

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 2012 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2012 or fiscal plan year beginning <u>01/01/2012</u> and ending <u>12/31/2012</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input checked="" type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>007</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/2004</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>007</u>	1c Effective date of plan <u>01/01/2004</u>	
1b Three-digit plan number (PN) ▶	<u>007</u>				
1c Effective date of plan <u>01/01/2004</u>					
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>THE MOUNT SINAI MEDICAL CENTER</u> <u>ONE GUSTAVE L. LEVY PLACE</u> <u>NEW YORK, NY 10029</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>13-1624096</u></td> </tr> <tr> <td>2c Sponsor's telephone number <u>212-241-6141</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>622000</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>13-1624096</u>	2c Sponsor's telephone number <u>212-241-6141</u>	2d Business code (see instructions) <u>622000</u>	
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2c Sponsor's telephone number <u>212-241-6141</u>					
2d Business code (see instructions) <u>622000</u>					

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	<u>07/22/2014</u> Date	<u>PAUL KELLER</u> Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)			Preparer's telephone number (optional)

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address		3b Administrator's EIN																												
		3c Administrator's telephone number																												
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:		4b EIN																												
a Sponsor's name		4c PN																												
5 Total number of participants at the beginning of the plan year		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">5</td> <td style="text-align: right;">6295</td> </tr> </table>	5	6295																										
5	6295																													
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).																														
a Active participants.....		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6a</td> <td style="text-align: right;">0</td> </tr> </table>	6a	0																										
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b Retired or separated participants receiving benefits.....		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6b</td> <td style="text-align: right;">0</td> </tr> </table>	6b	0																										
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c Other retired or separated participants entitled to future benefits.....		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6c</td> <td></td> </tr> </table>	6c																											
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d Subtotal. Add lines 6a , 6b , and 6c		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6d</td> <td style="text-align: right;">0</td> </tr> </table>	6d	0																										
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e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6e</td> <td></td> </tr> </table>	6e																											
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f Total. Add lines 6d and 6e		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6f</td> <td style="text-align: right;">0</td> </tr> </table>	6f	0																										
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g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6g</td> <td></td> </tr> </table>	6g																											
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h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">6h</td> <td></td> </tr> </table>	6h																											
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7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">7</td> <td></td> </tr> </table>	7																											
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: <div style="margin-left: 20px;">2M</div>																														
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:																														
9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)																												
<table border="0" style="width: 100%;"> <tr> <td style="width: 5%;">(1)</td> <td style="width: 5%;"><input checked="" type="checkbox"/></td> <td>Insurance</td> </tr> <tr> <td>(2)</td> <td><input type="checkbox"/></td> <td>Code section 412(e)(3) insurance contracts</td> </tr> <tr> <td>(3)</td> <td><input type="checkbox"/></td> <td>Trust</td> </tr> <tr> <td>(4)</td> <td><input type="checkbox"/></td> <td>General assets of the sponsor</td> </tr> </table>	(1)	<input checked="" type="checkbox"/>	Insurance	(2)	<input type="checkbox"/>	Code section 412(e)(3) insurance contracts	(3)	<input type="checkbox"/>	Trust	(4)	<input type="checkbox"/>	General assets of the sponsor	<table border="0" style="width: 100%;"> <tr> <td style="width: 5%;">(1)</td> <td style="width: 5%;"><input checked="" type="checkbox"/></td> <td>Insurance</td> </tr> <tr> <td>(2)</td> <td><input type="checkbox"/></td> <td>Code section 412(e)(3) insurance contracts</td> </tr> <tr> <td>(3)</td> <td><input type="checkbox"/></td> <td>Trust</td> </tr> <tr> <td>(4)</td> <td><input type="checkbox"/></td> <td>General assets of the sponsor</td> </tr> </table>		(1)	<input checked="" type="checkbox"/>	Insurance	(2)	<input type="checkbox"/>	Code section 412(e)(3) insurance contracts	(3)	<input type="checkbox"/>	Trust	(4)	<input type="checkbox"/>	General assets of the sponsor				
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)																														
a Pension Schedules		b General Schedules																												
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SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2012 This Form is Open to Public Inspection
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For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012	
A Name of plan THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN	B Three-digit plan number (PN) ▶ 007
C Plan sponsor's name as shown on line 2a of Form 5500 THE MOUNT SINAI MEDICAL CENTER	D Employer Identification Number (EIN) 13-1624096

