Consolidated Financial Statements (Unaudited)

Montefiore Health System, Inc.

For the Three Months Ended March 31, 2023 and 2022

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Contents

Montefiore Health System, Inc.

Consolidated Statements of Financial Position

	Unaudited March 31, 2023	Audited December 31, 2022
	(In Thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 284,897**	$ 315,671
Marketable and other securities	**1,437,533**	1,434,183
Assets limited as to use, current portion	**40,777**	39,618
Receivables for patient care, net	**545,514**	562,317
Other receivables	**142,083**	129,919
Estimated insurance claims receivable, current portion	**87,466**	87,466
Other current assets	**126,835**	128,194
Total current assets	**2,665,105**	2,697,368
Assets limited as to use, net of current portion	**260,758**	251,408
Property, buildings and equipment, net	**2,450,193**	2,456,448
Right-of-use assets – operating leases	**500,195**	509,644
Estimated insurance claims receivable, net of current portion	**346,429**	346,429
Other noncurrent assets	**384,885**	412,117
Due from members	**100**	100
Total assets	**$ 6,607,665**	$ 6,673,514
Liabilities and net assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 596,211**	$ 664,283
Accrued salaries, wages and related items	**554,074**	479,796
Self-insured professional and other insured liabilities, current portion	**140,106**	155,475
Estimated insurance claims liabilities, current portion	**89,352**	89,352
Estimated third-party payer liabilities, current portion	**254,941**	294,244
Long-term debt, current portion	**59,699**	78,834
Finance lease liabilities, current portion	**18,736**	18,446
Operating lease liabilities, current portion	**54,847**	54,555
Due to members	**58**	9,548
Total current liabilities	**1,768,024**	1,844,533
Long-term debt, net of current portion	**1,993,808**	1,994,616
Finance lease liabilities, net of current portion	**324,081**	326,827
Operating lease liabilities, net of current portion	**461,972**	471,163
Noncurrent defined benefit pension and other postretirement health plan liabilities	**246,178**	246,097
Self-insured professional and other insured liabilities, net of current portion	**222,202**	255,410
Employee deferred compensation	**102,292**	94,455
Estimated insurance claims liabilities, net of current portion	**352,186**	352,186
Estimated third-party payer liabilities, net of current portion	**289,881**	289,896
Other noncurrent liabilities	**60,709**	56,074
Total liabilities	**5,821,333**	5,931,257
Commitments and contingencies		
Net assets:		
Net assets without donor restrictions:		
Montefiore Health System, Inc.	**628,298**	581,715
Noncontrolling interest	**–**	–
Total net assets without donor restrictions	**628,298**	581,715
Net assets with donor restrictions	**158,034**	160,542
Total net assets	**786,332**	742,257
Total liabilities and net assets	**$ 6,607,665**	$ 6,673,514

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Operations

	Unaudited Three Months Ended March 31,	
	2023	**2022**
	(In Thousands)	
Operating revenue		
Net patient service revenue	**$ 1,690,287**	$ 1,523,473
Grants and contracts	**32,492**	136,902
Other revenue	**187,274**	53,749
Total operating revenue	**1,910,053**	1,714,124
Operating expenses		
Salaries and wages	**843,352**	780,745
Employee benefits	**257,068**	251,048
Supplies and other expenses	**684,093**	616,948
Depreciation and amortization	**67,552**	66,093
Interest	**26,216**	26,026
Total operating expenses	**1,878,281**	1,740,860
Excess (deficiency) of operating revenue over operating expenses before Value Based Payment and Vital Access Provider Programs	**31,772**	(26,736)
Value Based Payment and Vital Access Provider Programs	**–**	18,318
Excess (deficiency) of operating revenue over operating expenses before other items	**31,772**	(8,418)
Net realized and changes in net unrealized gains and losses on marketable and other securities	**23,536**	(46,684)
Net periodic pension and other postretirement benefit costs (non-service related)	**(2,608)**	(1,198)
Malpractice insurance program adjustments	**14,920**	–
Other nonoperating gains and losses, net	**(4,955)**	(1,241)
Excess (deficiency) of revenues over expenses before noncontrolling interest of joint venture	**62,665**	(57,541)
Income attributable to noncontrolling interest of joint venture	**–**	(116)
Excess (deficiency) of revenues over expenses	**62,665**	(57,657)
Change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods	**(291)**	–
Net assets released from restrictions used for purchases of property, buildings and equipment	**–**	2,080
Grants for the purchase of property, buildings and equipment	**6,158**	162
Transfers to members, net	**(21,949)**	(7,780)
Increase (decrease) in net assets without donor restrictions	**$ 46,583**	$ (63,195)

