Consolidated Financial Statements, Schedule Related to the Uniform Guidance, Audit Reports and Supplementary Information

Montefiore Health System, Inc.
Years Ended December 31, 2019 and 2018
With Reports of Independent Auditors

Ernst & Young LLP

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Montefiore Health System, Inc.

Consolidated Financial Statements, Schedule Related to the Uniform Guidance, Audit Reports and Supplementary Information

Year Ended December 31, 2019

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Montefiore Health System, Inc.

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Report of Independent Auditors

The Board of Trustees and Management
Montefiore Health System, Inc.

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Montefiore Health System, Inc. and its controlled organizations, which comprise the consolidated statements of financial position as of December 31, 2019 and 2018, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement.

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Montefiore Health System, Inc. and its controlled organizations at December 31, 2019 and 2018, and the consolidated results of their operations, changes in their net assets and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Adoption of ASU No. 2016-02, *Leases*

As discussed in Note 1 to the consolidated financial statements, Montefiore Health System, Inc. changed its method of accounting for leases as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2016-02, *Leases,* effective January 1, 2019. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. We have not performed any procedures except for those procedures related to Notes 15 and 16 with respect to the audited consolidated financial statements subsequent to April 15, 2020. The accompanying Schedule of Expenditures of Federal Awards for the year ended December 31, 2019, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, the Financial Responsibility Supplemental Schedule as of and for the year ended December 31, 2019, as required by the U.S. Department of Education, and the schedules related to the New York City Administration for Children's Services Contracts as required by the New York City Administration for Children's Services are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information, except for the portions marked "unaudited," has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information, except for the portions marked "unaudited" on which we express no opinion, is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our report dated April 15, 2020, on our consideration of Montefiore Health System, Inc. and its controlled organizations' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Montefiore Health System, Inc.'s internal control over financial reporting and compliance.

Ernst & Young LLP

April 15, 2020, except for Notes 15 and 16 and our report on the Schedule of Expenditures of Federal Awards, Financial Responsibility Supplemental Schedule, and schedules related to the New York City Administration for Children's Services Contracts for which the date is September 30, 2020.

Montefiore Health System, Inc.

Consolidated Statements of Financial Position

	December 31	
	2019	**2018**
	(In Thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 397,526**	$ 392,270
Marketable and other securities	**1,542,776**	1,460,882
Assets limited as to use, current portion	**65,723**	52,774
Receivables for patient care, net	**490,688**	412,242
Other receivables	**90,350**	83,741
Estimated insurance claims receivable, current portion	**90,757**	109,038
Other current assets	**110,054**	105,074
Total current assets	**2,787,874**	2,616,021
Assets limited as to use, net of current portion	**239,876**	229,632
Property, buildings and equipment, net	**2,045,928**	1,685,630
Right-of-use assets – operating leases	**494,387**	–
Estimated insurance claims receivable, net of current portion	**445,497**	470,203
Other noncurrent assets	**307,538**	393,220
Due from members	**100**	100
Total assets	**$ 6,321,200**	$ 5,394,806
Liabilities and net assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 606,876**	$ 596,558
Accrued salaries, wages and related items	**426,580**	398,050
Self-insured professional and other insured liabilities, current portion	**82,422**	67,637
Estimated insurance claims liabilities, current portion	**92,882**	104,008
Estimated third-party payer liabilities, current portion	**99,415**	87,542
Long-term debt, current portion	**69,781**	49,539
Finance lease liabilities, current portion	**10,913**	2,757
Operating lease liabilities, current portion	**49,242**	–
Due to members	**29,350**	18,665
Total current liabilities	**1,467,461**	1,324,756
Long-term debt, net of current portion	**1,415,205**	1,394,305
Finance lease liabilities, net of current portion	**251,293**	60,095
Operating lease liabilities, net of current portion	**455,051**	–
Noncurrent defined benefit pension and other postretirement health plan liabilities	**325,424**	295,389
Self-insured professional and other insured liabilities, net of current portion	**175,356**	130,700
Employee deferred compensation	**73,061**	53,869
Estimated insurance claims liabilities, net of current portion	**446,869**	488,950
Estimated third-party payer liabilities, net of current portion	**239,517**	225,004
Other noncurrent liabilities	**74,300**	137,538
Total liabilities	**4,923,537**	4,110,606
Commitments and contingencies		
Net assets:		
Net assets without donor restrictions:		
Montefiore Health System, Inc.	**1,244,938**	1,126,885
Noncontrolling interest	**3,067**	2,986
Total net assets without donor restrictions	**1,248,005**	1,129,871
Net assets with donor restrictions	**149,658**	154,329
Total net assets	**1,397,663**	1,284,200
Total liabilities and net assets	**$ 6,321,200**	$ 5,394,806

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Operations

	Year Ended December 31 2019	2018
	(In Thousands)	
Operating revenue		
Net patient service revenue	**$ 5,805,624**	$ 5,458,452
Grants and contracts	**137,983**	112,922
Other revenue	**315,331**	336,698
Total operating revenue	**6,258,938**	5,908,072
Operating expenses		
Salaries and wages	**2,882,613**	2,692,460
Employee benefits	**805,616**	762,111
Supplies and other expenses	**2,351,988**	2,207,820
Depreciation and amortization	**220,589**	210,957
Interest	**76,158**	55,422
Total operating expenses	**6,336,964**	5,928,770
Deficiency of operating revenue over operating expenses before Value Based Payment and Vital Access Provider Programs	**(78,026)**	(20,698)
Value Based Payment and Vital Access Provider Programs	**86,697**	74,186
Excess of operating revenue over operating expenses before other items	**8,671**	53,488
Net realized and changes in net unrealized gains and losses on marketable and other securities	**72,351**	(22,569)
Net periodic pension and other postretirement benefit costs (non-service related)	**(16,244)**	(8,240)
Malpractice insurance program adjustments	**31,095**	49,354
Gain on sale of equity interest in captive insurance company	**39,200**	–
Distribution from demutualization	**–**	28,944
Other nonoperating gains and losses, net	**(2,444)**	6,672
Excess of revenues over expenses before noncontrolling interest of joint venture	**132,629**	107,649
Income attributable to noncontrolling interest of joint venture	**(524)**	(2,986)
Excess of revenues over expenses	**132,105**	104,663
Change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods	**(19,542)**	(1,006)
Net assets released from restrictions used for purchases of property, buildings and equipment	**6,933**	7,312
Grants for the purchase of property, buildings and equipment	**25,506**	16,534
Other changes in net assets without donor restrictions	**33,460**	–
Transfers to members, net	**(60,409)**	(96,911)
Increase in net assets without donor restrictions	**$ 118,053**	$ 30,592

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Changes in Net Assets

	Without Donor Restrictions				
	Montefiore Health System, Inc.	**Non-Controlling Interest**	**Total**	**With Donor Restrictions**	**Total Net Assets**
			(In Thousands)		
Net assets at January 1, 2018	$ 1,096,293	$ –	$ 1,096,293	$ 158,378	$ 1,254,671
Increase in net assets without donor restrictions	30,592	2,986	33,578	–	33,578
Restricted gifts, bequests, and similar items	–	–	–	11,499	11,499
Restricted investment income	–	–	–	(605)	(605)
Net assets released from restrictions	–	–	–	(14,943)	(14,943)
Total changes in net assets	30,592	2,986	33,578	(4,049)	29,529
Net assets at December 31, 2018	1,126,885	2,986	1,129,871	154,329	1,284,200
Increase in net assets without donor restrictions	**118,053**	**524**	**118,577**	**–**	**118,577**
Distributions to noncontrolling partners	–	**(443)**	**(443)**	**–**	**(443)**
Restricted gifts, bequests, and similar items	–	–	–	**6,840**	**6,840**
Restricted investment income	–	–	–	**1,798**	**1,798**
Net assets released from restrictions	–	–	–	**(13,309)**	**(13,309)**
Total changes in net assets	**118,053**	**81**	**118,134**	**(4,671)**	**113,463**
Net assets at December 31, 2019	**$ 1,244,938**	**$ 3,067**	**$ 1,248,005**	**$ 149,658**	**$ 1,397,663**

See accompanying notes.

Montefiore Health System, Inc.

Consolidated Statements of Cash Flows

	Year Ended December 31 2019	2018
	(In Thousands)	
Operating activities		
Increase in net assets	**$ 113,463**	$ 29,529
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	**220,589**	210,957
Change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods	**19,542**	1,006
Transfers to members, net	**60,409**	96,911
Lease transition adjustments	**(35,038)**	–
Net realized gains and losses on marketable and other securities	**(9,594)**	(15,473)
Change in net unrealized gains and losses on marketable and other securities	**(62,757)**	38,042
Change in fair value of derivative instrument	**103**	(628)
Equity earnings from investments	**(24,178)**	(45,993)
Gain on sale of equity interest in captive insurance company	**(39,200)**	–
Write-off of long-term mortgage premium and deferred financing costs as a result of debt refinancing	**–**	4,005
Amortization of long-term mortgage premium	**(2,343)**	(1,051)
Amortization of deferred financing costs	**1,197**	1,142
Changes in operating assets and liabilities:		
Receivables for patient care	**(78,446)**	2,017
Other noncurrent assets	**(28,744)**	(18,934)
Accounts payable and accrued expenses	**7,233**	55,861
Accrued salaries, wages and related items	**28,530**	(13,916)
Non-current defined benefit and postretirement health plan liabilities	**10,493**	(1,995)
Other noncurrent liabilities	**(12,419)**	(361)
Net change in all other operating assets and liabilities	**137,074**	37,196
Net cash provided by operating activities	**305,914**	378,315
Investing activities		
Acquisition of property, buildings, and equipment, net	**(359,133)**	(215,822)
Proceeds from sale of equity interest in captive insurance company	**177,701**	–
Funding of self-insurance trust	**(35,448)**	(7,718)
Increase in marketable and other securities, net	**(124,832)**	(421,375)
(Increase) decrease in assets limited to use, net	**(52,787)**	121,376
Payments for investment in joint venture	**(27,250)**	(25,500)
Net cash used in investing activities	**(421,749)**	(549,039)
Financing activities		
Payments of long-term debt and finance lease liabilities	**(33,547)**	(74,107)
Extinguishment of long-term debt	**–**	(575,639)
Proceeds from long-term debt	**69,757**	1,252,450
Payments to members, net	**(60,002)**	(53,000)
Payments of deferred financing costs	**–**	(24,482)
Net cash (used in) provided by financing activities	**(23,792)**	525,222
Net (decrease) increase in cash, cash equivalents and restricted cash	**(139,627)**	354,498
Cash, cash equivalents and restricted cash at beginning of year	**825,304**	470,806
Cash, cash equivalents and restricted cash at end of year	**$ 685,677**	$ 825,304
Reconciliation of cash and cash equivalents at end of year to the consolidated statements of financial position:		
Cash and cash equivalents	**$ 397,526**	$ 392,270
Marketable and other securities: cash and cash equivalents	**228,647**	343,936
Assets limited as to use: cash and cash equivalents	**59,504**	89,098
Total cash, cash equivalents and restricted cash	**$ 685,677**	$ 825,304
Supplemental cash flow and non-cash information		
Deferred payments for acquisition of investment in joint venture	**$ 37,250**	$ 64,500
Property, building and equipment purchases in accounts payable and accrued expenses	**$ 3,305**	$ –
Finance lease obligations incurred	**$ 4,460**	$ 3,000

See accompanying notes.

1. Organization and Summary of Significant Accounting Policies

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 (the 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
  - WPHC Building Corp
  - 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

1. Organization and Summary of Significant Accounting Policies (continued)

  - 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 related organizations:
  - 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)
- 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 (deferred payments). In accordance with the purchase agreement, the Medical Center agreed to guarantee payments made by the Health System. As of December 31, 2019 and 2018, approximately $14.4 million and $30.0 million, respectively, was held in escrow as security for the deferred payments.

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 contribution and is included in other nonoperating gains and losses, net in the accompanying consolidated statement of operations

1. Organization and Summary of Significant Accounting Policies (continued)

for the year ended December 31, 2018. 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.

Captive insurance companies in which the Health System has an equity interest of more than 20%, but less than 50%, are accounted for under the equity method of accounting. In addition, investments in limited liability companies not wholly owned are recorded under the equity method.

Tax Status: The Health System and most of its subsidiaries are exempt from Federal income tax on related function income under Sections 501(a) and 501(c)(3) of the Internal Revenue Code (IRC) as well as New York State and local income taxes pursuant to the corresponding state exemption provisions. The exempt organizations within the Health System are subject to taxation on income derived from business activities that are not related to their exempt purpose. There are also various subsidiaries of the Health System that are for-profit entities. The effect of income taxes are not material to the consolidated financial statements.

The Taxpayer Certainty and Disaster Tax Relief Act of 2019, signed into law on December 20, 2019, retroactively repealed IRC Section 512(a)(7) which subjected amounts paid or incurred by an exempt organization to provide certain transportation fringe benefits to its employees to taxation as unrelated business taxable income. The impact of the Taxpayer Certainty and Disaster Tax Relief Act of 2019 was not significant to the accompanying consolidated financial statements.

Net Assets without Donor Restrictions: Net assets without donor restrictions are those that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Health System. These net assets may be used at the discretion of the Health System's management and board of trustees.

Net Assets with Donor Restrictions: Net assets with donor restrictions are those whose use has been limited by donors to a specific time frame or purpose or have been restricted by the donors to be maintained by the Health System in perpetuity. The Health System records donor restricted contributions if they are received with donor stipulations that limit their use either through purpose or time restrictions.

1. Organization and Summary of Significant Accounting Policies (continued)

When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is accomplished, donor restricted net assets are reclassified as net assets without donor restrictions and reported as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are classified as contributions without donor restrictions. Other revenue for the years ended December 31, 2019 and 2018, includes approximately $6.4 million and $7.6 million, respectively, of net assets released from restrictions used for operations.

Cash and Cash Equivalents: Cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less at the time of purchase which are not deemed to be assets limited as to use or part of the marketable securities portfolio. The Health System maintains cash on deposit with major banks and invests in highly rated commercial paper on an overnight basis or securities issued by either the United States Government or its agencies with a maturity of three months or less at the time of purchase. The Health System does not hold any money market funds with significant liquidity restrictions that would be required to be excluded from cash equivalents. Amounts within restricted cash include cash and cash equivalents held within marketable and other securities and assets limited as to use and represent funds set aside within the investment portfolio based on management’s policy or contractual arrangements. Book overdrafts of approximately $28.9 million and $65.6 million as of December 31, 2019 and 2018, respectively, are included within accounts payable and accrued expenses in the consolidated statements of financial position.

