AUDIT COMMITTEE
MEETING AGENDA

September 12th, 2013

11:00 A.M.

125 Worth Street,
Rm. 532
5th Floor Board Room

CALL TO ORDER

- Adoption of Minutes June 13, 2013 — Ms. Emily A. Youssouf

INFORMATION ITEMS

- Fiscal Year 2013 Draft Financial Statements and Related Notes — Jay Weinman
- Fiscal Year 2013 Report to the Audit Committee — Mr. Jim Martell, Partner KPMG
- Audit of eCommerce Update — Bert Robles
- Audits Update — Mr. Chris A. Telano
- Compliance Update — Mr. Wayne McNulty

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: June 13th, 2013
TIME: 12:00 PM

COMMITTEE MEMBERS
Emily A. Youssouf, Chair
Jo Ivey Boufford, MD
Josephine Bolus, RN

OTHER MEMBERS OF THE BOARD
Michael A. Stocker, MD

STAFF ATTENDEES
Antonio Martin, Executive Vice President/COO
Salvatore J. Russo, Senior Vice President & General Counsel, Legal Affairs
Deborah Cates, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
Tamiru Mammo, Chief of Staff, President's Office
Paul Albertson, Senior Assistant Vice President,
Jay Weinman, Corporate Comptroller
Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits
Wayne McNulty, Corporate Compliance Officer
Nelson Conde, Senior Director, CO-OPSA
Enrick Ramlakhan, Assistant Vice President, EITS, Central Office
John Delalio, Senior Director, EITS, Central Office
Jeff Lutz, Director, EITS, Central Office
Lorraine Szabo, Director, EITS, Central Office
Devon Wilson, Senior Director, Office of Internal Audits
Roger Mayer, Director, Office of Internal Audits
Chalice Diakhate, Director, Office of Internal Audits
Steve Van Schultz, Director, Office of Internal Audits
Zhanna Kelley, Assistant Director, Office of Internal Audits
Carol Parjohn, Audit Manager, Office of Internal Audits
Frank Zanghi, Audit Manager, Office of Internal Audits
Sonja Aborisade, Associate Confidential Examiner, Office of Internal Audits
George Asadoorian, Supervising Confidential Examiner, Office of Internal Audits
Jonathan Delgado, Supervising Confidential Examiner, Office of Internal Audits
Cynthia McIntosh, Supervising Confidential Examiner, Office of Internal Audits
Roger Novoa, Supervising Confidential Examiner, Office of Internal Audits
Delores Rahman, Supervising Confidential Examiner, Office of Internal Audits
Armel Sejour, Supervising Confidential Examiner, Office of Internal Audits
Luba Dovjenko, Confidential Examiner, Office of Internal Audits
Satish Malla, Confidential Examiner, Office of Internal Audits
George Payyapilli, Confidential Examiner, Office of Internal Audits
Gillian Smith, Confidential Examiner, Office of Internal Audits
Rosemarie Thomas, Confidential Examiner, Office of Internal Audits
Denise Soares, Senior Vice President, Generations + Northern Manhattan Health Care Network
Kiho Parks, Associate Executive Director, Queens Healthcare Network
Alex Scoufaras, Associate Executive Director, North Bronx Health Care Network
Victor Bekker, Chief Financial Officer, Generations + Northern Manhattan Health Care Network
Elizabeth Guzman, Chief Financial Officer, Metropolitan Hospital Center
Leithland Tulloch, Deputy Chief Financial Officer, Harlem Hospital Center
Milenko Milinic, Controller, Queens Healthcare Network
Anthony Saul, Senior. Associate Director, Dr. Susan Smith McKinney Nursing & Rehabilitation Center

AUDIT COMMITTEE

MEETING DATE: June 13th, 2013
TIME: 12:00 PM

Angela Buchanan, Assistant Director, Lincoln Medical Center & Mental Health Center
Ivan Figueroa, Assistant Director Woodhull Medical & Mental Health Center
Kim Wilcott, Assistant Director, Coney Island Hospital

OTHER ATTENDEES
KPMG: James Martell, Maria Tiso, Camille Fremont
TCBA Watson Rice LLP: Bennie Hannott
PAGNY: Howard Nelson

JUNE 13, 2013
AUDIT COMMITTEE OF THE BOARD OF DIRECTORS
NYC HEALTH & HOSPITALS CORPORATION

A meeting of the Audit Committee was held on Thursday, June 13, 2013. The meeting was called to order at 12:15 PM by Ms. Emily A. Youssouf, Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee meeting held on April 11, 2013. A motion was made and seconded with all in favor to adopt the minutes. An additional motion was made and seconded to hold an Executive Session of the Audit Committee to discuss matters involving the Fiscal Year 2014 Audit Work Plan, Compliance and EITS.

Ms. Youssouf then turned the floor over to Mr. Jim Martell, Lead Engagement Partner, KPMG to introduce the information item regarding the Fiscal Year 2013 Audit Plan. Mr. Martell saluted the Committee and introduced Maria Tiso, Client Care Partner, Camille Fremont, Senior Manager and Benny Hadnott, from BCA Watson Rice LLP who will be assisting them with the annual audit.

Mr. Martell continued by stating that their goal and role today is to present the 2013 planned audit approach. He said he used the word "planned" because as they go through the process the Committee may ask them to make changes. As in the past if there are other concerns or issues that the Committee may want us to look, we will incorporate that into the annual audit. Listed on page two is the client service team. There are a significant number of asterisks next to the individuals. Most of the individuals that have any asterisks are at the senior level. We do have a few new people who are rotating on due to resignations and things of that nature, but also to get a fresh perspective. The key item is that himself, Maria Tiso and Camille Fremont have gotten to know the organization very well in the past four years. They do have a new Concurring Review Partner, Greg Driscoll, who is one of their leading governmental partners in the New York office. After doing a rotation with the Government Accounting Standards Board (GASB) for two or three years they asked him to come back because of all the new GASB rules he has a first-hand knowledge of the new literature and can assist the engagement team in terms of assisting management as to how to implement them.

Ms. Youssouf stated that she is happy to hear that there is a staff member internally from Chris Telano's office that KPMG is using and that it is a bit more under control than it was. Mr. Martell added that they have tried to incorporate the internal audit group and it has been a pretty good result over the last several years.

Ms. Fremont then began the presentation by stating that on slide three they have laid out the other deliverables besides the Corporation's financial statements. They will issue various cost reports attestations that have to do with HHC's nursing homes, diagnostic and treatment centers and long term health care facilities. Additionally, they will issue the entire report for the 13 facilities along with statutory and financial statements. They will also issue HHC's statutory audited financial statements for the insurance company and MetroPlus Health Plan and then come back with management audit recommendations.

Ms. Fremont continued with slide four stating that they have laid out the objective of the audit, which is to enable the auditors to express an opinion about whether the financial statements are presented fairly in all material respects in conformity with Generally Accepted Accounting Principles (GAAP). In order to do that, they planned the audit to obtain reasonable but not absolute assurance that the financial statements taken as a whole are free from material misstatement, whether from error or fraud.

Ms. Fremont continued with slides five through seven in which they laid out the responsibilities of management, the Audit Committee and KPMG as it pertains to the audit. Some of management's responsibilities include adopting sound accounting policies and fairly representing the financial statements. She stated that as members of the Committee

their responsibility is one of oversight. As HHC's auditors, KPMG is responsible for forming and expressing an opinion about whether the financial statements are appropriate. KPMG conducts the audit with an attitude of professional skepticism, and evaluate HHC's internal controls over financial reporting as a basis for designing our audit procedures, but not for the purpose of expressing an opinion on the effectiveness of those controls.

Ms. Youssouf said that all of this is the stuff that is said every year – so rather than reading it line by line she would appreciate a summary.

Mr. Martell added that he was just going to say that the reality is that from pages four through seven, the roles and responsibilities of the Committee and management of KPMG have not changed.

Ms. Fremont continued with slide eight – Time line for the financial statements. It started in April where they had planning meetings to determine the audit strategy and it will continue through November. In June and July they will perform certain tests during their site visit test work. Starting at the end of July through September they will come back and do their standards test work. During that time, they will have their traditional SAS 99 meeting, and will come back to the Audit Committee to present the final draft financial statement.

Mr. Martell stated that there is one key difference this year as it relates to timing. It is almost two weeks earlier, September 13th of this year. The same time last year was September 18th, in the past it was always October 1st.

Ms. Youssouf stated that she thinks it is great that there has been an improvement every year since she has been the Chair of the Audit Committee and that makes her very happy.

Ms. Fremont continued with slide nine where they have laid out the critical audit areas, as well as some of the non-routine transactions KPMG will consider. The critical audit areas have not changed from the prior year. In terms of non-routine transactions, KPMG will walk through the new accounting pronouncements on slide fifteen through eighteen and what impact they will have on the Corporation. KPMG will additionally have to consider what impact Super Storm Sandy had in terms of potential impairment or business interruption, as well as the FEMA claims process that is ongoing at the organization.

Ms. Youssouf asked that given all the cuts that are proposed in Obama Care, is there anything in particular from your vantage point that you are going to be looking at?

Mr. Martell responded that typically they would not look at anything differently than what we have looked at in the past. Every year, we have looked at liquidity and going concern as part of our audit process. Obviously we look at cash flow, the future budget in terms of revenue streams and the strategic plans. They will talk with management as to how well our 2013 budget did compare to our 2013 actual. We have a slide in the back as to certain key trends that we have looked at; working capital, cash flow, day's revenue and accounts receivable. At the closing of last year he mentioned that HHC has a significant net deficit and have been generating operating losses. The bulk of the net deficit has always been and continues to be the one time or the ongoing reporting of Post-employment Benefits other than Pension (OPEB). That is why we have to at least address the going concern from a documentation perspective and a discussion for this purpose with management.

Ms. Fremont stated that on slide ten they included how they plan on using the Minority Business Enterprise, the Women's Business Enterprise and the Internal Auditor throughout the process.

Ms. Fremont continued with slide eleven and twelve where they are required to address the potential for fraud within the audit under SAS 99, and part of their key procedures are interviews that they have with various members of

management and the Committee. Those interviews are laid out on slide twelve and will consist of Audit Committee Chair, Emily Youssouf and Chairman of the Board Dr. Michael Stocker along with Senior Vice President & General Counsel Salvatore Russo.

Mr. Martell added that as they go forward throughout the audit, they may or may not, depending on how they feel, select someone from the facilities just to give us a little change, keep it a little fresh.

Ms. Fremont moved onto slides thirteen and fourteen which Mr. Martell has spoken about how they will consider liquidity and going concern. She said that on slide fifteen, they will start with the first new GASB Statement 61, which is effective for June 30, 3013. KPMG will have management look at all of HHC's component units and determine how they should be presented within the financial statements. In going through this process management has identified that MetroPlus' balances will need to be separately disclosed in the financial statements. In the past there has been one consolidated number on the balance sheet, now the activity of MetroPlus will be included in HHC's statement of activities as a footnote disclosure.

Mr. Martell said that it will end up having HHC being the parent, for lack of a better word; HHC is going to have MetroPlus as a column, and then a total. The literature is asking to break out separately identifiable components, subsidiaries that are unique and not part of the Board of HHC. They have separate Boards, separate Audit Committees and so forth. There is a little more detail associated with it. What is going to end up happening is that HHC is going to have MetroPlus, a billion dollar organization shown separately, with changes that also have to do with the last year also.

Mr. Weinman added that this is similar to the way it is reported within the City. HHC is a component unit of the City, and HHC is a column within their financial statements. HHC will also have similar presentations for MetroPlus. He thinks that MetroPlus is probably the only one that HHC will separately report.

Ms. Youssouf added that since in the past MetroPlus has been combined it made HHC look better. To which Mr. Martell responded yes.

Mr. Weinman said that one of the key components of MetroPlus is the premium revenue and that has already been separated on the financial statements, so there is no change in that, it is just the rest of the expenses which will be presented.

Ms. Youssouf asked if it impacts any funds that are due to HHC from MetroPlus. Mr. Martell said that this is purely presentation.

Mr. Fremont continued on to slide sixteen, the second GASB Statement 62 which is effective for the current year. This one will not have any impact on the organization. Turning to slide seventeen is the third GASB Statement 63 which is effective for the current year. This one will no longer call your net assets on the balance sheet net assets; they are now going to be net position. The other thing to consider is whether or not there are any deferred outflows and inflows for items that will be used in future periods. Mr. Martell added that he did not think this one will have conceptually a significant impact on the Corporation and that they won't know until management and us sit down and go through the literature.

Mr. Martell then turned to slide eighteen where it lists six or seven statements that are coming down the parkway in terms of what has to be changed. There are a lot changes to the presentation and going back to the management letter, we had an issue of oversight and the whole issue of the public markets and so forth. He believes most of these things are reactionary to where the Securities and Exchange Commission (SEC) is going, but to have almost seven or

eight new GASB literature implementations in two years, people are looking at not-for-profits and governmental institutions.

Ms. Youssouf agreed and stated that especially the pending GASB 70, non-exchange financial guarantees and disposals of government operations and then of course pension plans that those are going to be big impacts. She then asked when they become effective. Mr. Martell answered that they come next June. This June we stopped at the first two and the next five will be tough. There will be a lot of planning associated with the pension aspect and the disposal aspect that it will be an interesting 2014 audit.

Mr. Martell added that this is actually their planned presentation. The actual audit process will start sometime in early July. In fact we are out there at some of the facilities as we speak doing interim test work.

Ms. Youssouf asked if there were any questions. She thanked KPMG. She then stated that she is going to turn it over to Chris Telano for some audit updates.

Mr. Telano saluted the Committee and stated that he will be discussing six reports. There are three purchasing reports, two PAGNY reports and the IT audit of the eCommerce application. The first one he would like to discuss is the IT audit on page 10. He asked the representatives of IT to come to the table.

Ms. Youssouf asked them to introduce themselves. They did as follows: Enrick Ramlakhan, AVP for Corporate Applications; Jeff Lutz, Director of Corporate Applications; Bert Robles, SVP, Corporate CIO; Lorraine Szabo, Director of Corporate Applications.

Mr. Telano began his presentation by stating that he will discuss a few of the issues. The first one was that the eCommerce application does not lock out users after three login attempts. This is more of a concern since there was no formal review or follow-up of failed login attempts. Hence, a hacker can try an unlimited number of attempts to get an employee's password without recourse. The second issue is that eCommerce does not automatically disable user accounts due to inactivity for an excessive period of time. Instead, idle accounts are being monitored manually. We do not find that efficient, especially in light of finding 1,300 users that were not logged onto the system for more than 180 days. Mr. Telano commented that the eCommerce technical team is looking into both of these issues, and hope to resolve them in the near future.

Ms. Youssouf asked how quickly they are going to be able to resolve this, because the first one obviously is a major problem.

Mr. Ramlakhan answered that the current eCommerce application is several releases behind so there is a need for us to do some custom programming that it is not part of the current release in place. That requires us to take a step back and either code around the current application, look to upgrade to the current release at a substantial cost to the organization or continue using the manual process in a more periodic basis.

Ms. Youssouf asked whether this response was satisfactory. Mr. Telano responded his office will be doing a follow-up audit in six to twelve months to ensure that there is progress being made to resolve this. I know that with the disabled users, they were initially receiving a report on a quarterly basis to address this and it was changed to a monthly basis. So there was action taken during the course of the audit to address that.

Dr. Stocker asked to give more detail on the function where you try to enter the pass code multiple times and you are not locked out. Mr. Lutz responded that Mr. Ramlakhan's response is really something we could do somewhat immediately, but it is really an interim plan as opposed to the greater plan, which is on the way. That is reengineering

our active directory, which is the way; it is at a very high level. It is the engineering software that allows us to control who gets access and who does not. The access via the application, is done by the user role. Depending on your job description or your role, it is role based; it really controls what you can have access to, through the network. Based on what applications you are entitled to look at, it can be programmed for inactivity, which we do in some cases today for those sites that have active directories. Complicated by the release levels of the current software in eCommerce, which is not conducive to that, but the correct way to ultimately engineer it, which is work that has already been started a year ago. It requires another year to complete, because it is a substantial effort.

Ms. Youssouf stated that she does not understand about the disabling. In most organizations when you try to get on, and by the third time, you can't, you fail. We apparently do not have that. Mr. Telano and Mr. Lutz answered, yes, for eCommerce.

Ms. Youssouf then stated that that is incredibly difficult – that she just wants the question answered. Mr. Robles stated we cannot programmatically do this because of the antiquity of the architecture of eCommerce right now, the way it has been set up. The correct way to do this, and we do this today is we migrate it to an active directory. It is a high level of provision.

Ms. Youssouf asked that if you can make a fix now to prevent this, why wouldn't you do that now. To which Mr. Ramlakhan responded we are, we are working on that fix. It is custom programming that we will have to do.

Dr. Stocker added that it sounds like you have a work around now, and a year from now, you have an ongoing project that would resolved it. Mr. Ramlakhan responded correct. Mr. Robles added that it is one structure that controls both the access to the network, as you know when you first sign on, and what number of applications you are entitled to, you have access to. You can time it and recycle it. Just like today, you have the 90 day password reset. There is some protection, what you focus on is just one application. You have to really intrude through many layers before you can get at the application. But the best practice is to have both applications and network totally controlled.

Ms. Youssouf asked how long it is going to take to put in this quick fix. Mr. Ramlakhan responded that within the next 30 to 60 days we should have a fix. We have had our engineers looking at it. We have come up with a couple of different ways, especially with the inactivity, which is fairly simple. With the lockout, we are going to have little more of a complication, but that should also be within that 30 to 60 day time frame.

Ms. Youssouf asked to have an update about your progress at the next Audit Committee meeting. Mr. Ramlakhan responded absolutely.

Mrs. Bolus asked why it takes you a while to get there to ask them why they are not getting in. To which Mr. Ramlakhan replied that is also part of the program. What they are going to do is go through the blocked files and have an automatic blurb sent out to the systems administrator so that some custom programming is getting done on those blocked files.
Mrs. Bolus asked if out of the 1,300 user who have not logged in over a long time, are those people who have left the service. Mr. Ramlakhan responded that is a little bit more difficult – they just have not used the application. Often times they are not, they are still active.

Mrs. Bolus asked if they are still active people. Mr. Ramlakhan said yes, but they just do not use the application. Mr. Telano added that some of them were active and some of them were not.

Ms. Youssouf thanked them.

Mr. Telano continued with the next item by stating that he would like to discuss the purchasing audits on pages three, four and five of the briefing. Since we have discussed the procurement process at length during the last two Committee meetings, we are not requiring the individuals from the facilities to come to the table to discuss these audits. Instead, Mr. Paul Albertson, the Chief Procurement Officer is presenting an update of the status of the centralization of the purchasing function, and of Operating Procedure 100-5.

Mr. Albertson saluted everyone and introduced himself as Paul Albertson, Senior Assistant Vice President overseeing the centralization process of procurement. He asked two of his colleagues to introduce themselves: Jun Amora, Consultant, working out of the Breakthrough office; Francine Freise, representing the Greater New York Hospital Association for HHC.

Mr. Albertson continued by stating that he would like to be able to provide a kind of a context and an overview of where we are moving as it relates to our procurement approach. Then we are going to be talking about the process that we have actually been engaged for the last six weeks and what was established in the Road Ahead transformation documentation as it relates to the corporate agreement to achieve reduced costs across the organization. One of the goals is the standardization of the procurement process which will be driven by value, volume and cost. The need to have a centralized environment at a multi-million dollar savings it's already achieved and there are many more as we move forward in that centralized environment. In the context of looking at our current governance, technology and culture, our transformation efforts really require us to have good understanding of what is currently taking place. Towards that end we visited and met with purchasing and material management directors to talk about what is currently taking place and what some of their opportunities and concerns are and to have a chance to introduce myself in a way that we hope we will work together.

Ms. Youssouf stated that the Committee knows the background.

Mr. Albertson continued adding that in terms of our statement, we are looking at our deficit of $1.3 billion and using the Breakthrough methodology. Our current decentralized procurement infrastructure does not allow us to get to where we would like to go. We are working on an integrated system that provides the appropriate clinical input for evaluating products and the standardization. With that as our mantra, we are looking at a new machine, as it relates to how we would actually be able to transform our procurement process. Mr. Jun Amora has been very helpful in developing this and will take a moment to explain it and the phases we are taking.