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Changes in Net Assets

Unaudited Three Months Ended March 31, 2023 and 2022

	Without Donor Restrictions				
	Montefiore Health System, Inc.	**Noncontrolling Interest**	**Total**	**With Donor Restrictions**	**Total Net Assets**
	(In Thousands)				
Net assets at January 1, 2022	$ 845,562	$ 3,035	$ 848,597	$ 157,724	$ 1,006,321
(Decrease) increase in net assets without donor restrictions	(63,195)	116	(63,079)	–	(63,079)
Distributions to noncontrolling partners	–	(41)	(41)	–	(41)
Restricted gifts, bequests, and similar items	–	–	–	1,473	1,473
Restricted investment income	–	–	–	(935)	(935)
Net assets released from restrictions	–	–	–	(3,115)	(3,115)
Total changes in net assets	(63,195)	75	(63,120)	(2,577)	(65,697)
Net assets at March 31, 2022	$ 782,367	$ 3,110	$ 785,477	$ 155,147	$ 940,624
Net assets at January 1, 2023	**$ 581,715**	**$ –**	**$ 581,715**	**$ 160,542**	**$ 742,257**
Increase in net assets without donor restrictions	**46,583**	–	**46,583**	**–**	**46,583**
Restricted gifts, bequests, and similar items	**–**	**–**	**–**	**886**	**886**
Restricted investment income	**–**	**–**	**–**	**486**	**486**
Net assets released from restrictions	**–**	**–**	**–**	**(3,880)**	**(3,880)**
Total changes in net assets	**46,583**	**–**	**46,583**	**(2,508)**	**44,075**
Net assets at December 31, 2023	**$ 628,298**	**$ –**	**$ 628,298**	**$ 158,034**	**$ 786,332**

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Cash Flows

	Unaudited Three Months Ended March 31, 2023	2022
	(In Thousands)	
Operating activities		
Increase (decrease) in net assets	**$ 44,075**	$ (65,697)
Adjustments to reconcile increase (decrease) in net assets to net cash used in operating activities:		
Depreciation and amortization	**67,552**	66,093
Change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods	**291**	–
Transfers to members, net	**21,949**	7,780
Net realized gains and losses on marketable and other securities	**1,972**	(18,218)
Change in net unrealized gains and losses on marketable and other securities	**(25,508)**	64,902
Change in fair value of derivative instrument	**(12)**	(461)
Equity earnings from investments	**(5,570)**	(4,819)
Gain on sale of interest in joint venture	**(129,138)**	–
Amortization of long-term mortgage premium	**(1,016)**	(1,015)
Amortization of deferred financing costs	**378**	379
Changes in operating assets and liabilities:		
Receivables for patient care	**16,803**	35,420
Other receivables	**(12,164)**	(109,451)
Other noncurrent assets	**22,173**	(1,043)
Accounts payable and accrued expenses	**(68,072)**	(48,432)
Accrued salaries, wages and related items	**40,627**	3,855
Estimated third-party payer liabilities	**(39,318)**	(33,159)
Net change in all other operating assets and liabilities	**(43,830)**	(15,735)
Net cash used in operating activities	**(108,808)**	(119,601)
Investing activities		
Acquisition of property, buildings and equipment, net	**(60,028)**	(51,115)
Proceeds from sale of interest in joint ventures	**173,417**	–
Decrease in marketable and other securities, net	**7,838**	230,446
(Increase) decrease in assets limited to use, net	**(10,509)**	1,391
Net cash provided by investing activities	**110,718**	180,722
Financing activities		
Payments of long-term debt and finance lease liabilities	**(23,032)**	(9,225)
Payments to members, net	**(22,000)**	(7,780)
Net cash used in financing activities	**(45,032)**	(17,005)
Net (decrease) increase in cash, cash equivalents and restricted cash	**(43,122)**	44,116
Cash, cash equivalents and restricted cash at beginning of year	**490,601**	685,472
Cash, cash equivalents and restricted cash at end of period	**$ 447,479**	$ 729,588
Reconciliation of cash and cash equivalents at end of period to the consolidated statements of financial position:		
Cash and cash equivalents	**$ 284,897**	$ 268,117
Marketable and other securities and assets limited as to use: cash and cash equivalents	**162,582**	461,471
Total cash, cash equivalents and restricted cash	**$ 447,479**	$ 729,588

See accompanying notes.

