activities		
Payments of long-term debt and finance lease obligations	**(22,069)**	(15,437)
Loans and payments to members, net	**(75,737)**	(179,231)
Net cash used in financing activities	**(97,806)**	(194,668)
Net decrease in cash, cash equivalents and restricted cash	**(190,786)**	(266,114)
Cash, cash equivalents and restricted cash at beginning of year	**437,925**	840,603
Cash, cash equivalents and restricted cash at end of period	$ **247,139**	$ 574,489
Reconciliation of cash and cash equivalents at end of period to the consolidated statements of financial position:		
Cash and cash equivalents	**$ 113,858**	$ 70,917
Marketable and other securities and assets limited as to use: cash and cash equivalents	**133,281**	503,572
Total cash, cash equivalents and restricted cash	**$ 247,139**	$ 574,489
Supplemental cash flow and noncash information		
Finance lease obligations incurred	**$ –**	$ 98,564

See accompanying notes.

Montefiore Medical Center

Notes to Consolidated Financial Statements (Unaudited)

September 30, 2022

1. Organization

Montefiore Medical Center and its controlled organizations (collectively, the Medical Center) comprise an integrated health care delivery system. The majority of the facilities are located in the Bronx, New York. The Medical Center is incorporated under New York State Not-for-Profit Corporation law and provides health care and related services, primarily to residents of the Metropolitan New York area. The Medical Center is a not-for-profit membership organization whose sole member is Montefiore Health System, Inc. (MHS). In addition, MHS is the sole member of several other health care related entities (members). Montefiore Medicine Academic Health System, Inc. (MMAHS) is the sole member of MHS.

The Medical Center, together with its members, provides patient care, teaching, research, community services and care management. The Medical Center operates many community benefit programs, including wellness programs, community education programs and health screenings, as well as a variety of community support services, health professionals' education, school health programs and subsidized health services.

The accompanying consolidated financial statements include the accounts of the following tax-exempt and taxable organizations.

- Montefiore Medical Center
- MMC Corporation (MCORP)
- Mosholu Preservation Corporation (MPC)
- Montefiore Proton Acquisition, LLC (MPRO)
- MMC Residential Corp. I, Inc. (Housing I)
- Montefiore Hospital Housing Section II, Inc. (Housing II)
- Montefiore Hudson Valley Collaborative LLC (MHVC)
- Montefiore CERC Operations, Inc. (CERC)

All intercompany accounts and activities have been eliminated in consolidation.

On January 1, 2021, the Medical Center assigned and transferred all of its rights, title and interest in CMO The Care Management Company (CMO) to Montefiore Consolidated Ventures, Inc. (MCV), whose sole member is MHS. In accordance with Accounting Standards Codification Topic 805, *Business Combinations*, this transaction was accounted for as a net asset transfer between entities under common control, with no retrospective adjustment to the prior period consolidated financial statements. Accordingly, the activities of CMO are included in the consolidated statements of operations and changes in net assets through the date of transfer. The following table summarizes the assets, liabilities and net assets of CMO as of the date of transfer, January 1, 2021:

1. Organization (continued)

	January 1, 2021*
	(In Thousands)
Assets	
Cash and cash equivalents	**$ 2,060**
Receivables for patient, care, net	**1**
Other receivables	**2,345**
Other current assets	**563**
Due from members	**19,025**
Property, buildings and equipment, net	**3,254**
Total assets	**$ 27,248**
Liabilities	
Accounts payable and accrued expenses	**$ 4,133**
Accrued salaries, wages, and related items	**4,915**
Total liabilities	**9,048**
Net assets	
Net assets without donor restrictions	**18,200**
Total liabilities and net assets	**$ 27,248**

* Represents assets, liabilities and net assets transferred to MCV on January 1, 2021 and excluded from the consolidated statement of financial position as of December 31, 2021.

COVID-19 Pandemic and CARES Act Funding

On March 11, 2020, the World Health Organization designated the Coronavirus Disease 2019 (COVID-19) outbreak as a global pandemic. Federal, state and local government policies resulted in a substantial portion of the population to remain at home and forced the closure of certain businesses, which had an impact on the Medical Center's patient volumes and revenues for most services. Through executive order, effective March 25, 2020, a New York State Mandate was issued to suspend all non-essential medical and surgical procedures and suspended elective procedures, which resumed at different dates across the Medical Center during the year ended December 31, 2020. During this time, the Medical Center also experienced significant price increases in, and utilization of, medical supplies, particularly personal protective equipment, as global supply lines were disrupted by the pandemic. The Medical Center's volume and operations were impacted to varying degrees throughout 2021, particularly as the pandemic entered waves two and three in early 2021 and in late 2021, respectively.

In response to COVID-19, the Coronavirus Aid, Relief and Economic Security Act (the CARES Act) was signed into law on March 27, 2020. The CARES Act authorized funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (Relief Fund). Payments from the Relief Fund are to be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the recipient for health care related expenses and/or lost revenues attributable to coronavirus and are not required to be repaid except where Relief Funds received exceed the actual amounts of eligible health care related expenses and/or lost revenues as defined by the U.S. Department of Health and Human Services

1. Organization (continued)

(HHS), provided the recipients attest to and comply with the terms and conditions. HHS has issued several Post-Payment Notices of Reporting Requirements and published responses to frequently asked questions (FAQs) regarding the Relief Fund distributions.

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. CAA appropriated additional funding for COVID-19 response and relief through the Relief Fund to reimburse health care entities for health care-related expenses or lost revenues attributable to COVID-19. CAA also provided several changes to the administration of the Relief Fund. For any payment, including both general and targeted distributions, received by an eligible health care provider that is a subsidiary of a parent organization, the parent organization may allocate all or any portion of the distribution amongst any other eligible subsidiaries. The CAA also clarified the methods available to calculate lost revenues.

HHS distributions from the Relief Fund included general distributions and targeted distributions, to support hospitals in high impact areas and rural providers, for service periods through December 31, 2022. Additionally, funds are available to reimburse providers for COVID-19 related treatment of uninsured patients. For the nine months ended September 30, 2021, the Medical Center recognized approximately $30.8 million of the funding received which is included in grants and contracts in the accompanying consolidated statement of operations. No amounts were recognized for the nine months ended September 30, 2022.

The recognized revenue has been determined based on applicable accounting guidance, the most recent Post-Payment Notice of Reporting Requirements and FAQs that the Medical Center has interpreted as being applicable to the accompanying consolidated financial statements. Management continues to monitor compliance with the terms and conditions of the Provider Relief Fund. If unable to attest to or comply with the current or future terms and conditions, the Medical Center's ability to retain some or all of the distributions received may be impacted. Management will continue to monitor communications from HHS applicable to the Relief Fund distributions.

To enhance liquidity, the Medical Center is a participant in the Centers for Medicare and Medicaid Services' (CMS) Accelerated and Advance Payment Program, designed to increase cash flow to Medicare providers and suppliers impacted by COVID-19. This program allowed eligible health care facilities to request up to six months of advance Medicare payments for acute care hospitals or up to three months of advance Medicare payments for other health care providers. During April 2020, the Medical Center received approximately $278.7 million of expedited payment for future services. The advances are subject to recoupment through the provision of Medicare services beginning 12 months after receipt of funding under the following methodology: 25% of services provided within the first 11 months, 50% during the succeeding 6 months with any remaining balance to be paid within 29 months from the date of the initial payment. Recoupments of the advanced payments began in April 2021, in accordance with the terms and conditions of the program, and the advances were fully repaid as of September 30, 2022. Approximately $160.9 million is included as a contract liability in estimated third-party payer liabilities, current portion in the consolidated statements of financial position at December 31, 2021.