Mr. Amora stated that in looking at the target statement, it illustrates the design for the future state of procurement for HHC. They looked at literature and at some of the best practices from previous experience, on how to put together a centralized model for procurement. On the left side of the slide there some funnels, those are value analysis funnels. Their chief job is to do two things, evaluate products based on clinical evidence assuring patient safety and mission quality; and second, our quality of products to assure patient safety. The second is price and value. As we select products, there are decisions on what products to contract for and what products not to purchase. As those products flow through value analysis, they go through a centralized negotiation of the procurement department where we aggregate all of our volume of usage as a Corporation to assure best price. Then it flows cleanly into our Virtual Item Master so that we can transact through our favorite list and use our systems like ORACLE and GHX to produce POs. This is the kind of target state we have built; we are going to tackle this phase by phase. Phase 1 is building out the VIM through cleaning up the procurement process which is all aligned against preparing for centralization. Phase 2 is the actual centralization, building up a design for value analysis and building out what the centralized structure looks like as well, but the meat of phase 2 is centralization and integration. Phase 3 is continuous improvement and the launch of value analysis teams. We have worked very closely with Dr. Wilson's office and the Chief Nursing Officer to build out what the structure of value analysis looks like. There are already those existing committees that look at

clinical practice. We want to see how we can leverage those committees so that they can address supply chain issues as well, and become the structured value analysis.

Ms. Youssouf asked if this is going to be in effect by September.

Mr. Martin responded yes.

Mr. Amora then added that basically it is marked by the launch. The nomenclature that we have been tossing around is how we have HHC, which is one entity. We call it an integrated delivery network, or an IDN, how do we function as one IDN in front of our vendors, in front of our suppliers and in front of those who we buy from. A couple of examples that we look at was the Stryker Craniomaxillofacial. It is a contract with Premier and Stryker Corporation as well. These are two different contracts where savings have been identified. If we function as an IDN, and made corporate decisions on how we manage these contracts, instead of how we currently manage it, which is facility by facility, we would realize savings immediately.

Ms. Freise added that what they see across our 300 members is that this is just a starting point. What you can do with this information is leverage it further and make better product decisions in order to derive the best value as well as effectiveness. The savings here that you see are just a small representation.

Mr. Amora continued with the next slide where there is another example of that. Both of these examples are Premier contracts, but the process we are going to employ is going to be GPO diagnostic. It is going to be ensuring again best clinical value and best price. Suppose we talk about our proposed table of organization and how we intend to do this.

Mr. Albertson said that our interest is transforming ourselves from a decentralized model to a centralized model, and being to effectuate what Mr. Amora said. The best way for us to do that is really following the models that exist kind of across the country with a huge array of integrated facility setups that have, in fact, centralized their procurement. We would transform ourselves to having a single line that is more of the traditional purchasing. When we turn those requisitions into orders that go out to the companies that would be done in a centralized model with a director who would be managing that. Our interest is really having category experts as it relates to service lines. We would like to be able to specialize around areas like the business office support services. We have our perioperative radiology lab, cardiology, pharmacy and med surg categories as examples. We have more than 1,000 contracts that are currently in our system. For example, we have 171 that relate to perioperative services, we would like to be able to have a category director be that expert as it relates to those contracts. They would be serving as the principal staff to the value analysis committees, some of them are clinically oriented and some of them are not. Below that we would like to be able to establish category analysts, individuals with a skill set to be able to analyze the data that we have as it relates to our purchasing. Associated with that service line to be able to pull together our “what ifs” as it relates to doing scenarios as to the best buy, and to help us set up in negotiating.

Ms. Youssouf asked what the Capital Category Director is. To which Mr. Albertson responded that we bring in capital through the Finance Department, though the Office of Facilities Development and there is also some done through traditional purchasing. The interest is how do we leverage or consider if we will going to a single source, for example, for imaging services how that facilitates its way through what you buy to support it, to be able to look at value and the way that we may be able to save money. We are interested in being able to sort out If there is a way for those offices to work together up front in that kind of decision making with the appropriate clinical committee. The interest is being able to then also look at our business analytics. The second box talks about being able to manage the array of assistance that we have to work with, being able to keep track of our savings and key performance indicators. The last box is about strategy and innovation as we continue to process this forward to be able to assure that we are working effectively with changes that occur that can affect this and also how we can help the rest of the supply chain process.

Mrs. Bolus asked if all the titles are in place now. Mr. Albertson replied that these are functional job titles and are working with Human Resources to match the appropriate HHC title.

Mrs. Bolus asked if the category analysis person is the only ones he is trying to create and where would they fit. Mr. Martin added that what Mr. Albertson is doing is looking at the different forms of purchasing directors that we have across the Corporation and is evaluating them. Based upon the level of expertise that they bring, they are going to be the people that head up those different divisions.

Ms. Youssouf asked why IT was not included considering that we do massive amounts of purchasing in IT. Mr. Albertson said that that is included in the Business Analytics box. There is a current existing screen where IT is being valued and going through a process and coming up through the series of committees. There would be some linkage with the supply chain committee.

Ms. Youssouf stated that that is the largest, probably the most expensive. Mr. Martin said that we spend a lot of money on IT and that we have already made a commitment to EPIC, which is a major vendor. That encompasses a lot of our IT systems and there are other IT purchases as well. Maybe that is something that we will look at, this is a draft. He stated how proud he is of the work the guys have done in a short period of time to come up with a real roadmap to success.

Ms. Youssouf stated that she agreed, but she thinks part of the reason to bring it here is for comments and suggestions and she would really encourage them to look at IT and let them know.

Mr. Amore said that he thinks that is a great point and as Mr. Martin mentioned, this is in draft form. They are actually playing around with what the role of the business/office support service category directory. It may be exactly that, IT. They have worked a lot with Mr. Ramlakhan and his team to really understand the purchasing behavior and where it makes sense to put that value analysis decision making.

Ms. Freise added that traditionally in other major IDN, for example, the North Shore model, IT is treated as separate and outside of the typical supply chain, because it does not involve the procurement of goods that actually make it to the patient. The supply chain can be structured as you see it fit.

Ms. Youssouf said that she thinks we should look at it because it is so much.

Dr. Stocker inquired if the yellow boxes with those categories are those functional jobs that will be done by people who currently work in procurement in geographically distinct areas. Mr. Albertson responded yes, everyone I have met in the facilities is great, and we are interested in understanding either their expertise and helping to build these roles with individuals who are interested, and the skill set.

Dr. Stocker wanted to know if their objective is to provide a system to the people who actually need it; the hospitals and doctors and so on, that is easier and faster, not slower and more cumbersome. Mr. Albertson responded that that is clearly their goal. If we lose anything between now and then, and as we process through, we believe that by having these category directors and service lines, we can standardize across the Corporation, and be able to give better value and be able to have better relationships with our vendors. The next slide illustrates the fact that we would be having each of those category directors work very closely with those committees that we talked about, who in turn would be reporting to the Supply Chain Council, whose role becomes much more directive in being able to hear those reports and deciding on actions recommended by those committees to facilitate this implementation across the Corporation.

Ms. Youssouf asked if the new vendors are vetted and where does it occur. To which Mr. Albertson answered that that is a major transition also. We would like that instead of them going to the facilities to come to the corporate office so that the products being considered would be vetted in that manner and then go through the category directors up through their task force as appropriate.

Ms. Youssouf added that that means it would be essential to look at financials, capabilities, experience, etc. Mr. Albertson said that that is why we would like the analytics staff to be able to help us with that. That is the kind of the overview of what we are doing as it relates to our centralization process. We are moving to work with our labor relations and human resources to do the rest of the mapping then talk to the facilities. Our next step is we are evaluating our space and all of the activities that are associated with that, so that we make the transition occur beore the summer ends.

Mr. Albertson continued by stating that in his conversations with Mr. Telano and with some of the other staff on OP 100-5, we have looked at three components as it relates to finalizing the procedure. That is addressing the internal audit findings, having a policy of a centralized procurement department and also revising the SOPs that support it. From those internal audit findings, there has been a lot of work done by Mr. Quinones and Mr. Berman in Legal Affairs to be able to add some missing definitions, and clarify any ambiguities in the internal audit findings. Then refer the other remaining items to an SOP work group that was established yesterday at the Supply Chain Council.

Mr. Albertson continued with the next slide – Centralization Component. They drafted a centralized procurement by going through OP 100-5, made those revisions which will be circulated. Their plan is that by the end of June, they will have finished the definitions that needed to be added, revise the policy to reflect the centralized approach and be completed with that for review by Mr. Martin. The other component is the SOPs, there are a series of them that need to be reviewed and revised to reflect the changes. That group has committed itself to finish those by the end of August.

Mr. Albertson continued with the last slide which is the wrap up. As he mentioned, they are finalizing the table of organization. The solutions as it relates to the contract issues and our current state in terms of our statistics to our managing what we currently finding on our current state, which is where we would like to achieve, and the value analysis infrastructure to finalize what that looks like for consideration. Then we are working on a communication plan to assure that the leadership as well as all the facilities is kept appraised of how we are moving along. Everything we make in procurement affects material management and finance; we have to make sure our partners are well equipped. The last component is the partnerships that we have with an array of external facilities that we really need to enhance, whether it is the Premier, the Cardinal, the agencies that we use for providing support like the Advisory Board. There is a lot of collaboration that will bring to this as well.

Ms. Youssouf stated that she just wanted to say it looks good. She thanked all for the work that they put into it and the management in general, Tony Martin in particular, who has really taken this on. The Board appreciates it. Mr. Martin added that it is a lot of work, but they are doing the work though.

Mrs. Bolus thanked them for this marvelous piece of paper and appreciates them.

Mr. Telano resumed with the audit updates by stating that the last two audit reports he would like to discuss is Physician Affiliate Group of New York (PAGNY) affiliations. In general, we found a need to improve record keeping and internal controls. However, instead of discussing those issues in detail, Dr. Marcos has been asked to come to the table to provide us with an update of the PAGNY affiliations.

Dr. Marcos saluted everyone and introduced himself as Luis Marcos, CEO of PAGNY and introduced Mr. Anthony Mirdita as the new Chief Financial Officer, who just started last week. He also thanked Mr. Milton Nuñez who assisted us in this area for several months. He asked if anyone had any questions.

Ms. Youssouf said that perhaps he can spend a minute describing what he is planning to do here.

Dr. Marcos responded that he assumes that everyone here knows how PAGNY was developed and some of the challenges they have gone through. He stated that he would also like to acknowledge the help he received from everyone here, from Antonio Martin, Salvatore Russo, obviously the President, Marlene Zurack, Ross Wilson and many others. He has been there officially for two months, but was there before and from day one, it was a challenge. The basic legal matters were a challenge, the status of the company and so on. Those were the issues they had to deal with and that are their priority. It is important to remember that PAGNY was formed fast and also from five different affiliates that came with their own culture, their own history and their own way of doing things. From that we created this family, and it is going to take a little while until we all focus on the future and the strategic direction of this company that I am sure -- and my team is also sure -- that it has a great future. It is important to recognize that while we were doing this, we have been able to achieve some important goals. For example, in December, we reached an understanding with HHC for a three year affiliation contract, to me that is a very positive thing. We have a letter of intent, and it included our 25, 26 points, which are very important. We are working with the lawyers to finalize the legal aspect of the contract, but the Board of HHC approved those three years and I think that gave a lot of stability and was very instructing and helpful.

Dr. Marcos continued by stating that secondly, before PAGNY, not all of the physicians were part of the union. Today every physician in PAGNY except the chiefs are all part of the union. We have been working with the union, and for the most part, we have been doing well as relationships go. We have an extension until June of 2014 of the current contract. That gives us some stability and some time to work things out. There has been very positive, with the help of HHC, achievement for the benefit of the physicians. One is, for example, starting in July 1st of this year, the contribution of PAGNY to the 401K will increase to 10 percent. Average was about 7 and a half. We are working very hard with the performance indicators, and with Dr. Ross Wilson, and with the help of HHC, we are able to identify what we call academic activities funds. These are funds that are designated for Resident training as well as for development of the faculty. These are just examples of many good things that we have been able to do because of the collaboration of our team.

Dr. Marcos stated that specifically to the audits of Harlem and Metropolitan, we are very concerned about some of the findings. They show mistakes and they show the struggles of going through this process in an incremental way, and meeting all of these very important requirements. Our commitment to you and the Board is that we will do everything we can do to comply with every rule and every expectation.

Dr. Stocker stated that there has been amazing amount of change. You started a year and a half ago, a very short period of time. Each of these organizations has a life of their own, and putting them all together, not only is there a payroll function in all those, but there is a billing function also. To bring them all together in a single organization is very helpful for HHC, but difficult for them. We talked mainly about the Kaiser Model, where you have physicians who are organized and work as partners with the organization and management. I am sure they have contention, but from the outside, it looks to be successful, we are really glad to have you.

Ms. Youssouf said that what they would like to see is for you to come back with whatever kind of plan you have. Because the internal audits have not been very good and we are anxious to see what is going to be put in place to fix it. She also asked that the new CFO , get in contact with Chris Telano to give him a time period when PAGNY would be prepared to report back on some of the permanent fixes.

Dr. Stocker asked for the CFO to give them some of his background. Mr. Mirdita said that he started his career in 1990 at Jacobi as a budget analyst, and ultimately wound up working as deputy CFO for Coler/Goldwater. Since then, he went to on to take on positions as CFO of a hospital up in Carmel, as well as a Physician Group in Hudson Valley and he is glad to on board with Dr. Marcos.

Dr. Stocker said welcome back and God bless you.

Ms. Youssouf said thank you – it has been a pleasure to meet you both and we look forward to seeing you back here hopefully shortly.

Mr. Telano added that just to finalize my presentation, on page eleven is a list of the audits in progress. The majority of them are the remaining affiliations throughout the corporation. Three of the audits were impacted by Hurricane Sandy, as a result of the lapse in time; we will have to start all over. The last page is the status of our follow-up audits. That concludes my presentation.

Ms. Youssouf thanked Mr. Telano and turned to Mr. Wayne McNulty.

Mr. McNulty saluted everyone and introduced himself as Wayne McNulty, HHC's Chief Compliance Officer. He then directed the Audit Committee to turn to page three of the Compliance Report ("Report"). Mr. McNulty informed the Audit Committee that the Compliance Training for the Board of Directors module was completed. He stated that all of the members of the Board of Directors were enrolled into the course. He advised the Audit Committee that Information Services and the Office of the Chairman were working on a process to facilitate the remote access of the training module by Board members. He reported that there were several technological difficulties present, which he advised the Audit Committee were being addressed by Information Services.

Mr. McNulty continued by stating that, with the regard to the other training modules, the health professionals module, the general work force module, and the physicians module, were all in place. He informed the Audit Committee that all covered personnel were enrolled into the aforementioned modules. He further advised the Audit Committee that the training period would conclude on June 30th. He continued by stating that, moving forward, the training period would be on a fiscal year basis. He informed the Audit Committee that a report providing the results of their (Office of Corporate Compliance's ("OCC")) training activities would be presented in September to the Audit Committee. He asked the Audit Committee if there were any questions before he moved on to item number two of the Report.

Mr. McNulty moved on to item number two – the Corporate Compliance Work Plan. He informed the Audit Committee that the OCC continued to make progress with its Corporate Compliance Work Plan items. He added that, given the confidential, investigatory information contained in the OCC's risk assessment process and OCC's findings, such processes and findings would be discussed during Executive Session at the conclusion of the Report.

Mr. McNulty continued with item number three of the Report and stated that the OCC started to identify and prioritize corporate risks. He provided that, in May, the Executive Compliance Work Group ("ECW") and the Executive Compliance Work Group Subcommittee on Compliance (and Quality) ("ECW-CQ") convened to review the OCC Corporate-wide Assessment of Risks document. He explained that potential Corporate risks were identified at both meetings, and the risk prioritization process was explained to the ECW members. He added that the Network Compliance Committees had also started to undergo the risk assessment process. Mr. McNulty reported that a subgroup of the ECW was formed to specifically focus on finance, billing, and payment (risk items). He informed the Audit Committee that the subgroup had already convened two times. He stated that the subgroup discussed different corporate risks and scored a series of corporate risks. He provided that he would present all raised risks to the Audit

Committee in September, as well as how these risks were prioritized and scored. He added that he would also present HHC's Fiscal Year 2014 Corporate Compliance Work Plan to the Audit Committee in September.

Mr. McNulty then went on to item number four – the Compliance Index. He informed the Audit Committee that, for the first quarter of calendar year 2013, there were 90 compliance-based reports - - one Priority A report; 27 Priority B reports; and 62 Priority C reports. He advised the Audit Committee that the Priority A report would be discussed in the Executive Session. Mr. McNulty then moved on to the compliance privacy index. He provided that, for the first quarter of calendar year 2013, there were 22 HIPAA-related complaints - - five were found after investigation to be actual violations of the HIPAA privacy operating procedures; five were determined to be unsubstantiated; six were found not to be a violation of the HIPAA privacy operating procedures; and six were still under investigation. He explained that, out of the five confirmed violations, there was one breach. He advised the Audit Committee that, given the confidential nature of the informants who provided information regarding the breach, the details of said breach would be discussed in Executive Session.

Mr. McNulty provided a staffing update. He informed the Audit Committee that there were three vacant compliance officer positions within the OCC. He stated that he was hopeful that one of these positions would be filled by the conclusion of the day. He further stated that he was hopeful that he would be able to fill the other vacant positions by the following week.

Mr. McNulty continued by discussing excluded providers. He informed the Audit Committee that there were no disclosures related to excluded providers made since the last time the Audit Committee convened.

Mr. McNulty concluded his Report.

Ms. Youssouf thanked Mr. McNulty, and then indicated that the Committee was going into Executive Session. (Executive Session convened at 1:20pm and ended at 2:02pm).

In open session, Dr. Stocker stated that in Executive Session the Committee approved the Internal Audit Plan 2014, received the Compliance Report and received a report of the EITS Security Assessment Program.

There being no further business, the meeting was adjourned at 2:03 P.M

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of the City of New York)

Financial Statements

June 30, 2013 and 2012

(With Independent Auditors' Report Thereon)

Independent Auditors' Report

The Board of Directors
New York City Health and Hospitals Corporation:

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation (the Corporation), a component unit of the City of New York, as of and for the years ended June 30, 2013 and 2012, which collectively comprise the Corporation's basic financial statements 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 accordance 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 from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement. The financial statements of MetroPlus Health Plan, Inc., a discretely presented component unit, and HHC Insurance Company, Inc., a blended component unit, were not audited in accordance with *Government Auditing Standards*.

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

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

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation as of June 30, 2013 and 2012, and the respective changes in financial position, and where applicable, cash flows thereof for the year then ended in accordance with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the management's discussion and analysis on pages 3 through 14 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Emphasis of Matter

As discussed in note 1(q) to the financial statements, in 2013, the Corporation adopted GASB Statement No. 61, *The Financial Reporting Entity* that resulted in the 2012 financial statements being restated as a result of the retrospective adoption of this guidance. Our opinion is not modified with respect to this matter.