Montefiore Health System, Inc.

Notes to Consolidated Financial Statements (Unaudited)

March 31, 2023

1. Organization

Montefiore Health System, Inc. and its controlled organizations (collectively, the Health System) comprise an integrated health care delivery system. The facilities are located in the Bronx, Westchester, Rockland and Orange Counties in New York. The Health System is incorporated under New York State Not-for-Profit Corporation law and provides health care and related services. Various entities within the Health System are exempt from Federal income taxes under the provisions of Section 501(a) of the Internal Revenue Code as organizations described in Section 501(c)(3), while other entities are not exempt from such income taxes (the entities are collectively referred to herein as the members). The exempt organizations also are exempt from New York State and local income taxes. Montefiore Medicine Academic Health System, Inc. (MMAHS) is the sole member of the Health System.

The Health System, together with the members, provides patient care, teaching, research, community services and care management. The Health System 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. All intercompany accounts and activities have been eliminated in consolidation.

- Montefiore Health System, Inc. (MHS)
- Montefiore New Rochelle Hospital (MNR)
- Montefiore Mount Vernon Hospital (MMV)
- Schaffer Extended Care Center (SECC)
- Montefiore SS Holdings, LLC
- Montefiore MV Holdings, LLC
- Montefiore HA Holdings, LLC
- Montefiore Information Technology, LLC (MIT)
- Montefiore HMO, LLC
- Montefiore Westchester Community Corp.
- Specialty Surgeons of Connecticut, P.C.
- Montefiore Nyack Hospital (Nyack) and its controlled organizations:
  - Nyack Hospital Foundation, Inc.
  - MNH GarageCo, Inc.
  - Highland Medical P.C.
- White Plains Hospital Center (White Plains) and its controlled organizations:
  - White Plains Hospital Center Foundation, Inc.
  - 11 East Post Road, LLC
  - 34 EPR, LLC
  - East Post Road Ventures I, LLC
  - PY Development Corp
  - White Plains Medical Diagnostic Services P.C.
  - Cancer and Blood Medical Services of New York, P.C.
  - WPH Holdings, Inc.
  - White Plains Medical Services P.C.
  - New York Endoscopy Center, LLC
  - East Post Road Medical Services P.C.
- The Winifred Masterson Burke Rehabilitation Hospital (Burke)
- St. Luke's Cornwall Hospital (St. Luke's) and its controlled organizations:
  - St. Luke's Cornwall Health System, Inc.
  - St. Luke's Cornwall Health System Foundation, Inc.
  - Amos and Sarah Holden Home
  - Hudson Vista Physician Services, P.C.
  - Hudson Vista Medical, P.C.
  - Goldsmith & Mary B. Johnes Home for Aged Couples
  - St. Luke's Cornwall JV, LLC
- Montefiore Consolidated Ventures, Inc. (MCV)
  - Hudson Valley IPA, Inc.
  - The Montefiore IPA, Inc.
  - Bronx Accountable Healthcare Network IPA, Inc.
  - University Behavioral Associates, Inc.
  - Montefiore Behavioral Care IPA No. 1, Inc.
  - MMC GI Holdings East, Inc.
  - MMC GI Holdings West, Inc.
  - CRHT Acquisition, Inc.
  - Innovator Acquisition Corp.
  - CMO The Care Management Company, LLC (CMO)
- Montefiore Medical Center and its controlled organizations (collectively, the Medical Center):
  - Montefiore Medical Center
  - MMC Corporation
  - MMC Residential Corp. I, Inc.
  - Montefiore Hospital Housing Section II, Inc.
  - Mosholu Preservation Corporation
  - Montefiore Proton Acquisition, LLC
  - Montefiore Hudson Valley Collaborative LLC
  - Montefiore CERC Operations, Inc.

1. Organization (continued)

On January 1, 2022, MIT transferred all of its assets and liabilities to MHS. This transfer did not impact the Health System's consolidated financial statements.