At December 31, 2019 and 2018, the Health System invested excess cash in deposits with major banks and in money market funds with high credit quality financial institutions.

Inventories: Inventories, included in other current assets, consist primarily of drugs and supplies, and are valued at the lower of cost and net realizable value.

Marketable and Other Securities: All marketable and other securities are classified as trading securities. Marketable securities are carried at fair value and generally consist of fixed income securities issued or guaranteed by government entities, money market funds, mutual funds, fixed income securities issued by corporations, collective trust funds and equity securities. Marketable securities received as a gift are initially recorded at fair value at the date of the gift. The carrying amount of alternative investments (nontraditional, not readily marketable asset classes), some of which are structured such that the Health System holds limited partnership interests, are determined by the Health System’s management for each investment, based upon net asset values derived from the application of the equity method of accounting.

1. Organization and Summary of Significant Accounting Policies (continued)

Individual investment holdings within the alternative investments include both non-marketable and market-traded securities. Valuations of the non-marketable securities are determined by the investment manager or general partner. These values may be based on historical cost, appraisals, or other estimates that require varying degrees of judgment. Generally, the carrying amount reflects net contributions to the investee and an ownership share of realized and unrealized investment income and expenses. The investments may indirectly expose the Health System to securities lending, short sales of securities, and trading in futures and forwards contracts, options, and other derivative products. The Health System's risk is limited to its carrying value, in addition to any unfunded commitments. At December 31, 2019 and 2018, the Health System had approximately $46.4 million and $25.9 million, respectively, of future commitments to invest in alternative investments. Certain investments are subject to notification periods or restrictions in order to divest. The redemption notice period for this asset class ranges from 30 days to 90 days. Funds are generally available within 30 days after the redemption date. At December 31, 2019 and 2018, approximately 24% and 35%, respectively, of alternative investments are held in illiquid private equity funds and distributions are based on the investment managers' discretion. The financial statements of the investees are audited annually by independent auditors, although the timing for reporting the results of such audits does not coincide with the Health System's annual consolidated financial statement reporting.

There is uncertainty in the accounting for alternative investments arising from factors such as lack of active markets (primary or secondary), lack of transparency into underlying holdings and time lags associated with reporting by the investee companies. As a result, there is at least a reasonable possibility that estimates will change in the near term.

Investment Gains, Losses and Income: Net realized and unrealized gains and losses on marketable and other securities, including equity in earnings or losses of alternative investments, are recorded in the excess of revenues over expenses unless their use is restricted by explicit donor stipulations or by law. Investment income limited by donor-imposed restrictions is recorded as an increase in net assets with donor restrictions. Realized gains and losses on sales of marketable and other securities are based on the average cost method.

Assets Limited as to Use: Assets so classified represent assets whose use is restricted for specific purposes under terms of agreements (such as escrow agreements relating to the payment of claims and other health care service expenses upon occurrence or continuance of certain specific events as designated by the contracts), donor restrictions or employee deferred compensation plans.

1. Organization and Summary of Significant Accounting Policies (continued)

Property, Buildings and Equipment: Property, buildings and equipment purchased are carried at cost and those acquired by gifts and bequests are carried at fair value established at the date received. Property, buildings and equipment of acquired entities are recorded at fair value at the acquisition date based upon an independent valuation. Annual provisions for depreciation are made based upon the straight-line method over the estimated useful lives of the assets. The carrying amounts of assets and the related accumulated depreciation are removed from the accounts when such assets are disposed of and any resulting gain or loss is included in operations in the year of disposal.

Intangible Assets: Intangible assets have definite and indefinite lives and include a favorable leasehold interest at Burke of approximately $20.6 million and $20.8 million as of December 31, 2019 and 2018, respectively. In addition, White Plains carries goodwill in the amount of approximately $33.6 million and $33.9 million as of December 31, 2019 and 2018, respectively, related to the acquisition of certain health care organizations that occurred from 2015 through 2018. Intangible assets with indefinite lives are subject to impairment testing on an annual basis. For the years ended December 31, 2019 and 2018, there were no intangible asset impairment charges.

Intangible assets at December 31, 2019 and 2018, of approximately $68.4 million and $68.8 million, respectively, are included within other noncurrent assets in the accompanying consolidated statements of financial position.

Deferred Financing Costs: Deferred financing costs represent costs incurred to obtain financing for various construction and renovation projects. Amortization of these costs is determined by the effective interest method extending over the terms of the related indebtedness. Deferred financing costs are included as a reduction to long-term debt in the accompanying consolidated statements of financial position.

Employee Deferred Compensation Plan: Pursuant to various deferred compensation plans in which certain Health System employees or former employees participate, the Health System deposited employee contributions with trustees on behalf of the participating employees. The Health System is not responsible for investment gains or losses incurred. The assets, which are

carried at fair value with a corresponding liability, are restricted for payments under the plans and may only revert to the Health System under certain specified circumstances. The assets are included in assets limited as to use in the accompanying consolidated statements of financial position.

1. Organization and Summary of Significant Accounting Policies (continued)

Premium Revenue and Health Care Service Cost Recognition: 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. 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. The Health System reimburses these providers on either a capitated or negotiated fee-for-service basis. The cost of health care services is accrued based on processed and unprocessed claims and estimates for medical services, which have been incurred but not reported. Although it is not possible to measure with certainty the degree of variability inherent in such an estimate, such estimates are continually monitored and reviewed by management and independent actuaries, and any adjustments deemed necessary are reflected in current operations. Health care service costs included in supplies and other expenses were (decreased) increased by approximately ($3.7 million) and $106,000 for the years ended December 31, 2019 and December 31, 2018, respectively, reflecting the difference between claims paid and the liability originally estimated. Premium revenue included within the caption net patient service revenue in the accompanying consolidated statements of operations.

Distribution from Demutualization: In October 2018, Nyack and White Plains received distributions totaling approximately $28.9 million from MLMIC Insurance Company (formerly known as Medical Liability Mutual Insurance Company) (MLMIC). In the last quarter of 2018, MLMIC was acquired by National Indemnity Company, a subsidiary of Berkshire Hathaway Inc. As a result of the acquisition, MLMIC went through a demutualization whereby its legal structure converted from a customer-owned mutual organization to a joint-stock company. The cash consideration resulting from the conversion was paid out to eligible policyholders (policyholders with policies in effect from July 15, 2013, through July 14, 2016 (or their designees)) and is included in the excess of revenues over expenses in the accompanying consolidated statement of operations for the year ended December 31, 2018.

Performance Indicator: The consolidated statements of operations include excess of revenues over expenses as the performance indicator. Items excluded from excess of revenues over expenses are change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods, other changes in net assets without donor restrictions, grants for the purchase of property, buildings and equipment, net assets released from restrictions used for purchases of property, buildings and equipment and transfers to members, net.

1. Organization and Summary of Significant Accounting Policies (continued)

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 of operating revenues over operating expenses before certain items. Peripheral transactions or transactions of an infrequent nature are excluded from excess of operating revenues over operating expenses before other items.

Charity Care and Other Community Benefit Programs: The Health System is guided by its mission and charitable purpose to provide charity care and other community benefit programs. These activities include access to medically necessary treatment for individuals unable to pay for services, care provided under means-tested government insurance programs that reimburse the Health System at less than the cost of the services provided, education for future health providers, research to advance knowledge and other programs designed to meet local community needs.

The Health System is committed to serving all patients in need of health care services. Consistent with its mission and values, and taking into account an individual's ability to pay for medically necessary health care services, the Health System provides charity care, including free or discounted care, to all patients not covered by insurance. A key aspect of the policy includes assisting patients in obtaining insurance they are eligible to receive. Care provided under the charity care policy is not reported as net patient service revenue in the accompanying consolidated statements of operations. The cost of charity care is estimated based on charges associated with the care provided, applied to the ratio of total patient care expenses to total charges for all services rendered.

Medicaid and other means-tested programs comprise approximately one-third of the Health System's patient service revenue. The costs are estimated based on charges for services provided under the means-tested programs, applied to the ratio of total patient care expenses to total charges for all services rendered. The unpaid cost presented in the table below is based on estimated total costs, less reimbursement received for the services provided.

The Health System operates one of the largest medical residency and health professions training programs in the United States. The costs of the training programs are included in operating expenses in the accompanying consolidated statements of operations. The costs presented below are net of graduate medical education funding from the Medicare and Medicaid programs.

1. Organization and Summary of Significant Accounting Policies (continued)

Research and other community benefit program costs include expenses incurred to advance medical care and clinical knowledge. In addition, the Health System fosters community participation through advisory boards and linkages with community-based groups. It responds to identified community health related needs by offering specific services including, among others, wellness programs, community education programs, health screenings, community support services and subsidized health services. The research and other community benefit program costs presented below are included in operating expenses in the accompanying consolidated statements of operations.

A summary of the costs associated with the provision of charity care and other community benefit programs is as follows:

	Year Ended December 31	
	2019	**2018**
	(In Thousands)	
Charity care, at cost and net of subsidies	**$ 109,172**	$ 83,337
Unpaid cost of means-tested government-sponsored insurance programs	**405,667**	386,742
Health professions training, at cost	**113,854**	61,343
Community benefit programs	**104,125**	100,082
Research	**19,267**	19,077
	$ 752,085	$ 650,581

The New York State Department of Health (NYSDOH) Hospital Indigent Care Pool (the Pool) was established to provide funds to hospitals for the provision of uncompensated care and is funded, in part by a 1% assessment on hospital net inpatient service revenue. For the years ended December 31, 2019 and 2018, the Health System received approximately $29.4 million and $30.0 million, respectively, in Pool distributions related to charity care. The Health System made payments into the Pool of approximately $28.9 million and $28.5 million for the years ended December 31, 2019 and 2018, respectively, for the 1% assessment.

1. Organization and Summary of Significant Accounting Policies (continued)

Program Services: The Health System provides health care and related services primarily within its geographic area. Expenses related to providing these services for the year ended December 31, 2019, are as follows:

	Health Care and Related Services	Research	Fundraising	Program Support and General Services	Total
			(In Thousands)		
Salaries and wages	**$ 2,517,844**	**$ 2,115**	**$ 1,949**	**$ 360,705**	**$ 2,882,613**
Employee benefits	**699,999**	**663**	**415**	**104,539**	**805,616**
Supplies and other expenses	**2,099,436**	**2,255**	**1,896**	**248,401**	**2,351,988**
Depreciation and amortization	**157,277**	**–**	**188**	**63,124**	**220,589**
Interest	**72,759**	**–**	**5**	**3,394**	**76,158**
	$ 5,547,315	**$ 5,033**	**$ 4,453**	**$ 780,163**	**$ 6,336,964**

Expenses related to providing these services for the year ended December 31, 2018, are as follows:

	Health Care and Related Services	Research	Fundraising	Program Support and General Services	Total
			(In Thousands)		
Salaries and wages	$ 2,349,540	$ 1,930	$ 1,566	$ 339,424	$ 2,692,460
Employee benefits	663,483	622	352	97,654	762,111
Supplies and other expenses	2,146,671	2,232	2,492	56,425	2,207,820
Depreciation and amortization	147,183	–	170	63,604	210,957
Interest	50,618	–	4	4,800	55,422
	$ 5,357,495	$ 4,784	$ 4,584	$ 561,907	$ 5,928,770

1. Organization and Summary of Significant Accounting Policies (continued)

The financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including depreciation, amortization, interest, and other occupancy costs, are allocated to a function based on a square footage or units of service basis.

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. During 2019 and 2018, the Health System recorded net changes in estimates that (decreased) increased the excess of revenues over expenses by approximately ($5.6 million) and $14.0 million, respectively, which primarily relate to changes in previously estimated third-party payer settlements and changes to estimated liabilities.

Recently Adopted Accounting Pronouncements:

In January 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). ASU 2016-01 makes targeted improvements to the accounting for, and presentation and disclosure of, financial instruments. ASU 2016-01 requires that most equity instruments be measured at fair value, with subsequent changes in fair value recognized in excess of operating revenue over operating expenses before other items. ASU 2016-01 does not affect the accounting for investments that would otherwise be consolidated or accounted for under the equity method. The standard also impacts financial liabilities under the fair value option and the presentation and disclosure requirements for financial instruments. The Health System adopted ASU 2016-01 on January 1, 2019. With the exception of certain disclosures, the adoption of ASU 2016-01 did not have a material impact on the consolidated financial statements.

1. Organization and Summary of Significant Accounting Policies (continued)

In February 2016, the FASB issued ASU 2016-02, *Leases* (ASU 2016-02), which requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the consolidated balance sheet, including both finance and operating leases. ASU 2016-02 requires disclosures to help the financial statement users better understand the amount, timing and uncertainty of cash flows arising from leases. The recognition, measurement and presentation of expenses and cash flows arising from a lease primarily depend on its classification as a finance or operating lease. The Health System adopted ASU 2016-02 on January 1, 2019, utilizing the modified retrospective approach. ASU 2016-02 had a material impact on the Health System's consolidated statement of financial position, but did not have a material impact on the consolidated statement of operations. Under the modified retrospective approach, prior period amounts were not required to be adjusted. The Health System applied the transitional package of practical expedients allowed by ASU 2016-02 relating to the identification, classification and initial direct costs of leases commencing before the effective date of ASU 2016-02; however, the Health System did not elect the hindsight transitional practical expedient. The Health System also elected the practical expedient to utilize a risk-free rate as the incremental borrowing rate for all leases in transition and prospectively. Under ASU 2016-02, the Health System derecognized its build to suit asset and liability as of the transition date, which resulted in an increase to net assets without donor restrictions of approximately $19.7 million and is included in other changes in net assets without donor restrictions. Certain other transitional adjustments were made as a result of adopting ASU 2016-02 which were not considered significant and are included in other changes in net assets without donor restrictions.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows – Classification of Certain Cash Receipts and Cash Payments* (ASU 2016-15), which addresses the following eight specific cash flow issues in order to limit diversity in practice: debt prepayment or debt extinguishment costs; settlement of zero-coupon debt instruments or other debt instruments with coupon interest rates that are insignificant in relation to the effective interest rate of the borrowing; contingent consideration payments made after a business combination; proceeds from the settlement of insurance claims; proceeds from the settlement of corporate-owned life insurance policies, including bank-owned life insurance policies; distributions received from equity method investees; beneficial interests in securitization transactions; and separately identifiable cash flows and application of the predominance principle. The adoption of ASU 2016-15 did not have a material impact on the Health System's consolidated financial statements.