Other Reporting Required by *Government Auditing Standards*

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

Date

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Statements of Net Position

June 30, 2013 and 2012

(In thousands)

Assets		2013 Business Type Activities-HHC	2012 Business Type Activities-HHC	2011 Business Type Activities-HHC
Assets:				
Current assets	$	1,911,435	2,132,378	2,352,191
Capital assets, net		3,350,088	3,003,356	2,868,916
Other assets		166,471	258,248	322,239
Total assets		5,427,994	5,393,982	5,543,346
Liabilities:				
Current liabilities		1,717,687	1,432,788	1,428,226
Long-term debt, net of current installments		981,213	1,025,525	1,039,664
Postemployment benefits obligation, other than pension, net of current portion		4,574,865	4,382,843	4,181,084
Total liabilities		7,273,765	6,841,156	6,648,974
Net position:				
Net investement in capital assets		2,377,570	2,052,614	1,968,936
Restricted		146,786	169,771	165,979
Unrestricted		(4,370,127)	(3,669,559)	(3,240,543)
Total net position	$	(1,845,771)	(1,447,174)	(1,105,628)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Statements of Revenues, Expenses, and Changes in Net Position

Years ended June 30, 2013 and 2012

(In thousands)

	2013 Business Type Activities-HHC	2012 Business Type Activities-HHC	2011 Business Type Activities-HHC
Operating revenues:			
Net patient service revenue	$ 5,233,985	5,615,776	6,082,278
Appropriations from (remittances to) City of New York, net	(583)	(9,140)	27,593
Premium revenue	—	—	—
Grants revenue	566,019	249,252	212,984
Other revenue	45,915	71,239	47,515
Total operating revenues	5,845,336	5,927,127	6,370,370
Operating expenses:			
Personal services, fringes benefits, and employer payroll taxes	3,577,967	3,502,717	3,577,013
Other than personal services	1,443,697	1,410,017	1,393,476
Postemployment benefits, other than pension	293,745	299,850	611,561
Affiliation contracted services	915,581	884,436	857,467
Depreciation	282,345	259,045	254,458
Total operating expenses	6,513,335	6,356,065	6,693,975
Operating loss	(667,999)	(428,938)	(323,605)
Nonoperating expenses, net	(109,408)	(87,584)	(79,891)
Loss before other changes in net position	(777,407)	(516,522)	(403,496)
Other changes in net position:			
Capital contributions	378,810	174,977	200,270
Decrease in net position	(398,597)	(341,545)	(203,226)
Net position at beginning of year	(1,447,174)	(1,105,629)	(715,555)
Net position at end of year	$ (1,845,771)	(1,447,174)	(918,781)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Management's Discussion and Analysis (Unaudited)

June 30, 2013 and 2012

This section of New York City Health and Hospitals Corporation's (the Corporation) annual financial report presents management's discussion and analysis of the financial performance during the years ended June 30, 2013 and 2012. The purpose is to provide an objective analysis of the financial activities of the Corporation based on currently known facts, decisions, and conditions. Please read it in conjunction with the financial statements, which follow this section.

The financial statements of MetroPlus Health Plan, Inc. (MetroPlus), a component unit of the Corporation, are presented discretely from the Corporation; however the MD&A focuses primarily on the Corporation.

Overview of the Financial Statements

This annual report consists of two parts – management's discussion and analysis and the basic financial statements.

The basic financial statements include statements of net position, statements of revenues, expenses, and changes in net position, statements of cash flows, and notes to financial statements. These statements present, on a comparative basis, the financial position of the Corporation at June 30, 2013 and 2012, the end of the fiscal year, and the changes in net position and its financial activities for each of the years then ended. The statements of net position include all of the Corporation's assets and liabilities in accordance with U.S. generally accepted accounting principles. The statements of revenues, expenses, and changes in net position present each year's activities on the accrual basis of accounting, that is, when services are provided or obligations are incurred, not when cash is received or bills are paid. The financial statements also report the Corporation's net position and how they have changed. Net position, or the difference between assets and liabilities, is a way to measure the Corporation's financial health or position. The statements of cash flows provide relevant information about each year's cash receipts and cash payments and classify them as to operating, noncapital financing, capital and related financing, and investing activities. Notes to financial statements explain information in the statements and provide more detailed data.

Overall Financial Position and Operations

The Corporation's total net deficit position increased by $398.6 million from June 30, 2012 to June 30, 2013; it had increased by $341.5 million from June 30, 2011 to June 30, 2012. Net investment in capital assets increased by $325.0 million and $83.7 million in 2013 and 2012, respectively, as the Corporation continued to upgrade its facilities and pay down debt. The Corporation's unrestricted net deficit position increased to $4.370 billion at June 30, 2013 from $3.670 billion at June 30, 2012. The Corporation incurred an operating loss of $668.0 million in 2013 compared with $428.9 million in 2012. The Corporation's net deficit position benefited from $375.4 million and $173.6 million in capital contributions from The City of New York (The City) in 2013 and 2012, respectively.

Significant financial ratios are as follows:

	2013	2012	2011
Current ratio	1.11	1.49	1.65
Quick ratio	0.65	0.82	0.83
Days cash on hand	21.41	30.20	35.16
Net days revenue in patient receivables	68.38	65.93	59.48

The current ratio, quick ratio, and days cash on hand are common liquidity indicators. The Corporation's current ratio, quick ratio, and days cash on hand has decreased from 2012 to 2013 and decreased slightly from 2011 to 2012. The current ratio, quick ratio, and days cash on hand decreased from 2012 to 2013 and 2011 to 2012 as cash and cash equivalents decreased $134.9 million and $83.3 million, respectively. The net days revenue in patient receivables is an indicator of how quickly the Corporation collects its patient receivables.

Super Storm Sandy

The Corporation underwent a major effort to prepare for Super Storm Sandy (the Super Storm). Each of the HHC hospitals and the Corporation staffed and maintained command centers through the period beginning Friday, October 26th, 3 days prior to the Super Storm, and maintained these centers until after the subsequent nor'easter. During the Super Storm, patients were evacuated from Coney Island Hospital (Coney Island) and Bellevue Hospital (Bellevue). Medically fragile residents at the Coler campus of the Coler-Goldwater (Coler) Specialty Hospital and Nursing Facility were moved to the Goldwater campus. Several facilities were forced to rely on generators for power and steam.

Bellevue, Coney Island and Coler experienced major storm surge damage in basement, mechanical spaces and, in the case of Coney Island, first floor areas resulting in catastrophic failure of electric, heat, domestic cold and hot water, ventilation, information technology (IT) and communication systems. In addition, electrical distribution systems, electrical switches, network IT switches, oxygen and other medical gas distribution systems, medical vacuum systems, fuel pumps, steam pipe ejector pumps, domestic water pumps, circulatory heating pumps, air handling units, medical and surgical supplies, equipment, motors, life safety systems, vehicles, and emergency generators, were severely damaged or destroyed. Furthermore, other essential systems were disabled including nearly 40 elevators. Ida Israel, an offsite clinic of Coney Island Hospital, had its building flooded and appears to be irrecoverable.

Bellevue's basement housed the electrical, mechanical, medical gases, domestic water, pumps, and elevators in addition to serving as a major facility and supporting critical services such as labs and mortuary. Accordingly, when the basement was flooded in excess of 10 feet of water, all of these systems failed requiring evacuation. In addition, valuable contents were destroyed.

Flood waters washed through the entire first floor of Coney Island Hospital, requiring the removal of saturated sheetrock around the entire perimeter of the first floor and destroying a great deal of equipment which shut down the Emergency Department, imaging, pediatrics, and laboratory services. Moreover, Coney Island lost their electrical capacity which resulted in disabling the rest of the hospital.

Limited critical care services were opened at Bellevue in the middle of December and at Coney Island in the beginning of January. Coney Island began to accept new inpatients through the community in the middle of January. Bellevue was fully re-opened in February 2013, while Coney Island was mostly re-opened by July 2013.

Metropolitan Hospital's main building experienced basement flooding and the basement of Draper Hall, an administrative services building, was submerged, destroying the electrical and other systems that supported that building. Additionally, Harlem Hospital had roof damage, Queens Hospital had broken glass in its atrium and damage to revolving doors, Roberto Clemente, an offsite clinic of Gouverneur, sustained flood damage, and Neponsit, a building which is used by Elmhurst Hospital was severely damaged as well. Jacobi Medical Center also had downed trees, façade damage and roadway debris, while North Central Bronx Hospital sustained blown out windows and damage to the doors. Also, a rental facility in the Rockaways which housed the Neponsit Adult Day Care program was destroyed including contents. Central Office divisions, MetroPlus, and Home Care offices were displaced and required temporary housing for an extended period.

Immediately following the storm, New York City appropriated $300 million which was later increased to $710 million to ensure that the Corporation would have the cash flow needed as it processes its application for public assistance through the Federal Emergency Management Agency (FEMA). In addition, New York City allocated $183 million in Community Development Block Grant funds to support operational expenses not covered by FEMA.

FEMA public assistance is expected to cover the costs to repair or replace facilities to pre-storm conditions and to make improvements to meet codes and standards. The FEMA 406 mitigation program will further fund mitigation measures that would prevent further damage if those measures are proven to be cost effective. FEMA has obligated funds of $142 million, of which $62 million in cash was advanced to the Corporation as of June 30, 2013. The FEMA application process is ongoing and is extremely detailed and time consuming.

Variances in Financial Statements

In this section, the Corporation explains the reasons for certain financial statement items with variances relating to 2013 amounts compared to 2012 and, where appropriate, 2012 amounts compared to 2011.

Balance Sheets

Cash and cash equivalents – decreased $134.9 million from June 30, 2012 to June 30, 2013 due to reduced cash receipts from temporary hospital closures due to Super Storm Sandy and decreased patient volume. Cash and cash equivalents decreased $83.3 million from June 30, 2011 to June 30, 2012 due to payment of amounts due The City for 2011 and the cost of additional fringe benefits.

Patient accounts receivable, net – increased $80.9 million from 2012 to 2013 due to an increase in the MetroPlus risk pool receivable of $104.2 million. Patient accounts receivable, net increased $66.7 million from 2011 to 2012 due to inpatient delayed third party payments and outpatient increased revenue not yet collected.

Estimated third-party payor settlements, net – increased $266.0 million from June 30, 2012 to June 30, 2013 due to the timing of receipt of $434.2 million of State Fiscal Year 2012 inpatient UPL during 2012 and no cash received during 2013. Estimated third-party payor settlement net decreased $74.8 million June 30, 2011 to June 30, 2012 primarily due to collections of prior year's receivables.

Estimated pools receivable (payable), net – estimated pools receivable, net, decreased $529.7 million and changed from a receivable to a payable from June 30, 2012 to June 30, 2013 primarily due to the receipt of State Fiscal Years' 2014 DSH and DSH Max and the remainder of the State Fiscal Year 2013 receivable. Estimated pools receivable, net, decreased $276.9 million from June 30, 2011 to June 30, 2012 primarily due to the receipt of State Fiscal Year's 2011 and 2012 DSH Max and a reduction to the State Fiscal Year 2012 allocation.

Grants receivable – increased $193.0 million from June 30, 2012 to June 30, 2013 due to an accrual of $194.4 million in FEMA and CDBG revenues related to expenses incurred in the restoration of facilities after Super Storm Sandy. Grants receivable increased $35.8 million from 2011 to 2012 due to the timing of payments for the Medicaid Administration grant ($18.6 million) and HEAL NY program ($12.3 million).

Assets restricted as to use – decreased $106.5 million from June 30, 2012 to June 30, 2013 as $83.5 million of the Construction Fund was used for capital projects and the capital reserve fund decreased as a result of the 2013 bond refunding. Assets restricted as to use decreased $60.0 million from June 30, 2011 to June 30, 2012 due to use of the Construction Fund for various capital projects.

Other current assets – decreased $74.2 million from June 30, 2012 to June 30, 2013, as HHC received FICA refunds due to medical residents during 2013. Other current assets increased $115.9 million from June 30, 2011 to June 30, 2012 due to accrued medical resident FICA refunds in the amount of $94.2 million and increase in the amounts owed under affiliation agreements in the amount of $11.7 million.

Capital assets, net – increased $346.7 million from 2012 to 2013 and $134.4 million from 2011 to 2012. This was due to major modernization projects at Harlem Hospital Center and Gouverneur Healthcare Services, as well as entering into a capital lease and construction on the Henry J. Carter Center property (see note 7(k) to the financial statements). In addition, for 2013, net assets of $132.6 million increased for the restoration of affected facilities from Super Storm Sandy, net of related asset impairments.

Accrued salaries, fringe benefits, and payroll taxes – is consistent from June 30, 2012 to June 30, 2013. Accrued salaries, fringe benefits, and payroll taxes decreased $20.0 million from June 30, 2011 to June 30, 2012 due to decreases in prior year collective bargaining estimates offset by increases in accrued health benefits.

Accounts payable and accrued expenses – increased $41.5 million from June 30, 2012 to June 30, 2013 due to the increase in accrued expenses related to Super Storm Sandy. Accounts payable and accrued expenses increased $17.9 million from June 30, 2011 to June 30, 2012 primarily due to increases in affiliate physician fringe benefits of $7.3 million, pollution remediation payable increase of $2.7 million, and an increase in per diem nurses payable of $5.9 million.

Due to City of New York – increased $264.9 million from June 30, 2012 to June 30, 2013 as the Corporation and The City agreed to delay payments to maintain adequate cash flows. Due to the City decreased $35.7 million from June 30, 2011 to June 30, 2012 primarily due to the decrease in medical malpractice during 2012.

Long-term debt – decreased $61.8 million from June 30, 2012 to June 30, 2013 due to the payment of current debt obligations and the current refunding of debt (see note 7 to the financial statements). Long-term debt decreased $13.1 million from June 30, 2011 to June 30, 2012 primarily due to the payment of current debt

obligations during fiscal year 2012 and offset by the recording of the Henry J. Carter capital lease (see note 7 to the financial statements).

Postemployment benefits obligation, other than pension – increased $196.7 million from June 30, 2012 to June 30, 2013 and increased $207.0 million from June 30, 2011 to June 30, 2012 as the Corporation recognized its annual OPEB costs as determined by the New York City Office of the Actuary (see note 10 to the financial statements).

Other current liabilities – decreased $14.2 million from June 30, 2012 and June 30, 2013 for FICA refunds paid to medical residents. Other Current Liabilities increased $36.1 million from June 30, 2011 and June 30, 2012 and represents amounts owed to medical residents for FICA refunds.

Changes in Components of Net Position

Net investment in capital assets – increased $325.0 million from June 30, 2012 to June 30, 2013 as capital assets, net, increased by $346.7 million, related assets restricted as to use decreased by $83.5 million, and related debt decreased by $61.8 million. Invested in capital assets, net of related debt increased $83.7 million from June 30, 2011 to June 30, 2012 as capital assets, net, increased by $134.4 million, related assets restricted as to use decreased by $63.8 million, and related debt decreased by $13.1 million.

Restricted – decreased $23.0 million from June 30, 2012 to June 30, 2013 as a result of a current refunding of debt during 2013. Restricted net assets increased $3.8 million from June 30, 2011 to June 30, 2012 due to $4.3 million increase in the revenue fund under bond resolution.

Unrestricted – net position activities, other than those mentioned above, resulted in decreases of $700.6 million and $459.0 million for years 2013 and 2012, respectively. Please see the statements of revenues, expenses, and changes in net position.

Capital Assets, Net and Long-Term Debt Activity

Capital Assets, Net

At June 30, 2013, the Corporation had capital assets, net of accumulated depreciation, of $3.350 billion compared to $3.003 billion at June 30, 2012 and $2.869 billion at June 30, 2011, representing an increase of 11.6% from 2012 to 2013 and 4.7% from 2011 to 2012, as shown in the table below (in thousands of dollars):

		2013	2012	2011
Land and land improvements	$	28,460	24,160	24,445
Buildings and leasehold improvements		2,021,122	1,601,186	1,639,743
Equipment		699,942	703,728	698,499
Construction in progress		600,564	674,282	506,230
Total	$	3,350,088	3,003,356	2,868,917

The Corporation incurred a significant physical damage to Bellevue Hospital Center and Coney Island Hospital as a result of Super Storm Sandy. The hospitals' were unable to service patients, and as such, there was a temporary loss of service utility. Using the restoration cost approach, the Corporation recorded a loss from impairment of assets of approximately $12.0 million to recognize the service utility loss in 2013.

2013's major capital asset additions included:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional spending of approximately $51.2 million in 2013
- Construction continued on the major modernization of Harlem Hospital Center, with additional spending of approximately $40.0 million in 2013
- Construction continued on the major modernization of Henry J. Carter Center, with additional spending of $126.9 million in 2013
- Restoration and reconstruction as a result of damage sustained from the storm at Bellevue Hospital Center, Coney Island Hospital, and Coler-Goldwater Memorial Hospital, with spending of $153 million in 2013.

2012's major capital asset additions included:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional spending of approximately $36.9 million in 2012
- Construction continued on the major modernization of Harlem Hospital Center, with additional spending of approximately $42.4 million in 2012
- Construction on the major modernization of Henry J. Carter Center with approximate spending of $28.2 million in 2012 and entering into a capital lease in the amount of $48.3 million

2011's major capital asset additions included:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional spending of approximately $41.2 million in 2011
- Construction continued on the major modernization of Harlem Hospital Center, with additional spending of approximately $66.5 million in 2011

The Corporation's 2014 capital budget projects spending of $662 million, which includes continuation of work on the major construction mentioned above. The 2014 capital budget is expected to be primarily financed by the Corporation's 2010 Series A bonds mentioned in note 7 to the financial statements, City General Obligation and Transitional Finance Authority Bonds, and other City funding.

More detailed information about the Corporation's capital assets is presented in note 5 to the financial statements.

Long-Term Debt

At June 30, 2013, the Corporation has approximately $1.0 billion in long-term debt financing relating to its capital assets, as shown with comparative amounts at June 30, 2012 and 2011 (in thousands of dollars):

		2013	2012	2011
Bonds payable	$	951,789	1,024,385	1,080,524
Capital lease obligation		—	75	175
New York Power Authority (NYPA) financing		1,465	2,101	3,050
Equipment and renovation financing		998	1,923	3,928
Clinical bed financing		4,637	6,866	8,983
North General capital lease obligation		48,258	48,258	—
New Market Tax Credit		14,700	—	—
Total	$	1,021,847	1,083,608	1,096,660

Since 2008, the Corporation in its refinancing efforts has reduced all of its insured bonds. Currently, the Corporation's debt is 82% uninsured fixed and 18% variable secured by letters of credit. The Corporation is rated Aa3, A+, and A+ by Moody's, S&P's, and Fitch, respectively. As of August 26, 2013, the variable rate bonds are secured by TD Bank's and JPMorgan Chase Bank's letters of credit. The Moody's, S&P's, and Fitch long-term/short-term ratings for TD Bank and JPMorgan Chase Bank are Aa3/P-1, AA-/A-1+, and AA-/F1+ and Aa3/P-1, A+/A-1, and A+/F1, respectively. There are no statutory debt limitations that may affect the Corporation's financing of planned facilities or services.

On March 28, 2013, the Corporation issued $112,045,000 of tax-exempt fixed rate Health System Bonds, 2013 Series A bonds (the 2013 Bonds). This issuance generated a premium of $21,422,488. This bond issue included $112,045,000 of 3.0% to 5.0% uninsured serial bonds, due February 15, 2016 through February 15, 2023 with interest payable on February 15 and August 15. The overall weighted average interest rate was 2.44%.

Proceeds of the 2013 Bonds and residual funds from the 2008 Series A bonds were used: (i) to refund and redeem all of the Corporation's 2003 Series A bonds; (ii) to refund and defease a portion of the Corporation's 2008 Series A bonds and (iii) to pay cost of issuance.

The Corporation completed the current refunding of the 2003 Series A bonds and the advance refunding of the 2008 Series A bonds to reduce its total debt service payments over the next 10 years by $23,026,587 and to obtain an economic gain (difference between the present values of the old and new debt service payments) of $21,904,183.

More detailed information about the Corporation's long-term debt is presented in note 7 to the financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Management's Discussion and Analysis (Unaudited)
June 30, 2013 and 2012

Statements of Revenues, Expenses, and Changes in Net Position

Net patient service revenue – decreased $381.8 million from June 30, 2012 to June 30, 2013 reflecting the revenue impact from the temporary closing of Bellevue Hospital Center ($153.9 million) and Coney Island Hospital ($110.7 million) and revenue losses associated with reduced inpatient census and outpatient visits for the remaining facilities of $152.9 million. Additional UPL revenue of $28.8 million was also recognized. Net patient service revenue decreased $466.5 million from June 30, 2011 to June 30, 2012 reflecting the following: 1) decreased outpatient UPL revenue of $84.8 million; 2) decreased DSH Maximization of $138.3 million 3) decreased Supplemental Medicaid Managed Care funds of $84.5 million and 4) additional reserve for HMO Graduate Medical Education Case Mix adjustment of $36.0 million and 5) patient service revenue decreases from lower inpatient census and outpatient visits.

Appropriations from (remittances to) City of New York, net – increased $8.5 million from June 30, 2012 to June 30, 2013 due to an increase of $6.4 million in debt service payable to The City offset by an increase of $18.2 million in interest expense paid by The City for HHC. Appropriations from (remittances to) City, net, decreased $36.7 million from June 30, 2011 to June 30, 2012 due to an increase of $31.1 million in debt service payable to The City.

