# FINANCIAL STATEMENTS

The New York Community Hospital of Brooklyn, Inc.
Years Ended December 31, 2012 and 2011
With Report of Independent Auditors

Ernst & Young LLP

ERNST & YOUNG

The New York Community Hospital of Brooklyn, Inc.

Financial Statements

Years Ended December 31, 2012 and 2011

## Contents

Ernst & Young LLP
5 Times Square
New York, NY 10036-6530
Tel: +1 212 773 3000
Fax: +1 212 773 6350
www.ey.com

# Report of Independent Auditors

The Board of Trustees
The New York Community Hospital of Brooklyn, Inc.

We have audited the accompanying financial statements of The New York Community Hospital of Brooklyn, Inc. (the "Hospital") which comprise the statements of financial position as of December 31, 2012 and 2011, and the related statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

## Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 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 financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 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 financial statements referred to above present fairly, in all material respects, the financial position of The New York Community Hospital of Brooklyn, Inc. at December 31, 2012 and 2011, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

**Change in Presentation of the Provision for Bad Debts**

As discussed in Note 1 to the financial statements, in 2012 the Hospital adopted the provisions of Accounting Standards Update No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*, which resulted in a change to the presentation of the provision for bad debts on the statements of operations and changes in net assets effective January 1, 2011. Our opinion is not modified with respect to this matter.

Ernst & Young LLP

May 30, 2013

The New York Community Hospital of Brooklyn, Inc.

Statements of Financial Position

| | December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| **Assets** | | |
| Current assets: | | |
| Cash and cash equivalents | **$ 40,936** | $ 34,020 |
| Patient accounts receivable, less allowance for uncollectibles (2012 – $10,372; 2011 – $9,424) | **16,352** | 12,796 |
| Other current assets | **2,054** | 2,784 |
| Assets limited as to use, current portion (self insurance fund) *(Notes 3 and 6)* | **978** | 828 |
| Total current assets | **60,320** | 50,428 |
| Assets limited as to use *(Notes 3 and 6):* | | |
| Trusteed self-insured fund | **8,871** | 8,015 |
| Funded depreciation | **881** | 1 |
| Assets limited as to use – noncurrent | **9,752** | 8,016 |
| Property, buildings and equipment – net *(Note 4)* | **17,544** | 17,977 |
| Insurance recovery receivable | **460** | 2,125 |
| Total assets | **$ 88,076** | $ 78,546 |

| | December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| **Liabilities and net assets** | | |
| Current liabilities: | | |
| Accounts payable and accrued expenses | **$ 13,288** | $ 11,086 |
| Accrued salaries and related liabilities | **3,890** | 3,023 |
| Due to related organizations *(Note 8)* | **121** | 158 |
| Current portion of estimated professional liabilities *(Note 6)* | **978** | 828 |
| Total current liabilities | **18,277** | 15,095 |
| Accrued pension liability *(Note 7)* | **5,765** | 5,411 |
| Estimated professional liabilities, less current portion *(Note 6)* | **9,261** | 9,580 |
| Other noncurrent liabilities and deferred revenue *(Note 2)* | **13,985** | 16,861 |
| Total liabilities | **47,288** | 46,947 |
| Commitments and contingencies *(Notes 2,5, 6, and 7)* | | |
| Net assets: | | |
| Unrestricted net assets | **40,788** | 31,599 |
| Total liabilities and net assets | **$ 88,076** | $ 78,546 |

*See accompanying notes.*

The New York Community Hospital of Brooklyn, Inc.

Statements of Operations and Changes in Net Assets

| | Year Ended December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| **Revenue** | | |
| Net patient service revenue | **$ 102,120** | $ 90,957 |
| Provision for bad debts | **(2,420)** | (2,304) |
| Net patient service revenue, less provision for bad debts | **99,700** | 88,653 |
| Other revenue *(Note 10)* | **2,610** | 2,809 |
| Total revenue | **102,310** | 91,462 |
| **Operating expenses** | | |
| Salaries and wages | **41,090** | 39,568 |
| Employee benefits | **15,644** | 14,671 |
| Supplies and other expenses | **33,040** | 28,543 |
| Depreciation | **2,949** | 2,856 |
| Total operating expenses | **92,723** | 85,638 |
| Income from operations | **9,587** | 5,824 |
| Change in unrealized gains and losses on marketable securities | **26** | 38 |
| Excess of revenue over expenses | **9,613** | 5,862 |
| **Other changes in unrestricted net assets** | | |
| Change in pension liability to be recognized in future periods *(Note 7)* | **(424)** | (1,840) |
| Increase in unrestricted net assets | **9,189** | 4,022 |
| Net assets at beginning of year | **31,599** | 27,577 |
| Net assets at end of year | **$ 40,788** | $ 31,599 |

*See accompanying notes.*

The New York Community Hospital of Brooklyn, Inc.