1. Organization and Summary of Significant Accounting Policies (continued)

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows – Restricted Cash* (ASU 2016-18), which requires that the statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The Health System adopted ASU 2016-18 using a retrospective transition method.

In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958); Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). ASU 2018-08 clarifies existing guidance in order to address diversity in practice in classifying grants (including governmental grants) and contracts received by not-for-profit entities, and requires entities to evaluate whether the resource provider receives commensurate value. In addition, the standard clarifies the guidance on how entities determine when a contribution is conditional, including whether the agreement includes a barrier (or barriers) that must be overcome for the recipient to be entitled to the transferred assets and a right of return of the transferred assets (or a right of release of the promisor's obligation to transfer the assets). The Health System adopted ASU 2018-08 on a retrospective basis. The adoption of ASU 2018-08 in relation to other revenue activity did not have a material impact on the Health System's consolidated financial statements.

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

1. Organization and Summary of Significant Accounting Policies (continued)

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 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* (ASU 2019-06). Under ASU 2019-06, entities that elect the goodwill accounting

1. Organization and Summary of Significant Accounting Policies (continued)

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 2018 consolidated financial statements to conform to the 2019 presentation. These reclassifications have no effect on the excess of revenues over expenses or net assets for the year ended December 31, 2018.

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

2. Net Patient Service Revenue (continued)

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.

2. Net Patient Service Revenue (continued)

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 years ended December 31, 2019 and 2018, 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 years ended December 31, 2019 and 2018, 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:

	Year Ended December 31	
	2019	**2018**
	(In Thousands)	
Medicare and Medicare managed care	**$ 1,936,474**	$ 1,906,075
Medicaid and Medicaid managed care	**1,563,106**	1,536,851
Commercial carriers and managed care	**2,233,561**	1,956,341
Self-pay and other	**72,483**	59,185
	$ 5,805,624	$ 5,458,452

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

2. Net Patient Service Revenue (continued)

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

	Year Ended December 31	
	2019	**2018**
	(In Thousands)	
Inpatient services	**$ 2,813,774**	$ 2,707,283
Physician and other outpatient services	**1,876,684**	1,675,282
Premium revenue	**841,107**	805,762
Emergency department	**204,318**	201,215
All other	**69,741**	68,910
	$ 5,805,624	$ 5,458,452

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.

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

	December 31	
	2019	**2018**
	(In Thousands)	
Patient receivables	**$ 399,882**	$ 335,013
Contract assets	**90,806**	77,229
	$ 490,688	$ 412,242

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.

2. Net Patient Service Revenue (continued)

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 years ended December 31, 2019 and 2018.

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 Payer 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.

2. Net Patient Service Revenue (continued)

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.

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

2. Net Patient Service Revenue (continued)

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. Availability and Liquidity of Financial Assets

Financial assets available for general expenditures within one year are as follows:

	December 31	
	2019	**2018**
	(In Thousands)	
Financial assets at year-end:		
Cash and cash equivalents	**$ 397,526**	$ 392,270
Marketable and other securities	**1,542,776**	1,460,882
Assets limited as to use	**305,599**	282,406
Receivables for patient care, net	**490,688**	412,242
Pledges receivable, net	**7,797**	10,632
Total financial assets	**2,744,386**	2,558,432
Less amounts not available to be used within one year:		
Donor restricted funds	**(107,211)**	(102,173)
Debt-related sinking and debt service funds	**(1,278)**	(1,393)
Managed care cash reserves required by contracts	**(4,053)**	(3,969)
Lease escrow deposits	**(6,958)**	(7,012)
Employee deferred compensation plan assets	**(73,061)**	(53,869)
Professional liabilities	**(1,855)**	(1,807)
Board designated funds	**(29,353)**	(26,894)
Security agreement escrow deposit	**(14,400)**	(30,000)
Other	**(1,707)**	(2,516)
Alternative investments held in illiquid private equity funds	**(36,336)**	(30,440)
Financial assets not available to be used within one year	**(276,212)**	(260,073)
Financial assets available to meet general expenditures over the next twelve months	**$ 2,468,174**	$ 2,298,359

The Health System has certain donor restricted assets limited as to use which are available for general expenditure within one year in the normal course of operations. Accordingly, these assets have been included in the qualitative information above for financial assets to meet general expenditures within one year. The Health System has other assets limited as to use which are detailed in Note 4. These assets limited as to use are not available for general expenditure within the next year. As part of the Health System's liquidity management plan, operating cash in excess of daily requirements are invested in short-term investments and money market funds.

3. Availability and Liquidity of Financial Assets (continued)

Additionally, as of December 31, 2019 and 2018, the Health System maintains various lines of credit aggregating to approximately $254.2 million and $79.3 million, respectively, as discussed in more detail in Note 7. As of December 31, 2019 and 2018, approximately $160.6 million and $55.1 million, respectively, remained available on the Health System's lines of credit.

4. Marketable and Other Securities

The composition of marketable and other securities and assets limited as to use follows:

	December 31	
	2019	**2018**
	(In Thousands)	
Marketable and other securities	**$ 1,542,776**	$ 1,460,882
Assets limited as to use	**305,599**	282,406
	$ 1,848,375	$ 1,743,288
Managed cash and cash equivalents held for investment	**$ 288,151**	$ 433,034
Corporate debt	**794,692**	795,772
U.S. Treasury securities	**126,664**	44,702
U.S. Government agency mortgage-backed securities	**84,745**	39,513
U.S. Government agency-backed securities	**1,136**	35,330
Equity securities	**83,468**	76,208
Non-equity mutual funds	**179,914**	128,111
Equity mutual funds	**66,305**	50,042
Alternative investments	**164,166**	87,515
Collective trust funds	**56,526**	48,587
Investment contracts	**2,483**	1,953
Interest and other receivables	**125**	2,521
	$ 1,848,375	$ 1,743,288

4. Marketable and Other Securities (continued)

The composition of assets limited as to use follows:

	December 31	
	2019	**2018**
	(In Thousands)	
Donor restricted funds	**$ 107,211**	$ 102,173
Debt-related sinking and debt service funds	**3,064**	2,968
Managed care cash reserves required by contracts	**61,845**	55,009
Lease escrow deposits	**13,086**	7,104
Employee deferred compensation plan assets	**73,061**	53,869
Professional liabilities	**1,856**	1,807
Board designated funds	**29,353**	26,894
Security agreement escrow deposit	**14,400**	30,000
Other	**1,723**	2,582
Total assets limited as to use	**305,599**	282,406
Less: current portion of assets limited as to use	**(65,723)**	(52,774)
Assets limited as to use, net of current portion	**$ 239,876**	$ 229,632

5. Property, Buildings, and Equipment

A summary of property, buildings, and equipment follows:

	December 31	
	2019	**2018**
	(In Thousands)	
Land and land improvements	**$ 154,843**	$ 142,008
Buildings, fixed equipment, and improvements	**2,561,404**	2,271,951
Movable equipment	**1,821,745**	1,679,914
	4,537,992	4,093,873
Less accumulated depreciation and amortization	**(2,696,621)**	(2,492,131)
	1,841,371	1,601,742
Construction-in-progress	**204,557**	83,888
	$ 2,045,928	$ 1,685,630

Substantially all property, buildings and equipment are pledged as collateral under various debt agreements.

6. 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.

6. Leases (continued)

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

	Statement of Financial Position Classification	December 31, 2019
Assets:		
Operating leases	Right-of-use assets – operating leases	$ 494,387
Finance leases	Property, buildings and equipment, net	256,522
Total lease assets		$ 750,909
Liabilities:		
Current:		
Operating leases	Operating lease liabilities, current portion	$ 49,242
Finance leases	Finance lease liabilities, current portion	10,913
Noncurrent:		
Operating leases	Operating lease liabilities, net of current portion	455,051
Finance leases	Finance lease liabilities, net of current portion	251,293
Total lease liabilities		$ 766,499

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

	December 31, 2019
Weighted-average remaining lease term (years)	
Operating leases	11.4
Finance leases[1]	57.5
Weighted-average discount rate	
Operating leases	2.7%
Finance leases	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 10.7 years.

6. Leases (continued)

The following table presents certain information related to lease expense for finance and operating leases for the year ended December 31, 2019 (in thousands):

Finance lease expense:	
Amortization of right-of-use assets	$ 12,001
Interest on finance lease liabilities	8,095
Operating lease cost	71,773
Variable and short-term lease expense	943
Total lease expense	$ 92,812

The following table presents cash flow information for the year ended December 31, 2019 (in thousands):

Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows for operating leases	$ 54,152
Operating cash flows for finance leases	8,091
Financing cash flows for finance leases	6,079

Future minimum lease payments under non-cancellable leases as of December 31, 2019, are as follows (in thousands):

	Operating Leases	Finance Leases
2020	$ 60,861	$ 14,257
2021	60,975	14,866
2022	55,174	15,187
2023	50,160	15,513
2024	48,742	15,611
2025 and thereafter	310,938	809,817
Total lease payments	586,850	885,251
Less imputed interest	(82,557)	(623,045)
Present value of lease payments	$ 504,293	$ 262,206

7. Long-Term Debt

A summary of long-term debt follows:

	December 31 2019	December 31 2018
	(In Thousands)	
Medical Center DASNY Series 2018A bonds payable[(a)]	**$ 309,045**	$ 309,045
Medical Center DASNY Series 2018B bonds payable[(a)]	**376,105**	376,105
Montefiore Obligated Group Series 2018C bonds payable[(a)]	**481,950**	481,950
Bank loans payable[(b)]	**92,645**	29,704
Housing II mortgages payable[(c)]	**17,878**	18,071
Build NYC bonds payable[(d)]	**58,081**	63,613
Equipment loan programs[(e)]	**61,591**	73,354
DASNY mortgages [(f)]	**25,577**	26,921
Nyack loans payable[(g)]	**18,888**	14,234
White Plains construction loans[(h)]	**2,932**	6,601
St. Luke's IDA bonds[(i)]	**34,220**	36,995
Other	**1,092**	1,123
	1,480,004	1,437,716
Add unamortized premiums and discounts, net[(a)]	**28,019**	30,362
Less deferred financing costs	**(23,037)**	(24,234)
Less current portion	**(69,781)**	(49,539)
	$ 1,415,205	$ 1,394,305

[(a)] In August 2018, three series of bonds were issued; the Dormitory Authority of the State of New York (DASNY) Montefiore Obligated Group Revenue Bonds, Series 2018A (Tax-Exempt) (the Series 2018A Bonds); the DASNY Montefiore Obligated Group Revenue Bonds, Series 2018B (Federally Taxable) (the Series 2018B Bonds); and the Montefiore Obligated Group Taxable Bonds, Series 2018C (the Series 2018C Bonds), (collectively, the Series 2018 Bonds). The proceeds from the Series 2018 Bonds were used to refund or refinance certain existing indebtedness, provide working capital, and fund future projects.

7. Long-Term Debt (continued)

As a result of the refinancing, the Medical Center recorded a gain on debt refinancing of approximately $2.1 million during 2018, included within other nonoperating gains and losses, net in the consolidated statements of operations. The Series 2018 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.

The Series 2018A Bonds were sold at a premium, of which approximately $29.4 million and $31.8 million was recorded as a component of the related long-term debt as of December 31, 2019 and 2018, respectively, and is being amortized using the effective interest method over the term of the Series 2018A Bonds. The Series 2018A Bonds maturing from 2024 through 2035 carry a coupon rate of 5.00% and the Series 2018A Bonds maturing from 2036 through 2038 carry a coupon rate of 4.00%. Semiannual interest payments began on February 1, 2019. With the exception of certain limited circumstances, the Series 2018A Bonds may not be prepaid prior to August 1, 2028. Subsequent to August 1, 2028, the Series 2018A Bonds may be prepaid without penalty.

The Series 2018B Bonds were sold at a discount, of which approximately $1.4 million and $1.5 million was recorded as a component of the related long-term debt as of December 31, 2019 and 2018, respectively, and is being amortized using the effective interest method over the term of the Series 2018B Bonds. The Series 2018B Bonds maturing August 1, 2034, carry a 5.10% coupon rate and begin to amortize in 2030. The Series 2018B Bonds maturing August 1, 2048, have a 4.96% coupon rate and begin to amortize in 2035. The Series 2018B Bonds maturing in 2034 may be prepaid at any time subject to certain restrictions. Semiannual interest payments began on February 1, 2019. With the exception of certain limited circumstances, the Series 2018B Bonds maturing in 2048 may not be prepaid prior to August 1, 2028, after which they may be prepaid without penalty. The principal and interest of the Series 2018B Bonds maturing in 2048 is insured by a third party.

The Series 2018C Bonds mature in 2048 and carry a coupon rate of 5.25% and begin to amortize November 1, 2035. Semiannual interest payments began in May 2019. The Series 2018C Bonds may be prepaid at any time, subject to certain restrictions.

7. Long-Term Debt (continued)

(b) Bank loans payable consist of the following at December 31, 2019 and 2018:

	December 31 2019	2018
	(In Thousands)	
Medical Center revolving credit agreement	**$ 55,400**	$ –
Medical Center bank loan payable due in September 2022 at a fixed rate of 4.00%	**224**	299
MCORP bank loan payable due in May 2028 at a fixed rate of 4.13%	**2,431**	2,475
White Plains bank notes payable at varying dates through 2027 at fixed rates ranging from 2.72% – 3.00%	**9,023**	10,136
White Plains lines of credit	**17,000**	7,227
Burke line of credit	**2,317**	2,667
St. Luke's bank loans payable due in April 2020 at variable rates ranging from 4.70% – 7.00%	**6,250**	6,900
	$ 92,645	$ 29,704

In June 2019, the Medical Center entered into a $200 million revolving credit agreement with a bank which expires in June 2021. Interest is variable and is based on LIBOR plus 0.60% and was 2.38% at December 31, 2019. The revolving credit agreement is secured on parity with the 2018 Series Bonds with a general obligation of the Medical Center and a mortgage on certain real property. Approximately $55.4 million was drawn down on the revolving credit agreement at December 31, 2019.

