Consolidated Financial Statements (Unaudited)

Montefiore Health System, Inc.

For the Three Months Ended March 31, 2020 and 2019

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Contents

Montefiore Health System, Inc.

Consolidated Statements of Financial Position

	Unaudited March 31, 2020	Audited December 31, 2019
	(In Thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 337,246**	$ 397,526
Marketable and other securities	**1,723,458**	1,542,776
Assets limited as to use, current portion	**193,145**	65,723
Receivables for patient care, net	**475,806**	490,688
Other receivables	**119,692**	90,350
Estimated insurance claims receivable, current portion	**90,757**	90,757
Other current assets	**112,754**	110,054
Total current assets	**3,052,858**	2,787,874
Assets limited as to use, net of current portion	**284,753**	239,876
Property, buildings and equipment, net	**2,076,439**	2,045,928
Right-of-use assets – operating leases	**486,013**	494,387
Estimated insurance claims receivable, net of current portion	**445,497**	445,497
Other noncurrent assets	**298,304**	307,538
Due from members	**100**	100
Total assets	**$ 6,643,964**	$ 6,321,200
Liabilities and net assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 544,282**	$ 606,876
Accrued salaries, wages and related items	**412,684**	426,580
Self-insured professional and other insured liabilities, current portion	**81,284**	82,422
Estimated insurance claims liabilities, current portion	**92,580**	92,882
Estimated third-party payer liabilities, current portion	**119,097**	99,415
Long-term debt, current portion	**94,238**	69,781
Finance lease liabilities, current portion	**10,860**	10,913
Operating lease liabilities, current portion	**50,366**	49,242
Due to members	**26,224**	29,350
Total current liabilities	**1,431,615**	1,467,461
Long-term debt, net of current portion	**2,001,154**	1,415,205
Finance lease liabilities, net of current portion	**250,519**	251,293
Operating lease liabilities, net of current portion	**446,655**	455,051
Noncurrent defined benefit pension and other postretirement health plan liabilities	**323,066**	325,424
Self-insured professional and other insured liabilities, net of current portion	**172,579**	175,356
Employee deferred compensation	**74,510**	73,061
Estimated insurance claims liabilities, net of current portion	**446,869**	446,869
Estimated third-party payer liabilities, net of current portion	**239,521**	239,517
Other noncurrent liabilities	**55,670**	74,300
Total liabilities	**5,442,158**	4,923,537
Commitments and contingencies		
Net assets:		
Net assets without donor restrictions:		
Montefiore Health System, Inc.	**1,049,399**	1,244,938
Noncontrolling interest	**3,062**	3,067
Total net assets without donor restrictions	**1,052,461**	1,248,005
Net assets with donor restrictions	**149,345**	149,658
Total net assets	**1,201,806**	1,397,663
Total liabilities and net assets	**$ 6,643,964**	$ 6,321,200

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Operations

	Unaudited Three Months Ended March 31,	
	2020	**2019**
	(In Thousands)	
Operating revenue		
Net patient service revenue	**$ 1,368,457**	$ 1,415,970
Grants and contracts	**31,575**	32,004
Other revenue	**95,521**	72,146
Total operating revenue	**$ 1,495,553**	$ 1,520,120
Operating expenses		
Salaries and wages	**753,885**	702,970
Employee benefits	**222,968**	215,273
Supplies and other expenses	**556,802**	546,016
Depreciation and amortization	**56,449**	54,768
Interest	**21,501**	18,970
Total operating expenses	**1,611,605**	1,537,997
Deficiency of operating revenue over operating expenses before Value Based Payment and Vital Access Provider Programs	**(116,052)**	(17,877)
Value Based Payment and Vital Access Provider Programs	**19,300**	19,057
(Deficiency) excess of operating revenues over operating expenses before other items	**(96,752)**	1,180
Net realized and changes in net unrealized gains and losses on marketable and other securities	**(84,689)**	31,911
Net periodic pension and other postretirement benefit costs (non-service related)	**(2,804)**	(3,277)
Malpractice insurance program adjustments	**5,614**	–
Other nonoperating gains and losses, net	**(479)**	(74)
(Deficiency) excess of revenues over expenses before noncontrolling interest of joint venture	**(179,110)**	29,740
Income attributable to noncontrolling interest of joint venture	**(139)**	(103)
(Deficiency) excess of revenues over expenses	**(179,249)**	29,637
Net assets released from restrictions used for purchases of property, buildings and equipment	**2,778**	414
Grants for the purchase of property, buildings and equipment	**14,332**	9,541
Other changes in net assets without donor restrictions	**–**	13,017
Transfers to members, net	**(33,400)**	(15,409)
(Decrease) increase in net assets without donor restrictions	**$ (195,539)**	$ 37,200

