AUDIT COMMITTEE
MEETING AGENDA

October 8, 2015

12:30 P.M.

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

CALL TO ORDER

- Adoption of Minutes September 17, 2015 — Ms. Emily A. Youssouf

INFORMATION ITEMS

- Fiscal Year 2015 Draft Financial Statements and Related Notes — Julian John
- Fiscal Year 2015 Report to the Audit Committee — Ms. Maria Tiso, Partner KPMG
- Audits Update — Mr. Chris A. Telano
- Compliance Update — Mr. Wayne McNulty

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: September 17, 2015
TIME: 12:30 PM

COMMITTEE MEMBERS
Emily Youssouf, Chair
Josephine Bolus, RN
Jo Ivey Boufford, MD (VIA VIDEO CONFERENCE)

STAFF ATTENDEES
Antonio Martin, Executive Vice President/COO
Barbara Keller, Deputy Counsel, Legal Affairs
Deborah Cates, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
Marlene Zurack, Senior Assistant Vice President/CFO, Corporate Finance
Paul Albertson, Senior Assistant Vice President, CO-Material Management
Randall Mark, Chief of Staff, President's Office
Julian John, Corporate Comptroller
Gassenia Guilford, Assistant Vice President, Finance
Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits
Wayne McNulty, Corporate Compliance Officer
Paul Albertson, Senior Assistant Director, Materials Management
Nelson Conde, Senior Director, Office of Professionals Services & Affiliations
Leithland Tulloch, Senior Director, Office of Facilities Development
Alice Berkowitz, Assistant Director, Finance
Darren Ng, Supervising Systems Analyst
Devon Wilson, Senior Director, Office of Internal Audits
Chalice Averett, Director, Office of Internal Audits
Carol Parjohn, Director, Office of Internal Audits
Steve Van Schultz, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Delores Rahman, Audit Manager, Office of Internal Audits
Frank Zanghi, Audit Manager, Office of Internal Audits
Roger Novoa, Supervising Confidential Examiner, Office of Internal Audits
Armel Sejour, Supervising Confidential Examiner
Sam Malla, Associate Staff Auditor, Office of Internal Audits
Barbarah Gelin, Associate Staff Auditor, Office of Internal Audits
Doriana Alikaj, Associate Staff Auditor, Office of Internal Audits
Nastasya Barnett, Staff Auditor, Office of Internal Audits
Guzal Contrera, Staff Auditor, Office of Internal Audits
Erica Nairne-Hamilton, Staff Auditor, Office of Internal Audits
Jean Saint-Preux, Confidential Examiner, Office of Internal Audits
Roshney Kaur, Staff Auditor, Office of Internal Audits
Linda Maldonado, Staff Auditor, Office of Internal Audits
Sandy Bhigroog, Staff Auditor, Office of Internal Audits
Sheldon McLeod, Chief Operating Officer, Kings County Hospital Center

Michelle Emmons, Associate Executive Director, Kings County Hospital Center
Anthony Saul, Chief Financial Officer, Kings County Hospital Center
Dorene Lewis, Associate Director, Kings County Hospital Center
Ron Townes, Associate Director, Kings County Hospital Center
Timi Diyaolu, Controller, Bellevue Hospital Hospital Center
Kiho Park, Associate Executive Director, Queens Health Network
Elsa Cosme, Chief Financial Officer, Governeur Healthcare Services
Rosely Lantigua, Assistant Director, Governeur Healthcare Services
Martin Novzen, Senior Associate Director, Woodhull Medical & Mental Health Center
Brian Stacey, Network Chief Financial Officer,
Lisa Stager, Network Deputy Chief Financial Officer
Milenko Milinic, Network Controller, Queens Health Network
Katrina Borruso, Associate Director, Queens Health Network

OTHER ATTENDEES

PAGNY: David N. Hoffman, Compliance Officer
MOUNT SINAI HOSPITAL: Caryn Pannone, Finance Director; Ken Feifer, Associate Dean

SEPTEMBER 17, 2015
AUDIT COMMITTEE OF THE BOARD OF DIRECTORS
NYC HEALTH & HOSPITALS CORPORATION

An Audit Committee meeting was held on Thursday, September 17, 2015. The meeting was called to order at 12:30 P.M. by Ms. Emily Youssouf, Committee Chair. Ms. Youssouf then asked for a motion to adopt the minutes of the Audit Committee meeting held on June 11, 2015. 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 of personnel and potential litigation.

Ms. Youssouf turned to Chris Telano for the audits update.

Mr. Telano saluted the Committee Members and said that we will start with the briefing on page three, which is the summary of the audit report issued by the New York City's comptroller's office of the audit of the Lincoln affiliation agreement with PAGNY. We have spoken about this the last few meetings. The only reason it's still in the briefing is that it was issued in final about two weeks after our last meeting; nothing has changed. The same exact findings they noted on the draft reports regarding subcontractor agreements being paid without supporting documents and the recalculation document not completed timely and bank accounts for the faculty practice plan were not established timely by PAGNY. This report is closed and issued in final on June 19th.

At this point in time there are no ongoing audits being conducted by either the state or the city comptroller's office, so we have nothing else pending.

Ms. Youssouf stated that that's good news.

Mr. Telano said that on page four is the completed audits that have been done since the last meeting in June, and the first audit is of the Mount Sinai affiliation within the Queens Health Care Network. He asked for the representatives to approach the table. Ms. Katrina Borruso introduced herself as the Security Officer for Queens Health Network.

Ms. Borruso stated that per this audit, we were given 17 personnel that were listed as active after 12 termination. Four of them were still active employees. Seven of them we were notified by the affiliation after they had separated. Two of them the corporate account manager was notified on a Friday. The corporate account manager is 18 not a 24 hour process. If they were notified Friday after four, they have a 72 hour turnover. They might not have gotten to it until Monday, Tuesday or even Wednesday.