White Plains has an unsecured line of credit and two unsecured letters of credit aggregating approximately $29.5 million. At December 31, 2019 and 2018, approximately $17.0 million and $7.2 million, respectively, was outstanding on the line of credit (no amounts are outstanding under the letters of credit). The interest rate on any advances are based on LIBOR plus 0.55%. Interest rates ranged from 2.20% to 5.25% during 2019 and 2018. The line of credit expires in November 2020 and the letters of credit expire in December 2020.

7. Long-Term Debt (continued)

Burke has a line of credit with a financial institution of approximately $4.73 million. Interest is based on the prime rate minus 75 basis points. The line is secured by investments. Approximately $2.3 million and $2.7 million was outstanding at an interest rate of 4.50% at December 31, 2019 and 2018.

(c) Housing II has primary and subordinate mortgage agreements with HDC. At December 31, 2019 and 2018, the primary mortgage amount outstanding was approximately $5.1 million and $5.3 million, respectively. The primary mortgage has a final maturity date in January 2035 and the interest rate is 6.50%. At December 31, 2019 and 2018, the subordinate mortgage amount outstanding was approximately $12.8 million and bears no interest. The subordinate mortgage is payable in full in April 2035 and Housing II has used 1.80% as the interest rate for the purposes of recognizing interest expense under the assumption that the mortgages will remain outstanding through 2035.

Substantially all of Housing II's property and equipment rents and profits are collateral for the mortgages. In addition, any requests for rental increases must be approved by HDC. During the years ended December 31, 2019 and 2018, Housing II maintained the reserve for replacement account in accordance with HDC requirements. Monthly deposits aggregating approximately $5,000 are required to be made into this account.

(d) During 2013, the Medical Center issued Build NYC Resource Corporation Revenue Bonds, Series 2013A and Series 2013B (2013 Bonds) through Build NYC Resource Corporation, to finance a leasehold renovation project secured by a leasehold mortgage. At December 31, 2019 and 2018, a total of approximately $58.1 million and $63.6 million was outstanding, respectively. Interest on the 2013 Bonds is payable monthly at variable rates (2.88% and 3.46% at December 31, 2019 and 2018, respectively). Principal is payable monthly through June 2030. The 2013 Bonds are subject to prepayment without penalty, upon satisfaction of certain notice provisions.

(e) The Medical Center has previously borrowed amounts under equipment loans to finance certain capital projects (no amounts were borrowed during the years ended December 31, 2019 or 2018). The interest rates associated with the Medical Center's various equipment loan borrowings range from 1.06% to 2.23%. Approximately $49.1 million and $56.5 million was outstanding at December 31, 2019 and 2018, respectively.

7. Long-Term Debt (continued)

White Plains has previously borrowed approximately $18.2 million under equipment loans. Proceeds were deposited into an escrow account which will be used to reimburse White Plains as approved capital expenditures are incurred. The interest rate under the agreement is 1.62%. Approximately $9.6 million and $13.3 million was outstanding at December 31, 2019 and 2018, respectively.

Nyack borrowed approximately $3.0 million during the year ended December 31, 2018, under equipment loans in addition to previously borrowed amounts. The interest rates associated with Nyack's various equipment loan borrowings range from 2.40% to 6.40%. Approximately $2.9 million and $3.6 million was outstanding at December 31, 2019 and 2018, respectively.

(f) The Medical Center has two loan agreements with DASNY in connection with substance abuse treatment facilities, one of which was entered into during 2018. The loans are secured by mortgages on the facilities. At December 31, 2019 and 2018, a total of approximately $25.6 million and $26.9 million was outstanding, respectively. Interest payments are due semiannually at rates ranging from approximately 3.85% to 4.40% and principal payments are due annually through February 2030 on the first loan and February 2036 on the second loan. To the extent that the Medical Center continues to meet certain conditions, its obligations to make interest and principal payments will be funded by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) under a state aid grant lien. During 2019 and 2018, OASAS funded approximately $2.5 million and $3.2 million, respectively, of principal, interest and fees associated with these loans.

(g) In February 2017, Nyack entered into a credit agreement with Gemino Healthcare Finance, LLC (Gemino). Gemino provides a revolving line of credit up to $20.0 million based on a borrowing base that is equal to 85% of the net collectible value of eligible billed accounts receivable aged up to 150 days and 75% of the net collectible value of eligible unbilled accounts receivable aged up to 45 days. The interest rate on the revolving line of credit is computed from a base rate of 3-month LIBOR plus 4.55%. The interest rate as of December 31, 2019 and 2018, was 6.50% and 7.40%, respectively.

7. Long-Term Debt (continued)

(h) In November 2015, in conjunction with the lease of office space for certain physician practices, White Plains entered into a construction loan agreement with the landlord to finance various leasehold improvements to the office space. The note bears an interest rate of 6.50% and is payable monthly through June 2025. Approximately $2.9 million and $3.3 million was outstanding at December 31, 2019 and 2018, respectively.

In July 2016, in conjunction with the lease of additional office space, White Plains entered into another construction loan agreement. In December 2018, White Plains exercised its option to purchase the building and the property. Approximately $3.3 million was outstanding at December 31, 2018. In July 2019, White Plains purchased the building and property for $13.0 million. Included in the purchase price was the unamortized construction loan of $3.0 million.

(i) In 2001, St. Luke's borrowed funds to finance certain projects. The proceeds were obtained in connection with the issuance and sale by the Orange County Industrial Development Agency (IDA) of its Civic Facility Revenue Bonds Series 2001A and Series 2001B. Approximately $11.4 million and $12.7 million was outstanding under these debt agreements at December 31, 2019 and 2018, respectively. The bonds are secured by certain buildings, fixtures and property and mature in 2021 and 2026. The interest rate was 5.38% at December 31, 2019 and 2018.

In November 2005, St. Luke's entered into an agreement with Community Development Properties Dubois Street II, Inc. (CDP) to construct, own and operate on property leased (through a ground lease) from St. Luke's, a 224,320 square-foot five-story public parking garage adjacent to St. Luke's containing approximately 550 parking spaces, a heliport and a skyway connecting the parking garage to St. Luke's. CDP is an affiliate of NDC Housing and Economic Development Corporation, a Virginia non-stock corporation exempt from federal income taxes.

7. Long-Term Debt (continued)

The parking garage is owned and operated by CDP. In the year 2036, the parking garage and related improvements will transfer to St. Luke's upon the expiration of the ground lease. In addition, St. Luke's entered into a MakeWell Agreement with a bank in order to guarantee minimum payments and sufficient revenue for CDP to maintain certain required ratios under its financing agreements. Under this arrangement, U.S. generally accepted accounting principles require the parking garage assets to be reflected in the consolidated statements of financial position, along with the related debt incurred to finance these assets, and St. Luke's is also required to report the underlying operations of the project in the consolidated statements of operations. The parking garage was initially placed in limited service in December 2006 and was fully operational in April 2007.

The proceeds were obtained by CDP through financing with the City of Newburgh IDA. The Series 2005A Bonds are Variable Rate Demand Civic Facility Revenue Bonds, issued in aggregate principal amount of approximately $21.2 million maturing in October 2030. KeyBank National Association (KeyBank) holds the outstanding bonds as bank qualified bonds which contain a demand purchase option which allows the bank to exercise a demand provision on or after November 30, 2020. Approximately $12.2 million and $13.1 million was outstanding under this debt agreement at December 31, 2019 and 2018, respectively. The interest rate was 3.28% at December 31, 2019 and 2018, respectively.

In June 2006, St. Luke's borrowed funds for various hospital renovation projects. The proceeds were obtained in connection with the issuance and sale by Orange County IDA of its Variable Rate Demand Civic Facility Revenue bonds Series 2006 issued in the aggregate principal amount of approximately $16.0 million, maturing in July 2032. KeyBank holds the outstanding bonds as bank qualified bonds which contain a demand purchase option which allows the bank to exercise a demand provision on or after November 30, 2020. Approximately $10.6 million and $11.2 million was outstanding under this debt agreement at December 31, 2019 and 2018, respectively. The interest rate was 3.12% at December 31, 2019 and 2018, respectively.

7. Long-Term Debt (continued)

The aggregate amount of principal payments required under all long-term indebtedness based on scheduled repayment terms at December 31, 2019, are as follows (in thousands):

2020	$ 68,753
2021	80,098
2022	26,195
2023	20,954
2024	19,601
2025 and thereafter	1,264,403
	$ 1,480,004

Substantially all of the Health System's property, buildings and equipment and other assets serve as collateral under the various debt arrangements. In addition, the Medical Center, Nyack, White Plains and St. Luke's must maintain certain financial ratios and, among other things, obtain approval to incur additional debt above specified amounts. There were no instances of noncompliance with such covenants at December 31, 2019 and 2018, for the Medical Center and White Plains.

Nyack was in compliance for the first three quarters of 2019, but was not in compliance for the last quarter of 2019. Based on projections including VBPQIP and VAPAP payments, Nyack has concluded it is probable it will meet the required fixed charge coverage ratio calculation throughout 2020. However, if Nyack was not to receive the VBPQIP and VAPAP payments, it is not probable that Nyack will meet the required fixed charge coverage ratio calculation throughout 2020. Due to the failure to meet the covenant requirements at December 31, 2019, and potential future noncompliance, Nyack's debt under the agreement with Gemino is classified as current in the accompanying consolidated statements of financial position.

In October 2017, St. Luke's entered into a Forbearance Agreement (FA) with its lenders that expired March 31, 2020. On April 7, 2020, the FA was extended through May 30, 2020, and encompasses the IDA debt described above. Under the FA, the lenders have agreed to take no remedial action against St. Luke's (relating to St. Luke's noncompliance with certain financial ratio covenants under the existing loan agreements), as long as St. Luke's maintains a minimum of 25 days cash on hand and debt service coverage of at least 1.25 on each subsequent December 31st and June 30th. All other covenants remain as stated in the original debt and loan

7. Long-Term Debt (continued)

agreements. Based on the compliance measurements at December 31, 2019, St. Luke's is in compliance with the covenant requirements. On April 1, 2020, St. Luke's entered into a commitment with a third party lender to refinance its existing indebtedness. In accordance with the commitment, the Medical Center is listed as a guarantor of the related indebtedness.

Interest paid during the years ended December 31, 2019 and 2018, amounted to approximately $80.8 million and $32.5 million, respectively.

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 future 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.

8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes:

	December 31	
	2019	**2018**
	(In Thousands)	
Health care related services	**$ 81,563**	$ 84,160
Collateralizing bank financing, teaching and research	**38,383**	38,346
Construction and renovation projects	**21,123**	22,607
Research	**6,782**	7,042
Other	**1,807**	2,174
	$ 149,658	$ 154,329

The Health System follows the requirements of the New York Prudent Management of Institutional Funds Act (NYPMIFA) as it relates to its endowments.

8. Net Assets with Donor Restrictions (continued)

The Health System's endowments consist of donor-restricted funds established for a variety of purposes. As required by U.S. generally accepted accounting principles, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

The Health System requires the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The Health System classifies as net assets with donor restrictions (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) if applicable, any accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. Endowment assets include those assets of donor-restricted funds that the Health System must hold in perpetuity or for a donor-specified term.

The Health System's investment and spending policies for endowment assets seek to provide a predictable stream of funding to programs supported by its endowment, while seeking to maintain the purchasing power of the endowment assets.

For the years ended December 31, 2019 and 2018, the Health System had the following endowment-related activities:

	2019		
	Without Donor Restrictions	**With Donor Restrictions**	**Total**
		(In Thousands)	
Endowment balance, beginning of year	**$ –**	**$ 58,720**	**$ 58,720**
Additions	–	–	–
Investment income	**1,087**	**1,745**	**2,832**
Amounts appropriated for expenditure	**(1,087)**	**(38)**	**(1,125)**
Net change in endowment funds	–	**1,707**	**1,707**
Endowment balance, end of year	**$ –**	**$ 60,427**	**$ 60,427**

8. Net Assets with Donor Restrictions (continued)

	2018		
	Without Donor Restrictions	With Donor Restrictions	Total
		(In Thousands)	
Endowment balance, beginning of year	$ –	$ 59,129	$ 59,129
Additions	–	–	–
Investment income	1,185	(320)	865
Amounts appropriated for expenditure	(1,185)	(89)	(1,274)
Net change in endowment funds	–	(409)	(409)
Endowment balance, end of year	$ –	$ 58,720	$ 58,720

9. Benefit Plans

Pension Plans

Certain entities in the Health System provide pension and similar benefits to its 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, 2018) (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.

Total expense, included in the accompanying consolidated statements of operations for the various plans, aggregated approximately $188.2 million and $166.1 million for the years ended December 31, 2019 and 2018, respectively. Cash payments relative to the various plans aggregated approximately $189.1 million and $174.4 million for the years ended December 31, 2019 and 2018, respectively.

9. Benefit Plans (continued)

Postretirement Benefits

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).

Multiemployer Plans

The Medical Center, MNR, MMV, SECC, Nyack, White Plains and St. Luke's contribute to various multiemployer defined benefit pension plans under the terms of collective bargaining agreements that cover its union-represented employees, including the New York State Nurses Association Pension Plan (NYSNA) and the 1199SEIU Healthcare Employees Pension Fund (1199SEIU). Contributions to union multiemployer pension plans are made in accordance with contractual agreements under which contributions are based on a percentage of salaries or a negotiated amount. The risks of participating in these multiemployer plans are different from single-employer plans in the following respects:

- Assets contributed to a multiemployer plan by one employer may be used to provide benefits to employees of other participating employers.

- If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.

- If an entity of the multiemployer defined benefit pension plan chooses to stop participating in some of its multiemployer plans, the entity may be required to pay those plans an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

These entities' participation in these plans for the years ended December 31, 2019 and 2018, is outlined in the table below. The "EIN/Pension Plan Number" column provides the Employee Identification Number (EIN) and the three-digit plan numbers. Unless otherwise noted, the most recent Pension Protection Act zone status available in 2019 and 2018 is for the plan's year end at December 31, 2018 and 2017, respectively. The zone status is based on information received from the plans and is certified by the plans' actuaries. Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are less than 80% funded, and plans in

9. Benefit Plans (continued)

the green zone are at least 80% funded. The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The last column lists the expiration dates of the collective bargaining agreements to which the plans are subject.