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Changes in Net Assets

Unaudited Three Months Ended March 31, 2020 and 2019

	Without Donor Restrictions				
	Montefiore Health System, Inc.	**Noncontrolling Interest**	**Total**	**With Donor Restrictions**	**Total Net Assets**
			(In Thousands)		
Net assets at January 1, 2019	$ 1,126,885	$ 2,986	$ 1,129,871	$ 154,329	$ 1,284,200
Increase in net assets without donor restrictions	37,200	103	37,303	–	37,303
Distributions to noncontrolling partners	–	(98)	(98)	–	(98)
Restricted gifts, bequests, and similar items	–	–	–	605	605
Restricted investment income	–	–	–	622	622
Net assets released from restrictions	–	–	–	(2,187)	(2,187)
Total changes in net assets	37,200	5	37,205	(960)	36,245
Net assets at March 31, 2019	$ 1,164,085	$ 2,991	$ 1,167,076	$ 153,369	$ 1,320,445
Net assets at January 1, 2020	$ 1,244,938	$ 3,067	$ 1,248,005	$ 149,658	$ 1,397,663
Decrease in net assets without donor restrictions	**(195,539)**	**139**	**(195,400)**	**–**	**(195,400)**
Distributions to noncontrolling partners	–	**(144)**	**(144)**	**–**	**(144)**
Restricted gifts, bequests, and similar items	**–**	**–**	**–**	**5,463**	**5,463**
Restricted investment income	**–**	**–**	**–**	**(1,919)**	**(1,919)**
Net assets released from restrictions	–	–	–	**(3,857)**	**(3,857)**
Total changes in net assets	**(195,539)**	**(5)**	**(195,544)**	**(313)**	**(195,857)**
Net assets at March 31, 2020	**$ 1,049,399**	**$ 3,062**	**$ 1,052,461**	**$ 149,345**	**$ 1,201,806**