Statements of Cash Flows

| | Year Ended December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| **Operating activities** | | |
| Increase in unrestricted net assets | **$ 9,189** | $ 4,022 |
| Adjustments to reconcile increase in unrestricted net assets to net cash provided by operating activities: | | |
| Depreciation | **2,949** | 2,856 |
| Change in unrealized gains and losses on marketable securities | **(26)** | (38) |
| Changes in operating assets and liabilities: | | |
| Patient accounts receivable, net | **(3,556)** | (3,026) |
| Other current assets | **730** | (390) |
| Insurance recovery receivable | **1,665** | (2,125) |
| Accounts payable and accrued expenses | **2,202** | 607 |
| Accrued salaries and related liabilities | **867** | 129 |
| Due to related organizations | **(37)** | (14) |
| Accrued pension liability | **354** | 1,694 |
| Estimated self-insured professional liabilities | **(169)** | 3,381 |
| Other liabilities and deferred revenue | **(2,876)** | 4,298 |
| Net cash provided by operating activities | **11,292** | 11,394 |
| **Investing activities** | | |
| Acquisitions of property, buildings and equipment | **(2,516)** | (2,377) |
| Net change in assets limited as to use | **(1,860)** | (355) |
| Net cash used in investing activities | **(4,376)** | (2,732) |
| Net increase in cash and cash equivalents | **6,916** | 8,662 |
| Cash and cash equivalents at beginning of year | **34,020** | 25,358 |
| Cash and cash equivalents at end of year | **$ 40,936** | $ 34,020 |

*See accompanying notes.*

# The New York Community Hospital of Brooklyn, Inc.

## Notes to Financial Statements

December 31, 2012

### 1. Organization and Significant Accounting Policies

*Organization:* The New York Community Hospital of Brooklyn, Inc. (the "Hospital") is incorporated under New York State not-for-profit corporation law for the purpose of providing health care services primarily to residents of Brooklyn, New York. The Hospital is a membership corporation, whose members are selected by the New York-Presbyterian Healthcare System, Inc. ("System, Inc."), which is a tax-exempt organization whose members are selected by New York-Presbyterian Foundation, Inc. ("Foundation, Inc."). The Hospital's members select the Hospital's Board of Trustees. System, Inc. and Foundation, Inc. are related to a number of organizations.

On February 26, 2013, NYHB, Inc., a New York not-for-profit corporation, became the sole member of the Hospital. NYHB, Inc. is a member corporation whose members are selected by System, Inc. NYHB, Inc. elects the Hospital's Board of Trustees and the governing board of The New York Methodist Hospital, a separate legal entity whose members prior to February 26, 2013 were also selected by System, Inc. This change is not expected to impact the Hospital's operations or financial reporting.

The following is a summary of significant accounting policies:

*Basis of Financial Statement Presentation:* The accompanying financial statements include only the accounts of the Hospital and do not contain the accounts of affiliated organizations.

*Use of Estimates:* The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, such as estimated uncollectibles for accounts receivable for services to patients, estimated settlements with third-party payors and professional insurance liabilities, and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the amounts of revenue and expenses reported during the period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from those estimates.

*Cash and Cash Equivalents:* The Hospital classifies as cash equivalents all highly liquid financial instruments with a maturity of three months or less when purchased which are not assets limited as to use.

*Receivables for Patient Care and Allowance for Doubtful Accounts:* Patient accounts receivable for which the Hospital receives payment under cost reimbursement, prospective payment formulae or negotiated rates, which cover the majority of patient services, are stated at the

**1. Organization and Significant Accounting Policies (continued)**

estimated net amounts receivable from such payors, which are generally less than the established billing rates of the Hospital. The amount of the allowance for doubtful accounts is based upon management's assessments of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

*Assets Limited as to Use and Investment Gains, Losses and Income:* Assets so classified represent assets whose use is restricted for specific purposes under internal designation or terms of agreements. These assets consist of cash and cash equivalents and U.S. government bonds. Marketable securities are carried at fair value based on quoted market prices. Realized gains and losses on the sales of marketable securities are based upon the average cost method. Realized gains and losses are recorded as investment income within the caption other revenue in the statements of operations and changes in net assets. The change in unrealized gains and losses on marketable securities is reported as a component of the excess of revenue over expenses in the statements of operations and changes in net assets.