Ms. Youssouf asked what do you mean a 72 hour turnover? To which Ms. Borruso responded that there is a 72 hour turnover for responses from the corporate account manager. So if I submit a request to create or remove an account today they have up to 72 hours to process it.

Ms. Youssouf asked who sets the 72 hours? Ms. Borruso answered that that would be the corporate account manager.

Mr. Telano then asked if there were other representatives from Queens. Ms. Youssouf asked them to come to the table and introduced themselves. They did as follows: Brian Stacey, Network Chief Financial Officer; Ken Feifer, Associate Dean, Mount Sinai; Caryn Pannone, Finance Director, Mount Sinai; Lisa Stager, Network Deputy Chief Financial Officer.

Mr. Telano said that we will start at item B, and the findings are that, at the Queens Network 12 of 30 terminated employees still had active status to Group Wise, which is our email system. And of the 12, eight were at Elmhurst

and four at Queens. One even logged into the system 30 days after their termination date. The second bullet point refers to ID cards in which we checked 15 ID cards at Elmhurst and 15 at Queens and 12 of the 15 at Elmhurst were not deactivated timely. While only one at Queens was not deactivated timely. Although that one was never deactivated and after 130 days it expired automatically.

Ms. Youssouf asked who is responsible at Elmhurst and Queens for the deactivation -- for these two matters? I'm trying to figure out what department it's in.

Ms. Borruso said that we are notified by the two HRs, Mount Sinai and HHC. They usually send an email to myself and to certain key individuals. Once I receive that email it is automatically forwarded with all pertinent information to the separation teams and the corporate account manager, where a ticket is opened for them to process the deactivation.

Ms. Youssouf asked who is the corporate manager and is that person here? Ms. Borruso answered no. Ms. Youssouf then asked if there is somebody that person reports to present?

Ms. Borruso answered that they are not Queens Health Network that they are corporate IT.

Mr. Martin said that I guess that is my responsibility. Ms. Youssouf then asked if Mr. Martin's group has 72 hours to do something with this information.

Ms. Borruso responded yes.

Ms. Youssouf asked Mr. Martin if it is possible that when it comes to a deactivation, that that 72 hours could be changed to immediate. To which Mr. Martin responded absolutely, I will make sure that that happens now that I understand the process. I thought it was actually done locally at the facility.

Ms. Borruso added that it is done by the corporate account manager but they are not a 24 hour operation.

Ms. Youssouf said I think IT is a 24 hour operation. Mr. Martin added that it sure is.

Ms. Youssouf stated that it is open 24 hours, there seems to be some confusion. To which Mr. Martin said that there sure is, I will take of care of it.

Mr. Russo asked was there a timely transmission of the information to them. Ms. Borruso answered yes, for all but three.

Mr. Martin said let me be clear, you got the information right away? Ms. Borruso said correct, for all but three.

Mr. Martin then said that the fault is here.

Ms. Youssouf asked if the three you did not submit was there any particular reason. Ms. Borruso answered that for the first time in five years I took a vacation and when I forwarded my messages there was a problem with the forwarding and so there was an overflow and they got delayed because of that. It was a mistake in my forwarding. I accidentally had it forwarding everything and the mailboxes got flooded and they were overloaded. That was my mistake.

Mr. Telano continued by stating that the other finding, A in our briefing, states that the recalculation document between Mount Sinai and the Queens Health Care Network was finalized on June 29, 2015 for the June 30, 2014 year end.

Dr. Boufford asked if this is causing us a problem or it isn't, therefore it's happening fairly routinely? Is there anything we should be doing or is it okay? Mr. Martin responded that I guess this is in my purview also. The recalcs have been a problem here. We had identified one other affiliate where there had been a number of years where the recalcs weren't done on a timely basis. We have corrected that issue, so that all of the recalcs for 2014 have been done. With the new affiliation contracts that we are putting in place, we are actually embedding a time frame for when the recalcs need to be done. We are actually trying to streamline the recalc process because it is a little onerous. We are quite aware of this being an issue and I think we are taking the appropriate steps.

Ms. Youssouf asked what is the time frame? To which Mr. Martin responded that I believe six months. I believe that's fair to the affiliate and to us for the recalc to be completed.

Mr. Youssouf stated that the reason it's an issue is because it's been cited. Mr. Telano said that it's been cited previously in this audit and also in the city comptroller's as I mentioned before. They also cited it with the Lincoln affiliation.

Ms. Youssouf added that because they've cited it, obviously the Corporation wants to correct it because it shouldn't happen. But if I could, can I just ask Ms. Zurack, perhaps you can explain the process, the steps here.

Ms. Zurack said that pursuant to the contract the affiliate is supposed to prepare a draft recalc and submit it to the facility affiliation officer, which would be Ms. Stager in the Queens Network for example. Once the hospital blesses it, it gets sent simultaneously to the Office of Professional Affairs (OPSA) and to finance. Then ultimately OPSA and finance check it. If there are mistakes they tell the hospital person. They go back to the affiliate and fix it, and when everyone agrees the numbers are correct, Mr. Martin and I sign it along with the Executive Director of the hospital and the recalc is done. It can result in money owed one way or another and change the payment amount.