Pension Fund	EIN/ Pension Plan Number	Pension Protection Act Zone Status January 1, 2019	Pension Protection Act Zone Status January 1, 2018	FIP/RP Pending/ Implemented	Contributions From the Health System 2019	Contributions From the Health System 2018	Surcharge Imposed	Expiration Dates of Collective-Bargaining Agreements
					(In Thousands)			
NYSNA	13-6604799/001	**Green**	**Green**	N/A	**$ 32,935**	$ 30,955	No	12/31/2022, 12/31/2023
1199SEIU	13-3604862/001	**Green**	**Green**	N/A	**$ 86,293**	$ 68,985	No	4/30/2019, 9/30/2021, 4/30/2022

The Medical Center was listed in the plans' Forms 5500 as providing more than 5% of the total contributions for the following plan years:

Pension Fund	Year Contributions to Plan Exceeded More Than 5% of Total Contributions (as of December 31 of the Plan's Year End)
NYSNA	2018 and 2017
1199SEIU	2018 and 2017

At the date the Health System's consolidated financial statements were issued, Forms 5500 were not available for the plans' year ended in 2019.

Certain White Plains employees represented by a bargaining unit participate in a multiemployer health and welfare plan. For these employees, White Plains contributes to the 1199SEIU National Benefit Fund for Health and Human Service Employees (the Multiemployer H&W Plan). The Multiemployer H&W Plan provides medical benefits to active union employees and retirees. White Plains contributed approximately $3.1 million and $2.9 million for the years ended December 31, 2019 and 2018, respectively.

9. Benefit Plans (continued)

Defined Benefit Plans

The Health System recognizes the funded status (i.e., the difference between the fair value of plan assets and the projected benefit obligations) of the defined benefit plans in its consolidated statements of financial position. Net unrecognized actuarial losses and net unrecognized prior service costs at the reporting date will be subsequently recognized in the future as net periodic pension benefit cost pursuant to the Health System's accounting policy for amortizing such amounts. Further, actuarial gains and losses that arise in subsequent periods and are not recognized as net periodic pension benefit cost in the same periods will be recognized as a component of net assets without donor restrictions.

Included in net assets without donor restrictions at December 31, 2019 and 2018, are the following amounts that have not yet been recognized in net periodic pension benefit cost:

	Pension Plans		Postretirement Plans	
	2019	**2018**	**2019**	**2018**
	(In Thousands)			
Unrecognized actuarial loss	**$ 39,102**	$ 32,495	**$ 44,184**	$ 31,480
Unrecognized prior service cost (credit)	**–**	45	**–**	(276)
	$ 39,102	$ 32,540	**$ 44,184**	$ 31,204

The unrecognized actuarial loss included in net assets without donor restrictions expected to be recognized as net periodic pension benefit cost during the year ending December 31, 2020, is approximately $4.3 million.

9. Benefit Plans (continued)

The following tables provide a reconciliation of the changes in the benefit obligations and fair value of plan assets for the years ended December 31, 2019 and 2018, and the funded status and accumulated benefit obligation as of December 31, 2019, and 2018 (combined for the plans):

	Pension Plans		Postretirement Plans	
	2019	**2018**	**2019**	**2018**
	(In Thousands)			
Changes in benefit obligation				
Benefit obligation at January 1	**$ 434,949**	$ 468,993	**$ 197,627**	$ 192,510
Service cost	**8,083**	7,665	**11,001**	12,644
Interest cost	**17,803**	16,579	**8,646**	7,371
Actuarial loss (gain)	**52,160**	(22,910)	**14,206**	(9,323)
Benefit payments, net	**(29,145)**	(35,378)	**(7,411)**	(5,575)
Plan settlements	**(13,691)**	–	**–**	–
Benefit obligation at December 31	**$ 470,159**	$ 434,949	**$ 224,069**	$ 197,627
Change in plan assets				
Fair value of plan assets at January 1	**$ 320,778**	$ 349,594	**$ –**	$ –
Actual return on plan assets	**57,486**	(17,553)	**–**	–
Employer contributions	**17,723**	24,091	**7,411**	5,575
Benefit payments, net	**(29,477)**	(35,354)	**(7,411)**	(5,575)
Settlements	**(13,817)**	–	**–**	–
Fair value of plan assets at December 31	**$ 352,693**	$ 320,778	**$ –**	$ –

	Pension Plans		Postretirement Plans	
	2019	**2018**	**2019**	**2018**
	(In Thousands)			
Funded status				
Amounts recognized in the consolidated statements of financial position	**$ (117,466)**	$ (114,171)	**$ (224,069)**	$ (197,627)
Accumulated benefit obligation at December 31	**$ 456,819**	$ 420,966		

At December 31, 2019 and 2018, approximately $16.1 million and $16.4 million, respectively, related to the funded status of the plans was included in accrued salaries, wages and related items in the accompanying consolidated statements of financial position.

9. Benefit Plans (continued)

The actuarial losses (gains) are primarily related to changes in the assumptions for the discount rate, mortality table and mortality projection scale used to measure the benefit obligation at December 31, 2019 and 2018.

The following table provides the components of the net periodic pension benefit cost for the years ended December 31, 2019, and 2018:

	Pension Plans		Postretirement Plans	
	2019	**2018**	**2019**	**2018**
	(In Thousands)			
Service cost	**$ 8,083**	$ 7,665	**$ 11,001**	$ 12,644
Interest cost	**17,803**	16,579	**8,646**	7,371
Expected return on plan assets	**(18,586)**	(20,901)	**–**	–
Amortization of prior service cost (benefit)	**45**	45	**(276)**	(1,779)
Amortization of net loss	**1,481**	1,805	**1,889**	3,545
Settlement cost	**5,242**	1,575	**–**	–
Net periodic pension benefit cost	**$ 14,068**	$ 6,768	**$ 21,260**	$ 21,781

The weighted-average assumptions used to determine benefit obligations and net periodic pension benefit cost as of and for the years ended December 31, 2019 and 2018, are as follows:

	Pension Plans		Postretirement Plans	
	2019	**2018**	**2019**	**2018**
Benefit obligations				
Discount rate	**2.42%–3.45%**	3.65%–4.45%	**3.26%–3.34%**	4.18%–4.46%
Rate of compensation increases	**3.00%–4.00%**	3.00%–4.00%	**3.00%**	3.00%
Net periodic pension benefit cost				
Discount rate	**3.65%–4.45%**	3.28%–3.90%	**4.18%–4.46%**	3.64%–3.90%
Expected long-term rate of return on plan assets	**5.50%–7.15%**	5.75%–7.00%	**N/A**	N/A
Rate of compensation increases	**3.00%–4.00%**	3.00%–4.00%	**N/A**	N/A

9. Benefit Plans (continued)

Assumed health care cost trend rates at December 31 are as follows:

	2019	2018
Health care cost trend rate	**6.5%**	6.80%
Rate to which the cost trend rate is assumed to decline (the ultimate trend rate)	**4.35%**	4.30%
Years that the rate reaches the ultimate trend rate	**2026**	2026

Assumed health care cost trend rates have a significant effect on the amounts reported for the defined benefit postretirement plans. A 1% change in assumed health care cost trend rates would have the following effects relating to the postretirement plans:

	2019		2018	
	1% Increase	1% Decrease	1% Increase	1% Decrease
	(In Thousands)			
Effect on total of service and interest cost components of net periodic postretirement health care benefit cost	**$ 4,371**	**$ (3,480)**	$ 3,461	$ (2,772)
Effect on the health care component of the accumulated postretirement benefit obligation	**36,235**	**(29,777)**	28,838	(23,776)

The overall expected long-term rate of return of the plan assets is based on the historical returns of each asset class weighted by the target asset allocation. The target asset allocation has been selected consistent with the Health System's desired risk and return characteristics. The Health System's independent consulting actuaries review the expected long-term rate periodically and, based on the building block approach, updated the rate for changes in the marketplace. The market conditions in 2019 and 2018 and changes in the pension asset allocations were considered in the Health System's evaluation of the expected long-term rate of return assumption.

9. Benefit Plans (continued)

Plan Assets

The Pension Plans have separate asset allocation targets. The overall objectives of the investment policies are to produce an asset allocation that will generate return annually in order to meet the expense and income needs and provide for sufficient annual asset growth. Funds are invested with a long-term return objective.

The Pension Plans' asset allocations (combined) at December 31, 2019 and 2018, by asset category, are as follows:

	2019	**2018**	**Target Allocation**
Equity securities and real estate	**81.7%**	72.9%	60%–80%
Fixed income investments and cash	**14.7**	22.0	20%–40%
Alternative investments	**3.6**	5.1	0%–10%
	100.0%	100.0%	

Defined benefit pension plan assets are carried at fair value and generally consist of fixed income securities issued or guaranteed by government agencies, money market funds, mutual funds, fixed income securities issued by corporations, equity securities, common collective funds and alternative investments. Common collective funds and alternative investments funds are stated at fair value based upon, as a practical expedient, net asset values derived from the application of the equity method of accounting. Refer to Note 11 for additional fair value measurement information related to the defined benefit plan asset categories noted in the table above.

The measurement dates used to determine defined benefit pension and postretirement plan costs were December 31, 2019 and 2018.

During the year ending December 31, 2020, the Health System expects to contribute approximately $23.0 million and $6.7 million to the Pension Plans and Postretirement Plans, respectively.

9. Benefit Plans (continued)

Expected benefit payments by year as of December 31, 2019, follow:

	Pension Plans	Postretirement Plans
	(In Thousands)	
2020	$ 33,818	$ 6,668
2021	31,375	7,260
2022	29,330	7,846
2023	30,248	8,461
2024	30,804	9,209
2025–2029	144,633	54,546

10. Contingencies and Other

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 December 31, 2019, 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.

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 carriers through the commercial market.

10. Contingencies and Other (continued)

Prior to January 2018, the Medical Center participated in a pooled excess insurance program for hospital professional liability with certain other health care facilitates 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 and recorded a gain on the sale of approximately $39.2 million. 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. As of December 31, 2019 and 2018, the Medical Center recorded its share of the MMHAS Trust, which consists of cash and investments held on behalf of the Medical Center of approximately $45.0 million and $7.6 million, respectively. Such amounts are recorded within other noncurrent assets in the consolidated statements of financial position. As of December 31, 2019 and 2018, the MMAHS Trust had actuarially determined liabilities specific to the Medical Center of approximately $141.8 million and $67.0 million, respectively discounted at 3.5%; such amounts are recorded within self-insured professional and other insured liabilities on the consolidated statements of financial position. 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.

The Medical Center's malpractice insurance programs offer a deferred premium arrangement with its captive insurance companies in which 36% of the annual premium is paid in the current year and the balance is payable over four years. Total liabilities associated with HRA were approximately $83.5 million and $115.1 million at December 31, 2019 and 2018, respectively. The liabilities principally relate to the deferred premium arrangement and retroactive premium adjustments.

10. Contingencies and Other (continued)

As of December 31, 2019, the Medical Center retained 25% ownership interests in two captive insurance companies affiliated with HRA. The Medical Center has recognized its allocated share of the program's accumulated surplus using the equity method of accounting. Such amounts (approximately $34.3 million and $171.9 million at December 31, 2019 and 2018, respectively) are included in other noncurrent assets in the accompanying consolidated statements of financial position.

The Medical Center has recognized estimated insurance claims receivable and estimated insurance claims liabilities of approximately $400.6 million (approximately $72.1 million current and $328.5 million long-term) and approximately $481.0 million (approximately $86.6 million current and $394.4 million long-term) at December 31, 2019 and 2018, respectively. Such amounts represent the actuarially determined present value, discounted at approximately 4.00% at December 31, 2019 and 2018, of insurance claims that are anticipated to be covered by insurance. The amounts reported in the December 31, 2019 and 2018, consolidated statements of financial position for estimated insurance claims receivable and estimated insurance claims liabilities reflect the financial impact of the Medical Center's employed physicians.

During the years ended December 31, 2019 and 2018, the Medical Center recorded approximately $31.1 million and $49.4 million, respectively, of positive malpractice insurance program adjustments. All of the 2019 adjustment and approximately $30.8 million of the 2018 adjustment related to retroactive premium adjustments. Approximately $18.6 million of the 2018 adjustment related to a net reduction in the amount owed for the guarantee of certain investment returns of the captive insurance companies.

Nyack Insurance Liabilities

Nyack was self-insured for medical malpractice claims until January 1, 2018, at which point Nyack began to utilize HRA. The policy with HRA provides coverage on a claims made basis up to $10.0 million per claim and $20.0 million in aggregate with a retroactive date for unreported claims to March 1, 2007.

10. Contingencies and Other (continued)

The estimated malpractice liability at December 31, 2019 and 2018, is based upon an actuarial valuation of the estimated effect of probable loss contingencies, including provisions for known and unknown incidents incurred but not yet reported. Accrued malpractice losses have been discounted at 2.5% at December 31, 2019 and 2018, and, in management's opinion in consultation with an independent actuary, provide an adequate reserve for loss contingencies. Malpractice liabilities are discounted based on the expected timing of the actuarially estimated future payments under the program.

The estimated malpractice liabilities recorded at December 31, 2019 and 2018, is approximately $22.3 million and $11.1 million, respectively, and is recorded within self-insured professional and other insured liabilities and estimated insurance claims liabilities in the consolidated statements of financial position. The related insurance recoveries receivable of approximately $16.9 million and $6.1 million as of December 31, 2019 and 2018, respectively, is recorded within estimated insurance claims receivable, current portion in the consolidated statements of financial position.

White Plains Insurance Liabilities

Effective July 1, 1986, White Plains purchased primary insurance on an occurrence basis and provided for potential losses in excess of primary coverage through a combination of self-insurance and purchased excess insurance on a claims-made basis. Effective November 15, 1998, White Plains and certain other members of Stellaris Health Network (Stellaris) participated in a combined insurance program that provides coverage through purchased primary and excess insurance on a claims-made basis. Effective January 1, 2004, White Plains purchased excess professional liability insurance above its primary placement layer, on a claims-made basis, from a captive insurance company previously formed by Stellaris, NWLP Insurance Company Ltd. (NWLP).