*Property, Buildings and Equipment:* Property, buildings and equipment purchased are recorded at cost and those acquired by gifts and bequests are recorded at appraised or fair value established at date of contribution. The carrying amount 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. Depreciation is computed using the straight-line method over the estimated useful lives of the assets.

*Supplies:* Supplies, which are recorded on the first-in, first-out method, are stated at the lower of cost or market value. Such amount is recorded within the caption other current assets in the statements of financial position. Supplies are used in the provision of patient care and generally are not held for sale.

*Classification of Net Assets:* The Hospital separately accounts for and reports donor restricted and unrestricted net assets. Unrestricted net assets are not externally restricted for identified purposes by donors or grantors. Unrestricted net assets include resources that the governing board may use for any designated purpose and resources whose use is limited by agreement between the Hospital and an outside party other than the donor or grantor. At December 31, 2012 and 2011, all of the Hospital's net assets are unrestricted.

**1. Organization and Significant Accounting Policies (continued)**

*Net Patient Service Revenue:* The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounts from charges, and per diem payments. Net patient service revenue is reported at estimated net realizable amounts due from patients, third-party payors and others for services rendered and includes estimated retroactive revenue adjustments due to ongoing and future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are provided, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

*Performance Indicator:* The statements of operations and changes in net assets include excess of revenue over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the performance indicator include the change in pension liability to be recognized in future periods. Transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenue and expenses.

*Tax Status:* The Hospital is a Section 501(c)(3) organization, exempt from Federal income taxes under Section 501(a) of the Internal Revenue Code. The Hospital also is exempt from New York State and City income taxes.

*Recent Accounting Pronouncements:* In July 2011, the FASB issued ASU No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. Under ASU No. 2011-07, certain health care entities that recognize significant amounts of patient service revenue at the time the services are rendered without assessing the patient's ability to pay are required to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities will be required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The guidance is effective for the Hospital for fiscal years, and interim periods within those years, ending after December 15, 2012, with early adoption permitted. The Hospital's adoption of ASU No. 2011-07 in 2012 did not have a material impact on the financial statements.

**2. Net Patient Service Revenue**

*Medicare Reimbursement:* Hospitals are paid for most Medicare inpatient and outpatient services under the National prospective payment systems and other methodologies of the Medicare program for certain other services. Federal regulations provide for certain 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 payors, except Medicaid, workers' compensation and no-fault insurance programs, negotiate hospitals' payment rates. If negotiated rates are not established, payors are billed at hospitals' established charges.

Medicaid, workers' compensation and no-fault payors pay hospital rates promulgated by the New York State Department of Health. Effective December 1, 2009, the New York State payment methodology was updated such that payments to hospitals for Medicaid, workers' compensation and no-fault inpatient services are based on a statewide prospective payment system, with retroactive adjustments; prior to December 1, 2009, the payment system provided for retroactive adjustments to payment rates, using a prospective payment formula. Outpatient services also are paid based on a statewide prospective system that was effective December 1, 2008. 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 Hospital is reasonably assured that such amounts are realizable. Adjustments to the current and prior years' payment rates for those payors will continue to be made in future years.

The Hospital has established estimates, based on information presently available, of amounts due to or from Medicare and non-Medicare payors for adjustments to current and prior years' payment rates, based on industry-wide and Hospital-specific data. Federal and other regulations require annual retroactive settlements for reimbursements through cost reports filed by the Hospital. Such regulations also provide for certain retrospective adjustments to current and prior years' payment rates, based on industry-wide and Hospital-specific data. The estimated settlements recorded at December 31, 2012 and 2011 could differ from actual settlements based on the results of cost report audits. Cost reports for all years through 2006 have been audited and settled as of December 31, 2012, although revisions to final settlements could be made. Other years remain open for settlement, as are settlements with the State Medicaid program.

During 2012 and 2011, the Hospital recorded approximately $3.1 million and $0.5 million, respectively, of net settlements and adjustments to revenue estimates. These amounts were recorded as an increase in net patient service revenue.

**2. Net Patient Service Revenue (continued)**

In April 2012 CMS settled a series of lawsuits filed in 2007 that challenged the calculation involving the use of the rural floor provision of the Balanced Budget Act of 1997. The Hospital participated in this lawsuit and as a result received a cash settlement of approximately $2.6 million, which is included in the increase in net patient service revenue for 2012 as described in the preceding paragraph, from Medicare for fiscal years 2005 through 2011. Fees associated with participating in this lawsuit were approximately $240,000 and are included in supplies and other expenses for the year ended December 31, 2012.