Grants revenue – increased $316.8 million from June 30, 2012 to June 30, 2013 due to $57.2 million in federal and state incentive payments for meaningful use of certified electronic health record technology and $194.4 million in FEMA and CDBG revenue for Super Storm Sandy expenses. Grants revenue increased $36.3 million from June 30, 2011 to June 30, 2012 due to the addition of prisoner and uniform grants.

Other revenue – decreased $25.3 million from June 30, 2012 to June 30, 2013 due to nonrecurrence of interest earned on the medical resident FICA refunds recorded in 2012. Other revenue increased $23.7 million from June 30, 2011 to June 30, 2012 due to interest earned on the medical resident FICA refunds.

Personal services – increased $22.5 million, or approximately 0.1%, from June 30, 2012 to June 30, 2013 due to reductions of 932 employee full-time equivalents (FTEs) or 2.6% and the reduction to prior year collective bargaining estimates in 2012. Personal services decreased $149.3 million, or approximately 5.9%, from June 30, 2011 to June 30, 2012 primarily due to decreases in prior year collective bargaining estimates and reductions of 528 employee full-time equivalents (FTEs) or 1.4%.

Other-than-personal services – increased $33.7 million, or 2.4%, from June 30, 2012 to June 30, 2013 due to the costs related to restoration services after Super Storm Sandy. Other-than-personal services was consistent from June 30, 2011 to June 30, 2012.

Fringe benefits and employer payroll taxes – increased $52.8 million from June 30, 2012 to June 30, 2013 due to the nonrecurrence of $30.5 million of medical resident FICA refunds and increases in health benefit costs of $36.6 million or 7.4%. Fringe benefits and employer payroll taxes decreased $75.0 million from June 30, 2011 to June 30, 2012 primarily for health benefit increases of $34.8 million or 7.6% and pension increase of $92.2 million or 27.8% offset by $30.5 million of medical resident FICA refunds.

Postemployment benefits, other than pension – decreased $6.1 million from June 30, 2012 to June 30, 2013 and decreased $311.7 million from June 30, 2011 to June 30, 2012 as determined by the New York City Office of the Actuary, and is mainly due to assumptions for healthcare cost trends being updated to reflect recent past

experience, and anticipated future experience, including the enactment of National Health Care Reform (see note 10 to the financial statements).

Affiliation contracted services – increased $31.1 million or 3.5% from June 30, 2012 to June 30, 2013 and increased $27.0 million or 3.1% from June 30, 2011 to June 30, 2012 due to market adjustments and enhanced services.

Investment income – decreased $9.4 million from June 30, 2012 to June 30, 2013 as the Corporation recognized the market value of the 2003 bond reserve fund decrease. Investment income is consistent from 2011 to 2012.

Capital contributions funded by City of New York – increased $201.8 million from June 30, 2012 to June 30, 2013 for continued major modernization projects. Capital contributions funded by City of New York decreased $24.6 million from June 30, 2011 to June 30, 2012 due to additional capital funding sources available from the HEAL grant (Health Care Efficiency and Affordability Law of New York State) and HHC's 2010 bond proceeds.

Corporation Issues and Challenges

The Corporation continues to adapt to the ever-increasing fiscal challenges placed on health care institutions in the New York City area. Specifically, these challenges include:

- Reduced Medicaid and Medicare reimbursements due to State and Federal budget cuts;
- Ability of New York City to increase capital and expense funding;
- Implementation of the new Health Care Exchanges and its effect on the uninsured; and
- Continued penetration of managed care and accountable care in the market place.

The Corporation has responded to these challenges by continuing to pursue cost reduction strategies that include: 1) contracting for the management of dietary, environmental, plant maintenance, and biomedical engineering services; 2) entering into a strategic partnership with another health system to provide laboratory services; and 3) centralizing procurement. Also, the Corporation has engaged in restructuring activities to consolidate long term care services, convert the designation of its diagnostic and treatment centers into federally qualified health center look-alike status, and further regionalize services. Additionally, the Corporation has created an Accountable Care Organization which is participating in the Medicare shared savings program and the Corporation is in the process of installing a new electronic medical record (EMR) – the EPIC system. All these changes are designed to assist the Corporation to compete in a more difficult environment.

Contacting the Corporation's Financial Management

This financial report provides the citizens of the City, HHC's patients, bondholders, and creditors with a general overview of the Corporation's finances and operations. If you have questions about this report or need additional financial information, please contact Ms. Marlene Zurack, Senior Vice President – Finance, New York City Health and Hospitals Corporation, 160 Water Street, Room 1014, New York, New York 10038.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Statements of Net Position
June 30, 2013 and 2012
(In thousands)

Balances as Restated (see note 1q)

Assets	2013 Business Type Activities-HHC	2013 Discretely Presented Component Unit-MetroPlus	2013 Eliminations	2013 Total	2012 Business Type Activities-HHC	2012 Discretely Presented Component Unit-MetroPlus	2012 Eliminations	2012 Total
Current assets:								
Cash and cash equivalents (note 2)	$ 360,579	703,306	—	1,063,885	495,467	493,140	—	988,607
U.S. government securities	—	81,671	—	81,671	—	113,950	—	113,950
Patient accounts receivable, net (notes 4, 7, and 11)	760,513	—	(309,043)	451,470	679,622	—	(208,320)	471,302
Premiums receivable	—	103,418	(1,299)	102,119	—	123,104	(1,273)	121,831
Estimated third-party payor settlements, net (notes 4, 7, and 11)	668,100	—	(58,275)	609,825	402,100	—	(64,322)	337,778
Estimated pools receivable, net (notes 4, 7, and 11)	(296,900)	—	—	(296,900)	232,800	—	—	232,800
Grants receivable	305,479	—	—	305,479	112,519	—	—	112,519
Supplies	19,116	—	—	19,116	24,240	—	—	24,240
Assets restricted as to use and required for current liabilities (notes 6 and 7)	37,283	—	—	37,283	54,185	—	—	54,185
Other current assets	57,265	3,234	—	60,499	131,445	3,645	—	135,090
Total current assets	1,911,435	891,629	(368,617)	2,434,447	2,132,378	733,839	(273,915)	2,592,302
Assets restricted as to use, net of current portion (notes 6 and 7)	158,863	84,345	—	243,208	248,484	65,896	—	314,380
U.S. government securities	—	32,372	—	32,372	—	—	—	—
Capital assets, net (notes 5 and 7)	3,350,088	7,485	—	3,357,573	3,003,356	6,608	—	3,009,964
Deferred financing costs, net	7,608	—	—	7,608	9,764	—	—	9,764
Total assets	$ 5,427,994	1,015,831	(368,617)	6,075,208	5,393,982	806,343	(273,915)	5,926,410
Liabilities and Net Position								
Current liabilities:								
Current installments of long-term debt (note 7)	$ 40,634	—	—	40,634	58,083	—	—	58,083
Accrued salaries, fringe benefits, and payroll taxes	729,681	10,081	(1,299)	738,463	724,225	9,166	(1,273)	732,118
Accounts payable and accrued expenses (notes 12 and 14)	385,904	512,721	(367,318)	531,307	344,427	418,119	(272,642)	489,904
Due to City of New York, net (note 8)	436,591	—	—	436,591	171,653	—	—	171,653
Current portion of postemployment benefits obligation, other than pension (note 10)	103,003	2,177	—	105,180	98,285	1,415	—	99,700
Other current liabilities	21,874	—	—	21,874	36,115	—	—	36,115
Total current liabilities	1,717,687	524,979	(368,617)	1,874,049	1,432,788	428,700	(273,915)	1,587,573
Long-term debt, net of current installments (note 7)	981,213	—	—	981,213	1,025,525	—	—	1,025,525
Postemployment benefits obligation, other than pension, net of current portion (note 10)	4,574,865	43,489	—	4,618,354	4,382,843	39,310	—	4,422,153
Total liabilities	7,273,765	568,468	(368,617)	7,473,616	6,841,156	468,010	(273,915)	7,035,251
Commitments and contingencies (note 11)								
Net position:								
Net investement in capital assets	2,377,570	7,514	—	2,385,084	2,052,614	6,639	—	2,059,253
Restricted:								
For debt service	134,776	—	—	134,776	159,714	—	—	159,714
Expendable for specific operating activities	11,082	—	—	11,082	9,129	—	—	9,129
Nonexpendable permanent endowments	928	—	—	928	928	—	—	928
For statutory reserve requirements	—	84,345	—	84,345	—	65,896	—	65,896
Unrestricted	(4,370,127)	355,504	—	(4,014,623)	(3,669,559)	265,798	—	(3,403,761)
Total net position	(1,845,771)	447,363	—	(1,398,408)	(1,447,174)	338,333	—	(1,108,841)
	$ 5,427,994	1,015,831	(368,617)	6,075,208	5,393,982	806,343	(273,915)	5,926,410

See accompanying notes to financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Statements of Revenues, Expenses, and Changes in Net Position

Years ended June 30, 2013 and 2012

(In thousands)

Balances as Restated (see note 1q)

	2013				2012			
	Business Type Activities-HHC	Discretely Presented Component Unit - Metroplus	Eliminations	Total	Business Type Activities-HHC	Discretely Presented Component Unit - Metroplus	Eliminations	Total
Operating revenues:								
Net patient service revenue (notes 4 and 7)	$ 5,233,985	—	(742,199)	4,491,786	5,615,776	—	(705,976)	4,909,800
Appropriations from (remittances to) City of New York, net (note 11)	(583)	—	—	(583)	(9,140)	—	—	(9,140)
Premium revenue (note 13)	—	2,201,790	(17,217)	2,184,573	—	1,907,877	(15,881)	1,891,996
Grants revenue	566,019	—	—	566,019	249,252	(25)	—	249,227
Other revenue	45,915	5	—	45,920	71,239	32	—	71,271
Total operating revenues	5,845,336	2,201,795	(759,416)	7,287,715	5,927,127	1,907,884	(721,857)	7,113,154
Operating expenses:								
Personal services	2,409,926	53,956	—	2,463,882	2,387,461	47,920	—	2,435,381
Other than personal services	1,443,697	2,006,799	(742,199)	2,708,297	1,410,017	1,750,837	(705,976)	2,454,878
Fringe benefits and employer payroll taxes	1,168,041	24,828	(17,217)	1,175,652	1,115,256	22,842	(15,881)	1,122,217
Postemployment benefits, other than pension (note 10)	293,745	6,212	—	299,957	299,850	3,315	—	303,165
Affiliation contracted services	915,581	—	—	915,581	884,436	—	—	884,436
Depreciation (note 5)	282,345	2,341	—	284,686	259,045	1,862	—	260,907
Total operating expenses	6,513,335	2,094,136	(759,416)	7,848,055	6,356,065	1,826,776	(721,857)	7,460,984
Operating (loss) income	(667,999)	107,659	—	(560,340)	(428,938)	81,108	—	(347,830)
Nonoperating revenues (expenses):								
Investment income	1,088	1,367	—	2,455	10,502	1,476	—	11,978
Interest expense	(112,568)	—	—	(112,568)	(98,678)	—	—	(98,678)
Contributions restricted for specific operating activities	2,072	—	—	2,072	592	—	—	592
Total nonoperating (expenses) revenues, net	(109,408)	1,367	—	(108,041)	(87,584)	1,476	—	(86,108)
(Loss) income before other changes in net position	(777,407)	109,026	—	(668,381)	(516,522)	82,584	—	(433,938)
Other changes in net position:								
Capital contributions funded by City of New York	375,386	4	—	375,390	173,608	2	—	173,610
Capital contributions funded by grantors and donors	3,424	—	—	3,424	1,369	—	—	1,369
Total other changes in net position	378,810	4	—	378,814	174,977	2	—	174,979
(Decrease) increase in net position	(398,597)	109,030	—	(289,567)	(341,545)	82,586	—	(258,959)
Net position at beginning of year - as restated (see note 1(q))	(1,447,174)	338,333	—	(1,108,841)	(1,105,629)	255,747	—	(849,882)
Net position at end of year	$ (1,845,771)	447,363	—	(1,398,408)	(1,447,174)	338,333	—	(1,108,841)

See accompanying notes to financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Statements of Cash Flows

Years ended June 30, 2013 and 2012

(In thousands)

	2013	2012
	Business Type Activities-HHC	**Business Type Activities-HHC**
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 4,769,271	5,303,493
Cash appropriations received from City of New York	299,629	126,688
Cash appropriations remitted to City of New York	(127,271)	(169,484)
Cash received from premiums and stop-loss insurance recoveries	—	—
Receipts from grants	373,059	213,450
Other receipts	121,370	34,718
Cash paid for personal services, fringe benefits, and employer payroll taxes	(3,688,906)	(3,630,772)
Cash paid for other than personal services	(644,299)	(815,662)
Cash paid for affiliation contracted services	(924,984)	(888,891)
Net cash provided by operating activities	177,869	173,540
Cash flows from noncapital financing activity:		
Proceeds from contributions restricted for specific operating activities	2,072	592
Net cash provided by noncapital financing activity	2,072	592
Cash flows from capital and related financing activities:		
Purchase of capital assets	(601,975)	(302,315)
Capital contributions by grantors and donors	3,424	1,369
Capital contributions by City of New York	375,386	173,608
Cash paid for retainage and construction accounts payable	(1,458)	(871)
Payments of long-term debt	(67,443)	(57,001)
Proceeds from issuance of long-term debt	148,167	—
Refunding of long-term debt	(142,485)	—
Cash paid for deferred financing costs	(2,156)	—
Interest paid	(142,554)	(143,338)
Net cash used in capital and related financing activities	(431,094)	(328,548)
Cash flows from investing activities:		
Purchases of assets restricted as to use	(90,325)	(164,975)
Sales of assets restricted as to use	199,578	237,457
Cash invested in U.S. government securities	—	—
Cash received from sales and maturities of U.S. government securities	—	—
Loan repayments from affiliates	—	—
Interest received	7,012	(1,379)
Net cash provided by (used in) investing activities	116,265	71,103
Net increase in cash and cash equivalents	(134,888)	(83,313)
Cash and cash equivalents at beginning of year	495,467	578,780
Cash and cash equivalents at end of year	$ 360,579	495,467
Supplemental disclosures:		
Capital lease incurred	$ —	48,258
Change in fair value of assets restricted as to use	(2,730)	6,263

(Continued)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Statements of Cash Flows

Years ended June 30, 2013 and 2012

(In thousands)

	2013	2012
	Business Type Activities-HHC	**Business Type Activities-HHC**
Reconciliation of operating loss to net cash provided by operating activities:		
Operating loss	$ (667,999)	(428,938)
Adjustments to reconcile operating loss to net cash provided by operating activities:		
Depreciation	282,345	259,045
Provision for bad debts	329,416	591,934
Changes in assets and liabilities:		
Patient accounts receivable, net	(410,307)	(658,627)
Premiums receivable	—	—
Estimated third-party payor settlements, net	(266,000)	74,800
Estimated pools receivable (payable), net	529,700	276,875
Grants receivable	(192,960)	(35,777)
Supplies and other current assets	79,304	(110,346)
Accrued salaries, fringe benefits, and payroll taxes	5,456	(20,042)
Accounts payable and accrued expenses	41,477	17,898
Due to City of New York	264,938	(35,721)
Other liabilities	(14,241)	36,115
Postemployment benefits obligation, other than pension	196,740	209,037
Net cash provided by operating activities	$ 177,869	176,253

See accompanying notes to financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Notes to Financial Statements
June 30, 2013 and 2012

(1) Summary of Significant Accounting Policies.

Organization

On July 1, 1970, the New York City Health and Hospitals Corporation (the Corporation), a New York State (the State) public benefit corporation created by Chapter 1016 of the Laws of 1969, assumed responsibility for the operation of the municipal hospital system of the City of New York (the City) pursuant to an agreement with the City dated June 16, 1970 (the Agreement). As a main element of its core mission, the Corporation provides, on behalf of the City, comprehensive medical and mental health services to City residents regardless of ability to pay. The Corporation operates eleven acute care hospitals, five long-term care facilities, five freestanding diagnostic and treatment centers, many hospital-based and neighborhood clinics, a certified home health agency, and MetroPlus Health Plan, Inc. (MetroPlus), a prepaid health services provider (PHSP). The Corporation's facilities are organized into seven vertically integrated healthcare networks that provide the full continuum of care – primary and specialty care, inpatient acute, outpatient, long-term care, and home health services – under a single medical and financial management structure. The networks were established to improve efficiencies through interfacility coordination.

The Corporation is a component unit of the City, and accordingly, its financial statements are included in the City's Comprehensive Annual Financial Report.

The accompanying financial statements include the operation of the following component units which are blended with the accounts of the Corporation:

- HHC Capital Corporation (HHC Capital) was created by the Corporation as a public benefit corporation, of which the Corporation is the sole member, in 1993 in order to secure its 1993 Series A bonds. The sole purpose of HHC Capital is to accept all payments assigned to it by the Corporation and its providers and remit monthly, from such assigned payments, amounts required for debt service on the 2002, 2003, 2008, 2010 and 2013 Bond issues to the bond trustee, with the balance transferred to the Corporation.

- HHC Insurance Company, Inc. (HHC Insurance) was created by the Corporation as a public benefit corporation, of which the Corporation is the sole member, in 2003. HHC Insurance is a domestic captive insurance company that underwrites medical malpractice insurance for the Corporation's attending physicians practicing in the areas of Neurosurgery, Obstetrics, and Gynecology. HHC Insurance also provides excess insurance coverage through the New York State Excess Liability Pool (State Pool). HHC Insurance obtained its license from the New York State Department of Insurance to commence operations on December 15, 2004.

  HHC Insurance commenced operations on January 1, 2005. HHC Insurance provides the insured with indemnity insurance coverage on a claims-made basis for the first $1.3 million per incident and $3.9 million in the aggregate on each claim. With the existence of this insurance coverage, the insured is able to access $1.0 million per incident and $3.0 million in the aggregate of excess insurance coverage provided by the Medical Malpractice Insurance Pool of New York (MMIP) for each claim greater than $1.3 million per incident and $3.9 million in the aggregate. During 2007, HHC Insurance began participation in MMIP. MMIP is the insurer of last resort for medical malpractice coverage in the State and is a joint underwriting facility, not a separate legal entity. The

members of MMIP are all the licensed medical malpractice carriers in New York State. As an MMIP member, HHC Insurance recognizes its allocable share of the premium, loss, underwriting expense, and administrative expense activities of MMIP.

- During 2003, the HHC Physicians Purchasing Group, Inc. (HHC Physicians), a public benefit corporation, was formed to purchase medical malpractice insurance for the Corporation's physicians from HHC Insurance. The Corporation is the sole member of HHC Physicians. HHC Physicians is registered and approved for operations by the New York State Department of Insurance on August 31, 2005.
- HHC Risk Services Corporation (HHC Risk), a public benefit corporation, was granted a license on December 30, 2003 to operate by the Vermont Department of Banking, Insurance, Securities and Health Care Administration. The Corporation is the sole member of HHC Risk. HHC Risk is inactive.

  The creation of HHC Insurance, HHC Physicians, and HHC Risk by the Corporation does not alter the indemnification by the City of the Corporation's malpractice settlements under the Agreement (see note 11(b)).

- During June 2012, HHC ACO Inc., a wholly owned subsidiary public benefit corporation of HHC was formed as an Accountable Care Organization (ACO) for purposes of applying to the federal Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare Shared Savings Program (MSSP).

  An ACO is a healthcare reform model authorized in the Patient Protection and Affordable Care Act of 2010, involving groups of doctors, hospitals, and other healthcare providers to collaboratively coordinate high-quality care to the patients they serve. When an ACO succeeds in delivering high-quality care at lower cost, it will share in the savings it achieves for the Medicare program, which savings are then distributed among the ACO participants. The MSSP (also authorized by the Patient Protection and Affordable Care Act) is a three-year program in which ACOs will be responsible for the care of a defined group of Medicare Fee-For-Service beneficiaries.