Ms. Youssouf asked is it necessary that it goes to OPSA? Ms. Zurack responded absolutely because of the separation of function. So, the truth is, I, as the corporate treasure for example, I would never sign something that Mr. Martin has not signed first; because you need that separation of function. Otherwise, I could be paying for something that he has not checked and that would not be correct. I think that the delay is, we have each affiliate and even in the same affiliate for each hospital they are doing their own worksheets and they are different, they are not standard. There is a level of detail that is required because of the way the budgets are set up. So, if you have overspending in one department and underspending in another that does not wash unless you do special paperwork to make it wash. In addition, some of the elements of the affiliation contract require data for the final settlement that actually could take longer than the six months we are putting in the contract. For example, this may be a bad example, I'm trying to fix this, some of the performance incentives you do not actually know how they performed until a certain period after the end of the contract year. Also, there are certain individual incentive payments for certain kinds of individual physicians that require a lot of data and sometimes those things kind of lag.

You want to have a process that is speedy. But also if you were audited by an outside party, you have to have this separation of function. You have to have everyone check it. And there are certain kinds of payment systems that require this data for all kinds of legal reasons that may require taking more time than the auditors may like. So, the solution really has to include making sure your contract terms are not so detailed that you're locked into a detailed recalc. So, if the contract terms says that Mount Sinai needs to show us by doctor every hour spent, then that's what they need to show us. There's no give on that. If the city Comptroller came in and we didn't check that we might not be cited for being late but cited for having it wrong. Which I think would be worse actually. So, I think while it may seem like skip a step or this that, it really means making the actual recalc standard across the Corporation. Not everyone doing their own form. Hopefully automated so that the data can just flow from a payroll system into a database as opposed to each person keying in. And hopefully not so detailed that you can't get the data for a very

long period of time. For some of the contracts transitioning to that is a bit of a challenge but we are committed to doing that.

Ms. Youssouf said that one, is that we don't like to be cited, especially by an outside auditor for anything. That's why this is critical to change this. Secondly is that if in fact they owe us money, I don't know how often that happens, I don't mean this particular but any affiliate owes us money, if that ever happens, that in my mind means that we are providing basically a working capital line to them and we can't afford to do that for anybody frankly. So, that's why this does need to be fixed. And it sounds like you're in the process of putting all this together.

I would ask that you keep us informed, the committee, so we know when it sticks because this is not the only time this has risen obviously. Now you are working on it, I think it sounds like the appropriate fix.

Mr. Martin added that I guess the other thing I mentioned, instead of the back and forth between all of the different entities that need to be involved we are talking about doing it together so everybody sits down in a room and goes through the process. All of this back and forth we can just cut out some steps. We are committed to number one, first and foremost, protect the Corporation but also to get this done in a timely manner.

Ms. Youssouf asked that would anybody from the institution or anyone like to add something?

Ms. Borruso stated that I misspoke before of the 17, 7 we were notified after the employee had already separated from service. So we were not notified until after they had separated and five of them were still considered active employees. They were marked terminated but they were still active because they either came back as an HHC employee or switched from Elmhurst to Queens or Queens to Elmhurst.

Ms. Zurack: stated that I want to add one thing. Typically this particular network does a really good job with the recalcs and has been as current as any of our networks have been. I don't know if this was a little slippage in this year but their track record has been very, very good as has been their affiliate in providing data. Sometimes you don't know the context when you see the audit. In terms of recalcs typically they have been current relative to the corporate average and so I think that we should take this in context.

Ms. Stager commented that one of the things, I know we were cited last year, we have put together the recalc process and had it paid within the fiscal year. What changed with this contract, and it contributed in this instance as well, is based off the additional language that went into the last contract. We were required to do an extensive amount of additional audit work. So once we get the recalc there is a lot of audit work on my part to validate the numbers that are showing up in the recalc that we did not in the past have to do as much of.

Ms. Youssouf if it was because there was a change in the contract language?

Ms. Zurack responded that my office insisted that they be a little stricter with their affiliate in terms of level of detail. So we upped the detail in the recalc. Because their detail used to be much less than the others. Their recalc went up to the other standard. I think they're still probably doing better than average but not doing as well as they used to do. And that's my point about time versus accuracy. There is a trade-off.

Ms. Youssouf stated that there is a trade-off but now that you know you have to do the detail -- I mean, this is not insurmountable. It should be able to be done all of these on time. It just always seems, my many years of experience, it seems unfortunately -- I'm not picking on you -- in general when it comes to the city and the city's money and all that it's always like well, there's so much work involved. You know what? I mean, it's kind of life. I appreciate what you're saying but I don't think that -- once, maybe twice but after that there is no good excuse.

Mr. Telano continued and stated that the next audit on page five of the briefing is once again an affiliation. This time it's the agreement between the State University of New York and Kings County Hospital Center. He asked the representatives to approach the table and introduce themselves. They introduced themselves as follows: Michelle Emmons, Director; Leo Johnson, SUNY; Sheldon McLeod, COO; Dorene Lewis, Associate Director; Anthony Saul, Chief Financial Officer.

Mr. Telano said that the first issue is once again about the recalc. We don't need to discuss that any further.

Ms. Youssouf stated that I'm assuming that all of the relevant parties are well aware you are working on a way to make it more cohesive all the way around.

Mr. Telano continued onto the other issue which was that two affiliate staffs were being paid without regularly submitting time sheets which would substantiate the times worked. One employee over a two-year period or even less did not submit their time sheet for 24 pay periods and the other employee did not submit their time sheet for seven pay periods.

Ms. Youssouf asked could we have an explanation about why that occurred and what you're going to do to make sure it doesn't happen again?

Mr. Johnson responded that one of those employees is in the assimilation program. We physically don't see that employee at Downstate. That person actually works at Kings County. It's somewhat of a challenge to get a time sheet from that individual. The FT is 20-20, the salary is $20,000. From my understanding the way the program works, the staff from Kings County goes to a facility in Manhattan and they train in some sort of assimilation program. That individual that is conducting a training, there's no schedule that you can tie him down to nine to five. It's sort of a challenge for us to get an accurate time sheet on that individual. Going forward we contacted the administrator and told him that we have to have time sheets for this individual. If not, we are going to remove him from the state payroll.