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Cash Flows

	Unaudited Three Months Ended March 31,	
	2020	**2019**
	(In Thousands)	
Operating activities		
(Decrease) increase in net assets	**$ (195,857)**	$ 36,245
Adjustments to reconcile (decrease) increase in net assets to net cash used in operating activities:		
Depreciation and amortization	**56,449**	54,768
Transfers to members, net	**33,400**	15,409
Lease transition adjustment	**–**	(13,017)
Net realized gains and losses on marketable and other securities	**(8,880)**	(168)
Change in net unrealized gains and losses on marketable and other securities	**93,569**	(31,743)
Change in fair value of derivative instrument	**479**	79
Equity earnings from investments	**(2,191)**	(2,741)
Amortization of long-term mortgage premium	**(662)**	(586)
Amortization of deferred financing costs	**311**	296
Changes in operating assets and liabilities:		
Receivables for patient care	**15,111**	(40,070)
Other noncurrent assets	**18,084**	6,488
Accounts payable and accrued expenses	**(64,754)**	(35,420)
Accrued salaries, wages and related items	**(13,896)**	(18,046)
Non-current defined benefit and postretirement health plan liabilities	**(2,359)**	(1,117)
Other noncurrent liabilities	**1,583**	(14,110)
Net change in all other operating assets and liabilities	**(18,459)**	(28,921)
Net cash used in operating activities	**(88,072)**	(72,654)
Investing activities		
Acquisition of property, buildings and equipment, net	**(83,655)**	(58,225)
Increase in marketable and other securities, net	**(342,463)**	16,237
(Increase) decrease in assets limited to use, net	**(172,463)**	145
Payments for joint venture investment	**(27,250)**	(19,500)
Net cash used in investing activities	**(625,831)**	(61,343)
Financing activities		
Payments of long-term debt and finance lease liabilities	**(6,468)**	(6,713)
Extinguishment of long-term debt	**(75,498)**	–
Proceeds from long-term debt	**701,419**	15,899
Payments to members, net	**(33,400)**	(15,001)
Payments of deferred financing costs	**(9,522)**	–
Net cash provided by (used in) financing activities	**576,531**	(5,815)
Net decrease in cash, cash equivalents and restricted cash	**(137,372)**	(139,812)
Cash, cash equivalents and restricted cash at beginning of year	**685,677**	825,304
Cash, cash equivalents and restricted cash at end of year	**$ 548,305**	$ 685,492
Reconciliation of cash and cash equivalents at end of year to the consolidated statements of financial position:		
Cash and cash equivalents	**$ 337,246**	$ 299,197
Marketable and other securities and assets limited as to use: cash and cash equivalents	**211,059**	386,295
Total cash, cash equivalents and restricted cash	**$ 548,305**	$ 685,492
Supplemental cash flow and non-cash information		
Deferred payments for acquisition of investment in joint venture	**$ 27,250**	$ 45,000
Property, building and equipment purchases in accounts payable and accrued expenses	**$ 3,305**	$ –

See accompanying notes.

Montefiore Health System, Inc.

Notes to Consolidated Financial Statements (Unaudited)

March 31, 2020

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 (SS Holdings)
- Montefiore MV Holdings, LLC (MV Holdings)
- Montefiore HA Holdings, LLC (HA Holdings)
- Montefiore HMO, LLC (MHMO)
- Montefiore Information Technology, LLC (MIT)
- Montefiore Nyack Hospital (Nyack) and its controlled organizations:
  - Nyack Hospital Foundation, Inc. (Nyack Foundation)
  - Highland Medical P.C. (Highland Medical)
- White Plains Hospital Center (White Plains) and its controlled organizations:
  - White Plains Hospital Center Foundation, Inc. (White Plains Foundation)
  - Davis Avenue Corporation
  - 8 Longview Development Corporation (Longview)
  - 11 East Post Road, LLC
  - White Plains Management Company
  - White Plains Building Corp, LLC
  - White Plains Medical Diagnostic Services P.C. (Medical Diagnostic Services)
  - Cancer and Blood Medical Services of New York, P.C. (Cancer and Blood)
  - WPH Holdings, Inc.
  - White Plains Medical Services P.C.
  - New York Endoscopy Center, LLC
  - East Post Road Ventures I, LLC
  - White Plains Physician Services P.C.
  - East Post Road Medical Services P.C.
  - White Plains Physician Medical Services P.C.
  - East Post Road Physician Services P.C.
  - Davis Avenue Medical Services P.C.
- The Winifred Masterson Burke Rehabilitation Hospital (Burke)
- St. Luke's Cornwall Hospital (St. Luke's) and its controlled organizations:
  - Hudson Vista Corporation
  - St. Luke's Cornwall Health System, Inc.
  - St. Luke's Cornwall Health System Foundation, Inc. (St. Luke's Foundation)
  - SLCH Insurance Co., Ltd.
  - 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. (HIPA)
  - The Montefiore IPA, Inc. (MIPA)
  - Bronx Accountable Healthcare Network IPA, Inc. (ACO-IPA)
  - University Behavioral Associates, Inc. (UBA)
  - Montefiore Behavioral Care IPA No. 1, Inc. (MBCIPA)
  - MMC GI Holdings East, Inc. (GI East)
  - MMC GI Holdings West, Inc. (GI West)
  - CRHT Acquisition, Inc. (CRHT)

