Consolidated Financial Statements (Unaudited)

Montefiore Medical Center

For the Years Ended December 31, 2019 and 2018

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Contents

Montefiore Medical Center

Consolidated Statements of Financial Position

	Unaudited December 31, 2019	Audited December 31, 2018
	(In Thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 144,569**	$ 184,019
Marketable and other securities	**1,424,522**	1,355,526
Assets limited as to use, current portion	**21,740**	10,930
Receivables for patient care, net	**306,712**	231,548
Other receivables	**46,153**	44,007
Estimated insurance claims receivable, current portion	**72,105**	86,575
Other current assets	**66,974**	68,014
Due from members, current portion	**88,982**	25,861
Total current assets	**2,171,757**	2,006,480
Assets limited as to use, net of current portion	**156,131**	153,938
Property, buildings and equipment, net	**1,253,521**	1,017,751
Right-of-use assets – operating leases	**390,044**	–
Estimated insurance claims receivable, net of current portion	**328,478**	394,399
Other noncurrent assets	**139,364**	215,213
Due from members, net of current portion	**154,837**	129,487
Total assets	**$ 4,594,132**	$ 3,917,268
Liabilities and net assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 304,674**	$ 305,583
Accrued salaries, wages and related items	**289,240**	270,386
Professional and other insured liabilities, current portion	**75,394**	61,989
Estimated insurance claims liabilities, current portion	**72,105**	86,575
Estimated third-party payer liabilities, current portion	**48,762**	33,334
Long-term debt, current portion	**16,365**	15,796
Finance lease liabilities, current portion	**10,310**	1,399
Operating lease liabilities, current portion	**34,520**	–
Total current liabilities	**851,370**	775,062
Long-term debt, net of current portion	**1,365,565**	1,326,514
Finance lease liabilities, net of current portion	**245,792**	53,991
Operating lease liabilities, net of current portion	**364,529**	–
Noncurrent defined benefit pension and other postretirement health plan liabilities	**215,284**	190,279
Professional and other insured liabilities, net of current portion	**149,892**	117,454
Employee deferred compensation	**62,576**	46,329
Estimated insurance claims liabilities, net of current portion	**328,478**	394,399
Estimated third-party payer liabilities, net of current portion	**225,628**	211,014
Other noncurrent liabilities	**29,349**	62,523
Total liabilities	**3,838,463**	3,177,565
Commitments and contingencies		
Net assets:		
Without donor restrictions	**646,668**	628,902
With donor restrictions	**109,001**	110,801
Total net assets	**755,669**	739,703
Total liabilities and net assets	**$ 4,594,132**	$ 3,917,268

See accompanying notes.

Montefiore Medical Center

Consolidated Statements of Operations

	Year Ended December 31, 2019 Unaudited	2018 Audited
	(In Thousands)	
Operating revenue		
Net patient service revenue	**$ 3,729,984**	$ 3,499,992
Grants and contracts	**91,232**	87,361
Other revenue	**337,716**	332,226
Total operating revenue	**4,158,932**	3,919,579
Operating expenses		
Salaries and wages	**1,956,131**	1,849,552
Employee benefits	**553,392**	531,248
Supplies and other expenses	**1,418,217**	1,338,110
Depreciation and amortization	**153,807**	150,151
Interest	**71,747**	48,585
Total operating expenses	**4,153,294**	3,917,646
Excess of operating revenues over operating expenses before other items	**5,638**	1,933
Net realized and changes in net unrealized gains and losses on marketable and other securities	**53,750**	(14,945)
Malpractice insurance program adjustments	**31,095**	49,354
Gain on sale of equity interest in captive insurance company	**39,200**	–
Net periodic pension and other postretirement benefit costs (non-service related)	**(16,158)**	(11,845)
Other nonoperating gains and losses, net	**(23,791)**	2,134
Excess of revenues over expenses	**89,734**	26,631
Change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods	**(6,560)**	9,485
Other changes in net assets without donor restrictions	**33,460**	–
Transfers to members, net	**(98,868)**	(139,963)
Increase (decrease) in net assets without donor restrictions	**$ 17,766**	$ (103,847)

See accompanying notes.