- In October 2012, the Corporation formed the HHC Assistance Corporation (HHCAC) which is a not-for-profit corporation that is closely affiliated with the Corporation. All members of HHCAC's board of directors are officers of the Corporation. The HHCAC's purpose is to perform activities that are helpful to the Corporation in the fulfillment of its statutory purposes. During 2012, the HHCAC facilitated the Corporation's participation in a New Market Tax Credit supplementary financing transaction that is projected to produce a net benefit to the Corporation of $3.4 Million to be used for the construction of certain new facilities at the Harlem Hospital Center.

The Corporation is the sole corporate member and appoints a voting majority of the governing board of each of the blended component units. Each of the blended component units provide services exclusively or almost exclusively to the Corporation.

The financial statements also include MetroPlus which is presented as a discretely presented component unit. MetroPlus is a public benefit corporation created by the Corporation. The Corporation is the sole member. MetroPlus contracts primarily with Corporation facilities for the purpose of providing managed

healthcare services on a prepaid basis and establishing and operating organized healthcare maintenance and delivery systems. MetroPlus has a contractual agreement with the New York State Department of Health, Division of Healthcare Access, to provide comprehensive medical services to Medicaid recipients (members). Additionally, Corporation employees can elect MetroPlus healthcare coverage as part of their employee benefits. MetroPlus provides Child Health Plus (CHP), Family Health Plus (FHP), and HIV Special Needs Plan (HIV-SNP) coverage through a State Department of Health (DOH) contract. MetroPlus has contracted with Centers for Medicare & Medicaid Services (CMS) and DOH to offer Medicare coverage to individuals, who are dually eligible for benefits under Medicare and New York State Medicaid. Beneficiaries have the option of selecting MetroPlus or the State as their Medicaid coverage provider.

MetroPlus and HHC Insurance issue separate statutory annual financial statements as of December 31st, which are available through the Office of the Corporate Comptroller, 160 Water Street, Room 636, New York, New York 10038.

The Corporation's significant accounting policies are as follows:

(a) Basis of Presentation

All significant intercompany balances and transactions between the Corporation and the blended component units have been eliminated within the business type activities column. All significant intercompany balances and transactions between the Corporation and MetroPlus have been eliminated in the elimination column.

MetroPlus is included as a discretely presented component unit.

Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

(b) Assets Restricted as to Use

Assets restricted as to use primarily include assets held by a trustee under bond resolutions and statutory reserve investments. Amounts required to meet current liabilities of the Corporation have been classified as current assets in the balance sheets at June 30, 2013 and 2012. Assets restricted as to use are stated at fair value, which approximates cost, with unrealized gains and losses included in investment income.

Donor-restricted net assets are used to differentiate resources, the use of which is restricted by donors, from resources of unrestricted assets on which donors or grantors place no restriction or that arise as a result of the operations of the Corporation for its stated purposes. Donor-restricted net assets represent contributions to provide healthcare services, of which $928,000 are held in perpetuity at June 30, 2013 and 2012. Resources restricted by donors for plant replacement and expansion are recognized as capital contributions and are added to the net investment in capital assets, net position balance to the extent expended within the period. Resources restricted by donors for specific operating activities are reported as nonoperating revenue. The Corporation utilizes

available donor-restricted assets on a limited basis before utilizing unrestricted resources for expenses incurred.

(c) Charity Care

The Corporation provides care to patients who meet certain criteria under its charity care policy at amounts less than its charges or established rates. The Corporation does not pursue collection of amounts determined to qualify as charity care, and they are not reported as revenue.

(d) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates. Excluding the change in estimate pertaining to net patient service revenue (see note 4), the change in estimate relating to collective bargaining was a net decrease to fringe benefits and employer payroll taxes for approximately $47.5 million for the year ended June 30, 2012. There was no such change for the year ended June 30, 2013.

(e) Statements of Revenues, Expenses, and Changes in Net Position

All transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are considered to be operating activities and are reported as operating revenues and operating expenses. Investment income, interest expense, and peripheral or incidental transactions are reported as nonoperating revenues and expenses. Other changes in net position, which are excluded from income or loss before other changes in net position, consist of contributions of capital assets funded by The City, grantors, and donors.

(f) Patient Accounts Receivable and Net Patient Service Revenue

The Corporation has agreements with certain third-party payors that provide for payments at amounts different from its charges or established rates. Payment arrangements include prospectively determined rates, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated third-party payor settlements resulting from audits, reviews, and investigations. These estimated third-party payor settlements are accrued in the period the related services are rendered and adjusted in future periods as revised information becomes known or as years are no longer subject to such audits, reviews, and investigations. Net patient service revenue is reported net of the provision for bad debts of $329.4 million in 2013 and $591.9 million in 2012.

The allowance for doubtful patient accounts is the Corporation's estimate of the amount of probable credit losses in its patient accounts receivable. The Corporation determines the allowance based on collection studies and historical write-off experience. Past-due balances are reviewed individually for collectability. Account balances are charged off against the allowance after all means of collection have been exhausted and the potential for recovery is considered remote. The allowance for

estimated doubtful accounts at June 30, 2013 and 2012 was approximately $512.3 million and $716.3 million, respectively.

(g) Appropriations from (Remittances to) City of New York

Funds appropriated from The City are payments, either directly or indirectly, for services rendered by the Corporation. The City pays for patient care rendered to prisoners, uniformed city employees, and various discretely funded facility-specific programs. The Corporation considers appropriations from (remittances to) The City to be ongoing and central to the provision of healthcare services and, accordingly, classifies them as operating revenues.

The Corporation records both revenues and expenses in an amount equal to expenditures made on its behalf by The City, that is, settlements of claims for medical malpractice, negligence, other torts, and alleged breach of contracts (see note 11(b)); interest on City General Obligation debt that funded Corporation capital acquisitions; interest on New York State Housing Finance Agency (HFA) debt on Corporation assets acquired through lease purchase agreements prior to April 1, 1993; and interest on Dormitory Authority of the State of New York (DASNY) debt and Transitional Finance Authority (TFA) debt on assets acquired through lease purchase agreements, other than amounts capitalized during construction (see note 5).

The Corporation typically reimburses The City for medical malpractice settlements, negligence, and other torts. The City pays on behalf of the Corporation, up to an agreed-upon amount negotiated annually. In 2013 and 2012, the medical malpractice and general liability settlements paid by The City were $121.6 million and $118.8 million, respectively, and the Corporation has agreed to reimburse The City $121.6 million and $118.8 million in 2013 and 2012, respectively. The reimbursements to The City are recorded by the Corporation as a reduction of appropriations from (remittances to) The City. Such medical malpractice, negligence, and other torts reimbursements by the Corporation do not alter the indemnification by The City of the Corporation's malpractice settlements under the Agreement (see note 11(b)).

In 2013 and 2012, respectively, the Corporation paid the City $150.4 million and $144.0 million, respectively, for debt service related to debt incurred by The City, which funded Corporation capital acquisitions. These debt service reimbursements to The City are recorded by the Corporation as a reduction of appropriations from (remittances to) The City.

(h) Capital Assets and Depreciation

In accordance with the Agreement, The City retains legal title to all Corporation facilities and certain equipment and subleases them to the Corporation for an annual rent of $1. Prior to April 1, 1993, The City funded substantially all of the additions to capital assets.

Since April 1, 1993, the Corporation has funded much of its capital acquisitions through the issuance of its own debt. However, The City financed the major modernizations of Harlem, Queens, Jacobi, Coney Island, Bellevue and Kings County Hospitals and Gouverneur Healthcare Services and Henry J. Carter campus.

The Corporation is the sole beneficiary as to use of the capital assets and is responsible for their control and maintenance. Accordingly, capital assets have been capitalized in the accompanying balance sheets as follows:

(i) Assets placed in service through June 30, 1972 were recorded at an estimated cost as determined by an independent appraisal company's physical inventory and valuation of such assets as of June 30, 1972.

(ii) Assets acquired subsequent to June 30, 1972 are recorded at cost.

(iii) Donated equipment is recorded at its fair market value at date of donation.

Construction in progress (CIP) is recorded on all projects under construction. Such CIP costs are transferred to depreciable assets and depreciated when the related assets are placed in service. Interest cost incurred on borrowed funds, net of related interest income, during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Depreciation is computed on a straight-line basis using estimated useful lives in accordance with American Hospital Association guidelines:

Land improvements	2 to 25 years
Buildings and leasehold improvements	5 to 40 years
Equipment	3 to 25 years

Capital assets under capital lease obligations are depreciated over either the lease term or the estimated useful life.

(i) Custodial Funds

The Corporation holds funds for safekeeping, primarily cash held for the benefit of its long-term care patients, amounting to approximately $4.5 million and $4.9 million as of June 30, 2013 and 2012, respectively. These amounts are included in other current assets and accrued expenses in the accompanying statements of net position. At June 30, 2013 and 2012, all custodial funds related bank balances are fully insured.

(j) Affiliation Contracted Services

The Corporation contracts with affiliated medical schools/professional corporations to provide patient care services at its facilities and reimburses the affiliate for expenses incurred in providing such services. Under the terms of the contract, the affiliate is required to furnish the Corporation with an independent audit report of receipts, workload and nonworkload expenditures, and commitments chargeable to the contract and refunds any excess advances or adjusts future payments depending upon the final settlement amount for reimbursable expenses for the fiscal year. The affiliate's reported expenditures are also subject to subsequent audit by the Corporation's Internal Audit Department.

The amounts due to/from the affiliates are based upon estimates of expenses, which include adjustments for patient care service modifications, and are included in accounts payable and accrued expenses/other current assets in the accompanying statements of net position. These estimates may differ from the final determination of amounts due to/from the affiliate upon completion of the annual recalculation schedule.

(k) Supplies

Supplies are stated at the lower of cost (first-in, first-out method) or market (net realizable value).

(l) Income Taxes

The Corporation and its component units are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying financial statements.

(m) Deferred Financing Costs

Deferred financing costs represent expenditures incurred during bond issuances (i.e., insurance, underwriters' discount, etc.) and are being amortized over the respective terms of the issues.

(n) Grants Receivable

Grants receivable relate to various healthcare provision programs under contract with the State and other grantors. Grants receivable also include grants from The City, which are reimbursement to the Corporation for providing such services as mental health, child health, and HIV-AIDS services. Additionally, any accrued reimbursement for Super Storm Sandy expenses is included in grants receivable.

(o) Net Position

Net positon of the Corporation are classified in various components. *Net investment in capital assets* consist of capital assets net of accumulated depreciation and reduced by outstanding borrowings used to finance the purchase or construction of those assets. *Restricted expendable net position* are noncapital net assets that must be used for a particular purpose, as specified by creditors, grantors, or donors external to the Corporation, including amounts deposited with trustees as required by revenue bond indentures, discussed in note 6(a). *Nonexpendable restricted net position* equal the principal portion of permanent endowments. *Restricted for statutory reserve requirements* are MetroPlus' investments required by the New York State Department of Health regulations for the protection of MetroPlus' enrollees. *Unrestricted net position* is remaining net position that does not meet the definition of *Net investment in capital assets or restricted.*

(p) Compensated Absences

The Corporation's employees earn vacation and holiday days at varying rates depending on years of service and title. Generally, vacation and holiday time may accumulate up to specified maximums, depending on title. Excess vacation and holiday time are converted to sick leave. Upon resignation or retirement, employees are paid for unused vacation and holiday days, most at the current rate. Most

employees accrue sick leave at a fixed rate; however, the rate can vary depending on years of service and the contractual terms for their title. There is no accumulation limit on sick leave. Depending on length of service and contractual terms for their title, employees separating from service are paid for sick leave at varying rates.

(q) New Accounting Standards Adopted

In 2013, the Corporation adopted four new accounting standards as follows:

GASB Statement No. 61, *The Financial Reporting Entity* (GASB 61), revises and clarifies the requirements for reporting component units. As a result of the adoption of GASB 61, MetroPlus is now presented as a discrete component unit of the Corporation. The Corporation adopted GASB 61which required the fiscal year 2012 financial statements to be retrospectively adjusted to reflect the presentation of MetroPlus as a discretely presented component unit.

GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements (GASB 62)*, incorporates into the GASB's authoritative literature certain accounting and financial reporting guidance included in FASB pronouncements, which does not conflict with or contradict GASB pronouncements, and eliminates the option to apply post-November 30, 1989 FASB pronouncements that do not conflict with or contradict GASB pronouncements. There was no impact on the Corporation's financial statements as a result of the adoption of GASB 62.

GASB Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position* (GASB 63), establishes a new statement of net position format that reports separately all assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position (which is the net residual amount of the other elements). The Statement requires deferred outflows of resources and deferred inflows of resources to be reported separately from assets and liabilities. The financial reporting impact resulting from the implementation of GASB 63 in the Corporation's financial statements was the renaming of "Net Assets" to "Net Position", including changing the name of the financial statement from "Balance Sheet" to "Statement of Net Position" as well as renaming "Statement of Revenues, Expenses, and Changes in Net Asset" to "Statement of Revenues, Expenses, and Changes in Net Position".

(2) Cash and Cash Equivalents

Cash and cash equivalents consist principally of a money market account and securities purchased under repurchase agreements stated at cost, which approximates fair value, because of their short-term maturities. The money market account is collateralized in excess of its carrying value by U.S. government securities in the name of the Corporation. The repurchase agreements are collateralized in excess of their carrying value by U.S. government securities in the name of the Corporation and held by a custodian. The Corporation considers all highly liquid investments with original maturities of three months or less to be cash equivalents.

Custodial credit risk is the risk that, in the event of a bank failure, the Corporation's deposits may not be returned to it. The Corporation's policy to mitigate custodial credit risk is to collateralize all balances

available (i.e., collected balances). Deposits in the process of collection within the banking system are not collateralized. At June 30, 2013 and 2012, all Corporation cash and cash equivalents bank balances were either insured or collateralized.

(3) Charity Care

The Corporation maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges forgone for services furnished under its charity care policy and the estimated cost of those services. The following information measures the level of charity care provided during the years ended June 30 (in thousands):

	2013	2012
Charges forgone, based on established rates	$ 980,810	1,008,017
Estimated expenses incurred to provide charity care	596,270	643,463

(4) Patient Accounts Receivable and Revenue

Most of the Corporation's net patient service revenue is from funds received on behalf of patients under governmental health insurance plans. Revenue from these governmental plans is based upon relevant reimbursement principles and is subject to audit by the applicable payors. Certain payors have performed audits and have proposed various disallowances, which other payors may similarly assert.

Included in net patient service revenue are adjustments to prior year estimated third-party payor settlements and estimated pools receivable that were originally recorded in the period the related services were rendered. The adjustments to prior year estimates and other third-party reimbursement receipts or recoveries that relate to prior years resulted in a decrease to net patient service revenue of $28.2 million and $2.5 million for the year ended June 30, 2013 and 2012, respectively.

Net patient service revenue for the years ended June 30, 2013 and 2012 is as follows (in thousands):

	2013		2012	
Medicaid	$ 1,492,874	28.5%	$ 1,858,865	33.0%
Medicare	570,322	10.9	694,479	12.4
Bad debt/charity care pools	445,420	8.5	440,984	7.9
DSH supplemental pool	812,000	15.5	742,525	13.2
Other third-party payors that include Medicaid and Medicare managed care	1,114,495	21.3	1,124,284	20.0
MetroPlus	742,199	14.2	705,976	12.6
Self-pay	56,675	1.1	48,663	0.9
	$ 5,233,985	100.0%	$ 5,615,776	100.0%

The Corporation provides services to its patients, most of whom are insured under third-party payor agreements. Patient accounts receivable, net were as follows as of June 30 (in thousands):

	2013		2012	
Medicaid	$ 176,451	23.2%	$ 196,436	28.9%
Medicare	64,704	8.5	70,195	10.3
Other third-party payors, that include Medicaid and Medicare managed care	183,065	24.1	187,277	27.6
MetroPlus	309,043	40.6	208,320	30.7
Self-pay	27,250	3.6	17,394	2.5
	$ 760,513	100.0%	$ 679,622	100.0%

(5) Capital Assets

Capital assets consist of the following as of June 30 (in thousands):

	2013	2012
Land and land improvements	$ 55,707	50,396
Buildings and leasehold improvements	3,831,385	3,353,325
Equipment	3,166,436	3,110,019
	7,053,528	6,513,740
Less accumulated depreciation	4,304,004	4,184,666
	2,749,524	2,329,074
Construction in progress	600,564	674,282
Capital assets, net	$ 3,350,088	3,003,356

Capital assets activity for the years ended June 30, 2013 and 2012 was as follows (in thousands):

	Land and land improvements	Buildings and leasehold improvements	Equipment	Construction in progress	Total
June 30, 2011 balance	$ 49,628	3,295,734	2,981,486	506,230	6,833,078
Net of acquisitions, net of transfers	965	59,457	165,484	168,052	393,958
Sales, retirements, and adjustments	(197)	(1,866)	(36,951)	—	(39,014)
June 30, 2012 balance	50,396	3,353,325	3,110,019	674,282	7,188,022
Net of acquisitions, net of transfers	5,733	527,435	157,484	—	690,652
Sales, retirements, and adjustments	(422)	(49,375)	(101,067)	(73,718)	(224,582)
June 30, 2013 balance	$ 55,707	3,831,385	3,166,436	600,564	7,654,092

Related information on accumulated depreciation for the years ended June 30, 2013 and 2012 was as follows (in thousands):

	Land and land improvements	Buildings and leasehold improvements	Equipment	Total
June 30, 2011 balance	$ 25,183	1,655,991	2,282,987	3,964,161
Depreciation expense	1,251	98,012	160,190	259,453
Sales, retirements, and adjustments	(198)	(1,864)	(36,886)	(38,948)
June 30, 2012 balance	26,236	1,752,139	2,406,291	4,184,666
Depreciation expense	1,332	104,015	176,998	282,345
Sales, retirements, and adjustments	(321)	(45,891)	(116,795)	(163,007)
June 30, 2013 balance	$ 27,247	1,810,263	2,466,494	4,304,004

The Corporation incurred significant physical damage to Bellevue Hospital Center and Coney Island Hospital as a result of Super Storm Sandy. The hospitals' were unable to service patients, and as such, there was a temporary loss of service utility. Using the restoration cost approach, the Corporation recorded a loss from impairment of assets of approximately $12.0 million to recognize the service utility loss in 2013.

The Corporation capitalizes interest costs incurred in connection with construction projects. Interest activity relating to construction projects and net capitalized interest for the years ended June 30, 2013 and 2012 was as follows (in thousands):

		2013	2012
Interest costs subject to capitalization	$	26,664	41,085
Interest income		(1,699)	(417)
Capitalized interest costs, net	$	24,965	40,668

The Corporation capitalized net interest costs on TFA debt and City General Obligation Bonds in both 2013 and 2012, as well as the Corporation's own bonds. Such debt was issued to finance construction of certain Corporation facilities, with such debt to be paid by The City on behalf of the Corporation. Such amounts capitalized in 2013 and 2012 approximated $20.9 million and $37.2 million, respectively. In addition, the Corporation capitalized net interest costs of $4.0 million in 2013 and $3.5 million in 2012 related to its 2008 and 2010 Series bonds.

(6) Assets Restricted as to Use

Assets restricted as to use consist of the following as of June 30 (in thousands):

		2013	2012
Under bond resolutions (a):			
Construction funds	$	49,360	132,899
Capital reserve funds		86,739	99,793
Revenue funds		47,526	59,920
		183,625	292,612
New Market Tax Credit (b)		511	—
By donors for specific operating activities and permanent endowments (c)		12,010	10,057
Total assets restricted as to use		196,146	302,669
Less current portion of assets restricted as to use		37,283	54,185
	$	158,863	248,484

(a) Assets restricted as to use under the terms of the bond resolutions (see note 7) are to provide for debt service requirements and the acquisition of capital assets. Terms of the bond resolutions provide that assets be maintained in separate funds held by the trustee. The funds invested in accordance with the bond resolutions were substantially invested in U.S. government securities money market funds, U.S. government securities, and a negotiable order of withdrawal (NOW) account. $0.8 million and $0.6 million were uninsured and uncollateralized at June 30, 2013 and 2012, respectively.

(b) The New Market Tax Credit (NMTC) transaction required the execution of a loan agreement between HHC/NCF Sub-CDE, LLC and Health and Hospitals Corporation. This agreement referenced the establishment of a NCF Fee Reserve Account which HHC would use to pay interest or fees associated with the loan.