1. Organization (continued)

- Montefiore Medical Center and its controlled organizations (collectively, the Medical Center):
  - Montefiore Medical Center
  - MMC Corporation (MCORP)
  - CMO The Care Management Company, LLC (CMO)
  - Gunhill MRI P.C. (Gunhill)
  - MMC Residential Corp. I, Inc. (Housing I)
  - Montefiore Hospital Housing Section II, Inc. (Housing II)
  - Mosholu Preservation Corporation (MPC)
  - Montefiore Proton Acquisition, LLC (MPRO)
  - Montefiore Hudson Valley Collaborative LLC (MHVC)
  - Montefiore CERC Operations, Inc. (CERC)

In January 2018, the Health System acquired an equity interest in a joint venture with Crystal Run Healthcare, LLP for a purchase price of $90.0 million, of which $25.5 million was due at closing and $20.0 million, $25.0 million and $19.5 million is due on the first, second and third anniversaries of the closing date, respectively. In accordance with the purchase agreement, the Medical Center agreed to guarantee payments made by the Health System.

On October 1, 2018, WPH Holdings, Inc. entered into a Membership Interest Purchase Agreement with New York Endoscopy Center, LLC (the Center) to acquire a 51% controlling interest in the Center for a purchase price of $3.0 million. As a result of the transaction, goodwill in the amount of approximately $5.9 million was recognized by White Plains, which approximates the fair value of the Center as of that date. The difference between the fair value of the Center and the purchase price (approximately $2.9 million) was recognized as an inherent. The noncontrolling interest of the Center represents the portion of the Center not controlled by White Plains, but is required to be presented in the Health System’s consolidated financial statements in accordance with U.S. generally accepted accounting principles.

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, 2019 and 2018 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 conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets, such as the valuation of accounts receivable for services to patients and estimated insurance recoveries receivable, and liabilities, such as estimated third-party payer liabilities, estimated insurance claims liabilities and 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. For the three months ended March 31, 2020 and 2019, there were no material changes in estimates.

Recent Accounting Pronouncements Not Yet Adopted:

In June 2016, the FASB issued 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 31, 2021. The Health System has not completed the process of evaluating the impact of ASU 2016-13 on its consolidated financial statements.

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. This guidance is effective for the Health System for annual periods beginning after December 15, 2021, with early adoption permitted for any impairment tests performed after January 1, 2017. The Health System has not completed the process of evaluating the impact of ASU 2017-04 on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract* (ASU 2018-15). The standard aligns the requirement for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal use software license). The accounting for the service element of a hosting arrangement that is a service contract is not affected by amendments ASU 2018-15. ASU 2018-15 requires an entity (customer) in a hosting arrangement that is a service contract to follow the guidance in ASC Subtopic 350-40 to determine which implementation costs to capitalize as an asset related to the service contract and which costs to expense by determining which project stage an implementation activity relates to and the nature of the costs. ASU 2018-15 also requires the entity (customer) to expense the capitalized implementation costs of a hosting arrangement that is a service contract over the term of the hosting

1. Organization (continued)

arrangement. The amendments in ASU 2018-15 also require the entity (customer) to present the expense related to the capitalized implementation costs in the same line item in the statement of income as the fees associated with the hosting element (service) of the arrangement and classify payments for capitalized implementation costs in the statement of cash flows in the same manner as payments made for fees associated with the hosting element. The entity (customer) is also required to present the capitalized implementation costs in the consolidated balance sheet in the same line item that a prepayment for the fees of the associated hosting arrangement would be presented. ASU 2018-15 is effective for the Health System for fiscal years beginning after December 15, 2020, and interim periods within fiscal years beginning after December 15, 2021. Early adoption is permitted, including adoption in any interim period. Either retrospective or prospective adoption is permitted. The Health System is in the process of evaluating the impact of ASU 2018-15 on its consolidated financial statements.