In March 2023, the Health System sold its interest in a joint venture and recorded a gain of approximately $129.1 million as a result of the sale, which is included in other revenue in the consolidated statement of operations.

COVID-19 Pandemic and CARES Act Funding

In response to Coronavirus Disease 2019 (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 include general distributions and targeted distributions, to support hospitals in high impact areas and rural providers, for service periods through June 30, 2023. Additionally, funds are available to reimburse providers for COVID-19 related treatment of uninsured patients. For the three months ended March 31, 2022, the Health System recognized revenue of approximately $1.0 million of the funding received which is included in grants and contracts in the accompanying consolidated statements of operations. No amounts were recognized in 2023.

The recognized revenue has been determined based on applicable accounting guidance, the most recent Post-Payment Notice of Reporting Requirements and FAQs that the Heath System 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 Health System'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.

1. Organization (continued)

To enhance liquidity, the Health System was 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 allows 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 Health System received approximately $456.9 million of expedited payment for future services. The advances were 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 December 31, 2022.

The Health System also applied for reimbursement for qualifying expenses under the Federal Emergency Management Agency (FEMA) Disaster Relief Fund. The Health System submitted project worksheets totaling approximately $578.5 million under FEMA's expedited claim submission process and streamlined submission process. For the three months ended March 31, 2022, the Health System recognized approximately $46.3 million of amounts approved by FEMA, which is included in grants and contracts in the consolidated statements of operations. No amounts were recognized in 2023. The Health System 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 Health System may be reimbursed is uncertain.

The Health System was 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. In February 2022, the Health System finalized its application for the employee retention credit for approximately $57.8 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 Health System 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, 2022, the Medical Center was in compliance with the applicable financial covenants of its debt agreements. 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. As a result of not meeting the DSCR requirement in 2021, the Medical Center was required to retain an independent consultant and provide a copy of the independent

1. Organization (continued)

consultant's report to the Master Trustee. As the Medical Center complied with the independent consultant provisions of the MTI, there was no event of default.

The Medical Center plans to maintain adequate liquidity to fund operations 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 funding in future periods. 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 excess (deficiency) of revenues over expenses as the performance indicator. Items excluded from excess (deficiency) of revenues over expenses are change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods, net assets released from restrictions used for purchases of property, buildings and equipment, 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 excess (deficiency) of operating revenue over operating expenses before other items. Peripheral transactions or transactions of an infrequent nature are excluded from excess (deficiency) of operating revenue over expenses before other items.

Interim Financial Statements

The Health System presumes that users of this unaudited consolidated financial information have read or have access to the Health System's audited consolidated financial statements which include certain disclosures required by U.S. generally accepted accounting principles. The audited consolidated financial statements of the Health System for the years ended December 31, 2022 and 2021 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 Health System'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.

1. Organization (continued)

Use of Estimates

The preparation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States (GAAP) requires management to make estimates and assumptions that affect the reported 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 2023 or 2022.

Recently Adopted Accounting Pronouncements

In September 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 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 adoption of ASU 2016-13 did not have a material impact on the consolidated financial statements.

Subsequent Events

The Health System evaluated subsequent events through May 25, 2023, which is the date the unaudited consolidated financial statements were issued, for potential recognition or disclosure in the accompanying consolidated financial statements for the three months ended March 31, 2023. No subsequent events have occurred that require disclosure in or adjustment to 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 Health System expects to be entitled in exchange for providing patient care.

The Health System 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 Health System 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 Health System'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 Health System's standard charges. The Health System determines the transaction price associated with services provided to patients who have third-party payer

2. Net Patient Service Revenue (continued)

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 Health System's discount policies and historical experience. For uninsured and under-insured patients who do not qualify for charity care, the Health System 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 Health System's historical collection experience for applicable patient portfolios.

Under the Health System'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 Health System's criteria for free care are provided care without charge; such amounts are not reported as revenue.

Generally, the Health System 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 Health System. Net patient service revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total charges.

The Health System 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 Health System's outpatient and ambulatory care centers or in their homes (home care). The Health System 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.

As substantially all of its performance obligations relate to contracts with a duration of less than one year, the Health System 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 Health System'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 three months ended March 31, 2023 and 2022, changes in the Health System'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

2. Net Patient Service Revenue (continued)

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 three months ended March 31, 2023 and 2022 was not significant.