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

For each of the years ended December 31, 2012 and 2011, revenue from Medicare and Medicaid programs accounted for approximately 70% of the Hospital's net patient service revenue. The current Medicaid, Medicare and other third-party payor programs are based upon extremely complex laws and regulations that are subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital is not aware of any allegations of noncompliance that could have a material adverse effect on the accompanying financial statements and believes that it is in compliance, in all material respects, with all applicable laws and regulations. Action for noncompliance could result in repayment of amounts received, fines, penalties and exclusion from such programs.

The Hospital recognizes accounts receivable and patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered (see description of third-party payor payment programs above). For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates under the Hospital's self-pay patient policy. Under the policy, a patient who has no insurance and is ineligible for any government assistance program has his or her bill reduced to the amount which would be billed to a commercially insured patient. The impact of this policy on the consolidated financial statements is lower net patient service revenue, as the discount is considered a revenue allowance, and a lower provision for bad debts.

**2. Net Patient Service Revenue (continued)**

Patient service revenue for the years ended December 31, 2012 and 2011, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources based on primary insurance designation, is as follows:

| | 2012 | 2011 |
|---|---|---|
| Patient service revenue (net of contractual allowances and discounts) | | |
| Third-party payors | **$ 101,560** | $ 90,475 |
| Self-pay | **560** | 482 |
| | **$ 102,120** | $ 90,957 |

Deductibles and copayments under third-party payment programs within the third-party payor amount above are the patient's responsibility and the Hospital considers these amounts in its determination of the provision for bad debts based on collection experience.

Accounts receivable is recorded at its expected net realizable value. In evaluating the collectibility of accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

**2. Net Patient Service Revenue (continued)**

The Hospital's allowance for doubtful accounts totaled approximately $10.4 million and $9.4 million at December 31, 2012 and 2011, respectively. The allowance for doubtful accounts for self-pay patients was approximately 76% and 82% of self-pay accounts receivable as of December 31, 2012 and 2011, respectively. Overall, the total of self-pay discounts and write-offs has not changed significantly for the year ended December 31, 2012. The Hospital has not experienced significant changes in write-off trends and has not changed its charity care policy for the year ended December 31, 2012.

*Uncompensated Care and Community Benefit Costs*

The Hospital's commitment to community service is evidenced by services provided to the poor and benefits provided to the broader community. Services provided to the poor include services provided to persons who cannot afford health care because of inadequate resources and/or who are uninsured or underinsured.

The Hospital provides quality medical care regardless of race, creed, sex, sexual orientation, national origin, handicap, age or ability to pay. Although payment for services rendered is critical to the operations and stability of the Hospital, it is recognized that not all individuals possess the ability to pay for essential medical services and, furthermore, the Hospital's mission is to serve the community with respect to health care and health care education. Therefore, in keeping with the Hospital's commitment to serve members of the community, the Hospital provides the following: charity care to the indigent; care to persons covered by governmental programs at below cost; and health care activities and programs to support the community. These activities include wellness programs, community education programs, health screenings and a broad variety of community support services.

The Hospital believes it is important to quantify comprehensively the benefits it provides to the community, which is an area of emphasis for not-for-profit health care providers. The costs of uncompensated care and community benefit activities are derived from various Hospital records.

Amounts for activities as reported below are based on estimated and actual data, subject to changes in estimates upon the finalization of the Hospital's cost report and other government filings. The amounts reported below are calculated in accordance with guidelines prescribed by the Internal Revenue Service ("IRS"). The net cost of charity care includes the direct and indirect cost of providing charity care services, offset by revenues received from indigent care pools and

**2. Net Patient Service Revenue (continued)**

other subsidies. The cost is estimated by utilizing a ratio of cost to gross charges applied to the gross uncompensated charges associated with providing charity care.

Costs related to uncompensated care and community benefit activities are summarized as follows (in thousands):

| | 2012 | 2011 |
|---|---|---|
| Charity care, net (a) | **$ 1,539** | $ 1,674 |
| Means-tested programs (b) | **4,772** | 3,631 |
| Other community benefits (c) | **539** | 745 |
| Total charity care and other community benefits | **$ 6,850** | $ 6,050 |

Charity care, at cost, and means-tested programs include the following (and exclude losses incurred on providing services to Medicare patients):

(a) *Charity Care:* As part of its charity care and financial aid policy, the Hospital obtains and uses additional financial information for uninsured or under-insured patients who have not supplied the requisite information to qualify for charity care. The additional information obtained is used by the Hospital to determine whether to qualify patients for charity care and/or financial aid in accordance with the Hospital's policies.