In May 2019, the FASB issued ASU 2019-06, *Intangibles — Goodwill and Other (Topic 350), Business Combinations (Topic 805), and Not-for-Profit Entities (Topic 958), Extending the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities.* Under ASU 2019-06, entities that elect the goodwill accounting alternative will amortize goodwill and perform a one-step impairment test, at either the entity level or the reporting unit level, only when an impairment indicator exists. Entities that elect the intangible asset accounting alternative may recognize fewer intangible assets in an acquisition, and they would be required to elect the goodwill accounting alternative. Entities that elect to adopt the alternatives do not have to demonstrate preferability and will follow the alternatives' transition guidance. Entities that elect this accounting alternative will amortize goodwill on a straight-line basis over 10 years or over a shorter period if they are able to demonstrate that another useful life is more appropriate. ASU 2019-06 was effective immediately upon issuance. The Health System did not elect to adopt the accounting alternatives noted above.

Reclassifications

For purposes of comparison, certain reclassifications have been made to the accompanying 2019 consolidated financial statements to conform to the 2020 presentation. These reclassifications have no effect on the excess of revenues over expenses or net assets for the three months ended March 31, 2019.

Subsequent Events

The Health System evaluated subsequent events through May 28, 2020, 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, 2020. Except as discussed in notes 4 and 8, no events 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 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.

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 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, 2020 and 2019, 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 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, 2020 and 2019 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 for the three months ended March 31, 2020 and 2019 by payer is as follows:

	2020	2019
	(In Thousands)	
Medicare and Medicare managed care	**$ 417,070**	$ 469,521
Medicaid and Medicaid managed care	**364,800**	377,417
Commercial carriers and managed care	**567,442**	547,874
Self-pay and other	**19,145**	21,158
	$ 1,368,457	$ 1,415,970

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 for the three months ended March 31, 2020 and 2019 by line of business is as follows:

	2020	2019
	(In Thousands)	
Inpatient services	**$ 721,739**	$ 689,422
Physician and other outpatient services	**441,618**	444,283
Premium revenue	**131,163**	212,144
Emergency department	**57,681**	51,672
All other	**16,256**	18,449
	$ 1,368,457	$ 1,415,970

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.

At March 31, 2020 and December 31, 2019, receivables for patient care, net is comprised of the following components:

	March 31, 2020	December 31, 2019
	(In Thousands)	
Patient receivables	**$ 396,362**	$ 394,090
Contract assets	**79,444**	96,598
	$ 475,806	$ 490,688

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

2. Net Patient Service Revenue (continued)

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, 2020 and 2019.

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:

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 New York State Department of Health (DOH). 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 the Centers for Medicare and Medicaid Services (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.

2. Net Patient Service Revenue (continued)

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, 2014 to 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. 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.

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.

3. Benefit Plans (continued)

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 $49.6 million and $48.2 million for the three months ended March 31, 2020 and 2019, respectively. Cash payments relative to the various pension plans aggregated approximately $59.5 million and $56.2 million for the three months ended March 31, 2020 and 2019.

The following table provides the components of the net periodic benefit cost for the three months ended March 31, 2020 and 2019:

	Pension Plans		**Postretirement Plans**	
	2020	**2019**	**2020**	**2019**
	(In Thousands)			
Service cost	**$ 2,105**	$ 2,300	**$ 3,549**	$ 2,944
Interest cost	**4,897**	5,867	**1,856**	2,056
Expected return on plan assets	**(5,816)**	(6,051)	–	–
Amortization of prior service cost (benefit)	–	11	–	(69)
Amortization of net loss	**192**	391	**875**	466
Settlement cost	**800**	606	–	–
Net periodic benefit cost	**$ 2,178**	$ 3,124	**$ 6,280**	$ 5,397

4. Long-Term Debt

In February 2020 two series of bonds were issued; the DASNY Montefiore Obligated Group Revenue Bonds, Series 2020A (Tax-Exempt); and the Montefiore Obligated Group Taxable Bonds, Series 2020B (collectively, the Series 2020 Bonds) in the aggregate amount of approximately $706.5 million. The proceeds from the issuance of the Series 2020 Bonds were used to refund or refinance approximately $121.1 million of existing indebtedness; the remainder is being used to fund capital projects. The Series 2020 Bonds are general obligations of the Montefiore Obligated Group (of which the Medical Center is currently the only member) and further secured by a mortgage on certain real property.