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier THE PRUDENTIAL INSURANCE COMPANY OF AMERICA					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
22-1211670	68241	004869	0	01/01/2012	12/31/2012

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4** 0**5** Current value of plan's interest under this contract in separate accounts at year end **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier **6b****c** Premiums due but unpaid at the end of the year **6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☒ other ▶ **GUARANTEED INTEREST ACCOUNT****b** Balance at the end of the previous year **7b** 2238727**c** Additions: (1) Contributions deposited during the year **7c(1)** 576209(2) Dividends and credits **7c(2)**(3) Interest credited during the year **7c(3)** 87374(4) Transferred from separate account **7c(4)**(5) Other (specify below) **7c(5)** 329401

▶

(6) Total additions **7c(6)** 992984**d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 3231711**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 81474(2) Administration charge made by carrier **7e(2)**(3) Transferred to separate account **7e(3)**(4) Other (specify below) **7e(4)** 3150237▶ **TRANSFER TO MOUNT SINAI MEDICAL CENTER 403(B) RETIREMENT PLAN DUE TO PLAN MERGER**(5) Total deductions **7e(5)** 3231711**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**). **7f** 0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
 b ☐ Dental
 c ☐ Vision
 d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
 f ☐ Long-term disability
 g ☐ Supplemental unemployment
 h ☐ Prescription drug
i ☐ Stop loss (large deductible)
 j ☐ HMO contract
 k ☐ PPO contract
 l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2012 This Form is Open to Public Inspection
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A Name of plan THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN	B Three-digit plan number (PN) ▶ 007
C Plan sponsor's name as shown on line 2a of Form 5500 THE MOUNT SINAI MEDICAL CENTER	D Employer Identification Number (EIN) 13-1624096

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier
TIAA-CREF

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1624203	69345	151288	0	01/01/2012	12/31/2012

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4** 0**5** Current value of plan's interest under this contract in separate accounts at year end **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier **6b****c** Premiums due but unpaid at the end of the year **6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☒ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **7b** 3495316**c** Additions: (1) Contributions deposited during the year **7c(1)** 768191(2) Dividends and credits **7c(2)**(3) Interest credited during the year **7c(3)** 154684(4) Transferred from separate account **7c(4)**(5) Other (specify below) **7c(5)** 61323

▶

(6) Total additions **7c(6)** 984198**d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 4479514**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 53027(2) Administration charge made by carrier **7e(2)**(3) Transferred to separate account **7e(3)**(4) Other (specify below) **7e(4)** 4426487

▶ TRANSFER TO MOUNT SINAI MEDICAL CENTER 403(B) PLAN DUE TO PLAN MERGER

(5) Total deductions **7e(5)** 4479514**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**). **7f** 0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
 b ☐ Dental
 c ☐ Vision
 d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
 f ☐ Long-term disability
 g ☐ Supplemental unemployment
 h ☐ Prescription drug
i ☐ Stop loss (large deductible)
 j ☐ HMO contract
 k ☐ PPO contract
 l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☐ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2012
		This Form is Open to Public Inspection.

For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012

A Name of plan <u>THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN</u>	B Three-digit plan number (PN) ▶ <u>007</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>THE MOUNT SINAI MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>13-1624096</u>

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☒ Yes ☐ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

TIAA

13-1624203

(b) Enter name and EIN or address of person who provided you disclosure on eligible indirect compensation

THE PRUDENTIAL INSURANCE COMPANY

22-1211670

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

THE VANGUARD GROUP

23-1945930

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III **Termination Information on Accountants and Enrolled Actuaries (see instructions)**
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2012 This Form is Open to Public Inspection.
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For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012