The Hospital makes available free care programs for qualifying patients under its charity care and financial aid policy. During the registration, billing and collection process, a patient's eligibility for free care funds is determined. For patients who do not receive free care and who are determined to be eligible for charity care in the form of discounted medical services under the Hospital's charity care and financial aid policy, care given but not paid for is classified as charity care. For patients who were determined by the Hospital to have the ability to pay but did not, the uncollected amounts are classified as bad debt expense ($2.4 million in 2012 and $2.3 million in 2011). Distinguishing between bad debt and charity care is difficult in part because services are often rendered prior to full evaluation of a patient's ability to pay.

**2. Net Patient Service Revenue (continued)**

Annually, the Hospital accrues for potential losses related to its uncollectible accounts and the amounts that meet the definition of charity care (including free and discounted medical care) allowances.

(b) *Means-Tested Programs:* Community benefits include losses incurred in providing services to patients who participate in certain public health programs such as Medicaid. Payments received by the Hospital for patient services provided to Medicaid program participants are less than the actual cost of providing such services. Therefore, to the extent Medicaid payments are less than the cost of care provided to Medicaid patients, the uncompensated cost of that care is considered to be a community benefit.

Other community benefits include the following:

(c) *Community Health Improvement Services and Community Benefit Operations:* The Hospital is committed to serving the neighborhoods comprising its service area and recognizes the importance of preserving a local community focus to effectively meet community need. The Hospital adheres to a single standard for assessing and meeting community need, while retaining a geographically focused approach for soliciting community participation and involvement and providing community outreach.

The Hospital has fostered continued community participation and outreach activities through linkages with numerous community-based groups. Community health improvement services and related operations include screening and exams, and other education or support services in areas such as the following: asthma, behavioral health, cancer, community-based outreach and health education, digestive diseases, emergency services/emergency preparedness, heart disease, HIV/AIDS, and vascular disease (a complete description of each service can be found in the Hospital's annual community service plan).

The DOH Hospital Indigent Care Pool (the "Pool") was established to help hospitals subsidize the cost of uncompensated care and is funded, in part, by a 1% assessment on hospital net inpatient service revenue. During each of the years ended December 31, 2012 and 2011, the Hospital paid approximately $0.8 million for the 1% assessment.

**3. Assets Limited as to Use**

The composition of assets limited as to use is as follows:

| | December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| Cash equivalents | **$ 9,917** | $ 7,095 |
| U.S. Treasury notes | **809** | 1,732 |
| Accrued interest | **4** | 17 |
| | **10,730** | 8,844 |
| Less current portion of assets limited as to use | **978** | 828 |
| Assets limited as to use – noncurrent | **$ 9,752** | $ 8,016 |

Investment return included in the statements of operations and changes in net assets consists of the following:

| | Year Ended December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| Interest and dividend income, included in other revenue *(Note 10)* | **$ 71** | $ 109 |
| Change in unrealized gains and losses on marketable securities | **26** | 38 |
| | **$ 97** | $ 147 |

## 4. Property, Buildings and Equipment

A summary of property, buildings and equipment follows:

| | December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| Land and land improvements | **$ 83** | $ 83 |
| Buildings and improvements | **34,255** | 33,025 |
| Movable equipment | **32,128** | 30,936 |
| | **66,466** | 64,044 |
| Less accumulated depreciation and amortization | **49,116** | 46,167 |
| | **17,350** | 17,877 |
| Construction-in-progress | **194** | 100 |
| | **$ 17,544** | $ 17,977 |

## 5. Operating Leases

Total rental expense charged to operations for each the years ended December 31, 2012 and 2011 aggregated approximately $0.8 million.

Future minimum payments under noncancellable operating leases with initial or remaining terms of one year or more at December 31, 2012 consisted of the following (in thousands):

| | |
|---|---|
| 2013 | $ 820 |
| 2014 | 388 |

## 6. Professional Liabilities

Effective April 1, 1996, the Hospital began purchasing primary and excess professional liability insurance and general liability insurance, on an occurrence basis, from Network Insurance Company Ltd. (“NICL”), a related entity that is an offshore captive insurance company. NICL has capped the Hospital’s insurance coverage for the period from September 17, 2002 through September 16, 2004 at approximately $2.9 million (aggregate of open case reserves and committed settlements); the Hospital is self-insured for liabilities above the capped limit.

**6. Professional Liabilities (continued)**

At December 31, 2012 and 2011, the Hospital recorded an estimated insurance recovery receivable and insurance claim liability in relation to the claims insured by NICL of $460,000 and $2.1 million, respectively.