Under the CARES Act, the Medical Center elected to defer payment of approximately $75.4 million of the employer portion of social security taxes in 2020. The CARES Act required that 50% of the total deferred

1. Organization (continued)

amount be paid by December 31, 2021, with the remaining balance due by December 31, 2022. Approximately $37.7 million was repaid in 2021. The remaining balance of approximately $37.7 million is due by December 31, 2022. The amount expected to be paid in 2022 is recorded within accrued salaries, wages and related items in the consolidated statements of financial position.

The Medical Center also applied for reimbursement for qualifying expenses under the Federal Emergency Management Agency (FEMA) Disaster Relief Fund. In 2020 and 2021, the Medical Center submitted project worksheets totaling approximately $107.5 million under FEMA's expedited claim submission process and streamlined submission process. For the nine months ended September 30, 2022 and 2021, the Medical Center recognized approximately $55.9 million and $26.0 million, respectively, of FEMA reimbursements. Approximately $45.8 million and $26.0 million is included in grants and contracts in the consolidated statements of operations for the nine months ended September 30, 2022 and 2021, respectively. Approximately $10.1 million of FEMA reimbursements for capital acquisitions is included in grants for the purchase of property, buildings and equipment in the consolidated statement of operations for the nine months ended September 30, 2022. The Medical Center will continue to finalize the project worksheets previously submitted to FEMA and intends to submit additional applications for funding the costs related to COVID-19; however, the ultimate amount that the Medical Center may be reimbursed is uncertain.

The Medical Center is also eligible to receive an Employee Retention Credit under the CARES Act, which is a credit against the employer portion of Social Security taxes for certain wages between March 13, 2020 and December 31, 2020. The CAA extended the employee retention credit through September 30, 2021, while also modifying the provisions of the credit. In February 2022, the Medical Center finalized its application for the employee retention credit and recognized approximately $51.8 million, which is included in grants and contracts in the accompanying consolidated statement of operations.

Due to the evolving nature of the COVID-19 pandemic, the ultimate impact to the Medical Center and its financial condition is presently unknown.

Operating and Liquidity Considerations

Pursuant to its debt agreements, the Medical Center is required to comply with certain financial covenants. At December 31, 2021, the Medical Center was in compliance with the applicable financial covenants of its debt agreements, except for the requirement in the Medical Center's Master Trust Indenture (MTI) which requires it to maintain a Debt Service Coverage Ratio (DSCR) of not less than 1.10:1.00. The MTI provides that if the DSCR is not met, the Medical Center is required to retain an independent consultant to make recommendations to increase the DSCR in the following fiscal year to the level required or, if in the opinion of the independent consultant the attainment of such level is impracticable, to the highest level attainable. The MTI requires that the Medical Center provide a copy of the independent consultant's recommendations to the Master Trustee within 20 days of the receipt of such recommendations. If the Medical Center complies with the independent consultant provisions of the MTI, the failure to maintain the DSCR at the required level is not an event of default under the MTI, unless the DSCR for any two consecutive fiscal years is less than 1.00:1.00. The Medical Center retained an independent consultant and has provided a copy of the independent consultant's report to the Master Trustee. As the Medical Center has complied with the consultant provisions of the MTI, the long-term debt has been classified based on scheduled maturities in

1. Organization (continued)

the accompanying consolidated statements of financial position at September 30, 2022 and December 31, 2021. If the Medical Center does not maintain a DSCR of at least 1.00:1.00 for the year ended December 31, 2022, all debt outstanding under the MTI at that time could be declared due and payable. This could trigger cross default provisions in other agreements.

The Medical Center expects to meet the DSCR requirement for the year ended December 31, 2022 through both revenue generating and operating cost containment initiatives; along with Medicaid rate enhancements received by the New York State Department of Health (NYSDOH). The Medical Center continues to have ongoing discussions with the NYSDOH and other governmental agencies related to the availability of additional rate enhancements and other grant funding. In addition, and as noted above, the Medical Center is applying for reimbursement for qualifying expenses related to COVID-19 under the FEMA Disaster Relief Fund and finalized its Employee Retention Credit application in 2022.

Performance Indicator

The consolidated statements of operations include deficiency of revenues over expenses as the performance indicator. Items excluded from deficiency of revenues over expenses are transfer of CMO The Care Management Company, LLC to Montefiore Consolidated Ventures, Inc., grants for the purchase of property, buildings and equipment and transfers to members, net.

Transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenue and operating expenses and are included in deficiency of operating revenue over operating expenses before other items. Peripheral transactions or transactions of an infrequent nature are excluded from deficiency of operating revenue over expenses before other items.

Interim Financial Statements

The Medical Center presumes that users of this unaudited consolidated financial information have read or have access to the Medical Center's audited consolidated financial statements which include certain disclosures required by U.S. generally accepted accounting principles. The audited consolidated financial statements of the Medical Center for the years ended December 31, 2021 and 2020 are on file with the Municipal Securities Rulemaking Board and are accessible through its Electronic Municipal Market Access Database. Accordingly, footnotes and other disclosures that would substantially duplicate the disclosures contained in the Medical Center's most recent audited consolidated financial statements have been omitted from the unaudited consolidated financial information. In the opinion of management, all material adjustments considered necessary for a fair presentation have been included.

Health care operations and the financial results thereof are subject to seasonal variations. Quarterly and other periodic operating results are not necessarily representative of operations for a full year for various reasons including patient volumes associated with seasonal illnesses, elective services, variations in interest rates, infrequent or one-time events and changes in regulatory or industry policies.

Use of Estimates

The preparation of the consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported

1. Organization (continued)

amounts of assets and liabilities, as well as the disclosure of contingent assets and liabilities, at the date of the consolidated financial statements. Estimates also affect the amounts of revenue and expenses reported during the period. Actual results could differ from those estimates. Net changes in estimates were not significant in 2022 or 2021.

Recently Adopted Accounting Pronouncements

In January 2017, the FASB issued ASU 2017-04, *Intangibles-Goodwill and Other* (ASU 2017-04). ASU 2017-04 will simplify the accounting for goodwill impairment and will remove Step 2 of the current goodwill impairment test, which requires a hypothetical purchase price allocation. Under ASU 2017-04, a goodwill impairment charge will now be recognized for the amount by which the carrying value of a reporting unit exceeds its fair value, not to exceed the carrying amount of goodwill. The adoption of ASU 2017-04 did not have a material impact on the consolidated financial statements.

Recent Accounting Pronouncements Not Yet Adopted:

In September 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* (ASU 2016-13). The new credit losses standard changes the impairment model for most financial assets and certain other instruments. For trade and other receivables, contract assets recognized as a result of applying Accounting Standards Codification (ASC) 606, loans and certain other instruments, entities will be required to use a new forward looking "expected loss" model that generally will result in earlier recognition of credit losses than under today's incurred loss model. ASU 2016-13 is effective for annual periods beginning after December 15, 2022. The Medical Center has not completed the process of evaluating the impact of ASU 2016-13 on its consolidated financial statements.

Reclassifications

For purposes of comparison, certain reclassifications have been made to the accompanying 2021 consolidated financial statements to conform to the 2022 presentation. These reclassifications have no effect on the deficiency of revenues over expenses or net assets for the nine months ended September 30, 2021.

Subsequent Events

The Medical Center evaluated subsequent events through November 28, 2022, which is the date the unaudited consolidated financial statements were issued, for potential recognition or disclosure in the accompanying consolidated financial statements for the nine months ended September 30, 2022. No subsequent events have occurred that require disclosure in the consolidated financial statements.

2. Net Patient Service Revenue

Net patient service revenue is reported at the amount that reflects the consideration to which the Medical Center expects to be entitled in exchange for providing patient care.