A Name of plan <u>THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN</u>	B Three-digit plan number (PN) ►	<u>007</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>THE MOUNT SINAI MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>13-1624096</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
---------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: TIAA REAL ESTATE

b Name of sponsor of entity listed in (a): TIAA-CREF

c EIN-PN <u>12-1624203-004</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>0</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: GLOBAL ACCOUNT

b Name of sponsor of entity listed in (a): THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

c EIN-PN <u>06-1050034-071</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>0</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: EQUITY ACCOUNT

b Name of sponsor of entity listed in (a): THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

c EIN-PN <u>06-1050034-069</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>0</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: CAPITAL GROWTH

b Name of sponsor of entity listed in (a): THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

c EIN-PN <u>06-1050034-005</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>0</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 <div style="font-size: 24pt; font-weight: bold;">2012</div> This Form is Open to Public Inspection
For calendar plan year 2012 or fiscal plan year beginning <u>01/01/2012</u> and ending <u>12/31/2012</u>		
A Name of plan <u>THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN</u>		B Three-digit plan number (PN) ► <u>007</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>THE MOUNT SINAI MEDICAL CENTER</u>		D Employer Identification Number (EIN) <u>13-1624096</u>

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.				
	Assets			
a	Total noninterest-bearing cash	1a		
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)	1941733	0
	(2) Participant contributions	1b(2)		
	(3) Other.....	1b(3)		
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	5724377	0
	(2) U.S. Government securities.....	1c(2)		
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)		
	(B) All other.....	1c(3)(B)		
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)		
	(B) Common	1c(4)(B)		
	(5) Partnership/joint venture interests	1c(5)		
	(6) Real estate (other than employer real property)	1c(6)		
	(7) Loans (other than to participants)	1c(7)		
	(8) Participant loans	1c(8)		
	(9) Value of interest in common/collective trusts.....	1c(9)		
	(10) Value of interest in pooled separate accounts.....	1c(10)	583658	0
	(11) Value of interest in master trust investment accounts	1c(11)		
	(12) Value of interest in 103-12 investment entities	1c(12)		
	(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	62443894	0
	(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	5734043	0
	(15) Other	1c(15)	-1679	0

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	76426026	0

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	0

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	76426026	0
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Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income**a Contributions:**

		(a) Amount	(b) Total
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	25142270	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		25142270

b Earnings on investments:**(1) Interest:**

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	1892484	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		1892484

(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0

(3) Rents	2b(3)		
-----------------	--------------	--	--

(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0

(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		8903107
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		35937861

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	3313714	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		3313714
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		0
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		3313714

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		32624147
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		109050172

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☐ Unqualified (2) ☐ Qualified (3) ☒ Disclaimer (4) ☐ Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)?

☒ Yes ☐ No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: ERNST & YOUNG

(2) EIN: 34-6565596

d The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....

b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....

	Yes	No	Amount
4a		X	
4b		X	

	Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
e Was this plan covered by a fidelity bond?.....		X	
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.).....		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?

If "Yes," enter the amount of any plan assets that reverted to the employer this year.....

☒ Yes ☐ No Amount:

0

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)

THE MOUNT SINAI MEDICAL CENTER 403(B) RETIREMENT PLAN

5b(2) EIN(s)	5b(3) PN(s)
13-1624096	005

Part V Trust Information (optional)

6a Name of trust

6b Trust's EIN

<div>SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Retirement Plan Information</div> <div>This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ File as an attachment to Form 5500.</div>	<div>OMB No. 1210-0110</div> <div>2012</div> <div>This Form is Open to Public Inspection.</div>
For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012		
A Name of plan THE MOUNT SINAI MEDICAL CENTER EMPLOYER CONTRIBUTION 403(B) PLAN		B Three-digit plan number (PN) ▶ 007
C Plan sponsor's name as shown on line 2a of Form 5500 THE MOUNT SINAI MEDICAL CENTER		D Employer Identification Number (EIN) 13-1624096
Part I	Distributions	
All references to distributions relate only to payments of benefits during the plan year.		
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....		1 0
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 22-1211670 23-1945930		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....		3
Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)	
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If the plan is a defined benefit plan, go to line 8.		
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____		
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)		6a
b Enter the amount contributed by the employer to the plan for this plan year		6b
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....		6c
If you completed line 6c, skip lines 8 and 9.		
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Part III	Amendments	
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Both <input type="checkbox"/> No		
Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.	
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
11 a Does the ESOP hold any preferred stock?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.		
Schedule R (Form 5500) 2012 v. 120126		

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

- 14** Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	14a	
b The plan year immediately preceding the current plan year	14b	
c The second preceding plan year	14c	