4. Long-Term Debt (continued)

St. Luke's various debt and loan agreements include compliance requirements for certain financial ratio and other covenants. On October 20, 2017, St. Luke's entered into a forbearance agreement with its lenders that expired on March 31, 2020, which was subsequently extended until May 30, 2020. Under the forbearance agreement St Luke's lenders have agreed to take no remedial action against St. Luke's. St. Luke's is currently working with the lenders on an extension of this agreement, which may or may not occur. St. Luke's debt is not guaranteed by the Obligated Group.

In May 2020, White Plains entered into an unsecured line of credit with a bank for $25.0 million. The interest on any advances are based on LIBOR plus 1%. The line of credit expires on April 30, 2021.

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.

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.

5. Leases (continued)

The following table presents the Health System's lease-related assets and liabilities at March 31, 2020 and December 31, 2019 (in thousands):

	Statement of Financial Position Classification	March 31, 2020	December 31, 2019
Assets:			
Operating leases	Right-of-use assets – operating leases	**$ 486,013**	$ 494,387
Finance leases	Property, buildings and equipment, net	**253,524**	256,522
Total lease assets		**$ 739,537**	$ 750,909
Liabilities:			
Current:			
Operating leases	Operating lease liabilities, current portion	**$ 50,366**	$ 49,242
Finance leases	Finance lease liabilities, current portion	**10,860**	10,913
Noncurrent:			
Operating leases	Operating lease liabilities, net of current portion	**446,655**	455,051
Finance leases	Finance lease liabilities, net of current portion	**250,519**	251,293
Total lease liabilities		**$ 758,400**	$ 766,499

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

Weighted-average remaining lease term (years)	March 31, 2020	December 31, 2019
Operating leases	11.2	11.4
Finance leases[(1)]	57.8	57.5
Weighted-average discount rate		
Operating leases	2.7%	2.7%
Finance leases	3.1%	3.1%

(1) Includes a lease agreement that extends through 2114. Excluding this lease agreement, the weighted-average remaining lease term of all other leases is 10.4 years at March 31, 2020 and 10.7 years at December 31, 2019.

5. Leases (continued)

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

	Three Months Ended March 31	
	2020	**2019**
	(In Thousands)	
Finance lease expense:		
Amortization of right-of-use assets	**$ 2,998**	$ 3,001
Interest on finance lease liabilities	**2,007**	2,040
Operating lease cost	**18,080**	18,489
Variable and short-term lease expense	**1,361**	1,387
Total lease expense	**$ 24,446**	$ 24,917

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

	Three Months Ended March 31	
	2020	**2019**
	(In Thousands)	
Cash paid for amounts included in the measurement of lease liabilities		
Operating cash flows for operating leases	**$ 15,068**	$ 14,827
Operating cash flows for finance leases	**2,007**	2,040
Financing cash flows for finance leases	**2,043**	2,007

Future minimum lease payments under non-cancellable leases as of March 31, 2020 are as follows (in thousands):

	Operating Leases	Finance Leases
2020 (excluding the three months ended March 31, 2020)	$ 49,230	$ 11,472
2021	61,222	14,866
2022	55,427	15,187
2023	50,346	15,513
2024	48,931	15,611
2025 and thereafter	311,821	809,817
Total lease payments	576,977	882,466
Less imputed interest	(79,956)	(621,087)
Present value of lease payments	$ 497,021	$ 261,379

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, 2020 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) (formerly The Federation of Jewish Philanthropies or FOJP), 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.