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

The Medical Center's initial estimate of the transaction price for services provided to patients subject to revenue recognition is determined by reducing the total standard charges related to the patient services provided by various elements of variable consideration, including contractual adjustments, discounts, implicit price concessions, and other reductions to the Medical Center's standard charges. The Medical Center determines the transaction price associated with services provided to patients who have third-party payer coverage on the basis of contractual or formula-driven rates for the services rendered (see description of third-party payer payment programs below). The estimates for contractual allowances and discounts are based on contractual agreements, the Medical Center's discount policies and historical experience. For uninsured and under-insured patients who do not qualify for charity care, the Medical Center determines the transaction price associated with services on the basis of charges reduced by implicit price concessions. Implicit price concessions included in the estimate of the transaction price are based on the Medical Center's historical collection experience for applicable patient portfolios. Under the Medical Center's charity care policy, a patient who has no insurance or is under-insured and is ineligible for any government assistance program has his or her bill reduced to (1) the lesser of charges or the Medicaid diagnostic-related group for inpatient and (2) a discount from Medicaid fee-for-service rates for outpatient. Patients who meet the Medical Center's criteria for free care are provided care without charge; such amounts are not reported as revenue.

Generally, the Medical Center bills patients and third-party payers several days after the services are performed and/or the patient is discharged. Net patient service revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by the Medical Center. Net patient service revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total charges. The Medical Center believes that this method provides a reasonable depiction of the transfer of services over the term of the performance obligations based on the services needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services or patients receiving services in the Medical Center's outpatient and ambulatory care centers or in their homes (home care). The Medical Center measures the performance obligation from admission into the hospital or the commencement of an outpatient service to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or the completion of the outpatient visit.

2. Net Patient Service Revenue (continued)

As substantially all of its performance obligations relate to contracts with a duration of less than one year, the Medical Center has elected to apply the optional exemption provided in ASU 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09) 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 for patients who remain admitted at that time (in-house patients). The performance obligations for in-house patients are generally completed when the patients are discharged, which for the majority of the Medical Center's in-house patients occurs within days or weeks after the end of the reporting period.

Subsequent changes to the estimate of the transaction price (determined on a portfolio basis when applicable) are generally recorded as adjustments to patient service revenue in the period of the change. For the nine months ended September 30, 2022 and 2021, changes in the Medical Center's estimates of expected payments for performance obligations satisfied in prior years were not significant. Portfolio collection estimates are updated based on collection trends. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (determined on a portfolio basis when applicable) are recorded as bad debt expense. Bad debt expense for the nine months ended September 30, 2022 and 2021 was not significant.

The Medical Center has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the following factors: payers, lines of business and timing of when revenue is recognized. Tables providing details of these factors are presented below.

Net patient service revenue by payer is as follows:

	Nine Months Ended September 30	
	2022	**2021**
	(In Thousands)	
Medicare and Medicare managed care	**$1,049,088**	$ 924,181
Medicaid and Medicaid managed care	**1,031,580**	788,030
Commercial carriers and managed care	**982,211**	1,109,130
Self-pay and other	**41,401**	28,527
	$3,104,280	$2,849,868

Deductibles, copayments and coinsurance under third-party payment programs which are the patient's responsibility are included within the self-pay and other category above.

2. Net Patient Service Revenue (continued)

Net patient service revenue by line of business is as follows:

	Nine Months Ended September 30	
	2022	**2021**
	(In Thousands)	
Inpatient services	**$ 1,696,654**	$ 1,624,709
Physician and other outpatient services	**1,144,511**	1,045,024
Premium revenue	**156,067**	85,343
Emergency department	**67,283**	63,198
All other	**39,765**	31,594
	$ 3,104,280	$ 2,849,868

The Medical Center has elected the practical expedient allowed under ASU 2014-09 and does not adjust the promised amount of consideration from patients and third-party payers for the effects of a significant financing component due to the Medical Center's expectation that the period of time between the service being provided and billing will be one year or less. However, the Medical Center does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Receivables for patient care, net is comprised of the following components:

	September 30 2022	**December 31 2021**
	(In Thousands)	
Patient receivables	**$ 188,905**	$ 252,591
Contract assets	**70,196**	38,340
	$ 259,101	$ 290,931

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

Settlements with third-party payers (see description of third-party payer payment programs below) for cost report filings and retroactive adjustments due to ongoing and future audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and the Medical Center's historical settlement activity (for example, cost report final settlements or repayments related to recovery audits), including an assessment to

2. Net Patient Service Revenue (continued)

ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Such estimates are determined through either a probability-weighted estimate or an estimate of the most likely amount, depending on the circumstances related to a given estimated settlement item. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in the transaction price were not significant for the nine months ended September 30, 2022 and 2021.

Third-Party Payment Programs

The Medical Center has agreements with third-party payers that provide for payment for services rendered at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare Reimbursement: Hospitals are paid for most Medicare patient services under national prospective payment systems and other methodologies of the Medicare program for certain other services. Federal regulations provide for adjustments to current and prior years' payment rates, based on industry-wide and hospital-specific data.

Non-Medicare Reimbursement: In New York State, hospitals and all non-Medicare payers, except Medicaid, workers' compensation and no-fault insurance programs, negotiate hospitals' payment rates. If negotiated rates are not established, payers are billed at hospitals' established charges. Medicaid, workers' compensation and no-fault payers pay hospital rates promulgated by the NYSDOH. Payments to hospitals for Medicaid, workers' compensation and no-fault inpatient services are based on a statewide prospective payment system, with retroactive adjustments.

Outpatient services also are paid based on a statewide prospective system. Medicaid rate methodologies are subject to approval at the Federal level by CMS, which may routinely request information about such methodologies prior to approval. Revenue related to specific rate components that have not been approved by CMS is not recognized until the Medical Center is reasonably assured that such amounts are realizable. Adjustments to the current and prior years' payment rates for those payers will continue to be made in future years.

Other Third-Party Payers: The Medical Center also has entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Medical Center under these agreements includes prospectively determined rates per discharge or days of hospitalization and discounts from established charges.

Medicare cost reports, which serve as the basis for final settlement with the Medicare program, have been audited by the Medicare fiscal intermediary and settled through December 31, 2017, although revisions to final settlements or other retroactive changes could be made. Other years and various issues remain open for audit and settlement, as are numerous issues related to the New York State Medicaid program for prior years.

2. Net Patient Service Revenue (continued)

As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount when open years are settled, audits are completed and additional information is obtained.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Medical Center's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Medical Center. The Medical Center is not aware of any allegations of non-compliance that could have a material adverse effect on the accompanying consolidated financial statements and believes that it is in compliance with all applicable laws and regulations. In addition, certain contracts the Medical Center has with commercial payers also provide for retroactive audit and review of claims.

There are various proposals at the federal and state levels that could, among other things, significantly change payment rates or modify payment methods. The ultimate outcome of these proposals and other market changes, including the potential effects of or revisions to health care reform that has been or will be enacted by the federal and state governments, cannot be determined presently. Future changes in the Medicare and Medicaid programs and any reduction of funding could have an adverse impact on the Medical Center. Additionally, certain payers' payment rates for various years have been appealed by the Medical Center. If the appeals are successful, additional income applicable to those years could be realized.

3. Benefit Plans

The Medical Center is a contributing employer to two union multiemployer pension plans. In addition, the Medical Center also maintains two tax deferred annuity plans under Section 403(b) of the Internal Revenue Code as well as two noncontributory defined benefit pension plans. The Medical Center also sponsors two unfunded defined benefit postretirement health and welfare plans that cover certain full-time and part-time employees and eligible dependents.

Contributions to union multiemployer pension plans are made in accordance with contractual agreements under which contributions are based on a percentage of salaries or a negotiated amount. Contributions to the non-contributory tax deferred annuity plan are based on percentages of salary. Contributions to the noncontributory defined benefit plans are based on actuarial valuations. Benefits under the noncontributory defined benefit plans are based on years of service and salary levels. The Medical Center's policy is to contribute amounts sufficient to meet funding requirements in accordance with the Employee Retirement Income Security Act of 1974 and the Pension Protection Act of 2006.