(c) The donor-restricted funds are invested in a certificate of deposit and an interest bearing commercial money market account at June 30, 2013 and 2012. $7.0 million was invested in a fully insured certificate of deposit at June 30, 2013 and 2012; the money market account is fully collateralized by the U.S. government securities held by a custodian in the Corporation's name.

(7) Long-Term Debt and Other Liabilities

Long-term debt consists of the following as of June 30 (in thousands):

	2013	2012
Bonds payable:		
2013 Series A Fixed Rate Health System Bonds – weighted average interest of 2.44%, payable in installments to 2023:		
Uninsured Bonds (a)	$ 127,573	—
2010 Series A Fixed Rate Health System Bonds – average interest of 3.89%, payable in installments to 2030:		
Uninsured Bonds (b)	523,480	528,342
2008 Series A Fixed Rate Health System Bonds – weighted average interest of 4.51%, payable in installments to 2026:		
Uninsured Bonds (c)	111,736	187,966
2008 Series B, C, D, and E Variable Rate Health System Bonds – subject to short-term liquidity arrangements, weighted average interest of 0.83% in 2013, payable in installments to 2031:		
Uninsured Bonds (d)	189,000	174,144
2003 Series A Fixed Rate Health System Bonds – weighted average interest of 4.77%, payable in installments to 2023:		
Insured Bonds (e)	—	132,298
2002 Series A Fixed Rate Health System Bonds – weighted average interest of 5.14%, payable in installments to 2026:		
Insured Bonds (f)	—	1,635
Total bonds payable	951,789	1,024,385

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Notes to Financial Statements
June 30, 2013 and 2012

	2013	2012
Capital lease obligation (g)	$ —	75
New York Power Authority (NYPA) financing (h)	1,465	2,101
Equipment and renovation financing (i)	998	1,923
Clinical bed financing (j)	4,637	6,866
Henry J. Carter capital lease obligation (k)	48,258	48,258
New Market Tax Credit (l)	14,700	—
	1,021,847	1,083,608
Less current installments	40,634	58,083
	$ 981,213	1,025,525

Long-term debt activity for the years ended June 30, 2013 and 2012 were as follows (in thousands):

	June 30, 2012 balance	Additions	Reductions	June 30, 2013 balance	Amounts due within 1 year
Long-term debt:					
Bonds payable	$ 1,024,385	127,573	(200,169)	951,789	37,205
Capital lease obligation	75	—	(75)	—	—
NYPA financing	2,101	—	(636)	1,465	625
Equipment and renovation financing	1,923	—	(925)	998	458
Clinical bed financing	6,866	—	(2,229)	4,637	2,346
Henry J. Carter capital lease obligation	48,258	—	—	48,258	—
New Market Tax Credit	—	14,700	—	14,700	—
	$ 1,083,608	142,273	(204,034)	1,021,847	40,634

	June 30, 2011 balance	Additions	Reductions	June 30, 2012 balance	Amounts due within 1 year
Long-term debt:					
Bonds payable	$ 1,080,524	—	(56,139)	1,024,385	54,185
Capital lease obligation	175	—	(100)	75	75
NYPA financing	3,050	—	(949)	2,101	631
Equipment and renovation financing	3,928	—	(2,005)	1,923	961
Clinical bed financing	8,983	—	(2,117)	6,866	2,231
Henry J. Carter capital lease obligation	—	48,258	—	48,258	—
	$ 1,096,660	48,258	(61,310)	1,083,608	58,083

On November 19, 1992, the Corporation's Board of Directors adopted the General Resolution requiring the Corporation to pledge substantially all reimbursement revenues, investment income, capital project, and bond proceed accounts to HHC Capital. All of the Corporation's Health System Bonds are secured by the pledge. The General Resolution imposes certain restrictive covenants on the issuance of additional bonds and working capital borrowing, and requires that the Corporation satisfy certain measures of financial performance, such as maintaining certain levels of net cash available for debt service, as defined and certain levels of healthcare reimbursement revenues, as defined.

(a) 2013 Series A Bonds

On March 28, 2013, the Corporation issued $112,045,000 of tax-exempt fixed rate Health System Bonds, 2013 Series A bonds (the 2013 Bonds). This issuance generated a premium of $21,422,488. This bond issue included $112,045,000 of 3.0% to 5.0% uninsured serial bonds, due February 15, 2016 through February 15, 2023 with interest payable on February 15 and August 15. The overall weighted average interest rate was 2.44%.

Proceeds of the 2013 Bonds and $13,229,202 in residual funds from the 2008 Series A bonds were used: (i) to refund and redeem all of the Corporation's 2003 Series A bonds totaling $111,810,000; (ii) to refund and defease a portion of the Corporation's 2008 Series A bonds totaling $30,675,000 ($2,405,000 maturing in 2014 bearing interest at 4%, $16,450,000 maturing in 2014 bearing interest at 5%, and $11,820,00 maturing in 2015 bearing interest at 5% were refunded); and (iii) to pay cost of issuance of $1,131,283. Proceeds used to refund and redeem the 2003 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2003 Series A bonds to and including their final redemption date of April 22, 2013. Also, proceeds used to refund and defease 2008 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2008 Series A bonds to and including their final redemption date of February 15, 2015.

The Corporation completed the current refunding of the 2003 Series A bonds and the advance refunding of the 2008 Series A bonds to reduce its total debt service payments over the next 10 years by $23,026,587 and to obtain an economic gain (difference between the present values of the old and new debt service payments) of $21,904,183.

	Principal	Interest	Total
Year:			
2014	$ —	4,661	4,661
2015	—	5,294	5,294
2016	640	5,294	5,934
2017	690	5,274	5,964
2018	675	5,274	5,949
2019 – 2023	110,040	20,965	131,005
Total	112,045	46,762	158,807
Premium on 2013 Bonds	20,851	—	20,851
Unamortized refunding cost	(5,323)	—	(5,323)
	$ 127,573	46,762	174,335

(b) 2010 Series A Bonds

On October 26, 2010, the Corporation issued $510,460,000 of tax-exempt fixed rate Health System Bonds, 2010 Series A bonds (the 2010 Bonds). This issuance generated a premium of $49,767,349. This bond issue included $345,575,000 of 2.0% to 5.0% uninsured serial bonds, due February 15, 2011 through February 15, 2025; and a $7,995,000 of 4.125% and $156,890,000 of 5.0% uninsured term bond due February 15, 2030 with interest payable on February 15 and August 15. The overall weighted average interest rate was 3.89%.

Proceeds of the 2010 Bonds were used: (i) to finance and reimburse the Corporation of $199,758,168 for the costs of its capital improvement program; (ii) to refund and redeem all of the Corporation's 1999 Series A bonds totaling $199,715,000; (iii) to refund and defease substantially all of the Corporation's 2002 Series A bonds totaling $142,315,000 ($11,905,000 of the 2002 Series A bonds were unrefunded); (iv) to fund the Capital Reserve Fund of $1,751,329; and (v) to pay cost of issuance of $3,281,608. Proceeds used to refund and redeem the 1999 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 1999 Series A bonds to and including their final redemption date of November 26, 2010. Also, proceeds used to refund and defease 2002 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2002 Series A bonds to and including their final redemption date of February 15, 2012.

The following table summarizes debt service requirements as of June 30, 2013 (in thousands):

		Principal	Interest	Total
Year:				
2014	$	25,260	24,891	50,151
2015		26,420	23,733	50,153
2016		35,970	22,431	58,401
2017		37,705	20,657	58,362
2018		39,615	18,784	58,399
2019 – 2023		122,725	67,894	190,619
2024 – 2028		139,980	41,523	181,503
2029 – 2030		78,161	5,859	84,020
Total		505,836	225,772	731,608
Premium on 2010 Bonds		34,098	—	34,098
Unamortized refunding cost		(16,454)	—	(16,454)
	$	523,480	225,772	749,252

(c) 2008 Series A Bonds

During 2008, the Corporation restructured its 2002 Series B, C, D, E, F, G, and H auction rate bonds ($346,025,000). The related bond insurance was canceled. The auction rate bonds were refunded into uninsured fixed rate bonds (2008 Series A – $268,915,000, of which $152,890,000 was used for refunding and the remaining $116,025,000 used for capital projects) and into variable rate bonds supported by letters of credit (2008 Series B, C, D, and E – $189,000,000).

On August 21, 2008, the Corporation issued $268,915,000 of tax-exempt fixed rate Health System Bonds, 2008 Series A bonds (the 2008 Series A Bonds). This issuance generated a premium of $9,939,369. This bond issue included $245,725,000 of 4.0% to 5.5% uninsured serial bonds, due February 15, 2009 through February 15, 2026; a 5% uninsured term bond of $11,295,000 due February 15, 2024; and a 5% uninsured term bond of $11,895,000 due February 15, 2025 with interest payable on February 15 and August 15. The overall weighted average interest was 4.51%.

Proceeds of the 2008 Series A Bonds and $4,359,500 in residual funds from the 2002 Series B, C, and H bonds were used: (i) to finance and reimburse the Corporation of $99,367,379 for the costs of its capital improvement program; (ii) to refund and defease all of the Corporation's 2002 Series B, C, and H auction rate bonds totaling $156,750,000; (iii) to finance $2,285,938 in interest during the escrow period; (iv) to fund the Capital Reserve Fund of $22,755,766; and (v) to pay cost of issuance of $2,054,786. Proceeds used to refund and defease 2002 Series B, C, and H bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2002 Series B, C, and H bonds to and including their final redemption date of September 24, 2008.

(d) 2008 Series B, C, D, and E Bonds

On September 4, 2008, the Corporation issued $189,000,000 of tax-exempt variable rate Health System Bonds, 2008 Series B, C, D, and E bonds (the 52008 Variable Rate Bonds). This issuance included four subseries, consisting of $50,470,000 of 2008 Series B bonds, $50,470,000 of 2008 Series C bonds, $44,030,000 of 2008 Series D bonds, and $44,030,000 of 2008 Series E bonds. The 2008 Series B and C bonds are due February 15, 2025 through February 15, 2031 and the 2008 Series D and E bonds are due February 15, 2009 through February 15, 2026. The 2008 Variable Rate Bonds are supported by irrevocable direct-pay letters of credit issued from two banks. The 2008 Series B and C letters of credit will expire in September 2015 and the D and E letters of credit will expire in July 2017, unless extended by mutual agreement between the Corporation and the banks. The Corporation maintains the bank letters of credit to ensure the availability of funds to purchase any bonds tendered by bondholders that the remarketing agents are unable to remarket to new bondholders. Draws related to such tenders under the letters of credit will become Bank Bonds. As Bank Bonds, they can still be remarketed by the remarketing agents.

If not remarketed successfully as Bank Bonds, the Corporation will have the opportunity to refinance them during a period of up to 365 days from initial draw date. If the Bank Bonds are not refunded and remain outstanding exceeding 365 days from initial draw date, the Corporation will be required to make quarterly payments over four years commencing one year after the initial draw date. There were no draws under the letters of credit as of June 30, 2012.

The initial interest rates for the 2008 Variable Rate Bonds were set at 1.45% – 1.50%, bearing interest at a weekly interest rate mode. However, the 2008 Variable Rate Bonds of any series may be converted by the Corporation to bear interest at either a daily interest rate, a bond interest term rate, a NRS (nonputable remarketed securities) rate, an auction rate, an index rate, or a fixed rate. The overall weighted average interest was 0.83% for 2012 and 0.93% for 2011.

Proceeds of the 2008 Variable Rate Bonds and $3,920,273 in residual funds from the 2002 Series D, E, F, and G bonds were used: (i) to refund and defease all of the Corporation's 2002 Series D, E, F, and G auction rate bonds totaling $189,275,000; (ii) to finance $3,019,115 in interest during the escrow period; and (iii) to pay cost of issuance of $626,158. Proceeds used to refund and defease 2002 Series D, E, F, and G bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2002 Series D, E, F, and G bonds to and including their final redemption date of October 10, 2008.

The following table summarizes debt service requirements for all of the 2008 Series Bonds as of June 30, 2013 (in thousands):

		Principal	Interest	Total
Year:				
2014	$	11,945	10,951	22,896
2015		20,375	9,572	29,947
2016		12,380	8,104	20,484
2017		12,800	7,706	20,506
2018		13,255	7,262	20,517
2019 – 2023		74,820	28,002	102,822
2024 – 2028		102,920	11,056	113,976
2029 – 2030		51,036	1,543	52,579
Total		299,531	84,196	383,727
Premium on 2008 Bonds		1,865	—	1,865
Unamortized refunding cost		(660)	—	(660)
	$	300,736	84,196	384,932

(e) 2003 Series A Bonds

On January 15, 2003, the Corporation issued $245,180,000 of tax-exempt fixed rate Health System Bonds, 2003 Series A bonds (the 2003 Bonds). This issuance generated a premium of $9,029,318 and accrued interest of $818,452. This bond issue included $245,180,000 of 3.0% to 5.25% insured serial bonds, due February 15, 2004 through February 15, 2023 with interest payable on February 15 and August 15. The overall weighted average interest was 4.77%.

Proceeds of the 2003 Bonds, $250,469 of interest earning in escrow fund and $17,160,000 in residual funds from the 1993 Series A bonds (the 1993 Bonds) were used: (i) to refund and defease the Corporation's remaining 1993 Bonds totaling $252,955,000; (ii) to finance $6,178,859 in interest during the escrow period; (iii) to fund redemption premium of $4,817,900; (iv) to pay cost of issuance of $7,668,028; and (v) to pay accrued interest of $818,452. Proceeds used to refund and defease 1993 Bonds were deposited with the bond trustee sufficient to pay the interest and principal of the 1993 Bonds to and including their maturity date of February 15, 2003 for the 1993 Bonds maturing on such date, and, with respect to the refunded 1993 Bonds maturing after February 15, 2003, on their respective redemption dates of March 13, 2003 and March 18, 2003.

The 2013 Bonds refunded and redeemed all of the Corporation's 2003 Series A bonds.

(f) 2002 Series A, B, C, D, E, F, G, and H Bonds

On July 1, 2002, the Corporation issued $192,750,000 of tax-exempt fixed rate Health System Bonds, 2002 Series A bonds (the 2002 Series A Bonds). This issuance generated a premium of $3,016,172 and accrued interest of $616,667. This bond issue included $11,950,000 of 3.0% to 4.0% uninsured serial bonds, due February 15, 2005 through February 15, 2006; $154,140,000 of 3.2% to 5.5% insured serial bonds, due February 15, 2007 through February 15, 2019; and $26,660,000 of uninsured term bonds of 5.375% to 5.45%, due February 15, 2024 through February 15, 2026 with interest payable on February 15 and August 15. The overall weighted average interest was 5.14%.

Proceeds of the 2002 Series A Bonds were used: (i) to finance and reimburse the Corporation of $159,997,658 for the costs of its capital improvement program; (ii) to fund the Capital Reserve Fund of $11,754,803; (iii) to fund the Capitalized Interest Fund of $19,085,411; and (iv) to pay cost of issuance of $5,544,968.

The 2002 Series B, C, D, E, F, G, and H auction rate bonds were current refunded and defeased in August 2008 and September 2008 ((see notes (c) and (d)).

On October 26, 2010, the Corporation refunded and defeased substantially all of the Corporation's 2002 Series A bonds (see note (b)).

(g) Capital Lease Obligation

The Corporation is a party to a long-term lease agreement, which commenced in 1993 and resulted in the construction of a parking garage at Elmhurst Hospital, which was financed by $11.8 million of New York City Industrial Development Agency Triple Tax-Exempt Bonds. These bonds and related interest costs will be paid over an 11-year period at rates of 7.4% and 7.5%. The Corporation hired Elmpark Associates (Elmpark) to construct and manage the garage and is required to pay Elmpark $100,000 per year in years 11 through 20 of the agreement for Elmpark's equity interest in the garage.

All assets acquired under this lease agreement have been capitalized and the related obligation is reflected in the accompanying financial statements. As of June 30, 2013, the payment of all principal and interest due is subordinate to the payment of principal and interest on the Corporation's 2008, 2010, and 2013 Bonds. The cost of the parking garage is included in capital assets in the amount of $12.8 million, with accumulated depreciation of $10.5 million at June 30, 2013. The Corporation satisfied its capital lease obligation in 2013.

(h) New York Power Authority (NYPA) Financing

NYPA has provided construction services and unsecured financing to various Corporation facilities for energy-efficient heating/cooling systems and lighting improvements.

Monthly payments of principal and interest are due on the initial par amount (approximately $12.7 million) of the outstanding financing, at variable interest rates over ten years. Variable interest rates are based on NYPA's cost of money related to its outstanding debt in the prior calendar year, with a maximum of 8.0%. NYPA adjusts the variable rate effective January 1 each year. At June 30,

2013, approximately $2.1 million was due at 0.88% interest. The effective interest rate for 2013 was approximately 0.9%.

The following table summarizes debt service requirements as of June 30, 2013 (in thousands):

	Principal	Interest	Total
Year:			
2014	$ 625	10	635
2015	626	5	631
2016	214	—	214
	$ 1,465	15	1,480

(i) Equipment and Renovation Financing

In February 2005, the Corporation entered into a food service management agreement. As part of the agreement, the contractor purchased food service equipment for the Corporation and made renovations to Corporation facilities to improve food service processing. The Corporation is making monthly payments, at 7% interest, over periods of 3, 5, 7, and 10 years. All assets acquired under this agreement have been capitalized and the related obligation is reflected in the accompanying financial statements. The original loan amount was $17,327,803.

The following table summarizes debt service requirements as of June 30, 2013 (in thousands):

	Principal	Interest	Total
Year:			
2014	$ 458	53	511
2015	405	26	431
2016	135	4	139
	$ 998	83	1,081

(j) Clinical Bed Financing

During 2011, the Corporation entered into agreements for the purchase of beds for several facilities. The Corporation is making monthly payments to the vendor on the original loan amounts of $11.5 million financed during March 2010 and June 2010. Interest rates are at 5.00% and 5.75% for the purchases in March 2010 and June 2010, respectively, and all assets acquired under this agreement have been capitalized and the related obligation is reflected in the accompanying financial statements.

The following table summarizes debt service requirements as of June 30, 2013 (in thousands):

		Principal	Interest	Total
Year:				
2014	$	2,346	187	2,533
2015		1,773	69	1,842
2016		442	18	460
2017		76	1	77
	$	4,637	275	4,912

(k) Henry J. Carter Capital Lease Obligation

In September 2010, the Corporation and the City of New York entered into a Memorandum of Understanding with the New York State Department of Health, the Dormitory Authority of the State of New York (DASNY) and the recently closed North General Hospital, to relocate the Goldwater operations of the Coler-Goldwater Specialty Hospital and Nursing Facility to the North General Hospital campus in northern Manhattan. This relocation will allow the Corporation to relinquish an aging and outdated campus, while facilitating the reorganization and downsizing of the Corporation's long-term care services consistent with the Corporation's restructuring plan.

The agreement provides for a capital lease of the existing North General Hospital building that will be renovated to house long term acute care hospital (LTACH) services. The Corporation has also acquired a parking lot on the North General campus, where a new tower building may be constructed to house skilled nursing (SNF) services. The Corporation has renamed the site of the former North General Hospital to the Henry J. Carter site. The Henry J. Carter site will have approximately 400 fewer SNF beds and 200 fewer LTACH beds than the Goldwater campus. The City is financing acquisition, renovation, and construction of the Henry J. Carter campus, with supplemental funding from State grants.

A lease agreement was executed in June 2011. The lease expires at the later of the date of full repayment of the North General Hospital DASNY bonds issued in relation to the leased property, or the date of the Corporation's rent payment based on the final Medicaid capital reimbursement receipt attributable to depreciation expense for leased assets. Assets acquired under this lease agreement have been capitalized and the related obligation is reflected in the accompanying financial statements. Upon expiration of the lease, all leased property will be conveyed to HHC, upon payment of a nominal sum.