Effective February 25, 2005, the Hospital discontinued its primary and excess arrangements with NICL and became self-insured; the Hospital still purchases excess liability insurance. In connection with the current and prior self-insurance program (see below), the Hospital established an irrevocable trust for the purpose of setting aside assets based on actuarial funding recommendations. Under the trust agreement, the trust assets can only be used for payment of professional and general liability losses and related expenses. The actuarially determined undiscounted liabilities, including estimated liabilities for claims that have been incurred but not reported, aggregated approximately $11.1 million and $9.4 million, respectively, at December 31, 2012 and 2011, and the amount included in the accompanying financial statements is approximately $9.8 million and $8.3 million, respectively, based on a discount factor of 3% in 2012 and 2011. The amount funded in the self-insurance trust at December 31, 2012 and 2011 was approximately $9.8 million and $8.8 million, respectively.

Through November 30, 1978, the Hospital maintained primary and excess professional and general liability insurance coverage with commercial carriers. For the period December 1, 1978 through March 31, 1996, the Hospital was self-insured for primary and excess professional liabilities while continuing to maintain excess general liability insurance through commercial carriers in certain years. The liability related to this self-insured period was not significant at December 31, 2012 or 2011.

Professional liability and other claims have been asserted against the Hospital by various claimants. The claims are in various stages of processing and some have been or may ultimately be brought to trial. There are also known incidents that have occurred that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. It is the opinion of Hospital management, based on prior experience and the advice of risk management, actuarial and legal counsel, that the ultimate resolution of professional liabilities and other claims will not significantly affect the Hospital's financial position.

**7. Pension Benefits**

The Hospital provides pension and similar benefits to its employees through several pension plans, including multi-employer plans for union employees and a defined benefit plan primarily for eligible nonunion employees of the Hospital. The Hospital funds the noncontributory defined benefit plan in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), plus additional amounts that the Hospital may determine to contribute.

Amounts contributed to the defined benefit plan are based on actuarial valuations. Contributions to union plans are based on union employee gross salary levels and rates required under union contractual arrangements.

The benefits for all participants or their beneficiaries in the defined benefit plan sponsored by the Hospital are based on highest average compensation for five consecutive years during the last ten years of credited service, subject to ERISA limitations.

Effective January 1, 2009, the Internal Revenue Service issued final regulations for purposes of determining common control for qualified retirement plans sponsored by tax-exempt organizations. In general, tax-exempt entities that are under common control are treated as one entity for certain of the requirements of qualified plans. The regulations determine control based on facts and circumstances; for this purpose, common control would exist if, among other situations, at least 80% of the directors or trustees of one organization were either representatives of, or directly or indirectly controlled by, another organization. These regulations could have an effect on the operations of the Hospital's and its related entities' retirement plans and the responsibilities of those entities for associated liabilities, although such effects are uncertain at this time.

**7. Pension Benefits (continued)**

The reconciliation of the beginning and ending balances of the benefit obligation and the fair value of the defined benefit plan assets for the years ended December 31, 2012 and 2011 are as follows:

| | 2012 | 2011 |
|---|---|---|
| | *(In Thousands)* | |
| **Benefit obligation** | | |
| Benefit obligation at beginning of year | **$ 10,852** | $ 9,450 |
| Service cost | **610** | 538 |
| Interest cost | **415** | 450 |
| Net actuarial losses | **987** | 1,391 |
| Benefits paid | **(396)** | (977) |
| Benefit obligation at end of year | **12,468** | 10,852 |
| **Fair value of plan assets** | | |
| Fair value of plan assets at beginning of year | **5,441** | 5,733 |
| Actual return on plan assets | **598** | (255) |
| Employer contributions | **1,060** | 940 |
| Benefits paid | **(396)** | (977) |
| Fair value of plan assets at end of year | **6,703** | 5,441 |
| **Funded status** | | |
| Unfunded status of the plan | **$ (5,765)** | $ (5,411) |

The accumulated benefit obligation for the Hospital's pension plan was approximately $10.6 million and $9.2 million at December 31, 2012 and 2011, respectively.

Included in unrestricted net assets at December 31, 2012 and 2011 is approximately $5.2 million and $4.8 million, respectively, for the unrecognized actuarial loss that has not yet been recognized in net periodic pension cost. The actuarial loss included in changes in unrestricted net assets at December 31, 2012 and expected to be recognized in net periodic pension cost during the year ending December 31, 2013 is approximately $392,000.