3. Benefit Plans (continued)

Total expense, included in the accompanying consolidated statements of operations for the various pension plans, aggregated approximately $121.2 million and $129.0 million for the nine months ended September 30, 2022 and 2021, respectively. Cash payments relative to the various pension plans aggregated approximately $121.6 million and $135.0 million for the nine months ended September 30, 2022 and 2021, respectively.

The following table provides the components of the net periodic benefit cost for the defined benefit pension plans and postretirement benefit plan for the nine months ended September 30, 2022 and 2021:

	Pension		Postretirement	
	2022	**2021**	**2022**	**2021**
	(In Thousands)			
Service cost	**$ 3,290**	$ 3,365	**$ 9,736**	$ 10,732
Interest cost	**462**	458	**5,003**	4,753
Expected return on plan assets	**(983)**	(802)	–	–
Amortization of prior service cost (benefit)	–	–	–	–
Amortization of net loss	**569**	655	–	2,085
Settlement cost	**60**	538	–	–
Net periodic benefit cost	**$ 3,398**	$ 4,214	**$ 14,739**	$ 17,570

4. Leases

The Medical Center determines if an arrangement is a lease at inception. The Medical Center utilizes operating and finance leases for the use of certain hospitals, medical and administrative offices, medical and office equipment and automobiles. For leases with terms greater than 12 months, the Medical Center records the related right-of-use assets and right-of-use obligations at the present value of lease payments over the term. Leases with an initial term of 12 months or less are not recorded in the consolidated statements of financial position. Lease expense for operating leases is recognized on a straight-line basis over the lease term and included in supplies and other expenses in the consolidated statements of operations while the expense for finance leases is recognized as depreciation and amortization expense and interest expense in the consolidated statements of operations.

The lease terms used to calculate the right-of-use asset and related lease liability include options to extend or terminate the lease when it is reasonably certain that the Medical Center will exercise that option. The Medical Center does not separate lease and nonlease components of contracts.

4. Leases (continued)

The following table presents the Medical Center's lease-related assets and liabilities at September 30, 2022 and December 31, 2021 (in thousands):

	Statement of Financial Position Classification	September 30 2022	December 31 2021
Assets:			
Operating leases	Right-of-use assets – operating leases	**$ 330,176**	$ 361,140
Finance leases	Property, buildings and equipment, net	**317,775**	331,396
Total lease assets		**$ 647,951**	$ 692,536
Liabilities:			
Current:			
Operating leases	Operating lease liabilities, current portion	**$ 37,870**	$ 36,620
Finance leases	Finance lease liabilities, current portion	**17,241**	16,475
Noncurrent:			
Operating leases	Operating lease liabilities, net of current portion	**303,342**	335,237
Finance leases	Finance lease liabilities, net of current portion	**324,028**	334,198
Total lease liabilities		**$ 682,481**	$ 722,530

The weighted-average lease terms and discount rates for operating and finance leases are presented in the following table:

	September 30 2022	December 31 2021
Weighted-average remaining lease term (years)		
Operating leases	**9.2**	10.3
Finance leases[(1)]	**47.0**	47.5
Weighted-average discount rate		
Operating leases	**2.6%**	2.6%
Finance leases	**2.9%**	2.9%

(1) Includes a lease agreement that extends through 2114. Excluding this lease agreement, the weighted-average remaining lease term of all other leases is 12.9 years at September 30, 2022 and 13.5 years at December 31, 2021.

4. Leases (continued)

The following table presents certain information related to lease expense for finance and operating leases:

	Nine Months Ended September 30	
	2022	**2021**
Finance lease expense:	*(In Thousands)*	
Amortization of right-of-use assets	**$ 13,621**	$ 8,299
Interest on finance lease liabilities	**7,543**	6,987
Operating lease cost	**43,816**	39,300
Variable and short-term lease expense	**3,246**	2,719
Total lease expense	**$ 68,226**	$ 57,305

The following table presents cash flow information for finance and operating leases:

	Nine Months Ended September 30	
	2022	**2021**
Cash paid for amounts included in the measurement of lease liabilities	*(In Thousands)*	
Operating cash flows for operating leases	**$ 37,268**	$ 36,547
Operating cash flows for finance leases	**7,543**	6,987
Financing cash flows for finance leases	**13,159**	10,435

Future minimum lease payments under non-cancellable leases as of September 30, 2022 are as follows (in thousands):

	Operating Leases	**Finance Leases**
2022 (excluding the nine months ended September 30, 2022)	$ 12,104	$ 5,721
2023	46,219	22,085
2024	44,943	22,305
2025	42,084	21,898
2026	41,208	21,721
2027 and thereafter	198,976	872,577
Total lease payments	385,534	966,307
Less imputed interest	(44,322)	(625,038)
Present value of lease payments	$ 341,212	$ 341,269

5. Commitments and Contingencies

Litigation: Claims have been asserted against the Medical Center by various claimants arising out of the normal course of its operations. The claims are in various stages of processing and some may ultimately be brought to trial. Also, there are known incidents occurring through September 30, 2022 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Medical Center management and counsel are unable to conclude about the ultimate outcome of the actions. However, it is the opinion of Medical Center management, based on prior experience that adequate insurance is maintained and adequate provisions for professional liabilities, where applicable, have been established to cover all significant losses and that the eventual liability, if any, will not have a material adverse effect on the Medical Center's consolidated financial position.

Self-Insured Professional and Other Insured Liabilities: The Medical Center utilizes Healthcare Risk Advisors (HRA), a service organization that provides third party comprehensive insurance and risk management advisory services. Primary liability coverage is provided to the Medical Center through Hospitals Insurance Company (HIC), a New York State admitted and licensed insurance company. Primary general liability is also through HIC, while the umbrella/excess liability coverage is purchased from multiple admitted insurance carriers through the commercial market.

Effective January 1, 2018, the Montefiore Medicine Academic Health System Self Insurance Trust (MMAHS Trust) was established to provide coverage in excess of HIC program limits. MMAHS is the sole member of the MMAHS Trust. Currently, only the Medical Center participates in the MMAHS Trust, which is irrevocable. Amounts funded by the Medical Center into the MMAHS Trust are based upon actuarially determined liabilities. The net amounts outstanding between the Medical Center's beneficial interest in the MMAHS Trust and total actuarially determined claims liabilities are required to be funded over a certain period of time in accordance with the respective MMAHS Trust agreement.

Albert Einstein College of Medicine (Einstein): In 2015, Einstein, a controlled member of MMAHS, acquired substantially all of the assets and assumed substantially all of the liabilities of a medical school operating as a division of Yeshiva University (YU). In connection with this transaction, $175.0 million Build NYC Resource Corporation Revenue Bonds were issued. The Build NYC Resource Corporation Revenue Bonds carry a 5.50% coupon rate and mature on September 1, 2045. Interest is payable semiannually and principal is payable annually commencing on September 1, 2020.

In addition, in 2015, Einstein issued to YU a promissory note (the Note) under which it was obligated to pay to YU twenty annual payments of $12.5 million beginning September 2017, followed by a final, twenty-first payment of $20.0 million in September 2037. Pursuant to a guaranty agreement (Guaranty Agreement), the Medical Center guaranteed Einstein's obligation to make payments under the Note. If the Medical Center was required to make payments under the Guaranty Agreement, Einstein would have been obligated to repay the Medical Center, in full, over five years with interest. The Medical Center's right to repayment was subordinate in certain respects to Einstein's obligation to make payments on the Build NYC Resource Corporation Revenue Bonds.