Mrs. Bolus asked do you have to have some sort of special something to give him his paycheck on a regular basis? Does he get his paycheck on time? Mr. Johnson answered that we could hold his paycheck.

Mrs. Bolus then stated that there's no problem with the paycheck. It's just putting in the paper to get the paycheck? You understand what I'm saying? If he has a method of getting a paycheck he has a method of getting us his time sheets.

Mr. Saul commented that this was a special program where we were working in conjunction with Jacobi. We had this one individual who was actually stationed at Kings and had rotating hours. We do have an assimilation center set up there, so physicians would come in to train there as well as at Jacobi. We have spoken jointly with Jacobi and with the program for that particular department to ensure that they submit the annexes to us timely so that we can incorporate it with the other annexes that we do receive from SUNY on a monthly basis.

Mr. Russo asked if this an HHC employee. To which Mr. Saul responded yes and Mr. Russo asked is he a union position.

Mr. Saul said it is a union position, this individual also has an appointment at Downstate. This actually allows us to facilitate this special program. It was really Downstate partnering with HHC and Kings to ensure this program.

Ms. Youssouf said that this sounds like somebody else's responsibility. Mr. Saul said that it is our fault. It is our responsibility to change it.

Ms. Youssouf commented that I think it is great somebody is working in assimilation and can do the special program. But I would urge you that that exists and that's wonderful, but as Ms. Bolus just said, if somebody is getting paid and nobody knows -- there's no record to show that he showed up, he's getting paid for what he did, it's really just not acceptable. I'm sure you can appreciate why because if it happens once people are afraid it happens more than once.

Mr. Martin added that that's exactly my concern. I need Mr. Saul to assure me that you are doing the adequate checks to make sure this isn't occurring elsewhere in your facility.

Mr. Saul said that we are.

Mrs. Bolus asked if he is getting paid just by us not by SUNY? To which Mr. Saul responded that for our portion it is a point two FTE. $20,000 is the cap on what we pay. We do not look at the portion outside of our facility.

Mr. Russo asked if SUNY also paying him? Mr. Saul said that it is pass-through on our behalf.

Mrs. Bolus asked if he submits his pay vouchers to SUNY? Do they get it on time? Mr. Johnson responded that we have the normal state time sheets.

Mrs. Bolus then asked that he puts those in on time but ours he does not? To which Mr. Johnson answered right, yours he does not. Because yours has to be signed off on by a supervisor, and to lock in who's the responsible supervisor has been a challenge in the past.

Ms. Youssouf stated that to me is shocking that somebody does not know who their supervisor is for 24 months. Mr. Martin, we are believing that you are going to get a charge and whoever else is responsible to get your arms around this. I mean, this is something that could be incredibly problematic in many, many ways. We're paying someone and we have no record that they worked. I'm assuming everybody can appreciate that.

Ms. Zurack commented that the solution to the problem was that there was no one on-site at Kings to sign the time record because the activity was taking place at Jacobi. You have now made arrangements for Jacobi to sign the time records. The problem is solved for this individual, and you are going to make sure, Mr. Saul, that this is taken care of for the entire institution if there are any similar arrangements? Mr. Saul answered that that is right.

Ms. Youssouf thanked Ms. Zurack and thanked them for coming.

Mr. Telano continued and said that I just want to go through the rest of the briefing real quick. On page six is the audits in progress. You can see they are all affiliations. On page seven is just the status of our follow-up audits. I just wanted to note that our follow-up audit program is working. We have found since we implemented this a few years ago, 99 percent of the issues that were found originally were either partially resolved or resolved.

Ms. Youssouf said that the good news is that I know people hate to come to Audit Committee -- but that means the Office of Internal Audits is working because that's the point. You'd rather be here and having us say what's going on than having somebody from the outside, especially a regulatory authority, saying what's going on?

Mr. Telano commented that I would only bring someone back to the committee if we found that they did not take any action. So we have yet to bring anyone back.

Ms. Youssouf stated that this is all in saying that internal audit is your friend.

Mrs. Bolus said that on this sheet MetroPlus is behind six months. To which Telano acknowledged that we just have not gotten to the review yet. We are behind in some of our follow-ups. We have not done it. We will be doing it shortly. He then said that that concludes my presentation.

Ms. Youssouf then passed the presentation over to Compliance.

Mr. McNulty saluted everyone and said turn to section one paragraph one on page three of the corporate compliance report. This is a follow-up on an audit that took place by the Department of Health and Human Services Office of the Civil Rights in the first quarter of 2014. Since then we have responded with numerous documents to the Office of Civil Rights. The audit involved their review of Metropolitan's policies and procedures as it relates to limited English proficiency. And also the policies and procedures as it relates to the security and privacy of protected health 21 information. And actually when they look at the security and privacy of protected health information, because HHC is to cover any, they look at the entire Corporation. I want to provide the Audit Committee with an update. We have entered into a contract with a third-party vendor to provide a security risk analysis. The third-party vendor will provide infrastructure security and perimeter penetration assessment, application vulnerability assessment. They will also provide a risk analysis of all systems that house, store, process or transmit protected health information.

Please turn to page four of the report. The timetable for the assessment to be performed by the vendor, they actually started this week, they performed their audit of central office. Of all facilities in central office, and today they are up at the North Bronx Health Care Network to perform a perimeter assessment. And they will be performing a risk analysis in Metropolitan sometime next week. We will have to report back to the Office of Civil Rights on a periodic basis.