Montefiore Medical Center

Consolidated Statements of Changes in Net Assets

Years Ended December 31, 2019 (Unaudited) and 2018 (Audited)

	Without Donor Restrictions	With Donor Restrictions	Total Net Assets
		(In Thousands)	
Net assets at January 1, 2018	$ 732,749	$ 111,668	$ 844,417
Decrease in net assets without donor restrictions	(103,847)	–	(103,847)
Restricted gifts, bequests, and similar items	–	3,513	3,513
Restricted investment income	–	(488)	(488)
Net assets released from restrictions	–	(3,892)	(3,892)
Total changes in net assets	(103,847)	(867)	(104,714)
Net assets at December 31, 2018	628,902	110,801	739,703
Increase in net assets without donor restrictions	**17,766**	–	**17,766**
Restricted gifts, bequests, and similar items	–	**1,333**	**1,333**
Restricted investment income	–	**1,233**	**1,233**
Net assets released from restrictions	–	**(4,366)**	**(4,366)**
Total changes in net assets	**17,766**	**(1,800)**	**15,966**
Net assets at December 31, 2019	**$ 646,668**	**$ 109,001**	**$ 755,669**

See accompanying notes.

Montefiore Medical Center

Consolidated Statements of Cash Flows

	Year Ended December 31, 2019 Unaudited	2018 Audited
	(In Thousands)	
Operating activities		
Increase (decrease) in net assets	**$ 15,966**	$ (104,714)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	**153,807**	150,151
Change in defined benefit pension and other postretirement health plan liabilities to be recognized in future periods	**6,560**	(9,485)
Transfers to members, net	**98,868**	139,963
Lease transition adjustment	**(35,038)**	**–**
Net realized gains and losses on marketable and other securities	**(8,137)**	(12,169)
Change in net unrealized gains and losses on marketable and other securities	**(45,613)**	27,114
Equity earnings from investments	**(20,904)**	(42,674)
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 and debt discount	**(2,343)**	(1,141)
Amortization of deferred financing costs	**1,197**	1,081
Changes in operating assets and liabilities:		
Receivables for patient care	**(75,164)**	11,547
Accounts payable and accrued expenses	**(3,994)**	28,434
Accrued salaries, wages and related items	**18,854**	(15,465)
Noncurrent defined benefit and postretirement health plan liabilities	**18,445**	9,611
Net change in all other operating assets and liabilities	**17,139**	(19,221)
Net cash provided by operating activities	**100,443**	167,037
Investing activities		
Acquisition of property, buildings and equipment, net	**(167,823)**	(111,547)
Proceeds from sale of equity interest in captive insurance company	**177,701**	–
Funding of self-insurance trust	**(35,448)**	(7,718)
Payments from Montefiore Health System, Inc. on MHS Note	**30,582**	2,153
Increase in marketable and other securities, net	**(113,097)**	(406,870)
(Increase) decrease in assets limited to use, net	**(15,994)**	67,799
Net cash used in investing activities	**(124,079)**	(456,183)
Financing activities		
Payments of long-term debt and finance lease obligations	**(19,354)**	(49,152)
Extinguishment of long-term debt	–	(545,139)
Proceeds from long-term debt	–	1,213,837
Net proceeds from credit line	**55,400**	–
Payments of deferred financing costs	–	(24,482)
Loans and payments to members, net	**(152,702)**	(51,967)
Net cash (used in) provided by financing activities	**(116,656)**	543,097
Net (decrease) increase in cash, cash equivalents and restricted cash	**(140,292)**	253,951
Cash, cash equivalents and restricted cash at beginning of year	**548,659**	294,708
Cash, cash equivalents and restricted cash at end of year	$ **408,367**	$ 548,659
Reconciliation of cash and cash equivalents at end of year to the consolidated statements of financial position:		
Cash and cash equivalents	$ **144,569**	$ 184,019
Marketable and other securities: cash and cash equivalents	**224,000**	321,851
Assets limited as to use: cash and cash equivalents	**39,798**	42,789
Total cash, cash equivalents and restricted cash	**$ 408,367**	$ 548,659
Supplemental cash flow and noncash information		
Property, building and equipment purchases in accounts payable and accrued expenses	$ **3,305**	$ –
Finance lease obligations incurred	$ **4,460**	$ –