The Health System 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:

	Three Months Ended March 31	
	2023	**2022**
	(In Thousands)	
Medicare and Medicare managed care	**$ 536,964**	$ 453,885
Medicaid and Medicaid managed care	**474,728**	407,895
Commercial carriers and managed care	**657,595**	641,677
Self-pay and other	**21,000**	20,016
	$ 1,690,287	$ 1,523,473

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.

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

	Three Months Ended March 31	
	2023	**2022**
	(In Thousands)	
Inpatient services	**$ 868,858**	$ 778,402
Physician and other outpatient services	**624,918**	546,954
Premium revenue	**118,257**	132,161
Emergency department	**66,853**	50,913
All other	**11,401**	15,043
	$ 1,690,287	$ 1,523,473

The Health System 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 Health System's expectation that the period of time between the service being provided and billing will be one year or less. However, the Health System 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.

2. Net Patient Service Revenue (continued)

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

	March 31 2023	December 31 2022
	(In Thousands)	
Patient receivables	**$ 447,885**	$ 494,801
Contract assets	**97,629**	67,516
	$ 545,514	$ 562,317

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 Health System 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 Health System's historical settlement activity (for example, cost report final settlements or repayments related to recovery audits), including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. 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 three months ended March 31, 2023 and 2022.

Under certain managed care contracts, the Health System receives from the insurer a monthly premium per enrollee during the term of enrollment. The premium revenue, which is based on individual contracts, is recognized in the period earned and is included within net patient service revenue in the accompanying consolidated statements of operations. Under such arrangements, the Health System manages and, directly and through arrangements with other health care providers, delivers health care services to enrollees in accordance with the terms of the subscriber agreements.

Third-Party Payment Programs

The Health System 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:

2. Net Patient Service Revenue (continued)

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 Health System 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 Health System also has entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Health System 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 various dates from December 31, 2018 to December 31, 2020, 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. 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 Health System'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 Health System. The Health System 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 Health System has with commercial payers also provide for retroactive audit and review of claims.

2. Net Patient Service Revenue (continued)

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 Health System. Additionally, certain payers' payment rates for various years have been appealed by the Health System. If the appeals are successful, additional income applicable to those years could be realized.

3. Benefit Plans

Certain entities in the Health System provide pension and similar benefits to their employees through several plans, including various multiemployer plans for union employees, two noncontributory defined benefit pension plans for eligible employees of the Medical Center, a noncontributory defined benefit pension plan for eligible employees of Nyack, a noncontributory defined benefit retirement plan covering employees of White Plains (frozen in 2006), a noncontributory defined benefit retirement plan for St. Luke's employees (frozen in 2010), and a noncontributory defined benefit pension plan for employees of Burke (frozen effective December 31, 2017) (the non-multiemployer plans are collectively referred to as the Pension Plans). The entities also provide several other contributory defined contribution plans.

It is the policy for the entities 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. Amounts contributed to the Pension Plans are based on actuarial valuations. The benefits for participants or their beneficiaries in the Pension Plans are based on years of service and employees' compensation during their years of employment as applicable to each plan.

Certain entities in the Health System provide certain health care and life insurance benefits to certain eligible retired non-union employees and their dependents through several defined benefit postretirement or health and welfare plans (the Postretirement Plans).

Total expense related to these plans included in employee benefits expense in the accompanying consolidated statements of operations, aggregated approximately $55.8 million and $50.3 million for the three months ended March 31, 2023 and 2022, respectively. Cash payments relative to the various pension plans aggregated approximately $60.6 million and $55.6 million for the three months ended March 31, 2023 and 2022.

3. Benefit Plans (continued)

The following table provides the components of the net periodic benefit cost for the three months ended March 31, 2023 and 2022:

	Pension Plans		Postretirement Plans	
	2023	**2022**	**2023**	**2022**
	(In Thousands)			
Service cost	**$ 1,262**	$ 1,215	**$ 2,437**	$ 3,308
Interest cost	**4,056**	3,003	**2,574**	1,709
Expected return on plan assets	**(3,825)**	(3,749)	**–**	–
Amortization of net loss (gain)	**–**	178	**(197)**	–
Settlement cost	**–**	60	**–**	–
Net periodic benefit cost	**$ 1,493**	$ 3,477	**$ 4,814**	$ 5,014