On September 9th we received a letter from the Office of Civil Rights that they were closing this matter contingent on us following up with them on a periodic basis. They did have some recommendations with regard to our policies and procedures as it relates to limited English proficiency. We are going to meet internally to discuss those recommendations. We have a follow up phone call with the Office of Civil Rights at the end of the month to discuss those recommendations. We will brief the Audit Committee in October when we next convene to go through in detail what recommendation the Corporation will accept in regards to those recommendations.

Moving along to the privacy incidents and related reports. We received 22 complaints with respect to our HIPAA incident tracking system. Out of the 22 complaints, 11 were determined to be violations of the HIPAA operating procedures. Six were determined to be unsubstantiated. One was not a violation. And four were determined to be still under investigation. Out of the 11 violations, six were determined to be breaches of protected health information.

Please turn to the next page on page five, just briefly in paragraph three, you can see the definition of a breach, which is the impermissible use, access, acquisition and disclosure of protected health information that violates the privacy rule. Turn to page six. There are a couple of breaches I would like to go over with the committee. The first one occurred at Bellevue Hospital Center. There was a record that was released to the United States District Court. We received an order from a clerk of the court but not an order from the judge. So, Bellevue mistakenly thought that an order from the clerk of the court was the same as a court order but it's not. They released information back to the court. The patient complained to the Office of Civil Rights and the Office of Civil Rights contacted us. We instructed Bellevue to revise their policies and procedures with regard to that.

Ms. Youssouf stated that that's something I did not realize the difference, and I just want to be sure that perhaps all the facilities get reminded of that. That seems like a difference that not everybody would know.

Mr. Russo added that it is really a shame that our clerks who gets these things have to almost have a law degree. They're always encouraged to call our office if there is anything. That was such a nuanced difference. In terms of any harm or anything it was back to the court. It was a technical violation but that's really a close issue.

Mr. McNulty stated that we have policies and procedures in place that exist that make this clear. The other privacy offices throughout the facilities are aware of this and the Office of Civil Rights have on their website this distinction.

Ms. Zurack asked that if they had known what should they have done? Mr. McNulty responded that they should contact legal affairs, and legal affairs would need to quash the subpoena. Or probably just call the clerk and say to the clerk that can you please have a judge sign the court order. So then it would be an actual court order.

Mr. Russo said that the right procedure is to call us. To which Ms. Zurack said that I do not think they know that.

Mr. Wayne said that we can brief the facilities.

Ms. Youssouf said that I think that would be very helpful if you could schedule that. Mr. McNulty added that in this particular case it looked just like a court order.

Mr. McNulty continued and stated that there was another breach that I would like to briefly discuss. This occurred at Bellevue Hospital Center. This was a breach that occurred when the information was sent pertaining to protected health information to a case manager at a shelter. The shelter is not considered a health care provider under HIPAA regulations. Technically this is a breach of protected health information. So we will provide training and education with regard to the same.

If we can turn to page eight. The monitoring of excluded providers. We had one excluded provider out at Harlem Hospital. The individual worked in the OB-GYN department. He had privileges granted in January 2015. The affiliate PAGNY checked to ensure that he was not in fact excluded and they did a vendor check. However, the vendor did not pick up that he was excluded. Internally the medical staff office picked up that he was excluded but the individual that performed the check reported to their supervisor and the supervisor did not further escalate the situation. So the person was allowed to be brought on with regard to PAGNY. We learned about it in May or June at the same time as OMIG contacted us. It turns out that we're looking at $85,000 that we have to give back. This was a unique situation as the provider was excluded in 1992. The provider had since had their license reinstated. The provider thought they were in fact off the exclusion list. In fact they were not on the exclusion list for Medicare just for Medicaid. In fact, once the provider wrote the Office of the Medicaid Inspector General within I would say in 10 or 14 days, they took the exclusion off. I believe he's back at Harlem Hospital Center. We performed a self-disclosure protocol to the Office of Medicaid Inspector General and we are awaiting direction with regard to the payment. We are hopeful that they will waive the payment in this particular case.

Ms. Youssouf said that what is important is that if you could just briefly say how you caught this. Because we have three checks.

Mr. McNulty said that we have a check that's performed by the affiliate. So the affiliate should not bring anyone under their contract that is excluded. Then the Medical Staff Office performs a check. Any time the individual has to be re-credentialed they have to do another check. Then there is a check that's performed at central office by my office. There's three checks. That redundancy normally works, but in this case the vendor didn't pick up the exclusion check. We did pick it up at Harlem but when it was escalated for whatever reason he was still brought on. By the time we picked it up at central office OMIG had picked it up at the same time. I think we have a good process in place.

Ms. Youssouf stated that that's what I was going to comment on because I believe we do have a good process. I think it's great. It's a shame it all happened but you knew when OMIG picked it up you were like yes, we were on it I think speaks well how you do this.

Mr. McNulty continued on to section four on page nine. I want to provide an update on the corporate-wide risk assessment. As I previously informed the Audit Committee, we have started our enterprise-wide risk assessment. We started this process in March as far as assessing all the different risks. Then in late July, in the first week of August, if you could turn to page ten, the middle bullet on page ten, bullet number two, we have met with all the compliance committees at the various networks. We met with 19 different compliance committees in a three week period. And since then we have three additional different compliance committees in central office and we met with executive leadership at each facility and discussed all the corporate risks which were unique to each facility. Each facility had a unique set of risks.

We had a discussion about the risk here at central office with the executive compliance work group co-chaired by Mr. Martin and myself. We went through the top 15 risks that were identified throughout the Corporation through our scoring process. The executive compliance work group will meet again in another week to look at the risks that we have identified internally. And then we will come up with a corporate compliance work plan for Dr. Raju's approval and then submission to the Audit Committee for the Audit Committee's determination as to risk tolerance and risk appetite.