See accompanying notes.

Montefiore Medical Center

Notes to Consolidated Financial Statements (Unaudited)

December 31, 2019

1. Organization

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

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

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

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

All intercompany accounts and activities have been eliminated in consolidation.

Interim Financial Statements

The Medical Center presumes that users of this unaudited consolidated financial information have read or have access to the Medical Center's audited consolidated financial statements which include certain disclosures required by U.S. generally accepted accounting principles. The audited consolidated financial statements of the Medical Center for the years ended December 31, 2018 and 2017 are on file with the Municipal Securities Rulemaking Board and are accessible through its Electronic Municipal Market Access Database. Accordingly, footnotes and other disclosures that would substantially duplicate the disclosures contained in the Medical Center's most recent audited consolidated financial statements have been omitted from the unaudited consolidated financial information. In the opinion of management, all material adjustments considered necessary for a fair presentation have been included.

1. Organization (continued)

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

Use of Estimates

The preparation of the consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, as well as the disclosure of contingent assets and liabilities, at the date of the consolidated financial statements. Estimates also affect the amounts of revenue and expenses reported during the period. Actual results could differ from those estimates. The Medical Center recorded net changes in estimates that decreased the excess of revenues over expenses by approximately $7.6 million during 2019 and increased the excess of revenues over expenses by approximately $1.9 million during 2018. The changes were primarily related 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 Medical Center 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.

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 Medical Center adopted ASU 2016-02 on January 1, 2019, utilizing the modified retrospective approach. ASU 2016-02 had a material impact on the Medical Center's consolidated statement of financial position, but did not have an impact on the consolidated statement of operations. Under the modified retrospective approach, prior period amounts were not required to be adjusted. The Medical Center 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 Medical Center did not elect the hindsight transitional practical expedient. The Medical Center also elected the

1. Organization (continued)

practical expedient to utilize a risk-free rate as the incremental borrowing rate for all leases in transition and prospectively. Under the ASU 2016-02 standard, the Medical Center 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. The related lease was evaluated under the new guidance and recorded as a finance lease liability amounting to approximately $111.2 million.

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 Medical Center's consolidated financial statements.

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 Medical Center 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 Medical Center 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 Medical Center's consolidated financial statements.

1. Organization (continued)

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 Medical Center has not completed the process of evaluating the impact of ASU 2016-13 on its consolidated financial statements.

In January 2017, the FASB issued ASU 2017-04, *Intangibles-Goodwill and Other* (ASU 2017-04). ASU 2017-04 will simplify the accounting for goodwill impairment and will remove Step 2 of the current goodwill impairment test, which requires a hypothetical purchase price allocation. Under ASU 2017-04, a goodwill impairment charge will now be recognized for the amount by which the carrying value of a reporting unit exceeds its fair value, not to exceed the carrying amount of goodwill. This guidance is effective for the Medical Center for annual periods beginning after December 15, 2021, with early adoption permitted for any impairment tests performed after January 1, 2017. The Medical Center 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 Medical Center 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

1. Organization (continued)

prospective adoption is permitted. The Medical Center 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 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 Medical Center 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.

Subsequent Events

The Medical Center evaluated subsequent events through March 12, 2020, which is the date the unaudited consolidated financial statements were issued, for potential recognition or disclosure in the accompanying consolidated financial statements for the years ended December 31, 2019. Except as noted in Note 4, no subsequent events have occurred that require disclosure in the consolidated financial statements.