Prior to January 2018, the Medical Center participated in a pooled excess insurance program for hospital professional liability with certain other health care facilities affiliated with FOJP. Participation was through ownership of captive insurance companies.

In November 2018, Mount Sinai Health System, Beth Israel Medical Center, Maimonides Medical Center and the Medical Center, collectively the owners of HIC and FOJP, announced their agreement to sell HIC and FOJP to The Doctors Company for $650 million, subject to closing adjustments. The transaction closed on July 31, 2019, and the hospitals shared in the proceeds ratably according to their ownership. The Medical Center received approximately $177.7 million in proceeds from the sale. HRA continues to provide the same services to the Medical Center and the member hospitals as prior to the transaction.

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, Inc.: In 2015, a controlled member of MMAHS, Albert Einstein College of Medicine, Inc. (Einstein), 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 5.5% coupon rate and mature on September 1, 2045. Interest is payable semiannually and principal is payable annually commencing on September 1, 2020.

6. Commitments and Contingencies (continued)

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% effective March 17, 2017. The Guaranty Agreement was amended to cover payments made by Einstein under the Replacement Notes. On May 1, 2017, the aggregate amounts payable by Einstein under the Replacement Notes were amended to $3.8 million in 2017, with annual payments of $8.3 million from 2018 to 2020, $36.0 million in 2021, $12.5 million from 2022 to 2036, followed by a final payment of $20.0 million in 2037.

No amounts were paid by the Medical Center on Einstein's behalf pursuant to the Guaranty Agreement, as amended during 2020 or 2019.

The Medical Center has 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 Medical Center is providing this subsidy in varying amounts to be funded upon the receipt and approval of documentation of unreimbursed research expenses incurred. The subsidy will total an amount not to exceed $10.0 million per year in each of the first two years, and not to exceed $20.0 million per year in each of the third, fourth and fifth years. During the three months ended March 31, 2020 and 2019, the Medical Center made capital contributions of approximately $5.0 million to Einstein in accordance with this agreement.

The Medical Center also agreed to provide loans to Einstein in an aggregate amount of up to $75.0 million as necessary to allow it to meet its cash flow requirements. The first loan was funded in 2017 in the amount of $35.0 million. The loan was secured by a subordinate mortgage on certain of Einstein's real property. During 2018, the Medical Center reserved the amounts owed from Einstein of approximately $36.8 million under this agreement.

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, 2020 and 2019, the Medical Center provided approximately $28.4 million and $10.0 million, respectively, to Einstein which was recorded within transfers to members, net in the consolidated statements of operations.

6. Commitments and Contingencies (continued)

Other: At March 31, 2020 and December 31, 2019, approximately 58% 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 2022. Nyack's contract with NYSNA expires in December 2023. The Medical Center, MNR, MMV, SECC and St. Luke's collective bargaining agreements with 1199SEIU expire in September 2021. White Plains' contract with 1199SEIU expires in April 2022. Nyack's contract with 1199SEIU expires June 2022.

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.

In September 2018, the Health System entered into a commitment to loan up to $12.5 million to St. John's Riverside Hospital (SJRH) to support its working capital and operational needs. The commitment was revised in October 2019 increasing the commitment amount to $28.5 million. No amounts have been loaned at March 31, 2020 or December 31, 2019. SJRH and the Health System currently have a clinical affiliation. In August 2018, SJRH's board voted to begin exclusive negotiations to join the Health System.

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.

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.