4. Long-Term Debt

St. Luke's various debt and loan agreements include compliance requirements for certain financial ratio and other covenants. In October 2017, St. Luke's entered into an initial Forbearance Agreement (IFA) with its lenders that expired on May 30, 2020. During the term of the IFA, St. Luke's met all of the required financial ratio covenants. From May 30, 2020 until October 14, 2021, St. Luke's and its lenders negotiated the terms of a second Forbearance Agreement (SFA). During that period of time, St. Luke's was in violation of its financial ratio covenants under the original financing terms, however the lenders did not exercise any of their call provisions during this period. On October 14, 2021, the SFA went into effect. It is set to expire on December 31, 2023. To date, St. Luke's has made approximately $11.0 million of unscheduled principal payments in accordance with requirements of the SFA. The lenders have agreed to take no remedial action against St. Luke's as long as there are no violations to the terms of the SFA. At December 31, 2022, St. Luke's met the required financial ratio covenants. St. Luke's debt is not guaranteed by the Obligated Group.

5. Leases

The Health System determines if an arrangement is a lease at inception. The Health System 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 Health System 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.

5. Leases (continued)

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 Health System will exercise that option. The Health System does not separate lease and nonlease components of contracts.

The following table presents the Health System's lease-related assets and liabilities at March 31, 2023 and December 31, 2022 (in thousands):

	Statement of Financial Position Classification	March 31 2023	December 31 2022
Assets:			
Operating leases	Right-of-use assets – operating leases	**$ 500,195**	$ 509,644
Finance leases	Property, buildings and equipment, net	**313,933**	318,852
Total lease assets		**$ 814,128**	$ 828,496
Liabilities:			
Current:			
Operating leases	Operating lease liabilities, current portion	**$ 54,847**	$ 54,555
Finance leases	Finance lease liabilities, current portion	**18,736**	18,446
Noncurrent:			
Operating leases	Operating lease liabilities, net of current portion	**461,972**	471,163
Finance leases	Finance lease liabilities, net of current portion	**324,081**	326,827
Total lease liabilities		**$ 859,636**	$ 870,991

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

	March 31 2023	December 31 2022
Weighted-average remaining lease term (years)		
Operating leases	**11.3**	11.6
Finance leases[(1)]	**47.9**	47.6
Weighted-average discount rate		
Operating leases	**2.6%**	2.7%
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 12.4 years at March 31, 2023 and 12.6 years at December 31, 2022.

5. Leases (continued)

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

	Three Months Ended March 31	
	2023	**2022**
	(In Thousands)	
Finance lease expense:		
Amortization of right-of-use assets	**$ 4,920**	$ 4,920
Interest on finance lease liabilities	**2,495**	2,519
Operating lease cost	**21,546**	17,446
Variable and short-term lease expense	**2,002**	1,362
Total lease expense	**$ 30,963**	$ 26,247

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

	Three Months Ended March 31	
	2023	**2023**
	(In Thousands)	
Cash paid for amounts included in the measurement of lease liabilities		
Operating cash flows for operating leases	**$ 17,226**	$ 16,365
Operating cash flows for finance leases	**2,495**	2,519
Financing cash flows for finance leases	**3,726**	3,020

Future minimum lease payments under non-cancellable leases as of March 31, 2023 are as follows (in thousands):

	Operating Leases	**Finance Leases**
2023 (excluding the three months ended March 31, 2023)	$ 55,144	$ 18,136
2024	67,239	23,464
2025	63,924	23,145
2026	62,047	22,757
2027	59,878	22,459
2028 and thereafter	294,558	853,585
Total lease payments	602,790	963,546
Less imputed interest	(85,971)	(620,729)
Present value of lease payments	$ 516,819	$ 342,817

6. Commitments and Contingencies

Litigation: Claims have been asserted against the Health System 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 March 31, 2023 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. Health System management and counsel are unable to conclude about the ultimate outcome of the actions. However, it is the opinion of Health System 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 Health System'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, which commenced 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.

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

6. Commitments and Contingencies (continued)

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 three months ended March 31, 2023 or 2022.

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 three months ended March 31, 2023 and 2022, the Medical Center provided approximately $22.0 million and $8.0 million, respectively, to Einstein which was recorded within transfers to members, net on the consolidated statements of operations.