Effective June 30, 2014, NWLP implemented a segregated "cell captive" structure which replaced the previous insurance structure. Under this program, NWLP utilized individual cells for each participating hospital, under which invested assets and insurance-related liabilities were segregated for each participant and there was no shared risk among the entities.

Effective for claims incurred on or subsequent to July 1, 2015, White Plains utilizes HRA. Exposure for claims incurred prior to July 1, 2015, and reported after the expiration of an extended reporting period provided under White Plains' prior policies is retained by White Plains.

10. Contingencies and Other (continued)

Based on actuarially determined estimates that incorporate White Plains' past experience, as well as industry experience, including the nature of each claim or incident and relevant trend factors, management has recorded undiscounted, estimated professional liabilities for asserted claims and loss development estimates and incurred but not reported tail liabilities of approximately $15.5 million and $15.0 million as of December 31, 2019 and 2018, respectively. Estimated professional liabilities include approximately $46.3 million and $31.4 million as of December 31, 2019 and 2018, respectively, related to claims covered under the insurance programs described above. A corresponding estimated insurance recovery related to claims is included in the accompanying consolidated statements of financial position. The current portion of the estimated insurance claims receivable represent an estimate of expected settlements and insurance recoveries over the next twelve months. All estimated professional liabilities are recorded within self-insured professional and other insured liabilities and estimated insurance claims liabilities in the consolidated statements of financial position.

St. Luke's Insurance Liabilities

Prior to November 1, 2016, Physicians' Reciprocal Insurers Company and Covers insured St. Luke's for professional liability on a claims-made basis. St. Luke's maintained professional liability insurance of $1.0 million per claim and $6.0 million in the aggregate. St. Luke's also maintained a first layer of excess professional liability coverage of $1.0 million per claim and $1.0 million in the aggregate through SLCH Insurance, a second layer of excess professional liability coverage of $10.0 million per claim and $10.0 million in the aggregate through Lexington Insurance Company (AIG), and a third layer of excess coverage of $5.0 million per claim and $5.0 million in the aggregate through CNA Insurance Company (CNA).

Effective November 1, 2016, St. Luke's utilizes HRA. Primary liability coverage is provided on an occurrence basis to the Hospital through HIC. For the years ended December 31, 2019 and 2018, St. Luke's maintained professional liability insurance of $10,000,000/$22,000,000 and $17,000,000/$22,000,000, respectively, per occurrence/aggregate, respectively.

At December 31, 2019 and 2018, St. Luke's did not have any asserted claims exceeding its coverage. At December 31, 2019 and 2018, St. Luke's recorded an estimate for malpractice claims incurred but not reported within self-insured professional and other insured liabilities in the consolidated statements of financial position of approximately $6.2 million and $4.4 million,

10. Contingencies and Other (continued)

respectively, based on a discount rate of 3.0%, In addition, at December 31, 2019 and 2018, St. Luke's recorded and an estimated insurance claims receivable and estimated insurance claims liabilities in the consolidated statements of financial position of approximately $16.3 million and $16.9 million, respectively.

Albert Einstein College of Medicine, Inc. (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 previously operating as a division of Yeshiva University (YU). In connection with this transaction $175.0 million Build NYC Resource Corporation Revenue Bonds were issued. The Build NYC Resource Corporation Revenue Bonds carry a 5.50% coupon rate and mature on September 1, 2045. Interest is payable semiannually and principal is payable annually commencing on September 1, 2020.

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

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.

10. Contingencies and Other (continued)

During 2018 approximately $4.2 million was paid by the Medical Center on Einstein's behalf pursuant to the Guaranty Agreement, as amended. During 2018, the Medical Center forgave the amounts owed from Einstein of approximately $5.5 million under this agreement, which was recorded within transfers to members, net in the consolidated statements of operations.

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 will provide 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 (see Note 14).

The Medical Center has 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, which was recorded within transfers to members, net in the consolidated statements of operations.

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 2019 and 2018, the Medical Center provided approximately $40.0 million and $33.0 million, respectively, to Einstein which was recorded within transfers to members, net in the consolidated statements of operations.

Other

At December 31, 2019 and 2018, approximately 58% and 56%, respectively, 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 is effective through December 2023. The Medical Center, MNR, MMV, SECC's and St. Luke's collective bargaining agreements with 1199SEIU expire in September 2021. White Plains' contract with 1199SEIU expires in April 30, 2022. Nyack's contract with 1199SEIU expired on April 30, 2019. A new contract is currently being negotiated.

10. Contingencies and Other (continued)

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 December 31, 2019 or 2018. 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.

11. 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.

11. 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	–	–	7,255
Equity mutual funds	158,273	–	–	158,273
Non-equity mutual funds	163,530	–	–	163,530
	329,058	–	–	329,058
	$ 1,471,211	$ 883,056	$ –	2,354,267
Investments measured at net asset value (defined benefit pension plan assets)				23,635
				$ 2,377,902

11. 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, 2018:

	December 31, 2018			
	Level 1	Level 2	Level 3	Total
	(In Thousands)			
Assets				
Cash and cash equivalents	$ 392,270	$ –	$ –	$ 392,270
Managed cash and cash equivalents held for investment	433,034	–	–	433,034
Marketable and other securities:				
Non-equity mutual funds	128,111	–	–	128,111
Equity mutual funds	50,042	–	–	50,042
U.S. Government agency mortgage-backed securities	–	39,513	–	39,513
U.S. Treasury securities	44,702	–	–	44,702
U.S. Government agency-backed securities	–	35,330	–	35,330
Equity securities	76,208	–	–	76,208
Corporate debt	–	795,772	–	795,772
Investment contracts	–	1,953	–	1,953
Interest and other receivables	2,521	–	–	2,521
	1,126,888	872,568	–	1,999,456
Defined benefit pension plan assets				
Cash and cash equivalents	6,280	–	–	6,280
Equity mutual funds	112,304	–	–	112,304
Non-equity mutual funds	153,079	–	–	153,079
Redemption receivable	4,566	–	–	4,566
Investment contracts	–	2,480	–	2,480
	276,229	2,480	–	278,709
	$ 1,403,117	$ 875,048	$ –	2,278,165
Investments measured at net asset value (defined benefit pension plan assets)				42,069
				$ 2,320,234

11. Fair Value Measurements (continued)

At December 31, 2019 and 2018, the Health System's alternative investments and collective trusts, excluding those within the defined benefit plans, are reported using the equity method of accounting in the amount of approximately $220.7 million and $136.1 million, respectively, and, therefore, are not included in the tables above.

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.

12. Concentration of Credit Risk

At December 31, 2019 and 2018, excluding investments in bond mutual funds, approximately 11% and 6%, respectively, of the Health System's marketable securities were issued by either the United States Government or its agencies.

At December 31, 2019 and 2018, significant concentrations of receivables for patient care include approximately 8% and 10% from Medicaid, 20% from Medicare and 64% and 62% from commercial and managed care organizations, respectively, of which no individual commercial or managed care organization equaled 10% or greater.

Net patient service revenue from the Medicare and Medicare managed care programs accounted for approximately 33% and 35%, and net patient service revenue from the Medicaid and Medicaid managed care programs accounted for approximately 27% and 29% of the Health System's net patient service revenue for the years ended December 31, 2019 and 2018, respectively. For the year ended December 31, 2019, approximately 13% of net patient service revenue was from Blue Cross plans. No other specific payer exceeded 10% of net patient service revenue.

13. Other Revenue

Other revenue included in the consolidated statements of operations for the years ended December 31, 2019 and 2018, consisted of the following:

	2019	2018
	(In Thousands)	
DSRIP revenue	**$ 81,779**	$ 48,709
Patient care quality incentive revenue	**51,506**	54,345
Interest and dividend income	**43,212**	30,332
Equity earnings from investments	**24,178**	45,993
Staff housing and other rental income	**15,672**	17,133
Contributions	**10,931**	14,554
Cafeteria revenue	**9,958**	11,772
Continuing Medical Education programs	**9,182**	13,321
Care management administrative fees	**8,914**	9,222
Parking revenue	**8,507**	8,720
Information system services	**8,212**	7,925
Net assets released from restrictions used for operations	**6,376**	7,631
Government Electronic Health Record Incentive Program	**3,391**	10,142
Shared savings programs	**1,393**	11,060
Gain on sales of property, buildings and equipment	–	9,349
All other	**32,120**	36,490
	$ 315,331	$ 336,698

For the years ended December 31, 2019 and 2018, approximately $51.5 million and $54.3 million was recognized by the Health System related to several agreements under which insurance companies provide for additional revenue when certain patient care quality, compliance and patient satisfaction metrics are met. Due to the inherent uncertainty on timing and finalization of annual results of the patient care quality incentive programs, amounts are recorded by the Health System when received.

13. Other Revenue (continued)

New York State distributes federally-funded amounts through a payment mechanism referred to as the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program is a five-year program intended to promote community-level collaborations to focus on health system reform and enhance the value provided by the health care system. DSRIP funding is available to certain hospitals and providers participating in networks (referred to as Performing Provider Systems, PPS) that are able to establish performance improvement activities in certain predefined clinical improvement areas. The PPS that the Medical Center coordinates has submitted plans for clinical improvement projects in order to be eligible for payments under the DSRIP program. The Health System received approximately $56.2 million and $43.4 million during 2019 and 2018, respectively, and recorded approximately $81.8 million and $48.7 million, respectively, in other revenue during the years ended December 31, 2019 and 2018, for amounts received under the DSRIP program. Certain payments under the DSRIP program are subject to meeting specified performance criteria and other requirements which may be evaluated in future periods.

14. Related-Party Transactions

At December 31, 2019 and 2018, amounts due from (to) members, net were comprised of the following:

	December 31	
	2019	**2018**
	(In Thousands)	
Due from members:		
Albert Einstein College of Medicine, Inc.[a]	**$ 100**	$ 100
Due to members, net:		
Albert Einstein College of Medicine, Inc.[a]	**$ (1,007)**	$ (3,000)
MMAHS[b]	**(26,859)**	(13,846)
Montefiore Innovations, Inc.	**(1,484)**	(1,819)
Due to members, net	**$ (29,350)**	$ (18,665)

[a] Transactions between Einstein and the Health System relate to costs for clinical training, research, professional services and related supporting services (at cost). The Medical Center has 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

14. Related-Party Transactions (continued)

was funded in 2017 in the amount of $35.0 million. During 2018, the Medical Center reserved amounts owed from Einstein of approximately $42.3 million, recorded within transfers to members, net in the consolidated statements of operations. During 2019 and 2018, the Medical Center also made capital contributions of approximately $20.0 million to Einstein in accordance with an agreement to provide operating subsidies to Einstein over a five-year period (see Note 10).

(b) The Health System purchases various management, administrative and staffing services from MMAHS. For the years ended December 31, 2019 and 2018, transactions charged (at cost) by MMAHS to the Health System were approximately $37.0 million and $34.2 million, respectively, comprised of payroll and benefits charges.

During the years ended December 31, 2019 and 2018, the Medical Center's performing provider system (PPS), MHVC, received approximately $69.0 million and $70.3 million in DSRIP Value Based Payment Quality Improvement Program (VBP QIP) funding, which was distributed to MNR, MMV, Nyack and St. Luke's. VBP QIP was created by New York State to provide financially distressed hospitals and the PPSs with which they are associated the opportunity to collaborate with Medicaid managed care organizations for the successful implementation of VBP contracts as a means toward long-term financial sustainability.

15. Subsequent Events

The Health System evaluated subsequent events through September 30, 2020, which is the date the revised consolidated financial statements were issued, for potential recognition or disclosure in the accompanying consolidated financial statements for the year ended December 31, 2019. Other than as disclosed in Note 7 and below, no events occurred that require disclosure in or adjustment to the consolidated financial statements.

COVID-19

Due to the global viral outbreak caused by Coronavirus Disease 2019 (COVID-19) in 2020, there have been resulting effects which could 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. The accompanying consolidated financial statements do not reflect the effects of these subsequent events.

16. U.S. Department of Education Title IV Supplemental Information

During September 2019, the U.S. Department of Education issued regulations, effective for audit reporting filed after July 1, 2020, regarding additional disclosures deemed necessary to calculate certain ratios for determining sufficient financial responsibility under Title IV regulations. The Health System implemented the disclosures as of January 1, 2019. The financial information as of and for the year ended December 31, 2019 is as follows (in thousands):

Property, buildings and equipment, net (including construction-in-progress)		
Pre-implementation property, buildings and equipment, net at December 31, 2018	$	1,685,630
Debt financed post-implementation property, buildings and equipment, net acquired with debt subsequent to December 31, 2018:		
Finance leases		4,460
Post-implementation property, buildings and equipment, net acquired without debt subsequent to December 31, 2018:		355,838
	$	2,045,928
Right-of-use assets – pre-implementation		
Right-of-use assets – pre-implementation at December 31, 2018	$	50,074
Lease liabilities – pre-implementation		
Lease liabilities – pre-implementation at December 31, 2018	$	62,852
Net assets with donor restrictions		
Annuities	$	–
Term endowments		–
Life income funds		–
Other restricted by purpose and time		92,908
Restricted in perpetuity		56,750
	$	149,658

16. U.S. Department of Education Title IV Supplemental Information (continued)

Postretirement liabilities	
Noncurrent defined benefit pension and other postretirement health plan liabilities	$ 325,424
Employee deferred compensation	73,061
	$ 398,485

Total revenues and gains	
Total operating revenue	$ 6,258,938
Value Based Payment and Vital Access Provider Programs	86,697
Net realized and changes in net unrealized gains and losses on marketable and other securities	72,351
Malpractice insurance program adjustments	31,095
Gain on sale of equity interest in captive insurance company	39,200
Net assets released from restrictions used for purchases of property, buildings and equipment	6,933
Grants for the purchase of property, buildings and equipment	25,506
Other changes in net assets without donor restrictions	33,460
	$ 6,554,180

Schedule Related to the Uniform Guidance, Audit Reports and Supplementary Information

Montefiore Health System, Inc.