- 15** Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

- 16** Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	

- 17** If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

- 18** If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

- 19** If the total number of participants is 1,000 or more, complete lines (a) through (c)

a Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

FINANCIAL STATEMENTS

The Mount Sinai Medical Center Employer Contribution 403(b) Plan
Years Ended December 31, 2012 and 2011
With Report of Independent Auditors

Ernst & Young LLP



Building a better
working world

The Mount Sinai Medical Center Employer Contribution 403(b) Plan

Financial Statements

Years Ended December 31, 2012 and 2011

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Report of Independent Auditors

Plan Administrator

The Mount Sinai Medical Center Employer Contribution 403(b) Plan

We were engaged to audit the accompanying financial statements of The Mount Sinai Medical Center Employer Contribution 403(b) Plan, which comprise the statements of net assets available for benefits as of December 31, 2012 and 2011, and the related statements of changes in net assets available for benefits 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 conducting the audits in accordance with auditing standards generally accepted in the United States. Because of the matter described in the Basis for Disclaimer of Opinion paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

The Mount Sinai Medical Center Employer Contribution 403(b) Plan has not maintained sufficient accounting records and supporting documents relating to certain annuity contracts and custodial accounts issued to current and former employees prior to January 1, 2009, including such contracts and custodial accounts included in the January 1, 2011 transfer described in Note 1. Accordingly, we were unable to apply auditing procedures sufficient to determine the extent to which the accompanying financial statements may have been affected by those conditions.

Disclaimer of Opinion on Financial Statements

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Ernst + Young LLP

July 21, 2014

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Statements of Net Assets Available for Benefits

	December 31	
	2012	2011
Assets		
Investments	\$ –	\$ 74,485,972
Contributions receivable	–	1,941,732
Net assets reflecting investments at fair value	–	76,427,704
Adjustment from fair value to contract value for guaranteed investment contracts	–	(1,679)
Net assets available for benefits	<u>\$ –</u>	<u>\$ 76,426,025</u>

See accompanying notes.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Statements of Changes in Net Assets Available for Benefits

	Year Ended December 31	
	2012	2011
Additions		
Investment income:		
Net appreciation (depreciation) in fair value of investments	\$ 8,903,107	\$ (2,640,378)
Interest and dividends	1,892,484	1,345,164
	<u>10,795,591</u>	<u>(1,295,214)</u>
Employer contributions	25,142,270	21,382,941
Total additions	<u>35,937,861</u>	<u>20,087,727</u>
Deductions		
Benefit payments	3,313,714	1,794,468
Transfers to other Mount Sinai 403(b) Plans (<i>Note 1</i>)	–	1,648,040
Total deductions	<u>3,313,714</u>	<u>3,442,508</u>
Net increase	<u>32,624,147</u>	<u>16,645,219</u>
Transfer to The Mount Sinai Medical Center 403(b) Retirement Plan due to plan merger (<i>Note 1</i>)	(109,050,172)	–
Net assets available for benefits, beginning of year	76,426,025	59,780,806
Net assets available for benefits, end of year	<u>\$ –</u>	<u>\$ 76,426,025</u>

See accompanying notes.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements

December 31, 2012

1. Description of Plan

The following description of the Mount Sinai Medical Center Employer Contribution 403(b) Plan (the Plan) provides general information about the Plan's provisions. The Plan covered employees of the Mount Sinai Hospital (the Hospital) and certain affiliates, including the eligible faculty and staff of Queens Hospital Center and City Hospital Center of Elmhurst, the Mount Sinai Medical Center, Inc. and the Icahn School of Medicine at Mount Sinai (formerly the Mount Sinai School of Medicine) (the Affiliates). The Hospital and the Affiliates were the Plan sponsors, and participants should refer to the plan document and summary plan description for a more complete description of the Plan's provisions, copies of which may be obtained from the plan sponsors.

Plan Merger

Effective December 31, 2012 the Plan was merged into the Mount Sinai Medical Center 403(b) Retirement Plan (Original Plan). As a result of the merger, all Plan participants and net assets of \$109,050,172 were transferred to the Original Plan. Although it has not expressed any intent to do so, the Hospital and Affiliates have the right under the Original Plan to terminate the Original Plan subject to the provisions of ERISA. In the event of Original Plan termination, the rights of participants to their accounts shall be non-forfeitable.