5. Commitments and Contingencies (continued)

In April 2017, the Note was cancelled and exchanged with three Replacement Negotiable Promissory Notes (the Replacement Notes) in the total principal amount of $162.2 million. The Replacement Notes carry interest rates ranging from 4.52% to 5.74%. The Guaranty Agreement was amended to cover payments made by Einstein under the Replacement Notes. No amounts were paid by the Medical Center on Einstein's behalf pursuant to the Guaranty Agreement during the nine months ended September 30, 2022 or 2021.

The Medical Center had an agreement to provide operating subsidies to Einstein over a five-year period commencing September 2015 in an aggregate amount of up to $80.0 million. The five-year period ended during 2019 and is extended on a month-to-month basis at the discretion of the Medical Center. In addition, in March 2018, the Medical Center entered into a commitment to provide financial support, including working capital and bridge financing, as necessary, to Einstein in order for Einstein to meet its operational needs. During the nine months ended September 30, 2022 and 2021, the Medical Center provided approximately $75.0 million and $76.0 million, respectively, to Einstein which was recorded within transfers to members, net in the consolidated statements of operations.

Other: At September 30, 2022 and December 31, 2021, approximately 64% of the Medical Center's employees were covered by collective bargaining agreements. The collective bargaining agreement with NYSNA expires in December 2022 and the collective bargaining agreement with 1199SEIU expires in September 2024.

In connection with agreements entered into between The Montefiore IPA, Inc., Hudson Valley IPA, Inc. and several health insurance companies, the Medical Center has agreed to guarantee the performance and payment of certain hospital, physician and administrative services.

In December 2018, the Medical Center entered into a mortgage loan agreement with White Plains Hospital Center (White Plains) to fund up to $248.5 million for a certain construction project (the Loan Agreement). Interest on the Loan Agreement is based on a fixed rate of 4.50%. Principal payments began August 1, 2021. Approximately $240.8 million and $245.8 million was outstanding under this agreement at September 30, 2022 and December 31, 2021, respectively.

In December 2020, the Medical Center entered into a term loan agreement with White Plains for approximately $36.6 million for certain real estate acquisitions. Interest on the term loan agreement is based on a fixed rate of 3.25% and is payable through January 1, 2041. Approximately $34.4 million and $35.4 million was outstanding under this agreement at September 30, 2022 and December 31, 2021, respectively.

6. Fair Value Measurements

For assets and liabilities required to be measured at fair value, the Medical Center measures fair value based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are applied based on the unit of account from the Medical Center's perspective. The unit of account determines what is being measured by reference to the level at which the asset or liability is aggregated (or disaggregated) for purposes of applying other accounting pronouncements.

The Medical Center follows a valuation hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels, which are described below:

Level 1: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets or liabilities

Level 2: Observable inputs that are based on inputs not quoted in active markets, but corroborated by market data.

Level 3: Unobservable inputs are used when little or no market data is available.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Medical Center uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

6. Fair Value Measurements (continued)

Financial assets carried at fair value, including assets invested in the Medical Center's defined benefit plan, are classified in the table below in one of the three categories described above as of September 30, 2022:

	September 30, 2022			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	**$ 113,858**	**$ –**	**$ –**	**$ 113,858**
Managed cash and cash equivalents held for investment	**133,281**	**–**	**–**	**133,281**
Marketable and other securities:				
U.S. non-equity mutual funds	**39,781**	**–**	**–**	**39,781**
U.S. equity mutual funds	**54,268**	**–**	**–**	**54,268**
U.S. Government agency mortgage-backed securities	**–**	**57,149**	**–**	**57,149**
U.S. Treasury securities	**81,943**	**–**	**–**	**81,943**
U.S. Government agency-backed securities	**–**	**88,737**	**–**	**88,737**
U.S. equity securities	**27,840**	**–**	**–**	**27,840**
Corporate debt	**–**	**763,433**	**–**	**763,433**
	450,971	**909,319**	**–**	**1,360,290**
Defined benefit plan assets				
Cash and cash equivalents	**1,010**	**–**	**–**	**1,010**
Equity mutual funds	**8,074**	**–**	**–**	**8,074**
Fixed income mutual funds	**1,400**	**–**	**–**	**1,400**
	10,484	**–**	**–**	**10,484**
	$ 461,455	**$ 909,319**	**$ –**	**1,370,774**
Investments measured at net asset value (defined benefit pension plan assets)				**6,671**
				$ 1,377,445

6. Fair Value Measurements (continued)

Financial assets carried at fair value, including assets invested in the Medical Center's defined benefit plan, are classified in the table below in one of the three categories described above as of December 31, 2021:

	December 31, 2021			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	$ 36,113	$ –	$ –	$ 36,113
Managed cash and cash equivalents held for investment	401,812	–	–	401,812
Marketable and other securities:				
U.S. non-equity mutual funds	44,630	–	–	44,630
U.S. equity mutual funds	69,441	–	–	69,441
U.S. Government agency mortgage-backed securities	–	40,497	–	40,497
U.S. Treasury securities	44,988	–	–	44,988
U.S. Government agency-backed securities	–	54,788	–	54,788
U.S. equity securities	53,726	–	–	53,726
Corporate debt	–	994,646	–	994,646
	650,710	1,089,931	–	1,740,641
Defined benefit plan assets				
Cash and cash equivalents	1,029	–	–	1,029
Equity mutual funds	12,879	–	–	12,879
Fixed income mutual funds	1,662	–	–	1,662
	15,570	–	–	15,570
	$ 666,280	$ 1,089,931	$ –	1,756,211
Investments measured at net asset value (defined benefit pension plan assets)				7,899
				$ 1,764,110

At September 30, 2022 and December 31, 2021, the Medical Center's alternative investments and collective trust funds, excluding those within the defined benefit plan, are reported using the equity method of accounting in the amount of approximately $212.9 million and $239.0 million, respectively, and, therefore, are not included in the tables above.

The following is a description of the Medical Center's valuation methodologies for assets measured at fair value. Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets.

6. Fair Value Measurements (continued)

Inputs are obtained from various sources, including market participants, dealers and brokers. The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Medical Center 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 estimate of fair value at the reporting date.