**7. Pension Benefits (continued)**

Weighted-average assumptions used in determining the pension benefit obligations at December 31, 2012 and 2011 were as follows:

| | December 31 | |
|---|---|---|
| | **2012** | **2011** |
| Discount rate | **3.45%** | 4.00% |
| Rate of compensation increase | **3.50** | 3.50 |

Net periodic pension cost for the years ended December 31, 2012 and 2011 consists of the following components:

| | Year Ended December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| Service cost | **$ 610** | $ 538 |
| Interest cost | **415** | 450 |
| Expected return on plan assets | **(399)** | (390) |
| Recognized actuarial loss | **364** | 196 |
| Net periodic pension cost | **$ 990** | $ 794 |

Weighted-average assumptions used in determining the net periodic pension cost for the years ended December 31, 2012 and 2011 were as follows:

| | **2012** | **2011** |
|---|---|---|
| Discount rate | **4.00%** | 5.05% |
| Expected long-term rate of return on plan assets | **7.00** | 7.00 |
| Rate of increase in future compensation levels | **3.50** | 3.50 |

The overall expected long-term rate of return on 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 Hospital's desired risk and return characteristics. The Hospital reviews the expected long-term rate periodically and, based on the building block approach, updates the rate for changes in the marketplace.

**7. Pension Benefits (continued)**

The overall objective of the investment policy of the defined benefit pension plan is 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 (five years or greater) return objective. The Hospital's weighted-average asset allocations at December 31, 2012 and 2011, by asset category, are as follows:

| | Plan Assets at December 31 | |
|---|---|---|
| | **2012** | **2011** |
| **Asset category** | | |
| Equity securities | **90%** | 84% |
| Cash and cash equivalents | **10** | 16 |
| | **100%** | 100% |

Plan assets are invested in institutional funds and the target and policy ranges are reevaluated quarterly. Investment performance is reviewed quarterly with performance results and benchmarks compiled independently by the plan's trustee, JPMorgan Chase Bank, and the plan's investment consultant.

The Hospital expects to contribute approximately $0.4 million to its defined benefit pension plan in 2013.

Benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows (in thousands):

| | |
|---|---|
| 2013 | $ 595 |
| 2014 | 772 |
| 2015 | 892 |
| 2016 | 621 |
| 2017 | 597 |
| 2018 to 2022 | 5,420 |

**7. Pension Benefits (continued)**

*Multiemployer Pension Plan:* The Hospital contributes to the 1199 SEIU Healthcare Employees Pension Fund ("1199 SEIU"). This is a multiemployer defined benefit pension plan under the terms of a collective bargaining agreement that covers the Hospital's union-represented employees. Contributions to the union plan are based on union employee gross salary levels and rates required under union contractual arrangements. The risks of participating in 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 the Hospital chooses to stop participating in the multiemployer plan, the Hospital may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

The Hospital's participation in the multiemployer plan for the years ended December 31, 2012 and 2011, is outlined in the table below. The information included in this table is as follows:

- The "EIN/Pension Plan Number" column provides the Employee Identification Number ("EIN") and the three-digit plan numbers.

- The Pension Plan Protection Act of 2006 ("PPA") zone status is based on information that the Hospital received from the plan and is certified by the plan's 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 the green zone are at least 80% funded. Unless otherwise noted, the most recent PPA zone status available in 2012 and 2011 is for the plan's year-end at December 31, 2011 and December 31, 2010, respectively.

- 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.

## 7. Pension Benefits (continued)

- The column "Surcharge Imposed" indicates whether the Hospital was required to pay a surcharge to the plan.

- The last column lists the expiration date of the collective-bargaining agreement to which the plan is subject.

The number of employees covered by the Hospital's multiemployer plan did not change significantly from 2011 to 2012. Contribution rates required to be paid to the plans have increased from 2011 to 2012. The Hospital was not in its plan's 2011 Form 5500 as providing more than 5% of total plan contributions.

| Pension Fund | EIN/Pension Plan Number | Pension Protection Act Zone Status 2012 | Pension Protection Act Zone Status 2011 | FIP/RP Status | Contributions by the Hospital 2012 | Contributions by the Hospital 2011 | Surcharge Imposed | Expiration Date of Collective Bargaining - Agreement |
|---|---|---|---|---|---|---|---|---|
| | | | | | (*In Thousands)* | | | |
| 1199 SEIU | 13-3604862/ Plan No. 001 | **Green** | Green | No | **$ 2,469** | $ 2,263 | No | 4/30/2015 |

## 8. Related Organizations

The following balances are due to the Hospital's related organizations at December 31, 2012 and 2011:

| | 2012 | 2011 |
|---|---|---|
| | *(In Thousands)* | |
| The New York and Presbyterian Hospital ("NYPH")(a) | **$ 93** | $ 87 |
| Network Recovery Services, Inc. ("NRS")(b) | **28** | 71 |
| | **$ 121** | $ 158 |

(a) Amounts due to NYPH at December 31, 2012 and 2011 represent unpaid amounts for allocation of costs, including medical related services, data processing and personnel. The total allocated costs approximated $5.1 million and $5.2 million for the years ended December 31, 2012 and 2011, respectively.