General – Prior to Plan Merger

The Plan was a defined contribution plan originally effective as of January 1, 2004 and established to provide retirement income benefits to certain employees of the Mount Sinai Hospital and the Affiliates through group annuity contracts and custodial accounts under Section 403(b)(7) of the Internal Revenue Code of 1986, as amended (the Code). The Plan was amended and restated effective January 1, 2009 to comply with the final Treasury Regulations under Code Section 403(b), the applicable provisions of the Pension Protection Act of 2006 and other applicable legislation.

The Board of Trustees of the Mount Sinai Hospital (the Board) was responsible for the general administration of the Plan regarding all filings with any governmental entity and was responsible for all non-fiduciary matters under the Plan. The Plan Administrator is authorized to designate a Benefit Committee to carry out the responsibilities of the Plan Administrator. The Benefit Committee was the named trustee pursuant to Section 402(a)(1) of the Employee Retirement Income Security Act of 1974 (ERISA) to carry out all of the fiduciary responsibilities under the Plan. The Prudential Life Insurance Company of America (Prudential), Teachers Insurance and

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

Annuity Association of America and College Retirement Equities Fund (TIAA-CREF) and The Vanguard Group (Vanguard) were the recordkeepers and custodians of the Plan. The Plan was subject to the provisions of ERISA, as amended.

Participation

To become eligible for an employer contribution under the Plan, the employee must have been hired on or after January 1, 2004 and be in an eligible category designated by the summary plan description. Effective January 2006, any member of the Mount Sinai Hospital Pharmacy Association (the Pharmacy Association) hired on or prior to October 31, 2005 who elected prior to January 1, 2006, to make a one-time election to cease to accrue benefits under The Pension Plan for Members of the Pharmacy Association and to become a participant under the Plan, was eligible to become a participant in the Plan. On April 28, 2011, the Plan was amended such that hourly paid employees hired or rehired on or after May 1, 2010 who worked off-site at satellite physician practices owned by the Hospital or the Icahn School of Medicine at Mount Sinai and hourly paid employees hired or rehired on or after May 1, 2011 to work at any North Shore Medical Group office, were not eligible to be credited with employer contributions under the Plan. On December 20, 2011, the Plan was amended such that any non-union employee who was in a category designated as eligible for Plan participation or any employee who was a member of the Mount Sinai Hospital Pharmacy Association, who was hired or rehired on or after January 1, 2012, was eligible to become a participant under the Plan. Independent contractors, agents, leased employees, certain union employees and participants in the Mount Sinai Medical Center 403(b) Retirement Plan were not eligible to participate in the Plan.

An employee was eligible to participate in the employer's nonelective contributions upon completion of one year of service, which was equivalent to at least 1,000 hours of service with the Hospital or the Affiliates during the Plan year, if the employee was employed by the Hospital or the Affiliates on the last day of the Plan year. Effective January 1, 2008, eligible participants were required to complete enrollment forms, and if required forms were not timely submitted, eligible participants were automatically enrolled in the Plan and the employer contributions were automatically invested in the Vanguard Target Retirement Funds.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

Contributions

The employer contribution was based on employee's base pay, exclusive of any applicable shift differentials, bonuses, overtime or severance pay. The employer contributions ranged from 4.5% to 10% of pay according to the base pay scale established. All contributions were subject to certain limitations of the Code. The Code provided that combined employee voluntary contributions (to The Mount Sinai Salary Reduction Contribution 403(b) Plan) and employer contributions could not exceed the lesser of \$49,000 (\$54,500 if 50 years or older) or 100% of the employee's gross annual earnings. Employer contributions expressed as a percentage of pay were limited by the Code to annual employee pay not to exceed \$245,000.

Participants could direct the employer's contribution to be invested into various investment options offered by the Plan and could change their investment options on a daily basis after the applicable waiting period and eligibility requirements were satisfied and applicable enrollment forms were completed. If an employee was not enrolled to direct the employer contribution to be invested according to his or her election, the contributions were invested in a qualified default investment alternative fund until the participant changed the election.

Participant Accounts

Each participant's account was credited with the Hospital's or the Affiliates' contributions and allocations of Plan earnings, and was charged with an allocation of administrative expenses. Plan earnings were allocated based on the participant's share of net earnings or losses of his or her respective elected investment options. Allocations of administrative expenses were based on the participant's account balances, as defined. The benefit to which a participant was entitled was the benefit that could be provided from the participant's vested account.