(l) New Market Tax Credit

In October 2012, the Corporation formed the HHC Assistance Corporation (HHCAC) which is a not-for-profit corporation that is closely affiliated with the Corporation. All members of the HHCAC's board of directors are officers of the Corporation. The HHCAC's purpose is to perform activities that are helpful to the Corporation in the fulfillment of its statutory purposes. During 2012, the HHCAC facilitated the Corporation's participation in a New Market Tax Credit supplementary

financing transaction which involved two 30 year loans totaling $14.7 million (loan "A" $10.7 million and loan "B" $4.0 million) at an interest rate of 1.2%. The principal on the two loans does not begin to be payable, and cannot be paid until the end of the 7th year following the loan closing. At that point, the principal on the two loans is to be repaid over the remaining 23 years of the term of the loans. For the first seven years of the project, only amount for interest will be due and will have been pre-paid out of the loan "B" amount. After the 7 years, a "put" option is to be exercised for a nominal fee of $1,000 which would allow the Corporation to cancel the debts. This project is expected to produce a net benefit to the Corporation of $3.4 million to be used for the construction of certain new facilities at the Harlem Hospital Center.

(8) Due to City of New York, net

Amounts due to the City consist of the following at June 30 (in thousands):

	2013	2012
FDNY EMS operations (a)	$ 138,085	44,797
Medical malpractice payable (b)	121,362	113,595
Other accrued expenses (c)	27,855	13,094
Utilities prepaid expenses (d)	(1,122)	167
Debt service (e)	150,411	—
	$ 436,591	171,653

(a) The liability for Emergency Medical Services (EMS) operations represents the balance of third-party payor reimbursement received by the Corporation and due to The City for EMS services provided by The City's Fire Department (FDNY) on behalf of the Corporation.

(b) Payable represents final malpractice balances due The City.

(c) Payable represents final and reconciled fringe benefit costs.

(d) Payable represents final and reconciled utility costs due The City. Estimated utilities payments made by the Corporation to The City during 2013 exceeded final and reconciled utilities bills, resulting in a prepaid expense of $1.1 million at June 30, 2013.

(e) Payable represents final and reconciled debt service costs for the year ended June 30, 2013. These debt service costs relate to debt incurred by The City which funded HHC capital acquisitions.

(9) Pension Plan

The Corporation participates in the New York City Employees Retirement System (NYCERS), which is a cost-sharing, multiple-employer public employees retirement system. NYCERS provides defined pension benefits to 185,000 active municipal employees and 132,000 pensioners through $48.8 billion in assets. Employees who receive permanent appointment to a competitive position and have completed six months of service are required to participate in NYCERS, and all other employees are eligible to participate in NYCERS. NYCERS provides pay-related retirement benefits, as well as death and disability benefits.

Total amounts of the Corporation's employees' covered payroll and total related payroll for the year ended June 30, 2013 are approximately $2.103 billion and $2.008 billion, respectively.

The frozen entry age actuarial cost method of funding with six-year amortization of a revised unfunded frozen initial accrued liability is used to calculate the contribution from the Corporation. The Corporation's annual pension costs for fiscal 2013, 2012, and 2011, which includes contributions toward the actuarially determined accrued liability, were approximately $417.3 million, $424.6 million and $332.4 million, respectively. These costs paid by the Corporation represent the Corporation's required contribution as calculated by the Office of the Actuary, City of New York.

NYCERS issues a financial report that includes financial statements and required supplementary information, which may be obtained by writing to NYCERS, 335 Adams Street, Brooklyn, New York 11201-3751.

(10) Postemployment Benefits, Other than Pension (OPEB)

In accordance with collective bargaining agreements, the Corporation provides OPEB that include basic healthcare benefits to eligible retirees and dependents at no cost to many of the participants. Basic healthcare premium costs that are partially paid by the Corporation for the remaining participants vary according to the terms of their elected plans. To qualify, retirees must: (i) have at least ten years of credited service (five years of credited service if employed on or before December 27, 2001) as a member of a pension system approved by The City (requirement does not apply if retirement is as a result of accidental disability); (ii) have been employed by the Corporation prior to retirement; (iii) have worked regularly for at least 20 hours a week prior to retirement; and (iv) be receiving a pension check from a retirement system maintained by The City or another system approved by the City.

The Corporation's OPEB expense of $300.0 million, $303.2 million and $620.6 million in 2013, 2012, and 2011 were equal to the annual required contribution (ARC), an amount actuarially determined in accordance with the parameters of GASB Statement No. 45; however, implicit rate subsidy credits of $15 million, $16 million, and $16 million reduced OPEB expenses for 2013, 2012, and 2011, respectively. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities. The Corporation's ARC for 2013, 2012, and 2011 is composed of the following, as calculated by the Office of the Actuary, City of New York, and includes the information for MetroPlus (in thousands):

	2013	2012	2011
Normal cost	$ 244,614	219,718	264,044
Amortization of unfunded actuarial accrued liability over one year	264	(78,706)	202,623
Amortization of unfunded actuarial accrued liability over ten years	(115,952)	—	—
Interest at 4.0%	186,031	178,153	169,932
ARC	314,957	319,165	636,599
Less Corporation payments for retired employees' health care benefits and implicit rate subsidy credit	113,276	110,128	105,418
Net OPEB obligation increase	201,681	209,037	531,181
Net OPEB obligation – beginning of year	4,521,853	4,312,816	3,781,635
Net OPEB obligation – end of year	4,723,534	4,521,853	4,312,816
Less current portion of postemployment benefits obligation, other than pension	105,180	99,700	94,400
	$ 4,618,354	4,422,153	4,218,416

The Corporation has not funded any of its net OPEB obligations.

The schedule below presents the results of OPEB valuations as of June 30, 2012 for fiscal year 2013, as of June 30, 2011 for fiscal year 2012, and as of June 30, 2010 for fiscal year 2011 (in thousands):

Actuarial valuation date	Entry age actuarial accrued liability (AAL)	Frozen entry age actuarial accrued liability (AAL)	Unfunded AAL (UAAL)	Covered payroll	UAAL as a percentage of covered payroll
June 30, 2012	$ 3,544,019	—	3,544,019	2,083,349	170.1%
June 30, 2011	—	4,234,110	4,234,110	2,026,170	209.0
June 30, 2010	—	3,984,256	3,984,256	2,043,063	195.0

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Amounts determined regarding the ARC are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. Projections of benefits for financial reporting purposes are based on the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and employees to that point. The actuarial methods and assumptions used include techniques that are designed to reduce short-term volatility in actuarial accrued liabilities, consistent with the long-term perspective of the calculations.

The entry age actuarial cost method was used in the June 30, 2013 and the frozen entry age actuarial cost method was used in the 2012 and 2011 OPEB actuarial valuations as the basis for the 2013, 2012, and 2011 ARC calculations, respectively.

The actuarial assumptions include an annual healthcare cost trend rate (HCCTR). The HCCTR applied to Pre-Medicare plans was updated as of June 30, 2009 to reflect recent past experience and anticipated future experience, including the enactment of National Health Care Reform. The HCCTR for Pre-Medicare plans assumes an initial rate of 9.5% and is gradually reduced to an ultimate rate of 5% after 11 years. The complete set of actuarial assumptions and methods used in the June 30, 2011 OPEB actuarial valuation are contained in the Report on the Seventh Annual Actuarial Valuation of Other Postemployment Benefits Provided under the New York City Health Benefits Program (the Seventh OPEB Report). The Seventh OPEB Report was prepared as of June 30, 2011 in accordance with GASB Statements Nos. 43 and 45 for the fiscal year ended June 30, 2012 by the New York City Office of the Actuary and is dated September 19, 2012.

(11) Commitments and Contingencies

(a) Reimbursement

The Corporation derives significant third-party revenues from the Medicare and Medicaid programs. Medicare reimburses most inpatient acute services on a prospectively determined rate per discharge, based on diagnosis-related groups (DRGs) of illnesses, i.e., the Prospective Payment System (PPS). For outpatient services, Medicare payments are based on service groups called ambulatory payment classifications (APCs).

Commencing July 1, 2005, Medicare introduced PPS reimbursement for psychiatric units on a per diem basis, recognizing the intensity of care provided to the patients. The Corporation receives Medicare payments for rehabilitation services using a PPS methodology, which requires facilities to complete patient health assessments. Using these assessments, Medicare defines a case-based payment, accounting for acuity and co-morbidities.

Medicare adjusts the reimbursement rates for capital, medical education, costs related to treating a disproportionate share of indigent patients, and some physician services are reimbursed on a cost basis. Due to these adjustments and other factors, final determination of the reimbursement settlement for a given year is not known until Medicare performs its annual audit. The most recent

fiscal year for Medicare cost report audit and final settlement for the Corporation hospitals ranges from 2007 to 2011, with all but one hospital settled through at least 2009.

Effective July 1, 2004, Medicare instituted a new PPS for long-term acute care. Medicaid continues to reimburse for these services on a per diem basis.

Effective January 1, 1997, the State enacted the Health Care Reform Act (HCRA), which covers Medicaid, Workers' Compensation, and No-Fault. In January 2000, the State passed HCRA 2000 extending the HCRA methodology until June 30, 2003, which has subsequently been extended several times and is now scheduled to expire December 31, 2014. Medicaid pays for inpatient acute care services on a prospective basis using a combination of statewide and hospital specific 2005 costs per discharge trended forward to the current year and adjusted for severity of illness based on DRGs. Certain hospital specific noncomparable costs are paid as flat-rate per discharge add-ons to the DRG rate. Certain psychiatric, rehabilitation, and other services are excluded from this methodology and are reimbursed on the basis of per diem rates. Effective October 2010, per diem reimbursement for inpatient psychiatric services is determined by a PPS methodology taking into account co-morbidities and length of stay.

Commercial insurers, including HMOs, pay negotiated reimbursement rates or usual and customary charges, with the exception of inpatient Medicaid HMO cases that may be paid at the State-determined Alternate Payment Rate, which is related to the Medicaid rate. In addition, the State pays hospitals directly for graduate medical education costs associated with Medicaid HMO patients. The Corporation's current negotiated rates include per case, per diem, per service, per visit, and partial capitation arrangements.

HCRA continues funding sources for public goods pools to: finance healthcare for the uninsured; support graduate medical education; and fund initiatives in primary care. Medicaid outpatient services have been reimbursed based on fixed rates that are generally below cost. In December 2008, the State began implementing the Ambulatory Patient Groups (APGs) for outpatient reimbursement, and provides for service intensity adjusted prospective payments based on patient diagnoses and procedures groupings. The APG reimbursement methodology for hospital ambulatory surgery services is effective December 1, 2008, emergency room services effective January 1, 2009, and diagnostic and treatment center medical services effective September 1, 2009. APG payment for most chemical dependency and mental health clinic services is effective as of October 2010. APG payment for nonhospital based chemical dependency and mental health clinic services is phased in over four years. Outpatient services for all nongovernmental payors are based on charges or negotiated rates.

The Corporation is in varying stages of appeals relating to third-party payors' reimbursement rates. Management routinely provides for the effects of all determinable prior year appeals, settlements, and audit adjustments and records estimates based upon existing regulations, past experience, and discussions with third-party payors. However, since the ultimate outcomes for various appeals are not presently determinable, no provision has been made in the accompanying financial statements for such issues.

Certain provisions of PPS and HCRA require retroactive rate adjustments for years covered by the methodologies. Those that can be reasonably estimated have been provided for in the accompanying financial statements. However, those that are either (a) without current specific regulations to implement them or (b) are dependent upon certain future events that cannot be assumed have not been provided for in the accompanying financial statements.

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, Health Reform Law), which was signed into law on March 23, 2010, will change how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reduction in Medicaid Disproportionate Share Hospital payments, overall reduction and significant redistribution of Medicare Disproportionate Share Hospital payments, and the establishment of programs in which reimbursement is tied to quality and integration. In addition Health Reform Law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement.

Because of the many variables involved with the Health Reform Law, management is unable to predict the net effect on the Corporation of the expected increase in insured individuals using the Corporation's facilities and numerous other provisions in the law that may affect the Corporation. However, the Corporation does project that the change in Medicare Disproportionate Share Hospital reimbursement will increase Corporation revenue by over $100 million in the federal fiscal year beginning October 1, 2013. This additional revenue is expected to diminish substantially in subsequent years.

There are various proposals at the federal and state levels that could, among other things, reduce reimbursement rates, modify reimbursement methods, or increase managed care penetration, including Medicare and Medicaid. The ultimate outcome of these proposals and other market changes cannot presently be determined.

Laws and regulations governing Medicaid and Medicare are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Corporation believes that it is in compliance with all applicable regulations and that any pending or possible investigations involving allegations of potential wrongdoing will not materially impact the accompanying financial statements. While certain regulatory inquiries have been made, compliance with the regulations can be subject to future government review and interpretation as well as significant regulatory action, i.e., fines, penalties, and possible exclusion from Medicaid and Medicare, in the event of noncompliance. In accordance with recent trends in healthcare financial operations, the Corporation has established a Corporate Compliance Committee and appointed a Corporate Compliance Officer to monitor adherence to laws and regulations.

(b) Legal Matters

There are a significant number of outstanding legal claims against the Corporation for alleged negligence, medical malpractice, and other torts, and for alleged breach of contract. Pursuant to the

Agreement, the Corporation is indemnified by the City for such costs, which were $121.6 million for 2013 and $118.8 million for 2012. The Corporation records these costs when settled by the City as appropriations from the City and as other than personal services expenses in the accompanying financial statements (see note 8(b)). Accordingly, no provision has been made in the accompanying financial statements for unsettled claims, whether asserted or unasserted.

(c) Operating Leases

The Corporation leases equipment, off-site clinic space, and office space under various operating leases. Total rental expense for operating leases was approximately $44.8 million in 2013 and $43.0 million in 2012.

The following is a schedule by years of future minimum rental payments required under operating leases that have initial or remaining noncancelable lease terms in excess of one year as of June 30, 2013 (in thousands):

		Amount
Year:		
2014	$	20,776
2015		17,916
2016		15,384
2017		18,346
2018		5,494
2019 – 2023		3,642
Total minimum payments required	$	81,558

(d) Major Construction Projects

The Corporation has various major facility construction projects in progress, including major modernization projects at Harlem Hospital Center, Gouverneur Healthcare Services, and Henry J. Carter campus, with an estimated cost of completion of $201 million at June 30, 2013.

(12) Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses consist of the following as of June 30 (in thousands):

	2013	2012
Vendors payable	$ 248,080	207,848
Accrued interest	13,727	15,762
Affiliations payable	18,347	29,585
Pollution remediation liability	19,531	13,777
Other	86,219	77,456
	$ 385,904	344,428

(13) Super Storm Sandy

The Corporation has applied for public assistance through the Federal Emergency Management Agency (FEMA) to cover the costs of repairs and replacements of facilities to pre-storm conditions and to make improvements to meet codes and standards FEMA has obligated $142 million, of which approximately $62 million was advanced during 2013. In addition, New York City allocated $183 million in Community Development Block Grant (CDBG) funds to support operational expenses not covered by FEMA.

During 2013, the Corporation recognized, as grant revenue, the CDBG award of $183 million and $73 million in FEMA awards (including $62 million paid in advance). The Corporation also reported a loss on impairment of assets as a result of temporary service utility decline at two hospitals in the amount of $12 million.

(14) MetroPlus

(a) U.S. Government Securities

U.S. government securities consist of U.S. Treasury bills and U.S. Treasury notes, and U.S. Treasury bonds. Such securities are stated at fair value, with unrealized gains and losses included in investment income. Securities maturing within a year are presented as current assets in the balance sheets. Securities presented as noncurrent assets mature after a year.

Possible exposure to fair value losses arising from interest rates volatility is limited by investing in securities with maturities of less than one year and, at most, three years, and by intending to hold the security to maturity.

As of June 30, MetroPlus had the following U.S. government securities (in thousands):

Year	Investment type	Fair value	Investment maturities (in years) Less than 1	1 to 2
2013	U.S. Treasury bills, notes, and bonds	$ 114,043	81,671	32,372
2012	U.S. Treasury bills and notes	$ 113,950	113,950	—

(b) Premiums Receivable and Premium Revenue

Premiums earned are recorded in the month in which members are entitled to service. Medicaid and FHP premiums are based upon the age, and aid category of the enrollee, and plan premium rates are risk adjusted to reflect historical experience. In addition, Medicaid makes one-time maternity and newborn supplemental payments for the delivery of each child born to a member of MetroPlus. Medicaid, CHP, FHP, and HIV-SNP premium revenue received from the State represents a substantial portion of MetroPlus' premium revenues, and is subject to audit and adjustment by the DOH.

The related costs of healthcare and claims payable for healthcare services provided to enrollees are estimated by management based on the current value of the estimated liability for claims in process, unpaid primary care capitation, and incurred but not reported claims. The Corporation estimates the amount of incurred but not reported or paid claims on an accrual basis and adjusts in future periods as required.

Premium revenue, by percentage, from members and third-party payors for the years ended June 30, 2013 and 2012 was as follows:

	2013	2012
Medicaid	79%	78%
Medicare	4	4
Child Health Plus	1	2
Family Health Plus	6	7
Partnership In Care	10	9
	100%	100%

(c) Assets Restricted as to Use

Assets restricted as to use consist of the following as of June 30 (in thousands):

		2013	2012
MetroPlus statutory reserve investments	$	84,345	65,896

MetroPlus statutory reserve investments are required by the DOH regulations for the protection of MetroPlus enrollees. $84.3 million and $65.9 million, respectively, are invested in U.S. government securities at June 30, 2013 and 2012.

(d) Change in Claims Payable

Accounts payable and accrued expenses include MetroPlus claims payable of $489.1 million and $382.3 million at June 30, 2013 and 2012, respectively. Activity in the liability for claims payable, which includes health claims and claim adjustment expenses related to health claims included in other than personal services, is summarized as follows (in thousands):

		2013	2012
Balance, July 1	$	382,258	266,737
Less drug rebates receivable		(3,174)	(921)
Net balance		379,084	265,816
Incurred related to:			
Current year		1,851,849	1,717,602
Prior years		102,919	(6,710)
Total incurred		1,954,768	1,710,892
Paid related to:			
Current year		1,545,139	1,395,646
Prior years		302,453	201,977
Total paid		1,847,592	1,597,623
Net balance at June 30		486,261	379,084
Plus drug rebates receivable		2,794	3,174
Balance, June 30	$	489,055	382,258

Net reserves for unpaid claims and claim adjustment expenses attributable to insured claims of prior years increased by $102.9 million in 2013 and decreased by $6.7 million in 2012. These changes are generally the result of ongoing analysis of recent loss development trends that include expected healthcare cost and utilization.

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

The Board of Directors
New York City Health and Hospitals Corporation:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation (the Corporation), a component unit of the City of New York, as of and for the year ended June 30, 2013 and 2012, and the related notes to the financial statements, which collectively comprise the Corporation's basic financial statements, and have issued our report thereon dated September __, 2013.