2. Net Patient Service Revenue

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

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

2. Net Patient Service Revenue (continued)

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

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

As substantially all of its performance obligations relate to contracts with a duration of less than one year, the Medical Center has elected to apply the optional exemption provided in ASU 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period for patients who remain admitted at that time (in-house patients). The performance obligations for in-house patients are generally completed when the patients are discharged, which for the majority of the Medical Center's in-house patients occurs within days or weeks after the end of the reporting period.

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 Medical Center's estimates of expected payments for performance obligations satisfied in prior years were not significant. Portfolio collection estimates are updated based on collection trends. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (determined on a portfolio basis when applicable) are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2019 and 2018 was not significant.

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

Net patient service revenue by payer is as follows:

	Year Ended December 31	
	2019	**2018**
	(In Thousands)	
Medicare and Medicare managed care	**$ 1,220,035**	$ 1,133,826
Medicaid and Medicaid managed care	**1,212,037**	1,216,274
Commercial carriers and managed care	**1,258,990**	1,120,740
Self-pay and other	**38,922**	29,152
	$ 3,729,984	$ 3,499,992

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

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

	Year Ended December 31	
	2019	**2018**
	(In Thousands)	
Inpatient services	**$ 2,082,135**	$ 2,046,255
Physician and other outpatient services	**1,309,174**	1,173,174
Premium revenue	**177,577**	120,115
Emergency department	**98,738**	98,078
All other	**62,360**	62,370
	$ **3,729,984**	$ 3,499,992

2. Net Patient Service Revenue (continued)

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

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

	December 31	
	2019	**2018**
	(In Thousands)	
Patient receivables	**$ 234,715**	$ 173,448
Contract assets	**71,997**	58,100
	$ 306,712	$ 231,548

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

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

2. Net Patient Service Revenue (continued)

Third-Party Payment Programs

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

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

Non-Medicare Reimbursement: In New York State, hospitals and all non-Medicare payers, except Medicaid, workers' compensation and no-fault insurance programs, negotiate hospitals' payment rates. If negotiated rates are not established, payers are billed at hospitals' established charges. Medicaid, workers' compensation and no-fault payers pay hospital rates promulgated by the 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 Medical Center is reasonably assured that such amounts are realizable. Adjustments to the current and prior years' payment rates for those payers will continue to be made in future years.

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

Medicare cost reports, which serve as the basis for final settlement with the Medicare program, have been audited by the Medicare fiscal intermediary and settled through December 31, 2014, although revisions to final settlements or other retroactive changes could be made. Other years and various issues remain open for audit and settlement, as are numerous issues related to the New York State Medicaid program for prior years. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount when open years are settled, audits are completed and additional information is obtained.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge

2. Net Patient Service Revenue (continued)

the Medical Center's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Medical Center. The Medical Center is not aware of any allegations of non-compliance that could have a material adverse effect on the accompanying consolidated financial statements and believes that it is in compliance with all applicable laws and regulations. In addition, certain contracts the Medical Center has with commercial payers also provide for retroactive audit and review of claims.

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

3. Benefit Plans

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

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

Total expense, included in the accompanying consolidated statements of operations for the various pension plans, aggregated approximately $171.1 million and $149.1 million for the years ended December 31, 2019 and 2018, respectively. Cash payments relative to the various pension plans aggregated approximately $165.2 million and $152.3 million for the years ended December 31, 2019 and 2018, respectively.

3. Benefit Plans (continued)

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

	Pension		Postretirement	
	2019	**2018**	**2019**	**2018**
	(In Thousands)			
Service cost	**$ 6,708**	$ 6,300	**$ 10,611**	$ 12,450
Interest cost	**1,500**	1,400	**8,360**	7,155
Expected return on plan assets	**(1,939)**	(1,901)	–	–
Amortization of prior service cost (benefit)	**45**	45	**(276)**	(1,779)
Amortization of net loss	**1,481**	1,805	**1,745**	3,545
Settlement cost	**5,242**	1,575	–	–
Net periodic benefit cost	**$ 13,037**	$ 9,224	**$ 20,440**	$ 21,371

4. Long-Term Debt

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.