Schedule of Expenditures of Federal Awards

Year Ended December 31, 2019

Federal Department/Program Title/Cluster Name/Pass-Through Grantor	Federal CFDA Number	Pass-Through Entity Identifying Number	Research and Development Cluster	Student Financial Assistance Cluster	Total Expenditures	Expenditures to Subrecipients
93. U.S. Department of Health and Human Services						
Birth Defects and Developmental Disabilities – Prevention and Surveillance						
Pass-through Association of University Centers on Disabilities	93.073	AUCD-01	$ –	$ –	$ 904	$ –
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements:						
Pass-through Health Research, Inc.	93.074	NU90TP921924	–	–	88,791	–
Blood Disorder Program: Prevention, Surveillance, and Research:						
Pass-through Icahn School of Medicine at Mount Sinai	93.080	5U27DD00115503	–	–	15,714	–
Healthy Marriage Promotion and Responsible Fatherhood Grants	93.086		–	–	1,379,731	–
Enhance Safety of Children Affected by Substance Abuse	93.087		–	–	1,459,084	–
Affordable Care Act (ACA) Health Profession Opportunity Grants	93.093		–	–	2,140,841	–
Maternal and Child Health Federal Consolidated Programs:	93.110		52,756	–	52,756	–
Pass-through Icahn School of Medicine at Mount Sinai	93.110	5H30MC240480700	5,747	–	5,747	–
Total Maternal and Child Health Federal Consolidated Programs			58,503	–	58,503	–
HIV-Related Training and Technical Assistance:						
Pass-through Columbia University	93.145	5U1OHA292910300	–	–	50,588	–
Coordinated Services and Access to Research for Women, Infants, Children, and Youth	93.153		–	–	2,127,599	547,610
Human Genome Research:						
Pass-through University of Iowa	93.172	5R01HG00834803	18,128	–	18,128	–
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care) (Health Center Program Cluster)	93.224		–	–	3,334,767	–

Montefiore Health System, Inc.

Schedule of Expenditures of Federal Awards (continued)

Federal Department/Program Title/Cluster Name/Pass-Through Grantor	Federal CFDA Number	Pass-Through Entity Identifying Number	Research and Development Cluster	Student Financial Assistance Cluster	Total Expenditures	Expenditures to Subrecipients
93. U.S. Department of Health and Human Services (continued)						
Research on Healthcare Costs, Quality and Outcomes:						
Pass-through Brigham and Women's Hospital, Inc.	93.226	1R18HS02512801	$ –	$ –	$ 61,709	$ –
Mental Health Research Grants:						
Pass-through Icahn School of Medicine at Mount Sinai	93.242	5R01MH110623-02	–	–	40,510	–
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243		–	–	532,675	–
Occupational Safety and Health Program:						
Pass-through New York City Fire Department	93.262	U10OH00824205W1	1,429,724	–	1,429,724	–
Immunization Cooperative Agreements:						
Pass-through New York City Department of Health and Mental Hygiene	93.268		–	–	8,784,075	–
Pass-through New York State Vaccines for Children Program	93.268		–	–	773,089	–
Total Immunization Cooperative Agreements			–	–	9,557,164	–
Drug Abuse and Addiction Research Programs:						
Pass-through Kaiser Foundation	93.279	3UG1DA040314-05S1	348,793	–	348,793	–
21st Century Cures Act - Beau Biden Cancer Moonshot:						
Pass-through Dana Farber Cancer Institute	93.353	1U01CA23316901	10,716	–	10,716	–
Cancer Cause and Prevention Research:						
Pass-through Memorial Sloan Kettering Cancer Center	93.393	1R37CA21478501A	22,877	–	22,877	–
Cancer Detection and Diagnosis Research:						
Pass-through ECOG-ACRIN MRF, Inc.	93.394	U24CA196172	251,808	–	251,808	–

Federal Department/Program Title/Cluster Name/Pass-Through Grantor	Federal CFDA Number	Pass-Through Entity Identifying Number	Research and Development Cluster	Student Financial Assistance Cluster	Total Expenditures	Expenditures to Subrecipients
93. U.S. Department of Health and Human Services (continued)						
Cancer Treatment Research:	93.395		$ 1,076,723	$ –	$ 1,076,723	$ 228,831
Pass-through NRG Oncology Foundation, Inc.	93.395	5UG1CA189867-05	34,360	–	34,360	–
Pass-through UCLA	93.395	5UM1CA12194711	648,718	–	648,718	–
Pass-through ECOG-ACRIN MRF, Inc.	93.395	U10CA18082001/2	238,170	–	238,170	–
Total Cancer Treatment Research			1,997,971	–	1,997,971	228,831
Cancer Control	93.399		202,820	–	202,820	–
Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program:						
Pass-through New York State Department of Health	93.505	C33493GG	–	–	698,317	–
Temporary Assistance for Needy Families (TANF Cluster):						
Pass-through New York City Human Resources Administration	93.558	CT20181410096/ 20191400346/1417552	–	–	4,921,211	–
Pass-through New York City Administration for Child Services	93.558	CT10682016/348/ 10682017/546	–	–	2,529,287	–
Total Temporary Assistance for Needy Families (TANF Cluster)			–	–	7,450,498	–
Medical Assistance Program (Medicaid Cluster):						
Pass-through New York City Human Resources Administration	93.778	CT20181410096/ 20191400346/1417552	–	–	1,418,417	–
Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities:						
Pass-through Public Health Solutions	93.817	U3REP150506	–	–	55,000	–
Lung Disease Research:						
Pass-through University of Pennsylvania	93.838	UG3HL141736-01	5,693	–	5,693	–
Pass-through University of Washington	93.838	5R01HL132232-04	24,369	–	24,369	–
Total Lung Disease Research			30,062	–	30,062	–
Blood Diseases and Resources Research	93.839		6,793	–	6,793	–

Schedule of Expenditures of Federal Awards (continued)

Federal Department/Program Title/Cluster Name/Pass-Through Grantor	Federal CFDA Number	Pass-Through Entity Identifying Number	Research and Development Cluster	Student Financial Assistance Cluster	Total Expenditures	Expenditures to Subrecipients
93. U.S. Department of Health and Human Services (continued)						
Aging Research	93.866		$ 99,772	$ –	$ 99,772	$ –
Grants for Primary Care Training and Enhancement	93.884		–	–	554,319	–
National Bioterrorism Hospital Preparedness Program						
Pass-through Health Research, Inc.	93.889	1U3REP190608	–	–	58,205	–
Pass-through Public Health Solutions	93.889	U3REP190597	–	–	316,900	–
Total National Bioterrorism Hospital Preparedness Program			–	–	375,105	–
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918		–	–	946,727	–
Ryan White HIV/AIDS Dental Reimbursement and Community Based Dental Partnership Grants	93.924		–	–	422,035	–
HIV Prevention Activities Non-Governmental Organization Based	93.939		–		334,711	–
PPHF Geriatric Education Centers:						
Pass-through New York University	93.969	4U1QHP28713-03-02	–	–	431,387	–
Primary Care Medicine and Dentistry Clinician Educator Career Development Awards	93.976		–		179,129	–
Preventative Health and Health Services Block Grant:						
Pass-through New York State Department of Health	93.991	C028948	–	–	104,466	–
NCI Community Oncology Research Program Biomedical Research Project:						
Pass-through Leidos Biomedical Research, Inc.	93.RD	HHSN261201500003I	21,000	–	21,000	–
State Innovation Models Project:						
Pass-through Health Research, Inc.	93.U01	5812-02	–	–	287,698	–
Total U.S. Department of Health and Human Services			$ 4,498,967	$ –	$ 38,546,853	$ 776,441

Montefiore Health System, Inc.

Schedule of Expenditures of Federal Awards (continued)

Federal Department/Program Title/Cluster Name/Pass-Through Grantor	Federal CFDA Number	Pass-Through Entity Identifying Number	Research and Development Cluster	Student Financial Assistance Cluster	Total Expenditures	Expenditures to Subrecipients
10. U.S. Department of Agriculture						
Special Supplemental Nutrition Program for Women, Infants and Children:						
Pass-through New York State Department of Health	10.557	C30396GG, C30938GG, C30408GG,270,318	$ –	$ –	$ 20,670,723	$ –
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program (SNAP Cluster)			–	–	–	–
Pass-through New York City Human Resources Administration	10.561	CT 20191417552	–	–	1,341,035	–
Total U.S. Department of Agriculture			$ –	$ –	$ 22,011,758	$ –
12. U.S. Department of Defense						
Military Medical Research and Development			$ –	$ –	$ –	$ –
Pass-through Boston Children's Hospital	12.420		93	–	93	–
Total U.S. Department of Defense			$ 93	$ –	$ 93	$ –
84. U.S. Department of Education						
Federal Pell Grant Program	84.063		$ –	$223,679	$223,679	$ –
Federal Direct Student Loans	84.268		–	1,169,320	1,169,320	–
Total U.S. Department of Education			$ –	$ 1,392,999	$ 1,392,999	$ –
Total Expenditures of Federal Awards			$ 4,499,060	$ 1,392,999	$ 61,951,703	$ 776,441

See accompanying notes.

Montefiore Health System, Inc.

Notes to Schedule of Expenditures of Federal Awards

December 31, 2019

1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the Schedule) includes the federal grant activity of Montefiore Health System, Inc. and its controlled organizations (the Health System) and is presented on the accrual basis of accounting. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Therefore, some amounts presented in the Schedule may differ from amounts presented in, or used in the preparation of, the Health System's consolidated financial statements.

For purposes of the Schedule, federal awards include any assistance provided by a federal agency directly or indirectly in the form of grants, contracts, cooperative agreements, loan and loan guarantees, or other non-cash assistance.

Direct and indirect costs are charged to awards in accordance with cost principles contained in the United States Department of Health and Human Services *Cost Principles for Hospitals* at 45 CFR Part 75 Appendix IX and 45 CFR Part 74 Appendix E, as applicable. Under these cost principles, certain types of expenditures are not allowable or are limited as to reimbursement. The Uniform Guidance provides for a 10% de minimis indirect cost rate election; however, the Health System did not make this election and uses a negotiated indirect cost rate.

The Schedule includes Federal awards subject to the requirements of the Uniform Guidance, as well as Federal awards that were funded prior to the Uniform Guidance effective date of December 26, 2014.

2. Food and Nutrition Awards

During the year ended December 31, 2019, the Health System participated in the New York State Department of Health Special Supplemental Nutrition Program for Women, Infants and Children (WIC) through the receipt and distribution of food checks. The U. S. Department of Agriculture has determined that such WIC food instruments are considered "property in lieu of money" and, therefore, should be considered part of the subgrant received by the Health System. The value of WIC food instruments redeemed under the WIC program is as follows:

2. Food and Nutrition Awards (continued)

	Federal CFDA Number	Federal Expenditures for the Year Ended December 31, 2019
United States Department of Agriculture:		
Special Supplemental Nutrition Program for Women, Infants and Children:		
Pass-through New York State Department of Health	10.557	$ 20,670,723

The total amount reported as Federal awards above represents the value of food checks redeemed plus administrative costs ($5,689,647) for the year ended December 31, 2019. As state funds are commingled with the Federal funds received by New York State, percentages (96.9% for administrative costs and 100% for the value of checks redeemed for Federal fiscal year ended 2019) were applied to determine the total amount of Federal funds to be reported above. These percentages were supplied by the New York State Department of Health.

3. Loan Program

During the year ended December 31, 2019, the Health System processed $1,169,320 in new loans under the Federal Direct Student Loans Program (CFDA 84.268). Since this program is administered by outside financial institutions, new loans made in the year ended December 31, 2019 relating to this program are considered current period federal expenditures, whereas the outstanding balances are not. The new loans made in the year ended December 31, 2019 are reported in the Schedule.

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Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Board of Trustees and Management
Montefiore Health System, Inc.

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Montefiore Health System, Inc. and its controlled organizations (the Health System), which comprise the consolidated statement of financial position as of December 31, 2019, and the related consolidated statements of operations, changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated April 15, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the Health System's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

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Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

April 15, 2020

Building a better working world

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Report of Independent Auditors on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance Required by the Uniform Guidance

The Board of Trustees and Management
Montefiore Health System, Inc.

Report on Compliance for Each Major Federal Program

We have audited Montefiore Health System, Inc. and its controlled organizations' (the Health System) compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Compliance Supplement* that could have a direct and material effect on each of the Health System's major federal programs for the year ended December 31, 2019. The Health System's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the Health System's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Health System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the Health System's compliance.

Opinion on Each Major Federal Program

In our opinion, the Health System complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2019.

Report on Internal Control Over Compliance

Management of the Health System is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Health System's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Ernst & Young LLP

September 30, 2020

Montefiore Health System, Inc.

Schedule of Findings and Questioned Costs

For the Year Ended December 31, 2019

Section I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	Unmodified, with emphasis-of-matter paragraph for changes in accounting	
Internal control over financial reporting:		
Material weakness(es) identified?	______Yes	✓ No
Significant deficiency(ies) identified?	______Yes	✓ None Reported
Noncompliance material to financial statements noted?	______Yes	✓ No

Federal Awards

Internal control over major federal programs:		
Material weakness(es) identified?	______Yes	✓ No
Significant deficiency(ies) identified?	______Yes	✓ None Reported
Type of auditor's report issued on compliance for major federal programs:	Unmodified	
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	______Yes	✓ No

Section I – Summary of Auditor's Results (continued)

Identification of major programs:

CFDA Numbers	Name of Federal Program or Cluster
93.093	Affordable Care Act (ACA) Health Profession Opportunity Grants
93.153	Coordinated Services and Access to Research for Women, Infants, Children, and Youth
93.558	Temporary Assistance for Needy Families
Various	Research and Development Cluster

Dollar threshold used to distinguish between Type A and Type B programs: $ 1,858,551

Auditee qualified as low-risk auditee? ✓ Yes ______ No

Section II – Financial Statement Findings

There are no matters that are required to be reported.

Section III – Federal Award Findings and Questioned Costs

There are no matters that are required to be reported.

Financial Responsibility Supplemental Schedule Related to U.S. Department of Education Title IV

Montefiore Health System, Inc.