Internal Control over Financial Reporting

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

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

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

Compliance and Other Matters

As part of obtaining reasonable assurance about whether New York City Health and Hospitals Corporation's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and

accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

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

Date

KPMG

cutting through complexity

New York City Health and Hospitals Corporation

Report to the Audit Committee

September 12, 2013

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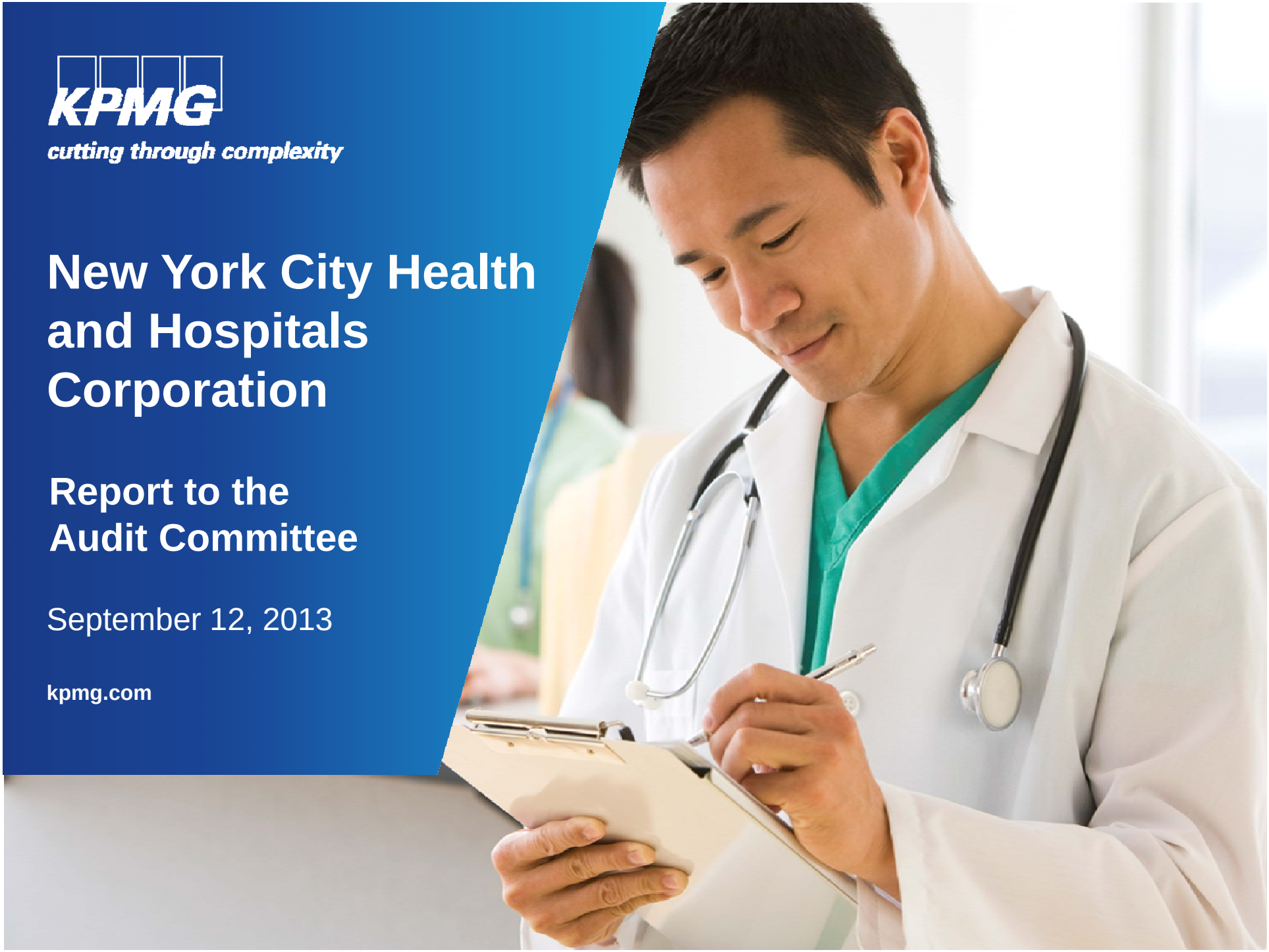

Agenda

Required communications

Required communications	Application to the Corporation
Responsibility Under Auditing Standards Generally Accepted in the U.S. (GAAS)	■ KPMG responsibilities are: – Forming and expressing an opinion about whether the financial statements that have been prepared by management with the oversight of the Audit Committee are presented fairly, in all material respects, in conformity with the applicable financial reporting framework and generally accepted accounting principles (GAAP) – Planning and performing the audit with an attitude of professional skepticism – Conducting the audit in accordance with professional standards and complying with the Code of Professional Conduct of the American Institute of Certified Public Accountants, and the ethical standards of relevant CPA societies and relevant state boards of accountancy – Evaluating internal control over financial reporting (ICFR) as a basis for designing audit procedures, but not for the purpose of expressing an opinion on the effectiveness of HHC's ICFR – Communicating to management and the Audit Committee all required information, including significant matters – Communicating to management and the Audit Committee in writing all significant deficiencies and material weaknesses in internal control identified in the audit and reporting to management all deficiencies noted during our audit that are of sufficient importance to merit management's attention

Required communications (continued)

Required communications	Application to the Corporation
Responsibility Under Auditing Standards Generally Accepted in the U.S (GAAS) (continued)	■ Management responsibilities are: – Adopting sound accounting policies – Fairly presenting the financial statements in conformity with GAAP – Establishing and maintaining effective ICFR, including internal controls to prevent, deter, and detect fraud – Identifying and confirming that the Corporation complies with laws and regulations applicable to its activities, and for informing us of any known material violations of such laws and regulations – Making all financial records and related information available to the auditor – Providing unrestricted access to personnel within the entity from whom the auditor determines it necessary to obtain audit evidence – Adjusting the financial statements to correct material misstatements – Providing the auditor with a letter confirming certain representations made during the audit that includes, but is not limited to, management's: – Disclosure of all significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect the Corporation's financial reporting – Acknowledgement of their responsibility for the design and implementation of programs and controls to prevent, deter, and detect fraud ■ Audit Committee responsibilities are: – Oversight of the financial reporting process and oversight of ICFR – Oversight of the establishment and maintenance of programs and internal controls designed to prevent and detect fraud ■ Management and the Audit Committee's responsibility is: – Setting the proper tone and creating and maintaining a culture of honesty and high ethical standards **The audit of the financial statements does not relieve management or the Audit Committee of their responsibilities.**

Required communications (continued)

Required communications	Application to the Corporation
Report on Audit	■ Unqualified opinion ■ Evaluated liquidity consideration which had no impact on our audit

Significant Accounting Policies	■ HHC's significant accounting policies are summarized in note 1 to financial statements
	■ During fiscal 2013, there were no transactions recorded, that we are aware of, which lacked authoritative accounting guidance or consensus
	■ New accounting pronouncements are disclosed in footnote 1q and include:
	  ■ GASB 61, *The Financial Reporting Entity*
	  ■ GASB 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICP Pronouncements*
	  ■ GASB 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*
	  ■ GASB 64, *Derivative Instruments: Application of Hedge Accounting Termination Provisions, an amendment of GASB Statement No. 53*
	  ■ GASB 65, *Items Previously Reported as Assets and Liabilities*

Required communications (continued)

Required communications	Application to the Corporation
Management Judgments and Accounting Estimates	■ Significant accounting estimates affecting HHC's financial statements include the following: – Valuation of patient accounts receivable – Valuation of estimated third-party payor settlements, net and estimated pools receivable, net – Valuation of post-employment benefits other than pension (OPEB) liability – Valuation of impairment of capital assets – Valuation of FEMA grant receivable – Valuation of MetroPlus incurred but not reported (IBNR) liability ■ We evaluated management's significant judgments and estimates noted above as part of our audit, and found them to be reasonable in the context of the financial statements taken as a whole
Audit Adjustments	■ There were no uncorrected or corrected misstatements during the 2013 audit
Disagreements with Management	■ We had no such disagreements with the Corporation's management during the 2013 audit
Consultation with Other Accountants	■ To the best of our knowledge, management has not consulted with or obtained opinions (written or oral) from other independent accountants
Major Issues Discussed with Management Prior to Retention	■ We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year. However, these discussions occurred in the normal course of our professional relationship, and our responses were not a condition to our retention as HHC's auditors
Difficulties Encountered in Performing the Audit	■ We encountered no difficulties in dealing with management during the performance of our 2013 audit
Material Written Communications	■ Material written communications between management and KPMG include: – Engagement letter – Management representation letter – Management letter

Required communications (continued)

Required communications	Application to the Corporation
Quality of Accounting Principles	■ Accounting principles have been consistently applied
Significant or Unusual Transactions	■ Except for those transactions discussed on slides 10 & 11, there were no significant or unusual transactions identified
Significant Deficiencies and Material Weaknesses in Internal Control	■ There were no significant deficiencies or material weaknesses identified
Other Information in Documents Containing Audited Financial Statements	■ Not applicable, as the financial statements are not included in other documents, except for the annual filing of the cost report
Material Errors, Fraud, and Illegal Acts	■ Planned audit procedures developed and inquiries made ■ None of which we are aware that would result in significant misstatement of the financial statements
Changes to Initial 2013 Audit Plan	■ No significant changes to planned audit procedures
Management Cooperation	■ Received full cooperation ■ Full access to books and records ■ Utilized internal audit personnel as a component of the engagement team
Independence	■ We hereby confirm we are independent with respect to the Corporation under all relevant professional and regulatory standards.

Required communications (continued)

Required communications	Application to the Corporation
Related-party transactions	■ Related party transactions with The City of New York are discussed in note 8 to the financial statements and slide 10
Litigations, claims, and assessments	■ No additional items that require disclosure within the financial statements that we are aware that would result in significant misstatement of the financial statements
Noncompliance with laws and regulations	■ None of which we are aware that would result in significant misstatement of the financial statements
Non-GAAP policies	No new policies identified, however, during the course of our audit, we noted the following inconsequential non-GAAP policies: ▪ The Corporation does not capitalize leases that are deemed to be immaterial ▪ The Corporation's policy is to capitalize fixed assets with unit values greater than $500 and with a useful life of two years or more ▪ The Corporation does not utilize the effective interest method to amortize deferred financing costs associated with the bonds

Significant estimates

Management Judgments and Accounting Estimates

The preparation of financial statements requires the use of accounting estimates. Certain estimates are particularly sensitive due to their significance to the financial statements and the possibility that future events may differ significantly from management's expectations.

Valuation of Patient Accounts Receivable

- Updated our understanding of the patient revenue billing and cash receipts cycle and performed tests of controls
- Performed independent review of the valuation of three facilities' inpatient and outpatient accounts receivable utilizing a computer assisted auditing tool (CAAT) to ensure that management's process was still operating appropriately and could be relied upon
- Performed various audit procedures, including ratio analyses, analytical comparison of aging and financial class, review of detailed trial balances, etc.
- Concluded that patient receivables, net was reasonable at June 30, 2013

Valuation of Estimated Third-Party Payor Settlements, Net and Estimated Pools Receivable, Net

- Reviewed all fiscal 2013 third-party reimbursement activity and correspondence.
- Utilized KPMG reimbursement professional to assist in the review of third-party payor liabilities and receivables
- Assessed management's process for estimates relating to open rate years based upon audited rate estimates, census data, and tested management's supporting calculations for accuracy and appropriateness
- Upper Payment Limit (UPL) revenue decreased $37 million from $565 million in 2012 to $528 million in 2013
- DSH max revenue increased $69 million from $412 million in 2012 to $481 million in 2013
- During 2013, the Corporation recorded adjustments to prior year estimates based on new information resulting in a $28.2 million decrease in net patient service revenue (see footnote 4)
- The Corporation's estimate for the RAC liability is based on the current information available to management and is subject to change
- Concluded that the estimated third-party payor settlements, net and the estimated pools receivable, net were reasonable at June 30, 2013

Significant estimates (continued)

Valuation of Post-employment Benefits Other Than Pension Liability

- The Corporation recorded costs in the amount of $299 million and $303 million for the years ended June 30, 2013 and 2012, respectively. The amount paid was approximately $98 million and $94 million for 2013 and 2012, respectively
- Change in methodology to determine the post-employment benefits liability from frozen age actuarial accrued liability to the entry age actuarial accrued liability
- A KPMG actuary reviewed the actuarial assumptions utilized by the City of New York actuary and determined the reasonableness
- Agreed the liability per the client's actuarial report to the general ledger
- Agreed current year OPEB expense to the general ledger and vouched current year contributions
- Performed attribute testwork over the data utilized in the City's actuarial calculation to determine completeness and accuracy of the data
- Concluded that the post-employment liability was reasonably stated at June 30, 2013

Valuation of MetroPlus Incurred But Not Reported (IBNR) Liability

- MetroPlus management has controls in place over both premium revenue and expense. Additionally, management has an actuary review performed over MetroPlus IBNR at both December 31 and June 30
- A KPMG actuary reviewed the actuarial assumptions and determined the reasonableness of the liability at December 31, 2012
- Performed a rollforward of substantive testwork from December 31, 2012 to June 30, 2013
- Performed attribute testwork over the claims triangle to determine the accuracy of the data (data utilized by actuary to calculate liability)
- Concluded that the IBNR liability was reasonably stated at June 30, 2013
- KPMG performed a statutory audit on MetroPlus as of December 31, 2012

Other significant areas/transactions

Information Technology Review

- Utilized KPMG Information Technology (IT) professionals to assist in the review of the Information Technology general controls as well as the application controls which included:
  - Access to programs and data
  - Program changes
  - Computer operations
- Reviewed specific applications and reports
- Concluded that Information Technology general controls are operating effectively

Appropriations From (Remittances to) City of New York (see footnote 1g)

- Decreased $8.4 million from remittances of $9 million in 2012 to remittances of $.6 million in 2013
- The Corporation received appropriations from the City in 2013 of approximately $271.2 million primarily relating to malpractice settlements, interest on DASNY and General Obligation Debt, and cash received for operations
- The Corporation was charged by the City for malpractice expense of $121 million and debt service of $150 million in FY13.

Long-Term Debt (see footnote 7)

- During 2013, the Corporation issued approximately $112 million of tax-exempt fixed rate Health System Bonds, 2013 Series A bonds (2013 Bonds)
- Proceeds of the 2013 Bonds and approximately $13.2 million in residual funds from the 2008 Series A bonds were used to:
  - Refund and redeem all of the Corporation's 2003 Series A bonds
  - Refund and defease a portion of the Corporation's 2008 Series A bonds

Other significant areas/transactions (continued)

Governmental Accounting Standards Board No. 61 (GASB 61)

- As a result of the adoption of GASB 61, MetroPlus is now classified as a discretely presented component unit, which require a new format in the financial statements and additional disclosures.

Impairment

- The Corporation has recorded a fixed asset impairment loss of approximately $12 million as a result of the impact of Super Storm Sandy on the facilities' service utility.

Super Storm Sandy Related Expenses

- FEMA public assistance will cover the costs to repair or replace facilities to pre-storm conditions and to make improvements to meet codes and standards. The Corporation hired an outside consultant to assist in the review of invoices being submitted for FEMA reimbursement to ensure eligibility
- As of June 30, 2013 the Corporation identified $153 million of capital costs and $92 million of expenses
- New York City allocated $183 million in Community Development Block Grant (CDBG) funds to support operational expenses not covered by FEMA
- The Corporation received $83 million in FEMA public assistance in cash as of June 30, 2013 from the City of New York ($62 million expense and $21 million capital)
- The Corporation accrued $194 million as of June 30, 2013

Fraud considerations

Identification of fraud risks

- Performed risk assessment procedures to identify fraud risks, both at the financial statement level and at the assertion level
- Discussed among the audit team the susceptibility to fraud
- Inquired of management and others
- Evaluated broad programs/controls that prevent, deter and detect fraud

Response to identified fraud risks

- Evaluated design of mitigating controls
- Tested effectiveness of controls
- Performed specific substantive audit procedures
- Utilized assistance of forensic professional in conducting selected interviews and addressing fraud risks
- Performed selected interviews:
  - Emily Youssouf, Audit Committee Chair
  - Dr. Stocker, Chairman of the Board
  - Alan Aviles, President and CEO
  - Marlene Zurack, Senior Vice President of Finance
  - Wayne McNulty, Chief Corporate Compliance Officer
  - Jay Weinman, Corporate Comptroller
  - Salvatore Russo, General Counsel
  - Chris Telano, Chief Internal Auditor and Assistant Vice President
  - Maxine Katz, Senior Assistant Vice President of Revenue Management

KPMG reports

- Auditors' report on the basic financial statements of the Corporation
- Stand-alone financial statements were issued for:
  - MetroPlus Health Plan (December 31, 2012)
  - HHC Insurance Company, Inc. (December 31, 2012)
- Management letter
- Auditors' reports on debt compliance
- Auditors' report on agreed upon procedures related to the 11 acute care hospitals and 2 specialty hospitals bad debt and charity care policies
- Auditors' report on Cost Reports (RHCF-4's, AHCF's and LTHHC)

Open items

- Finalization of financial statements, including footnotes, statement of cash flow and concurring review partner questions
- Finalization of review of Superstorm Sandy related items and accounting
- Search for unrecorded liabilities
- Debt covenant calculations
- SAS 99 meeting with Salvatore Russo, General Counsel

KPMG resources

KPMG's Healthcare & Life Sciences Institute

- The KPMG Healthcare & Life Sciences Institute has been established to provide an open forum for business leaders from across the industry to share perspectives, gain insight, and develop approaches to help balance risks and controls, and improve performance. To learn more about the Healthcare & Life Sciences Institute and become a member, please visit: http://www.kpmginstitutes.com/industries/healthcare-and-life-sciences.aspx

KPMG's Audit Committee Institute

- KPMG created the Audit Committee Institute (ACI) to serve as a resource for audit committee members and senior management. ACI's stated mission is to communicate with audit committee members and enhance their awareness, commitment, and ability to implement effective audit committee processes. The following link will take you to ACI website which contains information on upcoming seminars and publications available for download and also to become a member: www.kpmginstitutes.com/aci/index.aspx

KPMG's Audit Committee Insights

- KPMG's Audit Committee Insights is a biweekly e-mail alert that is designed to help audit committee members stay up to date on recent events. Audit Committee Insights' editors review hundreds of respected business journals, industry publications, and association web sites to bring the information to your desktop in an easy to read email. You can sign up for this e-mail at the following link: http://www.kpmginstitutes.com/aci/insights/2012/kpmg-audit-committee-insights-newsletter.aspx

AUDIT COMMITTEE OF THE HHC BOARD OF DIRECTORS

Corporate Compliance Report

September 12, 2013

Table of Contents

I. Compliance Training

- All members of the HHC Board of Directors ("Board") have been enrolled in the compliance computer-based training ("CBT") module. The CBT module is also available on compact disc ("CD") for those Board members who are unable to access the module via the HHC PeopleSoft system. CDs of the CBT module have been provided to the Office of the HHC Chairman for distribution. Although efforts were made to make the course available through HHC-issued smart tablets, there were several technological obstacles that prohibited such remote access. Board members will have until November 1, 2013, to complete the CBT.
- The compliance CBT period, which started on January 1, 2012, ended on June 30, 2013. All HHC healthcare professionals, physicians, and Group 11 employees (as well as other HHC employees or affiliates who were designated to complete CBT training) who have not completed the training have until September 16, 2013, to complete the same.

II. HHC Self-Identification of Corporate-wide Risks

- The Office of Corporate Compliance ("OCC") made significant progress in identifying and prioritizing corporate-wide risks. On July 10, 2013, the Executive Compliance Workgroup ("ECW") identified and scored potential corporate risks.
- Since June of 2013, 16 different Network/facility compliance committees (collectively hereinafter "NCCs") have convened to identify and score Network and/or facility specific risks.

III. Status of the FY14 HHC Corporate Compliance Work Plan

- In the upcoming weeks, the ECW and the various NCCs will select (based on the results of HHC's risk identification process) proposed risk items for inclusion on the FY14 HHC Corporate Compliance Work Plan ("Work Plan"). An interim-final FY14 Work Plan will be presented to the Audit Committee of the HHC Board of Directors (the "Audit Committee") in October of 2013.

IV. Compliance Index (Summary of Compliance-based Reports)

- For the second quarter CY2013 there were 120 compliance-based reports of which 7 were classified as a Priority "A" reports, 38 were classified as Priority "B" reports, and 75 were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. Of the 120 reports received in the second quarter of CY2013, 79 (or 65.8%) were compliance complaints received on the OCC's anonymous toll-free compliance hotline.

Summary:

1) Report Classification

There are three (3) different report categories: (i) Priority "A" reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority "B" reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority "C" reports – matters that do not require immediate action.

V. Privacy Compliance Index (Summary of Privacy-based Reports)

- During the period of April 1, 2013 through June 30, 2013, twenty-five (25) complaints were entered in the HHC HIPAA Complaint Tracking System, an HHC proprietary database. Of the twenty-five (25) complaints entered in the tracking system twelve (12) were found after investigation to be violations of HHC HIPAA Privacy Operating Procedures; zero (0) were determined to be unsubstantiated; seven (7) were found not to be a violation of HHC HIPAA Privacy Operating Procedures: and six (6) are still under investigation. Of the 12 confirmed violations, two (2) resulted in a breach. An additional incident occurred during the first quarter of calendar year 2013, but was omitted from the First Quarter CY2013 Corporate Compliance Report due to a late submission to the HIPAA tracking system.

VI. OCC Staffing Update

- The OCC has two vacant compliance officer positions: one in the North Bronx; and one in Queens. The recruitment process for the North Bronx and Queens positions has commenced.

VII. Monitoring of Excluded Providers

- No self-disclosures related to the use of excluded providers were made to regulatory bodies since the last time the Audit Committee convened in June of 2013.