Other: At March 31, 2023 and December 31, 2022, approximately 56% of the Health System's employees were covered by collective bargaining agreements. The Medical Center, MNR, MMV and SECC entered into collective bargaining agreements with NYSNA which expire in December 2025. Nyack's contract with NYSNA expires in December 2023. The Medical Center, MNR, MMV and SECC's collective bargaining agreements with 1199SEIU expire in September 2026 and St. Luke's collective bargaining agreement with 1199SEIU expires in September 2024. Nyack and White Plains' contracts with 1199SEIU expire in April 2025.

In connection with agreements entered into between HIPA, MIPA and several health insurance companies, the Medical Center has agreed to guarantee the performance and payment of certain hospital, physician and administrative services.

7. Fair Value Measurements

For assets and liabilities required to be measured at fair value, the Health System 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 Health System'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 Health System 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.

7. Fair Value Measurements (continued)

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 Health System 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.

Financial assets carried at fair value, including assets invested in the Health System's defined benefit pension plans, are classified in the table below in one of the three categories described above as of March 31, 2023:

	March 31, 2023			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	**$ 284,897**	**$ –**	**$ –**	**$ 284,897**
Managed cash and cash equivalents held for investment	**162,582**	**–**	**–**	**162,582**
Marketable and other securities:				
Non-equity mutual funds	**198,938**	**–**	**–**	**198,938**
Equity mutual funds	**117,992**	**–**	**–**	**117,992**
U.S. Government agency mortgage-backed securities	**–**	**24,505**	**–**	**24,505**
U.S. Treasury securities	**238,527**	**–**	**–**	**238,527**
U.S. Government agency-backed securities	**–**	**69,654**	**–**	**69,654**
Equity securities	**49,856**	**–**	**–**	**49,856**
Corporate debt	**–**	**618,836**	**–**	**618,836**
Investment contracts	**–**	**1,254**	**–**	**1,254**
Other investments	**–**	**–**	**1,450**	**1,450**
	1,052,792	**714,249**	**1,450**	**1,768,491**
Defined benefit pension plan assets				
Cash and cash equivalents	**6,201**	**–**	**–**	**6,201**
Managed separate account: fixed income	**–**	**89,454**	**–**	**89,454**
Equity mutual funds	**103,901**	**–**	**–**	**103,901**
Non-equity mutual funds	**66,983**	**–**	**–**	**66,983**
	177,085	**89,454**	**–**	**266,539**
	$ 1,229,877	**$ 803,703**	**$ 1,450**	**2,035,030**
Investments measured at net asset value (defined benefit pension plan assets)				**27,227**
				$ 2,062,257

7. Fair Value Measurements (continued)

Financial assets carried at fair value, including assets invested in the Health System's defined benefit pension plans, are classified in the table below in one of the three categories described above as of December 31, 2022:

	December 31, 2022			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	$ 315,671	$ –	$ –	$ 315,671
Managed cash and cash equivalents held for investment	174,930	–	–	174,930
Marketable and other securities:				
Non-equity mutual funds	193,564	–	–	193,564
Equity mutual funds	109,533	–	–	109,533
U.S. Government agency mortgage-backed securities	–	31,708	–	31,708
U.S. Treasury securities	87,543	–	–	87,543
U.S. Government agency-backed securities	–	115,954	–	115,954
Equity securities	55,589	–	–	55,589
Corporate debt	–	711,908	–	711,908
Investment contracts	–	2,168	–	2,168
Interest and other receivables	–	–	1,450	1,450
	936,830	861,738	1,450	1,800,018
Defined benefit pension plan assets				
Cash and cash equivalents	5,887	–	–	5,887
Managed separate account: fixed income	–	86,527	–	86,527
Equity mutual funds	108,084	–	–	108,084
Non-equity mutual funds	67,172	–	–	67,172
	181,143	86,527	–	267,670
	$ 1,117,973	$ 948,265	$ 1,450	2,067,688
Investments measured at net asset value (defined benefit pension plan assets)				27,177
				$ 2,094,865

At March 31, 2023 and December 31, 2022, the Health System'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 $246.1 million and $240.9 million, respectively, and, therefore, are not included in the tables above.

7. Fair Value Measurements (continued)

The following is a description of the Health System'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. 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 Health 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 estimate of fair value at the reporting date.