DISCLOSURE REPORT
DATED NOVEMBER 28, 2022
MONTEFIORE MEDICAL CENTER
FOR THE NINE MONTHS ENDED
SEPTEMBER 30, 2022

Table of Contents

Introduction

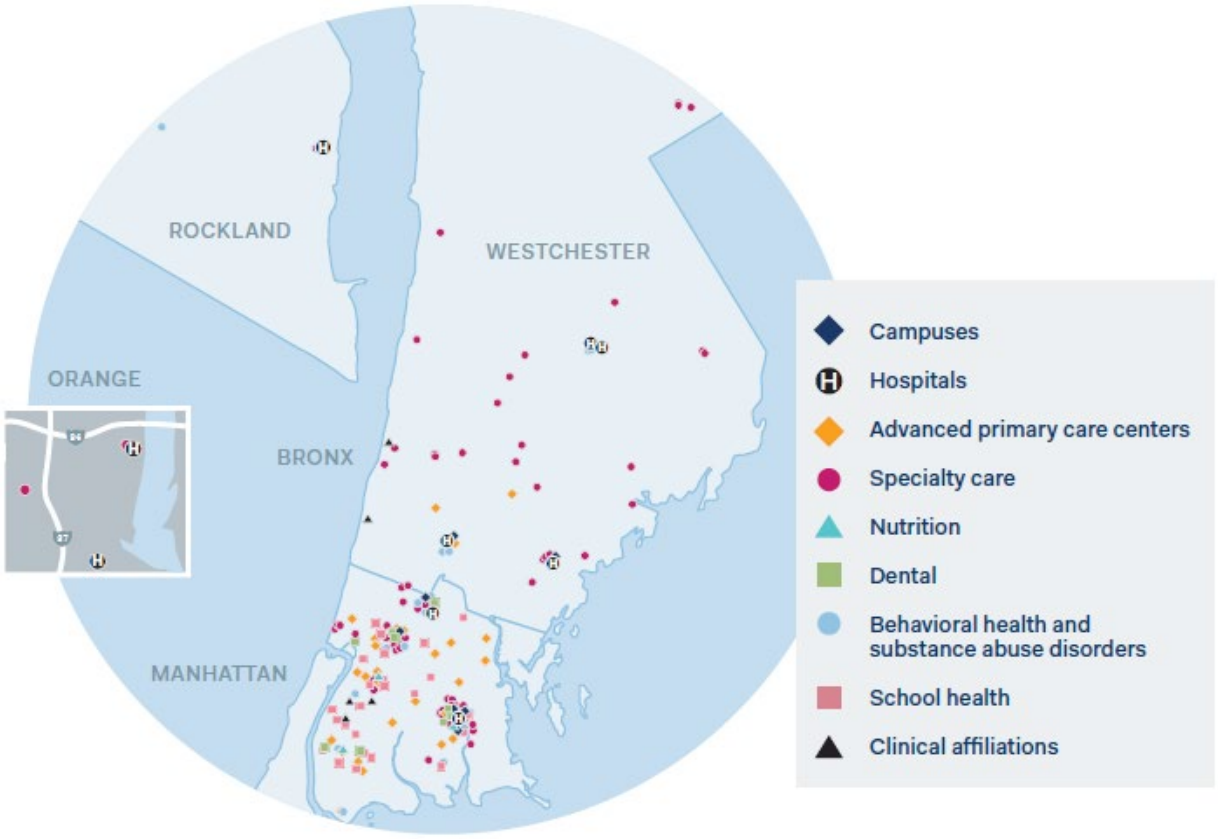
Certain statements included in this report on Management's Discussion and Analysis that relate to Montefiore Medical Center, Montefiore Health System, Montefiore Medicine Academic Health System and other System entities may include certain forward-looking statements that are based on the beliefs of, and assumptions made by, the management of the Obligated Group. Such forward-looking statements involve known and unknown risks, uncertainties and other factors which may cause the actual results or performance of the Obligated Group to be materially different from any expected future results or performance and management of the Obligated Group undertakes no obligation to update these statements.

Certain financial information and utilization data set forth herein with respect to past periods may differ from what the Obligated Group Members have previously reported in earlier disclosure documents. This is generally due to changes in accounting standards and related guidance, or the application of relevant accounting standards, that require a reclassification or restatement of certain items and to adjustments in utilization data that occur in the normal course of patient care or as services are billed and coded.

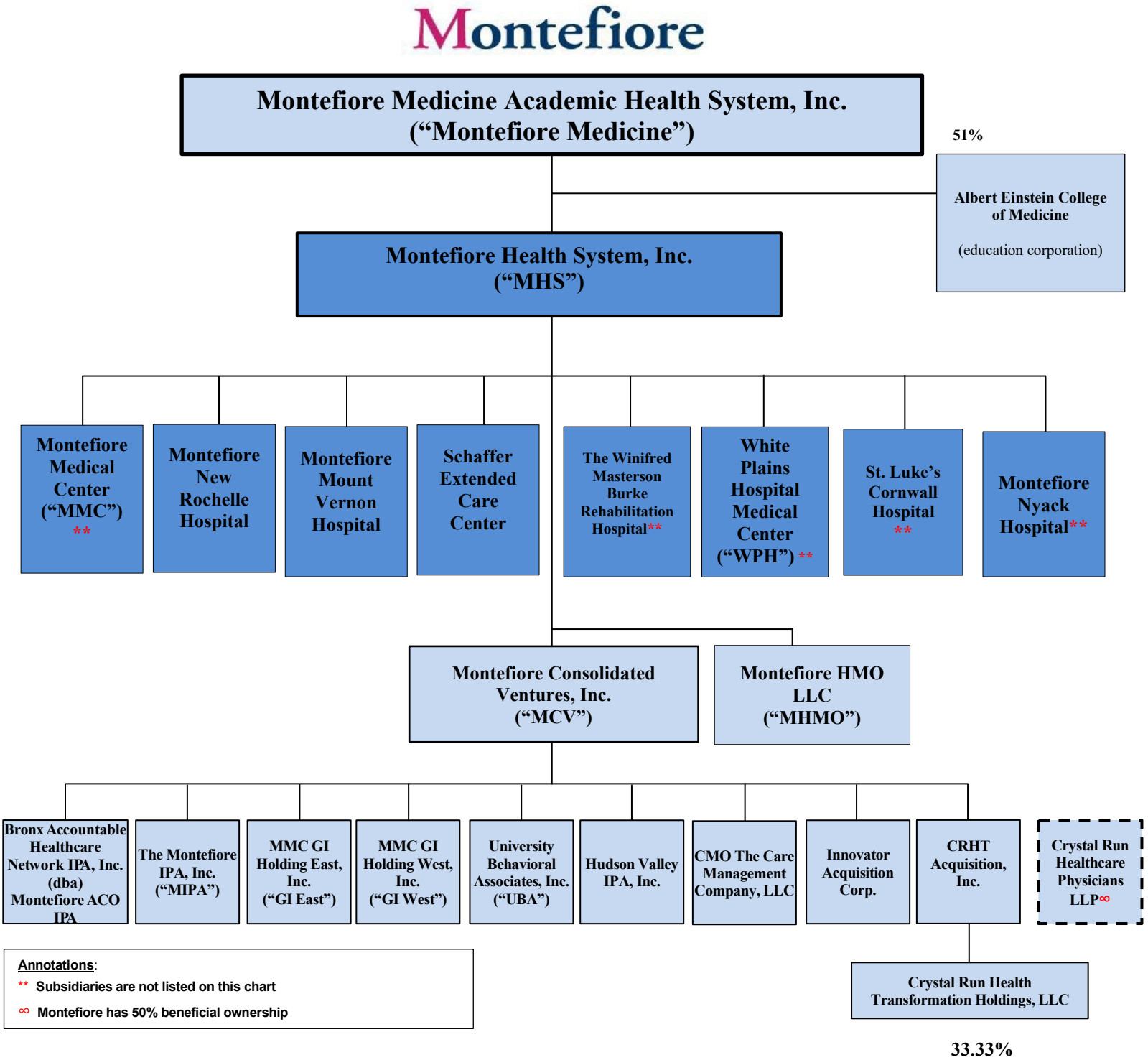
System Overview

Montefiore Medicine Academic Health System (Montefiore Medicine) is a New York not-for-profit corporation and a 501(c)(3) organization. It is the sole corporate member of Montefiore Health System and the Albert Einstein College of Medicine (the College).

Montefiore Health System has 10 hospital primary operating facilities in markets of the Bronx, Westchester, Rockland and Orange counties.



The organizational chart below shows Montefiore Medicine and certain of its controlled affiliates:



Montefiore Health System, Inc.

MHS is a New York not-for-profit corporation and a 501(c)(3) organization. It serves as the sole corporate member of Montefiore Medical Center and the other health care delivery entities within Montefiore Medicine. MHS has received establishment approval from the Public Health Council to participate in the governance and operations of the Medical Center and each of MHS's other hospital subsidiaries.

Montefiore Medical Center

Montefiore Medical Center (the Medical Center or MMC) is a voluntary, acute care teaching hospital with three inpatient facilities located in the Bronx, New York, with a total of 1,558 certified beds. MMC provides comprehensive primary, secondary, tertiary and quaternary healthcare services primarily to the residents of the Bronx. A New York not-for-profit corporation, the Medical Center is exempt from federal income tax pursuant to Section 501(a) of the Internal Revenue Code (the "Code") as an organization described in section 501(c)(3) of the Code.