We also will have Compliance Committee meetings with regard to DSRIP in the Accountable Care Organization. Actually the Accountable Care Organization Compliance Committee is meeting this afternoon and the World Trade Center Health Program Compliance Committee. We will be performing a risk assessment. So we look forward in October to providing the committee greater detail as to the different risks.

If you would turn to page 11. The Office of Corporate Compliance in the Corporation received a civil investigative demand from the United States Attorney's Office of the Southern District of New York with regard to information concerning HHC Health and Home Care. The Office of Legal Affairs sent out a litigation hold instructing all employees that may have pertinent information to preserve that information. This matter has been assigned to outside counsel, Katten, Muchin, Rosenman, Joe Willey for internal investigation and to respond to the CID. We should have more information once the investigation is concluded.

Mr. McNulty stated that this concludes my corporate compliance report.

Ms. Youssouf stated that they are back from the Executive Session.

There being no further business, the meeting was adjourned at 1:36 P.M.

Submitted by,

Emily Youssouf
Audit Committee Chair

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of The City of New York)

Financial Statements

June 30, 2015 and 2014

(With Independent Auditors' Reports Thereon)

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

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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, 2015 and 2014, and the related notes to the financial statements, which collectively comprise the Corporation's basic 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, 2015 and 2014, and the respective changes in financial position, and where applicable, cash flows thereof for the years 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 and the Schedule of the Corporation's Contributions and the Schedule of the Corporation's Proportionate Share of the Net Pension Liability on pages 59 and 60, respectively, 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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October __, 2015 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.

October __, 2015

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

Management's Discussion and Analysis (Unaudited)

June 30, 2015 and 2014

Financial Analysis

Summary of Assets, Liabilities, and Net Position

June 30, 2015, 2014, and 2013

(In thousands)

	2015 Business-type Activities – HHC	2014 Business-type Activities – HHC	2013 Business-type Activities – HHC
Assets:			
Current assets	$ 2,485,085	2,790,164	2,420,374
Capital assets, net	3,432,430	3,506,375	3,366,456
Other assets	118,444	131,927	169,524
Total assets	6,035,959	6,428,466	5,956,354
Deferred outflows:			
Unamortized refunding cost	15,349	18,240	22,437
Liabilities:			
Current liabilities	3,246,748	3,193,724	2,663,946
Long-term debt, net of current installments	882,848	941,289	1,003,650
Pension, net of current portion	2,334,651	2,045,366	2,734,690
Postemployment benefits obligation, other than pension, net of current portion	4,519,900	4,667,962	4,574,865
Total liabilities	10,984,147	10,848,341	10,977,151
Deferred inflows:			
Net differences between projected and actual earnings on pension plan investments	258,287	708,343	218,450
Net position:			
Net investment in capital assets	2,521,077	2,550,656	2,393,938
Restricted	149,231	150,112	146,786
Unrestricted	(7,861,434)	(7,810,746)	(7,757,534)
Total net deficit position	$ (5,191,126)	(5,109,978)	(5,216,810)

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

Management's Discussion and Analysis (Unaudited)

June 30, 2015 and 2014

Financial Analysis

Summary of Revenues, Expenses, and Changes in Net Position

Years ended June 30, 2015, 2014, and 2013

(In thousands)

	2015 Business-type Activities – HHC	2014 Business-type Activities – HHC	2013 Business-type Activities – HHC
Operating revenues:			
Net patient service revenue	$ 5,729,197	5,653,009	5,233,985
Appropriations from (remittances to) City of New York, net	140,597	399,165	(583)
Grants revenue	526,673	285,763	566,019
Other revenue	61,264	51,110	45,915
Total operating revenues	6,457,731	6,389,047	5,845,336
Operating expenses:			
Personal services, fringes benefits, and employer payroll taxes	3,423,547	3,305,159	3,160,507
Other than personal services	1,566,345	1,527,445	1,443,697
Pension	285,111	224,500	370,370
Postemployment benefits, other than pension	(40,299)	198,991	293,745
Affiliation contracted services	994,294	922,773	915,581
Depreciation	291,729	302,859	282,345
Total operating expenses	6,520,727	6,481,727	6,466,245
Operating loss	(62,996)	(92,680)	(620,909)
Nonoperating expenses, net	(125,067)	(114,392)	(107,252)
Loss before other changes in net position	(188,063)	(207,072)	(728,161)
Other changes in net position:			
Capital contributions	106,915	313,904	395,178
(Decrease) increase in net position	(81,148)	106,832	(332,983)
Net position at beginning of year	(5,109,978)	(5,216,810)	(4,883,827)
Net position at end of year	$ (5,191,126)	(5,109,978)	(5,216,810)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Management's Discussion and Analysis (Unaudited)
June 30, 2015 and 2014

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, 2015 and 2014. 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 for the fiscal year at June 30, 2015 and 2014, 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, deferred inflows and deferred outflows, 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 $81.1 million from June 30, 2014 to June 30, 2015; it had decreased by $106.8 million from June 30, 2013 to June 30, 2014. Net investment in capital assets decreased by $29.6 million and $156.7 million in 2015 and 2014, respectively, as the major modernization projects neared completion and the Corporation continued pay down debt. The Corporation's unrestricted net deficit position increased to $7.861 billion at June 30, 2015 from $7.811 billion at June 30, 2014. The Corporation incurred an operating loss of $63.0 million in 2015 compared with $92.7 million in 2014. The Corporation's net deficit position benefited from $105.7 million and $313.9 million in capital contributions from The City of New York (The City) in 2015 and 2014, respectively.