Vesting and Forfeitures

Participants with at least one hour of service on or after January 1, 2007 became 100% vested in their employer contributions and investment earnings upon completion of three years of service. A year of service for vesting purposes was defined as a plan year during which an employee has at least 1,000 hours of service.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

If a participant terminated prior to January 1, 2007 and was not rehired on or after that date, employer contributions and investment earnings were vested and non-forfeitable if the participant completed five years of service. If less than the required years of service and hours in each year had been completed at the time of the termination of employment, employer contributions and investment earnings were forfeited. If a participant was rehired within a five-year period, the forfeited contributions were reinstated. If the break in service was greater than five years, the years of service were not reinstated and a participant must have met the three-year vesting requirement following rehire. Forfeited balances of terminated participants' nonvested accounts were used to reduce future contributions, and were not material as of December 31, 2012 and 2011.

Payment of Benefits

Upon separation from service with the Hospital or the Affiliates due to death, attaining age 59 1/2, disability, retirement or termination, a participant whose account balance exceeded \$1,000 could elect to receive either a lump-sum or could elect installment payments. A participant whose vested account balance was \$1,000 or less and had not commenced receiving installment payments received an immediate lump-sum distribution equal to his or her vested account balance. Participants were not permitted to make any in-service withdrawals, including hardship withdrawals, from the Plan, except as required by law.

Administrative Expenses

All administrative expenses of the Plan were paid by the Plan unless reimbursed by the Hospital or the Affiliates. Any contribution, benefit, taxes applicable to contributions or maintenance charges or similar fees imposed by any custodian were deductible from the contributions from accounts of participants or from the benefit payments made by the custodian.

Transfers to Other Mount Sinai 403(b) Plans

The custodians and recordkeepers of the Plan are also the custodians and recordkeepers of the Original Plan and the Mount Sinai Medical Center Salary Reduction Contribution 403(b) Plan (Employee Plan) (collectively, the Plans). The Original Plan generally provides for employee and employer contributions to eligible employees hired prior to January 1, 2004 and eligible union employees regardless of hire date. The Employee Plan generally permits non-union

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

1. Description of Plan (continued)

employees hired after January 1, 2004 to contribute to it. In 2011 and 2012, it was discovered that certain participants' balances were classified incorrectly among the Plans. Management worked with the Plans' vendors to correct these errors and, as a result, the Plan recorded these reclassifications as a transfer in the accompanying 2011 statement of changes in net assets available for benefits.

2. Summary of Significant Accounting Policies

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 amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Payment of Benefits

Benefits are recorded when paid.

Investment Valuation and Income Recognition

Investments held by the Plan are stated at fair value. The Plan follows a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that inputs that are most observable be used when available.

Observable inputs are inputs that market participants operating within the same marketplace as the Plan would use in pricing the Plan's asset or liability based on independently derived and objectively determined market data. Unobservable inputs are inputs that cannot be sourced from a broad active market in which assets or liabilities identical or similar to those of the Plan are traded. The Plan estimates the price of any assets for which there are only unobservable inputs by using assumptions that market participants that have investments in the same or similar assets would use as determined by the money managers administering each investment based on the

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

best information available in the circumstances. The input hierarchy is broken down into three levels based on the degree to which the exit price is independently observable or determinable as follows:

- Level 1 – Valuation based on quoted market prices in active markets for identical assets or liabilities. Since valuations are based on quoted market prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.
- Level 2 – Valuation based on quoted market prices of investments that are not actively traded or for which certain significant inputs are not observable, either directly or indirectly.
- Level 3 – Valuation based on inputs that are unobservable and reflect management's best estimate of what market participants would use as fair value. The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of an input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The Plan had investments in TIAA Traditional Annuities. The TIAA Traditional Annuity guarantees principal and a specified interest rate, with the opportunity for additional amounts determined annually by TIAA's Board of Trustees. Certain restrictions limit participant access to funds based on the type of contract held. Participants with a Group Retirement Annuity contract are able to receive lump-sum withdrawals from the TIAA Traditional Annuity only within 120 days after termination of employment. All other transfers from the TIAA Traditional Annuity must be spread over a 10-year period (five years for withdrawals after termination of employment). Given the aforementioned limitations on participant access to the fund, management does not consider the contracts to be fully benefit responsive. All TIAA Traditional Annuities are reported at contract value, which approximates fair value.