The Medical Center is the flagship of the Montefiore Health System. For the nine months ended September 30, 2022, MHS and its consolidated subsidiaries, which includes all of the affiliated hospital corporations, recorded total operating revenue of approximately $5.2 billion. As of September 30, 2022, MHS had total assets of approximately $6.6 billion. Of these amounts, MMC represented 65.8% of the total operating revenue and 71.8% of total assets.

The Medical Center is currently the only member of the Obligated Group established pursuant to the Master Trust Indenture. Discussions within the MD&A focus primarily on the Montefiore Obligated Group unless where otherwise noted. The Medical Center operates three inpatient acute care facilities located on three campuses in Bronx County, New York, as well as numerous ambulatory care and outpatient facilities. MMC's secondary service area is composed of the New York counties of Westchester, Rockland and Orange. For tertiary and quaternary services, MMC's primary service area includes all four of these counties.

Bronx County had an estimated population of 1,479,199 in 2018 according to the U.S. Census Bureau and is expected to be one of the fastest growing counties in the State between 2017 and 2022.

No entity in the System other than MMC has any legal or contractual obligation with respect to the payment of the 2018 Obligations or 2020 Obligations or the Series 2018 Bonds or Series 2020 Bonds.

Utilization – Montefiore Medical Center

A summary of MMC's utilization data for the nine months ended September 30, 2022 and 2021 is presented in the following table:

Montefiore Medical Center
Utilization Statistics

	Nine Months Ended September 30,	
Utilization	**2022**	**2021**
Licensed beds	1,558	1,558
Discharges[(1)]	55,197	56,136
Patient days[(1)]	347,463	349,687
Average length of stay (days)[(1)]	6.3	6.2
Case mix index[(2)]	1.74	1.76
Average % occupancy[(1)]	81.7%	82.2%
Emergency room visits[(3)]	162,429	140,774
Ambulatory procedures	36,118	34,519
Montefiore Medical Group Primary Care visits	493,021	477,495
Home Care Visits	65,524	72,576
Faculty Practice Group Worked RVUs[(4)]	4,713,944	4,461,458

(1) Excludes normal newborns
(2) Case mix valued at the federal MS DRG grouper.
(3) Excludes patients seen in emergency department and admitted to the Medical Center.
(4) Relative value units (RVUs) are a measure of value used in Medicare reimbursement formula for physician services.

Management's Discussion and Analysis of Utilization

The outbreak of COVID-19 caused numerous wide-spread impacts on medical care providers and on economic activity. The 1st quarter of 2022 was significantly impacted by the Omicron wave experienced in January and February. Hospitalizations for COVID peaked in January and have declined in subsequent months. COVID related discharges represented 8% of discharges in both 2022 and 2021. Discharges overall remain below pre-pandemic levels.

Ambulatory volume increased as compared to the nine months ended September 30, 2021 in all significant categories.

Sources of Net Patient Service Revenue

Percent of Net Patient Service Revenue by Payor Source	Nine Months Ended September 30, 2022	2021
Medicaid and Medicaid Managed Care	33.2%	27.7%
Medicare and Medicare Managed Care	33.8%	32.4%
Commercial and Managed Care	31.7%	38.9%
Other	1.3%	1.0%
Total	100.0%	100.0%

The Medicaid increase observed in 2022 was offset by a decrease in Commercial. The increase in Medicaid is being driven by the Directed Payment Template Program (DPT) implemented by the New York State Department of Health during 2022. DPT revenue is a hospital-specific add-on to Medicaid Managed Care eligible claims. The above shows the dependence on commercial revenue even though the volume of governmental and governmental like payers is approximately 84% (includes Medicare Managed Care).

Management's Discussion and Analysis of Financial Performance

For the nine months ended September 30, 2022 compared to the nine months ended September 30, 2021

For the nine months ended September 30, 2022, the Medical Center had a deficiency of operating revenue over operating expenses of $63.1 million as compared to a deficiency of operating revenue over operating expenses of $177.9 million in the prior year, a decrease of $114.8 million. Operating revenue includes $97.6 million of employee retention credits and FEMA reimbursements in 2022, whereas 2021 includes $56.7 million of CARES Act funding and FEMA reimbursements.

Total operating revenue increased by $238.0 million, or 7.5% as compared to the prior year from $3,169.8 million to $3,407.8 million.

Net patient service revenue increased by $254.4 million, or 8.9% from $2,849.9 million to $3,104.3 million. Inpatient revenue increased 4.4% over the prior year, primarily due Medicaid rate enhancements along with contractual increases from managed care payors, as overall case-mix and total discharges both declined slightly. Outpatient revenue increased 9.8% driven by an increase in volume at the Faculty Practices, along with increases in Hospital based pharmacy revenue and ambulatory surgeries.

Other revenue decreased $16.4 million compared to the prior year primarily due to a decrease in equity earnings from the HRA captives offset by the FEMA reimbursement and employee retention credit recoded in 2022 compared to 2021, as noted above.

Total operating expenses increased by $123.3 million, or 3.7% as compared to the prior year from $3,347.7 million to $3,471.0 million. Salaries and wages increased $41.5 million or 2.7%. The increase was primarily due to merit increases offset by the impact of lower FTEs. Employee benefits increased $15.7 million or 3.2% in line with the increase in salaries. Benefits as a % of salaries increased from 32.1% to 32.3%. Supplies and other expenses increased $70.6 million or 6.2% due primarily to an increase in usage of contractual personnel in 2022 compared to 2021 (approximate $37 million increase), along with inflationary increases in supplies.

The deficiency of revenues over expenses was $168.5 million in 2022 compared to a deficiency of revenues over expenses of $193.6 million in 2021, a decrease of $25.1 million. Net realized and unrealized losses on investments were $87.7 million in 2022 compared to net realized and unrealized gains on investments of $32.7 million in 2021, a decrease of $120.5 million. This offset the improvement in the deficiency in operating revenue over operating expenses.

Transfers to members of the health system decreased by $29.2 million from 2021 to 2022. In 2021, transfers to members of the heath system included $18.2 million relating to the Medical Center transferring its ownership of the Care Management Company (the CMO) to another related MHS company.

COVID-19 Pandemic and CARES Act Funding

On March 11, 2020, the World Health Organization designated the Coronavirus Disease 2019 (COVID-19) outbreak as a global pandemic. Federal, state and local government policies resulted in a substantial portion of the population to remain at home and forced the closure of certain businesses, which had an impact on the Medical Center's patient volumes and revenues for most services. Through executive order, effective March 25, 2020, a New York State Mandate was issued to suspend all non-essential medical and surgical procedures and suspended elective procedures, which resumed at different dates across the Medical Center during the year ended December 31, 2020. During this time, the Medical Center also experienced significant price increases in, and utilization of, medical supplies, particularly personal protective equipment, as global supply lines were disrupted by the pandemic. The Medical Center's volume and operations were impacted to varying degrees throughout 2021, particularly as the pandemic entered waves two and three in early 2021 and in late 2021, respectively.

In response to COVID-19, the Coronavirus Aid, Relief and Economic Security Act (the CARES Act) was signed into law on March 27, 2020. The CARES Act authorized funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (Relief Fund). Payments from the Relief Fund are to be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the recipient for health care related expenses and/or lost revenues attributable to coronavirus and are not required to be repaid except where Relief Funds received exceed the actual amounts of eligible health care related expenses and/or lost revenues as defined by the U.S. Department of Health and Human Services (HHS), provided the recipients attest to and comply with the terms and conditions. HHS has issued several Post-Payment Notices of Reporting Requirements and published responses to frequently asked questions (FAQs) regarding the Relief Fund distributions

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. CAA appropriated additional funding for COVID-19 response and relief through the Relief Fund to reimburse health care entities for health care-related expenses or lost revenues attributable to COVID-19. CAA also provided several changes to the administration of the Relief Fund. For any payment, including both general and targeted distributions, received by an eligible health care provider that is a subsidiary of a parent organization, the parent organization may allocate all or any portion of the distribution amongst any other eligible subsidiaries. The CAA also clarified the methods available to calculate lost revenues.