Significant financial ratios are as follows:

	2015	2014	2013
Current ratio	0.90	0.87	0.91
Quick ratio	0.38	0.34	0.42
Days cash on hand	35.10	19.50	21.41
Net days revenue in patient receivables	63.78	71.91	81.28

(Continued)

The current ratio, quick ratio, and days cash on hand are common liquidity indicators. The net days revenue in patient receivables is an indicator of how quickly the Corporation collects its patient receivables.

Super Storm Sandy

Since Super Storm Sandy in late October 2012, the Corporation has been immersed in the initial emergency responses to the storm, conducted extensive assessments of damages, implemented large-scale recovery efforts, and begun the execution of reconstruction and mitigation programs for the facilities based on our negotiations with FEMA. Currently the Corporation's FEMA claims for repair, reconstruction and hazard mitigation are in excess of $1.8 billion. HHC achieved several major milestones in fiscal year 2015 including:

HHC signed a $1.72 billion Public Assistance Alternative Procedures Program Letter of Undertaking with FEMA, the State of New York and the New York City. This agreement secures the necessary funding to not only restore damages from Super Storm Sandy at Bellevue, Coler, Coney Island and Metropolitan Hospitals but also increases each facility's resiliency to future storms. The agreement includes:

$922 million for Coney Island Hospital in Brooklyn, including reimbursement for repairs already made to the hospital's basement, first floor, and electrical systems. It also includes construction of a new resilient critical services building that will house an Emergency Department on the second floor, plus critical medical services such as x-ray, CAT scan, MRI, pharmacy and labs. Vital mechanical services, such as emergency power generators, heating and cooling systems, and water pumps will also be installed in the new building. The hospital will also build a new flood wall that will protect the campus.

$499 million for Bellevue Hospital Center in Manhattan. Intensive restoration work has already repaired or replaced equipment damaged by the storm. In many cases, equipment such as electrical switching gear has been relocated out of the hospital's basement to higher elevation areas on the first floor. Bellevue has also installed removable flood barriers at its two loading dock entrances facing the East River, and raised its water and fuel pumps to higher elevations.

$120 million for Metropolitan Hospital Center in Manhattan, including almost $7 million for electrical repairs and $109 million for a flood wall that will protect critical infrastructure on the campus to the 500-year flood level.

$180 million for Coler Specialty Hospital on Roosevelt Island, including replacement of a generator that was destroyed, reimbursement for repairs already completed to the electrical system, and a flood wall / berm system that will protect critical parts of the campus to the 500-year flood level.

HHC has successfully worked with FEMA to obligate the funding for this agreement for Bellevue, Metropolitan and Coney Island hospitals and anticipates the obligation of the Coler funding in fiscal year 2016.

HHC has implemented Environmental Assessments and public notice periods to satisfy FEMA and Federal Environmental and Historical Protection requirements. This process has been completed for Coney Island, the remaining facilities are anticipated to be completed in fiscal year 2016.

HHC engaged the New York City Economic Development Corporation (EDC) to serve as the Corporation's facilitating agency for rebuilding, reconstruction and hazard mitigation efforts. EDC is in the process of procuring construction and program managers as well as the architectural and engineering design contracts for the major Sandy related projects.

HHC completed construction of the new Ida G. Israel Community Health Center which opened on September 15, 2015 at 2925 West 19th Street, Brooklyn, NY. The Clinic provides services for Chemical Dependence and Rehabilitation, Dental, Family Planning, Medical Social Services, Pediatric and Primary Medical Care.

During fiscal year 2015 HHC received over $33 million in reimbursement from FEMA for Sandy related expenditures. This includes: $23 million repairs and maintenance work conducted at Bellevue, $5.9 million for emergency work completed to stabilize the facilities, $2.9 million for emergency generators at Coler and $.8 million for a temporary MRI and CT Scanner at Coney Island Hospital.

Variances in Financial Statements

In this section, the Corporation explains the reasons for certain financial statement items with variances relating to 2015 amounts compared to 2014 and, where appropriate, 2014 amounts compared to 2013.

Statements of Net Position

Cash and cash equivalents – Increased $267.8 million from June 30, 2014 to June 30, 2015 primarily due to a receipt of $599.1 million of inpatient State Fiscal Year Upper Payment Limit (UPL) funds, during the fourth quarter. Cash and cash equivalents decreased $17.4 million from June 30, 2013 to June 30, 2014 to maintain vendor payables at reasonable levels.

Patient accounts receivable, net – Decreased $58.3 million from 2014 to 2015 due to a decrease in the risk incentive pool payable between MetroPlus and HHC. Patient accounts receivable, net decreased $67.4 million from 2013 to 2014 due to increased collection efforts.

Estimated third-party payor settlements, receivable – decreased $539.9 million from June 30, 2014 to June 30, 2015 due to the receipt of $1.0 billion of UPL payments. Estimated third-party payor settlements, net increased $539.4 million from 2013 to 2014 due to the delay of $539.4 million of State Fiscal Year UPL payments.

Grants receivable – Grants receivable increased $60.4 million from June 30, 2014 to June 30, 2015 due to a delay of payment of the Medicaid Administration grant. Grants receivable decreased $222.9 million from 2013 to 2014 primarily due to the receipt of Community Development Block Grant (CDBG) grant funds of $183 million that were recorded as a receivable in the prior year and received during 2014 for 2015.

Assets restricted as to use – Decreased $11.3 million from June 30, 2014 to June 30, 2015 and $28.0 million from June 30, 2013 to June 30, 2014 due to a continued use of the Construction Fund for various capital projects.

Other current assets – Increased $1.7 million from June 30, 2014 to June 30, 2015 primarily due to an increase in the amounts owed under affiliation agreements. Other current assets decreased $7.2 million from June 30, 2013 to June 30, 2014 primarily due to a decrease in the amounts owed under affiliation agreements in the amount of $11 million.