(b) Amounts due to NRS at December 31, 2012 and 2011 represent balances for collection services, net of rebates. For each of the years ended December 31, 2012 and 2011, the Hospital was charged approximately $0.3 million in fees for collection services.

## 9. Concentration of Credit Risk

The Hospital has all of its cash and marketable securities deposited in one financial institution at December 31, 2012 and 2011, and the amounts deposited exceed Federal depository insurance limits.

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under various third-party arrangements. Significant concentrations of net patient accounts receivable from patients and third-party payors are as follows:

| | December 31 | |
|---|---|---|
| | **2012** | **2011** |
| Medicare | **39%** | 35% |
| Medicaid | **20** | 21 |
| Commercial and other payors | **33** | 38 |
| Self-pay | **8** | 6 |
| | **100%** | 100% |

No individual self-pay or commercial payor exceeded 10% of the total receivables.

## 10. Other Revenue

Other revenue consists of the following:

| | Year Ended December 31 | |
|---|---|---|
| | **2012** | **2011** |
| | *(In Thousands)* | |
| Contributions | **$ 20** | $ 31 |
| Net investment income *(Note 3)* | **71** | 109 |
| Electronic health records incentive payments | **2,335** | 2,495 |
| Other | **184** | 174 |
| Total | **$ 2,610** | $ 2,809 |

**10. Other Revenue (continued)**

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act ("HITECH"). The provisions were designed to increase the use of electronic health record ("EHR") technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement, or upgrade certified EHR technology. In subsequent years, providers must demonstrate meaningful use of such technology to qualify for additional Medicaid incentive payments. Hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to payment penalties or downward adjustments to their Medicare payments beginning in federal fiscal year 2015.

The Hospital uses a grant accounting model to recognize revenue for the Medicare and Medicaid EHR incentive payments. Under this accounting policy, EHR incentive payment revenue is recognized when the Hospital is reasonably assured that the EHR meaningful use criteria for the required period of time were met and that the grant revenue will be received. EHR incentive payment revenue totaling $2.3 million and $2.5 million for the years ended December 31, 2012 and 2011 respectively (Medicare: $1.8 million and $2.5 million for 2012 and 2011, respectively; Medicaid approximately $500,000 for 2012), is included in other revenue in the accompanying statement of operations. Income from Medicare incentive payments is subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated. Additionally, the Hospital's attestation of compliance with the meaningful use criteria is subject to audit by the federal government.

**11. Fair Value Measurements**

For its financial assets and liabilities that are required to be measured at fair value, the Hospital calculates 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. The Hospital uses a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels, which are described as follows:

*Level 1:* Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets or liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.

**11. Fair Value Measurements (continued)**

*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. The fair value hierarchy gives the lowest priority to Level 3 inputs.

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 Hospital utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible. The Hospital also considers counterparty credit risk in its assessment of fair value.

Financial assets and liabilities carried at fair value as of December 31, 2012 and 2011 are classified in the table below in one of the three categories described above:

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| | | *(In Thousands)* | | |
| **December 31, 2012** | | | | |
| Cash and cash equivalents | **$ 50,853** | **$ –** | **$ –** | **$ 50,853** |
| US Treasury notes | **809** | **–** | **–** | **809** |
| Total | **$ 51,662** | **$ –** | **$ –** | **$ 51,662** |
| | | | | |
| **December 31, 2011** | | | | |
| Cash and cash equivalents | $ 41,132 | $ – | $ – | $ 41,132 |
| US Treasury notes | 1,732 | – | – | 1,732 |
| Total | $ 42,864 | $ – | $ – | $ 42,864 |

**11. Fair Value Measurements (continued)**

Financial assets invested in the Hospital's defined benefit pension plan at fair value are classified in the table below in one of the three categories described above:

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| | | *(In Thousands)* | | |
| **December 31, 2012** | | | | |
| Cash and cash equivalents | **$ 677** | **$ –** | **$ –** | **$ 677** |
| U.S. equity securities | **6,026** | **–** | **–** | **6,026** |
| | **$ 6,703** | **$ –** | **$ –** | **$ 6,703** |
| **December 31, 2011** | | | | |
| Cash and cash equivalents | $ 896 | $ – | $ – | $ 896 |
| U.S. equity securities | 4,545 | – | – | 4,545 |
| | $ 5,441 | $ – | $ – | $ 5,441 |

**12. Subsequent Events**

Subsequent events have been evaluated through May 30, 2013, which is the date the financial statements were available to be issued. No subsequent events have occurred that require disclosure in or adjustment to the financial statements.

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