Financial Responsibility Supplemental Schedule

As of and for the year ended December 31, 2019

Reference to Financial Statements and/or Notes	Ratio Element	2019
		(In Thousands)
Primary Reserve Ratio:		
Expendable net assets:		
Consolidated Statements of Financial Position	Net assets without donor restrictions	$ 1,248,005
Consolidated Statements of Financial Position	Net assets with donor restrictions	149,658
Consolidated Statements of Financial Position	Due from members (secured and unsecured)	100
Consolidated Statements of Financial Position	Due from members (unsecured)	100
Note 16. U.S. Department of Education Title IV Supplemental Information	Pre-implementation property, buildings and equipment, net at December 31, 2018	$ 1,685,630
	Debt financed post-implementation property, buildings and equipment, net acquired with debt subsequent to December 31, 2018:	
Note 16. U.S. Department of Education Title IV Supplemental Information	Finance leases	4,460
Note 16. U.S. Department of Education Title IV Supplemental Information	Post-implementation property, buildings and equipment, net acquired without debt subsequent to December 31, 2018:	355,838
Consolidated Statements of Financial Position	Total post-implementation property, buildings and equipment, net	$ 2,045,928
Note 16. U.S. Department of Education Title IV Supplemental Information	Pre-implementation right-of-use assets at December 31, 2018	$ 50,074
Note 6. Leases	Post-implementation right-of-use assets	750,909
Note 1. Organization and Summary of Significant Accounting Policies	Intangible Assets	47,800
Note 16. U.S. Department of Education Title IV Supplemental Information	Total postretirement liabilities	398,485
Consolidated Statements of Financial Position (current plus long-term)	Pre-implementation long-term debt at December 31, 2018	1,443,844
Consolidated Statements of Financial Position (current plus long-term)	Post-implementation long-term debt	1,484,986
Note 16. U.S. Department of Education Title IV Supplemental Information	Pre-implementation lease liabilities at December 31, 2018	62,852
Note 6. Leases	Post-implementation lease liabilities	766,499

Montefiore Health System, Inc.

Financial Responsibility Supplemental Schedule (continued)

Reference to Financial Statements and/or Notes	Ratio Element	2019
		(In Thousands)
Primary Reserve Ratio (continued):		
Expendable net assets (continued):		
Note 16. U.S. Department of Education Title IV Supplemental Information	Annuities	$ –
Note 16. U.S. Department of Education Title IV Supplemental Information	Term endowments	–
Note 16. U.S. Department of Education Title IV Supplemental Information	Life income funds	–
Note 16. U.S. Department of Education Title IV Supplemental Information	Other restricted by purpose and time	92,908
Note 16. U.S. Department of Education Title IV Supplemental Information	Restricted in perpetuity	56,750
Consolidated Statements of Financial Position	Total net assets with donor restrictions	$ 149,658
Total expenses and losses:		
Consolidated Statements of Operations	Total operating expenses	$ 6,336,964
Note 16. U.S. Department of Education Title IV Supplemental Information	Net periodic pension and other postretirement benefit costs (non-service related)	16,244
Equity ratio:		
Modified net assets:		
Consolidated Statements of Financial Position	Total net assets without donor restrictions	$ 1,248,005
Consolidated Statements of Financial Position	Total net assets with donor restriction	149,658
Note 1. Organization and Summary of Significant Accounting Policies	Intangible Assets	47,800
Consolidated Statements of Financial Position	Due from members (secured and unsecured)	100
Consolidated Statements of Financial Position	Due from members (unsecured)	100
Modified assets:		
Consolidated Statements of Financial Position	Total assets	$ 6,321,200
Note 1. Organization and Summary of Significant Accounting Policies	Intangible Assets	47,800
Consolidated Statements of Financial Position	Due from members (secured and unsecured)	100
Consolidated Statements of Financial Position	Due from members (unsecured)	100
Net income ratio:		
Consolidated Statements of Operations	Increase in net assets without donor restrictions	$ 118,053
Note 16. U.S. Department of Education Title IV Supplemental Information	Total revenues and gains	6,554,180

Schedules Related to the
New York City Administration for
Children’s Services Contract # 20160000348

Montefiore Health System, Inc.
New York City Administration for Children's Services
Family Treatment/Rehabilitation

Contract # 20160000348
Grant Period July 1, 2018 to June 30, 2019

Statement of Revenues and Expenditures

Year Ended December 31, 2019

	Approved Budget	2019 Amounts	Cumulative Amounts	Variance Cumulative to Budget
		(Unaudited)		
Revenues:				
Administration for Children's Services	$ 2,093,136	$ 1,488,901	$ 2,093,136	$ –
Total revenue	2,093,136	1,488,901	2,093,136	–
Expenditures:				
Personnel expenditures:				
Salaries	1,390,802	997,898	1,390,802	–
Fringe benefits	350,273	259,454	350,273	–
Total personnel expenditures	1,741,075	1,257,352	1,741,075	–
Other than personnel services (OTPS) expenditures:				
Rent and utilities	75,440	40,469	75,440	–
Other	86,337	52,971	86,337	–
Total OTPS expenditures	161,777	93,440	161,777	–
Administrative overhead	190,284	138,109	190,284	–
Total expenditures	2,093,136	1,488,901	2,093,136	–
Excess of revenues over expenditures	$ –	$ –	$ –	$ –
		(Unaudited)		
Private share	$ 40,082	$ –	$ 40,082	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Family Treatment/Rehabilitation

Contract # 20160000348
Grant Period July 1, 2018 to June 30, 2019

Schedule of Salaries

Year Ended December 31, 2019

Employee Identification Code	Title	Budgeted Salary	2019 Salary (Unaudited)	Cumulative Salary	Variance Cumulative to Budget
35442/46360	Program Director, PhD	$ 113,354	$ 68,268	$ 106,489	$ 6,865
505135/505823	Supervisor (FTR & COS)	71,443	29,110	78,196	(6,753)
506549	Supervisor (FTR & COS)	71,443	38,934	73,615	(2,172)
506817/507276	Supervisor (FTR & COS)	71,443	54,915	73,530	(2,087)
508523/508130	Supervisor (FTR & COS)	71,443	52,957	73,672	(2,229)
80243/507863	Supervisor (FTR & COS)	71,443	16,546	79,337	(7,894)
48537/506268	Supervisor (FTR & COS)	71,443	26,721	75,668	(4,225)
16676	MA-Level Case Planner	55,781	64,541	66,516	(10,735)
24159	MA-Level Case Planner	55,781	28,101	56,304	(523)
46369	MA-Level Case Planner	55,781	57,082	58,828	(3,047)
508959/509071	BA-Level Case Planner (FTR & COS)	52,608	53,023	53,836	(1,228)
505098	BA-Level Case Planner (FTR & COS)	52,608	27,128	52,865	(257)
31763	BA-Level Case Planner (FTR & COS)	52,608	28,537	55,889	(3,281)
38175	BA-Level Case Planner (FTR & COS)	52,608	26,733	53,224	(616)
501093/504540	BA-Level Case Planner (FTR & COS)	52,608	25,139	52,328	280
508172/508300	BA-Level Case Planner (FTR & COS)	52,608	43,487	52,175	433
508335/505503	BA-Level Case Planner (FTR & COS)	52,608	46,469	53,415	(807)
39596/506462	BA-Level Case Planner (FTR & COS)	52,608	53,505	55,555	(2,947)
508868	Conference Facilitator	30,567	31,907	33,317	(2,750)
505910	Conference Facilitator	30,567	15,687	31,375	(808)
38028	Program Director (COS)	45,000	18,751	37,109	7,891
509060	Intake Coordinator (COS)	23,250	25,244	27,404	(4,154)
49733	Receptionist	12,745	7,517	15,033	(2,288)
509266/509303/509806	Case Aides/Outreach Specialist	44,793	37,601	41,265	3,528
30896	Case Aides/Outreach Specialist	44,793	37,480	41,261	3,532
507671	QA/QI – Quality Assurance Manager	28,866	14,552	29,653	(787)
	Adjusting Journal Entries	2	67,963	(37,057)	37,059
Total		$ 1,390,802	$ 997,898	$ 1,390,802	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Family Treatment/Rehabilitation

Contract # 20160000348
Grant Period July 1, 2018 to June 30, 2019

Schedule of Fringe Benefits

Year Ended December 31, 2019

Description	Budgeted Amount	2019 Amounts	Cumulative Amounts	Cumulative Fringe % to Cumulative Salary	Variance Cumulative to Budget
			(Unaudited)		
FICA	$ 101,857	$ 76,339	$ 101,857	7.32%	$ –
Health	199,719	149,686	199,719	14.36	–
Worker's Compensation	13,315	9,979	13,315	0.96	–
Unemployment	6,657	4,989	6,657	0.48	–
Disability	6,657	4,989	6,657	0.48	–
Other	22,068	13,472	22,068	1.59	–
Total	$ 350,273	$ 259,454	$ 350,273	25.19%	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Family Treatment/Rehabilitation

Contract # 20160000348
Grant Period July 1, 2018 to June 30, 2019

Schedule of Fixed Assets Inventory

Year Ended December 31, 2019

Description	**Serial Number**	**Date Purchased**	**Cost**
	(Unaudited)		
N/A	N/A	N/A	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Family Treatment/Rehabilitation

Contract # 20160000348
Grant Period July 1, 2018 to June 30, 2019

Schedule of Questioned Costs

Year Ended December 31, 2019

Detailed Explanation of Questioned Costs	Questioned Costs
	(Unaudited)
Budget line category	
Please provide a detailed explanation of the questioned costs. Include such items as vendor name, why costs are being questioned and how the questioned costs were determined.	N/A
Budget line category	–
Total questioned costs	N/A

Montefiore Health System, Inc.
New York City Administration for Children's Services
Family Treatment/Rehabilitation

Contract # 20160000348
Grant Period July 1, 2018 to June 30, 2019

Schedule of Quantitative Program Results

Year Ended December 31, 2019

Quantifiable Indicators

(Unaudited)

Number of open cases at beginning of period	45
Number of new cases during audit period	88
Number of cases serviced during audit period	133
Cases terminated	52
Cases open as of current year	92
Cost per family	$ 9,514

Schedules Related to the
New York City Administration for
Children’s Services Contract # 20170000546

Montefiore Health System, Inc.
New York City Administration for Children's Services
Specialized Teen Preventive Services

Contract # 20170000546
Grant Period July 1, 2018 to June 30, 2019

Statement of Revenues and Expenditures

Year Ended December 31, 2019

	Approved Budget	2019 Amounts	Cumulative Amounts	Variance Cumulative to Budget
		(Unaudited)		
Revenues:				
Administration for Children's Services	$ 1,332,185	$ 725,573	$ 1,332,185	$ –
Total revenue	1,332,185	725,573	1,332,185	–
Expenditures:				
Personnel expenditures:				
Salaries	840,647	479,109	840,647	–
Fringe benefits	219,092	124,568	219,092	–
Total personnel expenditures	1,059,739	603,677	1,059,739	–
Other than personnel services (OTPS) expenditures:				
Rent and utilities	50,009	31,729	50,009	–
Other	101,329	40,290	101,329	–
Total OTPS expenditures	151,338	72,019	151,338	–
Administrative overhead	121,108	49,877	121,108	–
Total expenditures	1,332,185	725,573	1,332,185	–
Excess of revenues over expenditures	$ –	$ -	$ –	$ –
		(Unaudited)		
Private share	$ 60,344	$	$ 60,344	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Specialized Teen Preventive Services

Contract # 20170000546
Grant Period July 1, 2018 to June 30, 2019

Schedule of Salaries

Year Ended December 31, 2019

Employee Identification Code	Title	Budgeted Salary	2019 Salary (Unaudited)	Cumulative Salary	Variance Cumulative to Budget
37442	Program Director	$ 54,439	$ 41,481	$ 54,738	$ (299)
35442	Program Director	54,439	27,781	54,398	41
46360	Supervisor	76,341	28,912	76,169	172
46361	Supervisor	76,341	36,936	73,337	3,004
42961/502924	Therapist	61,029	26,753	54,872	6,157
46513	Therapist	61,029	34,232	68,109	(7,080)
503224	Therapist	61,029	34,395	67,693	(6,664)
47310/507603	Therapist	61,029	39,338	60,914	115
49527	Therapist	61,029	62,499	62,499	(1,470)
46369/507863/508130	Therapist	61,029	13,955	74,073	(13,044)
507198/507671	Therapist	61,029	39,750	52,673	8,356
505503/501142/16335	Therapist	61,029	44,629	56,782	4,247
505910	Conference Facilitator	26,152	13,722	26,611	(459)
506817	Case Aides/ Outreach Specialist	35,834	7,911	35,834	–
41385	QA/QI – Quality Assurance Manager	28,867	28,190	28,190	677
	Adjusting Journal Entry	2	(1,375)	(6,245)	6,247
Total		$ 840,647	$ 479,109	$ 840,647	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Specialized Teen Preventive Services

Contract # 20170000546
Grant Period July 1, 2018 to June 30, 2019

Schedule of Fringe Benefits

Year Ended December 31, 2019

Description	Budgeted Amount	2019 Amounts	Cumulative Amounts *(Unaudited)*	Cumulative Fringe % to Cumulative Salary	Variance Cumulative to Budget
FICA	$ 57,425	$ 36,652	$ 57,425	6.83%	$ –
Health	112,599	71,866	112,599	13.39	–
Worker's Compensation	7,507	4,791	7,507	0.89	–
Unemployment	3,753	2,396	3,753	0.45	–
Disability	3,753	2,396	3,753	0.45	–
Other	34,055	6,468	34,055	4.05	–
Total	$ 219,092	$ 124,568	$ 219,092	26.06%	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Specialized Teen Preventive Services

Contract # 20170000546
Grant Period July 1, 2018 to June 30, 2019

Schedule of Fixed Assets Inventory

Year Ended December 31, 2019

Description	Serial Number	Date Purchased	Cost
(Unaudited)			
N/A	N/A	N/A	$ –

Montefiore Health System, Inc.
New York City Administration for Children's Services
Specialized Teen Preventive Services

Contract # 20170000546
Grant Period July 1, 2018 to June 30, 2019

Schedule of Questioned Costs

Year Ended December 31, 2019

Detailed Explanation of Questioned Costs	**Questioned Costs**
	(Unaudited)
Budget line category	
Please provide a detailed explanation of the questioned costs. Include such items as vendor name, why costs are being questioned and how the questioned costs were determined	N/A
Budget line category	–
Total questioned costs	N/A

Montefiore Health System, Inc.
New York City Administration for Children's Services
Specialized Teen Preventive Services

Contract # 20170000546
Grant Period July 1, 2018 to June 30, 2019

Schedule of Quantitative Program Results

Year Ended December 31, 2019

Quantifiable Indicators

(Unaudited)

Number of open cases at beginning of period		24
Number of new cases during audit period		42
Number of cases serviced during audit period		66
Cases terminated		41
Cases open as of current year		28
Cost per family	$	16,652

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