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

5. Leases

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

5. Leases (continued)

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

The following table presents the Medical Center'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	$ 390,044
Finance leases	Property, buildings and equipment, net	249,746
Total lease assets		$ 639,790
Liabilities:		
Current:		
Operating leases	Operating lease liabilities, current portion	$ 34,520
Finance leases	Finance lease liabilities, current portion	10,310
Noncurrent:		
Operating leases	Operating lease liabilities, net of current portion	364,529
Finance leases	Finance lease liabilities, net of current portion	245,792
Total lease liabilities		$ 655,151

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

Weighted-average remaining lease term (years)	December 31, 2019
Operating leases	11.6
Finance leases[(1)]	58.6
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 10.5 years.

5. 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	$ 11,076
Interest on finance lease liabilities	7,888
Operating lease cost	53,281
Variable and short-term lease expense	943
Total lease expense	$ 73,188

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	$ 37,746
Operating cash flows for finance leases	7,888
Financing cash flows for finance leases	4,720

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

	Operating Leases	Finance Leases
2020	$ 44,627	$ 13,477
2021	45,976	14,348
2022	41,066	14,671
2023	38,004	14,995
2024	36,993	15,094
2025 and thereafter	260,749	805,216
Total lease payments	467,415	877,801
Less imputed interest	(68,366)	(621,699)
Present value of lease payments	$ 399,049	$ 256,102

6. Commitments and Contingencies

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

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

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

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

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.

6. Commitments and Contingencies (continued)

Albert Einstein College of Medicine, Inc.: In 2015, a controlled member of MMAHS, Albert Einstein College of Medicine, Inc. (Einstein), acquired substantially all of the assets and assumed substantially all of the liabilities of a medical school operating as a division of Yeshiva University (YU). In connection with this transaction, $175.0 million Build NYC Resource Corporation Revenue Bonds were issued. The Build NYC Resource Corporation Revenue Bonds carry a 5.5% coupon rate and mature on September 1, 2045. Interest is payable semiannually and principal is payable annually commencing on September 1, 2020.

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.

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 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.

6. Commitments and Contingencies (continued)

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 67% and 66%, respectively, of the Medical Center's employees were covered by collective bargaining agreements. The collective bargaining agreement with NYSNA expires in December 2022 and the collective bargaining agreement with 1199SEIU expires in September 2021.

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

In December 2018, the Medical Center entered into a mortgage loan agreement with White Plains Hospital Center to make funds available up to $248.5 million for a certain construction project (the Loan Agreement). Interest on the Loan Agreement is based on a fixed rate of 4.50%. Beginning February 1, 2019 to July 1, 2021 (the construction period), interest shall accrue and be paid monthly on the amounts drawn and outstanding. Principal payments are not due until August 1, 2021. Approximately $55.2 million was drawn under this agreement at December 31, 2019. No amount was drawn or outstanding at December 31, 2018.

7. Fair Value Measurements

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

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

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

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

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

7. Fair Value Measurements (continued)

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

Financial assets carried at fair value, including assets invested in the Medical Center's defined benefit plan, are classified in the table below in one of the three categories described above as of December 31, 2019:

	December 31, 2019			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	**$ 144,569**	**$ –**	**$ –**	**$ 144,569**
Managed cash and cash equivalents held for investment	**263,798**	**–**	**–**	**263,798**
Marketable and other securities:			**–**	
U.S. non-equity mutual funds	**65,587**	**–**	**–**	**65,587**
U.S. equity mutual funds	**40,482**	**–**	**–**	**40,482**
U.S. Government agency mortgage-backed securities	**–**	**83,392**	**–**	**83,392**
U.S. Treasury securities	**121,466**	**–**	**–**	**121,466**
U.S. Government agency-backed securities	**–**	**1,056**	**–**	**1,056**
U.S. equity securities	**59,921**	**–**	**–**	**59,921**
Corporate debt	**–**	**780,425**	**–**	**780,425**
	695,823	**864,873**	**–**	**1,560,696**
Defined benefit plan assets				
Cash and cash equivalents	**566**	**–**	**–**	**566**
Equity mutual funds	**10,786**	**–**	**–**	**10,786**
Fixed income mutual funds	**2,053**	**–**	**–**	**2,053**
	13,405	**–**	**–**	**13,405**
	$ 709,228	**$ 864,873**	**$ –**	**1,574,101**
Investments measured at net asset value (defined benefit pension plan assets)				**4,230**
				$ 1,578,331

7. Fair Value Measurements (continued)

Financial assets carried at fair value, including assets invested in the Medical Center's defined benefit plan, are classified in the table below in one of the three categories described above as of December 31, 2018:

	December 31, 2018			
	Level 1	**Level 2**	**Level 3**	**Total**
	(In Thousands)			
Assets				
Cash and cash equivalents	$ 184,019	$ –	$ –	$ 184,019
Managed cash and cash equivalents held for investment	364,640	–	–	364,640
Marketable and other securities:				
U.S. non-equity mutual funds	49,099	–	–	49,099
U.S. equity mutual funds	17,782	–	–	17,782
U.S. Government agency mortgage-backed securities	–	39,513	–	39,513
U.S. Treasury securities	44,512	–	–	44,512
U.S. Government agency-backed securities	–	35,330	–	35,330
U.S. equity securities	55,564	–	–	55,564
Corporate debt	–	792,556	–	792,556
Interest and other receivables	2,499	–	–	2,499
	718,115	867,399	–	1,585,514
Defined benefit plan assets				
Cash and cash equivalents	1,313	–	–	1,313
Equity mutual funds	9,386	–	–	9,386
Fixed income mutual funds	3,153	–	–	3,153
	13,852	–	–	13,852
	$ 731,967	$ 867,399	$ –	$ 1,599,366
Investments measured at net asset value (defined benefit pension plan assets)				12,806
				$ 1,612,172

At December 31, 2019 and 2018, the Medical Center's alternative investments and collective trust funds, excluding those within the defined benefit plan, are reported using the equity method of accounting in the amount of approximately $186.3 million and $118.9 million, respectively, and, therefore, are not included in the tables above.

7. Fair Value Measurements (continued)

The following is a description of the Medical Center's valuation methodologies for assets measured at fair value. Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources, including market participants, dealers and brokers. The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Medical Center believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

8. 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 Medical Center's financial condition. The ultimate impact of these matters to the Medical Center and its financial condition is presently unknown. The accompanying consolidated financial statements do not reflect the effects of these subsequent events.

Montefiore Medical Center
Utilization Statistics
Net Patient Service Revenue By Payor Source

	Year Ended December 31,	
Utilization	**2018**	**2019**
Licensed beds	1,558	1,558
Discharges[1]	89,963	88,064
Patient days[1]	509,400	517,794
Average length of stay (days)[1]	5.7	5.9
Case mix index[2]	1.54	1.58
Average % occupancy[1]	89.6%	91.1%
Emergency room visits[3]	253,935	249,772
Ambulatory procedures	48,464	49,786
Montefiore Medical Group Primary Care visits	798,162	808,209
Home Care Visits	191,684	150,917
Faculty Practice Group Worked RVUs[4]	5,704,677	5,901,551

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

	Year Ended December 31,	
Percent of Net Patient Service Revenue by Payor Source	**2018**	**2019**
Medicaid and Medicaid Managed Care	34.8%	32.5%
Medicare and Medicare Managed Care	32.4%	32.7%
Commercial and Managed Care	32.0%	33.8%
Other	0.8%	1.0%
Total	100.0%	100.0%