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 March 31, 2020:

	March 31, 2020			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	**$ 337,246**	**$ –**	**$ –**	**$ 337,246**
Managed cash and cash equivalents held for investment	**211,059**	**–**	**–**	**211,059**
Marketable and other securities:				
Non-equity mutual funds	**193,840**	**–**	**–**	**193,840**
Equity mutual funds	**51,823**	**–**	**–**	**51,823**
U.S. Government agency mortgage-backed securities	**–**	**65,411**	**–**	**65,411**
U.S. Treasury securities	**444,749**	**–**	**–**	**444,749**
U.S. Government agency-backed securities	**–**	**14,619**	**–**	**14,619**
Equity securities	**41,992**	**–**	**–**	**41,992**
Corporate debt	**–**	**973,619**	**–**	**973,619**
Investment contracts	**–**	**1,985**	**–**	**1,985**
	1,280,709	**1,055,634**	**–**	**2,336,343**
Defined benefit pension plan assets				
Cash and cash equivalents	**92,196**	**–**	**–**	**92,196**
Equity mutual funds	**125,135**	**–**	**–**	**125,135**
Non-equity mutual funds	**69,651**	**–**	**–**	**69,651**
	286,982	**–**	**–**	**286,982**
	$ 1,567,691	**$ 1,055,634**	**$ –**	**2,623,325**
Investments measured at net asset value (defined benefit pension plan assets)				**29,653**
				$ 2,652,978

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, 2019:

	December 31, 2019			
	Level 1	**Level 2**	**Level 3**	**Total**
		(In Thousands)		
Assets				
Cash and cash equivalents	$ 397,526	$ –	$ –	$ 397,526
Managed cash and cash equivalents held for investment	288,151	–	–	288,151
Marketable and other securities:				
Non-equity mutual funds	179,914	–	–	179,914
Equity mutual funds	66,305	–	–	66,305
U.S. Government agency mortgage-backed securities	–	84,745	–	84,745
U.S. Treasury securities	126,664	–	–	126,664
U.S. Government agency-backed securities	–	1,136	–	1,136
Equity securities	83,468	–	–	83,468
Corporate debt	–	794,692	–	794,692
Investment contracts	–	2,483	–	2,483
Interest and other receivables	125	–	–	125
	1,142,153	883,056	–	2,025,209
Defined benefit pension plan assets				
Cash and cash equivalents	7,255	–	–	7,254
Equity mutual funds	158,273	–	–	158,272
Non-equity mutual funds	163,530	–	–	163,531
	329,058	–	–	329,057
	$ 1,471,211	$ 883,056	$ –	2,354,267
Investments measured at net asset value (defined benefit pension plan assets)				23,635
				$ 2,377,902

At March 31, 2020 and December 31, 2019, 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 $202.3 million and $220.7 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.

8. COVID-19

Due to the global viral outbreak caused by Coronavirus Disease 2019 (COVID-19) in 2020, there have been resulting effects which have, and will continue to negatively impact the Health System's financial condition. The ultimate impact of these matters to the Health System and its financial condition is presently unknown.

Management continues to closely monitor the operational and financial impact of COVID-19 in many respects and is pursuing opportunities for Federal and any other funding that is or will become available, including from the Federal Coronavirus Aid, Relief and Economic Security Act (CARES Act), the Federal Emergency Management Agency or other sources.

The CARES Act provides for deferred payment of the employer portion of social security taxes between March 27, 2020 and December 31, 2020, with 50% of the deferred amount due December 31, 2021 and the remaining 50% due December 31, 2022. The Health System began deferring the employer portion of social security taxes in April 2020.

In April 2020, the Health System received approximately $453.6 million from CMS through its advance payment program. Approximately $149.5 million of this amount will be recouped by CMS beginning 120 days after receipt by withholding future Medicare fee-for-service payments. The remaining $304.1 million is expected to be repaid to CMS in May 2021 with the filing of the Health System's annual cost report. The program currently requires that any outstanding balance not repaid in accordance with the advance payment program terms will be subject to a 10.25% interest rate.

During April and May 2020, the Health System received a total of approximately $630.0 million in stimulus funds granted as part of the CARES Act for COVID-19 related expenses and lost revenue. The CARES Act grants received to date are not required to be repaid provided that recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using funds received to reimburse expenses or losses that other sources are obligated to reimburse. The CARES Act stimulus and CMS advance payment program funds received did not qualify for recognition during the three months ended March 31, 2020.