The Plan also had investments in Prudential's Group Annuity Contract (GAC). Generally withdrawals of all or a portion of the GAC balance is without fees or restrictions for termination of employment, retirement, disability, death. Exchanges from the GAC to other Prudential investment options and transfers to other investment providers in excess of 20% of the participants beginning of year balance may be subject to a market value charge. Such charge will be equal to a percentage which is calculated based on 2.5 times the difference in the weighted

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

average interest rate being credited to the amount requested to be exchanged and the rate being credited to new contributions (the New Rate). If the New Rate is the same or lower than the participant's weighted average rate, a market value charge will not apply. As an alternative, the participant may request that his or her GAC balance be exchanged or transferred in five annual installments without any market value charges. Prudential's GAC is reported at fair value as determined by Prudential, with an adjustment to contract value because the contract is considered benefit responsive.

All other investments are measured at market value.

Investment income is recognized when earned and consisted of interest and dividends. Purchases and sales of investments are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

New Accounting Pronouncements

In May 2011, the Financial Accounting Standards Boards issued Accounting Standards Update 2011-04, *Amendments to Achieve Common Fair Value Measurements and Disclosure Requirements in U.S. GAAP and IFRSs* (ASU 2011-04). ASU 2011-04 amended ASC 820 to converge the fair value measurement guidance in U.S. generally accepted accounting principles (GAAP) and International Financial Reporting Standards (IFRS). Some of the amendments clarify the application of existing fair value measurement requirements, while other amendments change a particular principle in ASC 820. In addition, ASU 2011-04 requires additional fair value disclosures, although certain of these new disclosures will not be required for nonpublic entities. The amendments are to be applied prospectively and are effective for annual periods beginning after December 15, 2011. Adoption of ASU 2011-04 did not have an effect on the Plan's net assets available for benefits or it changes in net assets available for benefits.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

3. Investments

Investment information at December 31 is summarized as follows (due to the Plan merger, no assets were held as of December 31, 2012):

	December 31	
	2012	2011
Equity mutual funds	\$ —	10,781,670
Money market mutual funds	—	5,724,377
Fixed income funds	—	3,554,584
Lifecycle funds (hybrid funds)	—	48,107,640
Pooled separate accounts	—	583,658
Guaranteed investment contracts	—	5,732,364
Adjustment from contract value to fair value of guaranteed investment contracts	—	1,679
Total investments	<u>\$ —</u>	<u>\$ 74,485,972</u>

The fair values of individual investments that represent 5% or more of the Plan's net assets available for benefits are as follows:

	December 31	
	2012	2011
TIAA-CREF – CREF Stock	\$ —	\$ 4,415,099
Vanguard Target Retirement 2035 Fund	—	5,386,190
Vanguard Target Retirement 2040 Fund	—	6,522,725
Vanguard Target Retirement 2045 Fund	—	6,254,600

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

4. Fair Value Measurements

The Plan's assets and liabilities recorded at fair value have been categorized based upon a fair value hierarchy. See Note 2 for a discussion of the Plan's policies regarding this hierarchy. The following table sets forth by level, within the fair value hierarchy, the Plan's assets carried at fair value as of December 31, 2011 (due to the Plan merger, no assets were held as of December 31, 2012):

Assets at Fair Value as of December 31, 2011					
	Level 1	Level 2	Level 3	Total	
Equity mutual funds ^(a)	\$ 10,781,670	\$ —	\$ —	\$ 10,781,670	
Money market mutual funds ^(b)	5,724,377	—	—	5,724,377	
Fixed income funds ^(c)	3,554,584	—	—	3,554,584	
Lifecycle funds (hybrid funds) ^(d)	48,107,640	—	—	48,107,640	
Pooled separate accounts ^(e)	—	583,658	—	583,658	
Guaranteed investment contracts ^(f)	—	—	5,734,043	5,734,043	
Total assets at fair value	<u>\$ 68,168,271</u>	<u>\$ 583,658</u>	<u>\$ 5,734,043</u>	<u>\$ 74,485,972</u>	

^(a) This category includes investments in mutual funds that invest primarily in common stock of large-cap, mid-cap, and small-cap domestic and international corporations.