HHS distributions from the Relief Fund included general distributions and targeted distributions, to support hospitals in high impact areas and rural providers, for service periods through December 31, 2022. Additionally, funds are available to reimburse providers for COVID-19 related treatment of uninsured patients. For the nine months ended September 30, 2021, the Medical Center recognized approximately $30.8 million of the funding received which is included in grants and contracts in the accompanying consolidated statement of operations. No amounts were recognized for the nine months ended September 30, 2022.

The recognized revenue has been determined based on applicable accounting guidance, the most recent Post-Payment Notice of Reporting Requirements and FAQs that the Medical Center has interpreted as being applicable to the accompanying consolidated financial statements. Management continues to monitor compliance with the terms and conditions of the Provider Relief Fund. If unable to attest to or comply with the current or future terms and conditions, the Medical Center's ability to retain some or all of the distributions received may be impacted. Management will continue to monitor communications from HHS applicable to the Relief Fund distributions.

To enhance liquidity, the Medical Center is a participant in the Centers for Medicare and Medicaid Services' (CMS) Accelerated and Advance Payment Program, designed to increase cash flow to Medicare providers and suppliers impacted by COVID-19. This program allowed eligible health care facilities to request up to six months of advance Medicare payments for acute care hospitals or up to three months of advance Medicare payments for other health care providers. During April 2020, the Medical Center received approximately $278.7 million of expedited payment for future services. The advances are subject to recoupment through the provision of Medicare services beginning 12 months after receipt of funding under the following methodology: 25% of services provided within the first 11 months, 50% during the succeeding 6 months with any remaining balance to be paid within 29 months from the date of the initial payment. Recoupments of the advanced payments began in April 2021, in accordance with the terms and conditions of the program, and the advances were fully repaid as of September 30, 2022. Approximately $160.9 million is included as a contract liability in estimated third-party payer liabilities, current portion in the consolidated statements of financial position at December 31, 2021.

Under the CARES Act, the Medical Center elected to defer payment of approximately $75.4 million of the employer portion of social security taxes in 2020. The CARES Act required that 50% of the total deferred amount be paid by December 31, 2021, with the remaining balance due by December 31, 2022. Approximately $37.7 million was repaid in 2021. The remaining balance of approximately $37.7 million is due by December 31, 2022. The amount expected to be paid in 2022 is recorded within accrued salaries, wages and related items in the consolidated statements of financial position.

The Medical Center also applied for reimbursement for qualifying expenses under the Federal Emergency Management Agency (FEMA) Disaster Relief Fund. In 2020 and 2021, the Medical Center submitted project worksheets totaling approximately $107.5 million under FEMA's expedited claim submission process and streamlined submission process. For the nine months ended September 30, 2022 and 2021, the Medical Center recognized approximately $55.9 million and $26.0 million, respectively, of FEMA reimbursements. Approximately $45.8 million and $26.0 million is included in grants and contracts in the consolidated statements of operations for the nine months ended September 30, 2022 and 2021, respectively. Approximately $10.1 million of FEMA reimbursements for capital acquisitions is included in grants for the purchase of property, buildings and equipment in the consolidated statement of operations for the nine months ended September 30, 2022. The Medical Center will continue to finalize the project worksheets previously submitted to FEMA and intends to submit additional applications for funding the costs related to COVID-19; however, the ultimate amount that the Medical Center may be reimbursed is uncertain.

The Medical Center is also eligible to receive an Employee Retention Credit under the CARES Act, which is a credit against the employer portion of Social Security taxes for certain wages between March 13, 2020 and December 31, 2020. The CAA extended the employee retention credit through June 30, 2021, while also modifying the provisions of the credit. In February 2022, the Medical Center finalized its application for the employee retention credit and recognized approximately $51.8 million, which is included in grants and contracts in the accompanying consolidated statement of operations.

Due to the evolving nature of the COVID-19 pandemic, the ultimate impact to the Medical Center and its financial condition is presently unknown.

Operating and Liquidity Considerations

Pursuant to its debt agreements, the Medical Center is required to comply with certain financial covenants. At December 31, 2021, the Medical Center was in compliance with the applicable financial covenants of its debt agreements, except for the requirement in the Medical Center's Master Trust Indenture (MTI) which requires it to maintain a Debt Service Coverage Ratio (DSCR) of not less than 1.10:1.00. The MTI provides that if the DSCR is not met, the Medical Center is required to retain an independent consultant to make recommendations to increase the DSCR in the following fiscal year to the level required or, if in the opinion of the independent consultant the attainment of such level is impracticable, to the highest level attainable. The MTI requires that the Medical Center provide a copy of the independent consultant's recommendations to the Master Trustee within 20 days of the receipt of such recommendations. If the Medical Center complies with the independent consultant provisions of the MTI, the failure to maintain the DSCR at the required level is not an event of default under the MTI, unless the DSCR for any two consecutive fiscal years is less than 1.00:1.00. The Medical Center retained an independent consultant and has provided a copy of the independent consultant's report to the Master Trustee. As the Medical Center has complied with the consultant provisions of the MTI, the long-term debt has been classified based on scheduled maturities in the accompanying consolidated statements of financial position at September 30, 2022 and December 31, 2021. If the Medical Center does not maintain a DSCR of at least 1.00:1.00 for the year ended December 31, 2022, all debt outstanding under the MTI at that time could be declared due and payable. This could trigger cross default provisions in other agreements.

The Medical Center expects to meet the DSCR requirement for the year ended December 31, 2022 through both revenue generating and operating cost containment initiatives; along with Medicaid rate enhancements received by the New York State Department of Health (NYSDOH). The Medical Center continues to have ongoing discussions with the NYSDOH and other governmental agencies related to the availability of additional rate enhancements and other grant funding. In addition, and as noted above, the Medical Center is applying for reimbursement for qualifying expenses related to COVID-19 under the FEMA Disaster Relief Fund and finalized its Employee Retention Credit application in 2022.

Other Discussions

Montefiore Transformation Initiatives

Montefiore has partnered with a national consulting firm to drive future transformation with targets of improving financial operations by $500 million per year throughout the health system. Driven by top-down executive leadership, planning focuses across key areas of the organization by targeting initiatives on multi-year initiatives on revenue growth and expense management, as well as at affiliates including AECOM. We have progressed on a significant number of initiatives tracking towards identified key performance indicators and metrics. We have incorporated $65 million in our 2022 budget related to transformation.

Montefiore Medical Center
Utilization Statistics

Utilization	Nine Months Ended September 30, 2022	2021
Licensed beds	1,558	1,558
Discharges[(1)]	55,197	56,136
Patient days[(1)]	347,463	349,687
Average length of stay (days)[(1)]	6.3	6.2
Case mix index[(2)]	1.74	1.76
Average % occupancy[(1)]	81.7%	82.2%
Emergency room visits[(3)]	162,429	140,774
Ambulatory procedures	36,118	34,519
Montefiore Medical Group Primary Care visits	493,021	477,495
Home Care Visits	65,524	72,576
Faculty Practice Group Worked RVUs[(4)]	4,713,944	4,461,458

(1) Excludes normal newborns
(2) Case mix valued at the federal MS DRG grouper.
(3) Excludes patients seen in emergency department and admitted to the Medical Center.
(4) Relative value units (RVUs) are a measure of value used in Medicare reimbursement formula for physician services.

Percent of Net Patient Service Revenue by Payor Source	Nine Months Ended September 30, 2022	2021
Medicaid and Medicaid Managed Care	33.2%	27.7%
Medicare and Medicare Managed Care	33.8%	32.4%
Commercial and Managed Care	31.7%	38.9%
Other	1.3%	1.0%
Total	100.0%	100.0%