^(b) This category includes investments in mutual funds that invest primarily in short term debt securities, including treasury bills, commercial paper and certificates of deposit.

^(c) This category includes investments in mutual funds that invest primarily in debt securities of the U.S. government and corporations with short-term, intermediate and long-term maturities.

^(d) This category includes investments in mutual funds that are made up primarily of a mix of stocks and bonds, which vary proportionally over time or remain fixed. Lifecycle funds are automatically adjusted during the course of the funds time horizons.

^(e) This category includes investments in a mix of securities maintained by an insurance carrier.

^(f) This category includes fixed annuity contracts that are fully and unconditionally guaranteed by two of the custodians of the Plan.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

4. Fair Value Measurements (continued)

The table below sets forth a summary of changes in the fair value of the Plan's Level 3 assets for the years ended December 31, 2012 and 2011:

	Level 3 Assets	
	2012	2011
Balance, beginning of year	\$ 5,734,043	\$ 4,635,602
Transfers	—	(202,919)
Purchases	1,509,979	1,396,723
Sales	331,178	(78,204)
Unrealized gain (loss) relating to adjustment from contract value to fair value for guaranteed investment contracts	1,525	(17,159)
Transfer to The Mount Sinai Medical Center 403(b) Retirement Plan due to merger (<i>Note 1</i>)	(7,576,725)	—
Balance, end of year	<u>\$ —</u>	<u>\$ 5,734,043</u>

Following is a description of the valuation methodologies used for major categories of assets measured at fair value by the Plan.

- *All mutual funds:* Valued at the net asset value of shares held by the Plan at year end.
- *Pooled separate accounts:* Valued at the net asset value as determined by the insurance carrier.
- *Guaranteed investment contracts:* See Note 2.

5. Investment Contracts with Insurance Companies

The Plan offered investment contracts with Prudential and TIAA-CREF. The issuers maintain the contributions in a general account. The account is credited with participant contributions plus earnings and charged for participant withdrawals and administrative expenses. The issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan. The crediting interest rate is based on a formula agreed upon with the issuer. The Plan's contractual minimum crediting rate shall never fall below 3%.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

5. Investment Contracts with Insurance Companies (continued)

There are provider specific restrictions for each contract offered by the Plan. See Note 2 for additional information.

Average Yields for Investment Contracts	2012	2011
Based on actual earnings	3.05%	3.44%
Based on interest rate credited to participants	3.05%	3.44%

6. Tax Status

The Plan has not received a determination letter from the Internal Revenue Service stating that the Plan is qualified under Section 401(a) of the Code. However, the plan administrator believes that the Plan has been designed to comply with the requirement of the Code and has indicated that it will take the necessary steps, if any, to bring the Plan's operations and/or document into compliance with the Code.

Accounting principles generally accepted in the United States require Plan management to evaluate uncertain tax positions taken by the Plan. The financial statement effects of a tax position are recognized when the position is more likely than not, based on the technical merits, to be sustained upon examination by the IRS. The plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2012, there are no uncertain positions taken or expected to be taken. The Plan has recognized no interest or penalties related to uncertain tax positions. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The plan administrator believes the Plan is no longer subject to income tax examinations for years prior to 2009.

7. Related-Party Transactions

Certain of the Plan's assets were invested in funds managed by the custodians of the Plan. These transactions qualify as party-in-interest transactions; however, they are exempt from the prohibited transactions rules under ERISA.

Mount Sinai Medical Center Employer Contribution 403(b) Plan

Notes to Financial Statements (continued)

8. Subsequent Events

The Plan has considered for accounting and disclosure events that occurred through July 21, 2014, the date the financial statements were available to be issued. On September 30, 2013, the Boards of Trustees of The Mount Sinai Medical Center and Continuum Health Partners completed the transaction to establish a new, integrated health system called the Mount Sinai Health System. The Mount Sinai Hospital is a member of this newly formed health system. Management has not yet determined the impact of this transaction, if any, on the Plan. Additionally, effective November 2013, TIAA-CREF became the recordkeeper and custodian of the Original Plan. Plan assets from Prudential and Vanguard were transferred to TIAA-CREF. There were no other subsequent events or transactions which either resulted in recognition in the accompanying financial statements or required additional disclosure.

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