Capital assets, net – Decreased $73.9 million from 2014 to 2015 as there were less acquisitions in fiscal year 2015 due to the completion of major modernization projects, in the prior year. Increased $139.9 million from 2013 to 2014. This was due to major modernization projects at Harlem Hospital Center and Gouverneur Healthcare Services, as well as construction on the Henry J. Carter Center property (note 7(h) to the financial statements).

Accrued salaries, fringe benefits, and payroll taxes – Decreased $9.1 million from June 30, 2013 to June 30, 2014 due to an accrual for collective bargaining settlements. Accrued salaries, fringe benefits, and payroll taxes were consistent from June 30, 2012 to June 30, 2013, with the prior year.

Accounts payable and accrued expenses – Increased $3.4 million from June 30, 2014 to June 30, 2015 primarily due to increases in affiliations payable of $12.8 million and affiliations vacation accrual of $9.2 million. Accounts payable and accrued expenses increased $23.4 million from June 30, 2013 to June 30, 2014 primarily due to increases in vendors payable due to cash flow.

Estimated third-party payor settlement, payable – Decreased by $36.1 million from June 30, 2014 to June 30, 2015 and $40.2 million from June 30, 2013 to June 30, 2014 due to a re-estimation of third party anticipated take backs for Medicaid and Medicare rate changes.

Estimated pools receivable (payable), net – Estimated pools payable, net, decreased $259.3 million from June 30, 2014 to June 30, 2015 primarily due to a $353.5 million decrease in the State's advance payments of Disproportionate Share Hospital (DSH) and DSH Max funds. Estimated pools payable, net, increased $414.7 million and remained a payable from June 30, 2013 to June 30, 2014 primarily due to the receipt of State Fiscal Years' 2015 Disproportionate Share Hospital (DSH), DSH Max, and Supplemental SLIPA allocations.

Due to City of New York – Increased $337.0 million from June 30, 2014 to June 30, 2015 mainly due to $271.2 million that is payable to The City in the form of malpractice and debt service, since the Corporation and the City agreed that the Corporation would not reimburse the City for the 2013 malpractice and debt service of $121.5 million and $150.4 million.. Due to City of New York decreased $103.7 million from June 30, 2013 to June 30, 2014 as The City agreed to fund collective bargaining settlements in the amount of $117.0 million. (note 8 to the financial statement)

Long-term debt – Decreased $57.7 million from June 30, 2014 to June 30, 2015 due to a continuation of scheduled principal payments during fiscal year 2015 (note 7 to the financial statements). Long-term debt decreased $52.3 million from June 30, 2013 to June 30, 2014 due to scheduled principal payments during fiscal year 2014 (note 7 to the financial statements).

Pension (current and long-term) – Increased $298.2 million as the Corporation recognized its annual pension costs and payments towards its liability as determined by the New York City Office of the Actuary (note 9 to the financial statements).

Postemployment benefits obligation, other than pension – Decreased $145.1 million from June 30, 2014 to June 30, 2015 and increased $98.0 million from June 30, 2013 to June 30, 2014 as the Corporation recognized its annual OPEB credits and costs, respectively, as determined by the New York City Office of the Actuary (note 10 to the financial statements).

Other current liabilities – Remained constant during the period from June 30, 2014 to June 30, 2015 and decreased $16.8 million June 30, 2013 to June 30, 2014 due to FICA refunds paid to medical residents.

Changes in Components of Net Position

Net investment in capital assets – Decreased $29.6 million from June 30, 2014 to June 30, 2015 as capital assets, net, decreased by $73.9 million, related assets restricted as to use decreased by $11.3 million, and related debt and deferred outflows decreased by $60.6 million. Investment in capital assets, net of related debt increased $156.7 million from June 30, 2013 to June 30, 2014 as capital assets, net, increased by $139.9 million, related assets restricted as to use decreased by $28.0 million, and related debt and deferred outflows decreased by $56.5 million.

Restricted – remained constant from June 30, 2014 to June 30, 2015. Restricted net assets increased $3.3 million from June 30, 2013 to June 30, 2014 due to a $2.7 million increase in the revenue fund under bond resolution.

Unrestricted – Net position activities, other than those mentioned above, resulted in increases in unrestricted net assets of $50.7 million and $53.2 million for years 2015 and 2014, 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, 2015, the Corporation had capital assets, net of accumulated depreciation, of $3.432 billion compared to $3.506 billion at June 30, 2014 and $3.366 billion at June 30, 2013, representing a decrease of 2.2% from 2014 to 2015 and an increase of 4.2% from 2013 to 2014, as shown in the table below (in thousands of dollars):

		2015	2014	2013
Land and land improvements	$	29,159	29,187	28,460
Buildings and leasehold improvements		2,265,891	2,369,694	2,021,122
Equipment		833,143	867,101	699,942
Construction in progress		304,237	240,393	616,932
Total	$	3,432,430	3,506,375	3,366,456

2015's major capital asset additions included:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional spending of approximately $9.9 million in 2015
- Construction has been mostly completed on the major modernization of Harlem Hospital Center, with additional spending of approximately $1.93 million in 2015
- Construction has been mostly completed on the major modernization of Henry J. Carter Center, with additional spending of approximately $11.02 million in 2015
- Construction of the new Ida G. Israel Community Health Center continued, with spending of approximately $7.1 million in 2015.
- Developing the electronic medical record system continued with spending of approximately $71.3 million in 2015

2014's major capital asset additions included:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional spending of approximately $41.8 million in 2014
- Construction continued on the major modernization of Harlem Hospital Center, with additional spending of approximately $12.5 million in 2014
- Construction continued on the major modernization of Henry J. Carter Center, with additional spending of approximately $82.2 million in 2014
- Developing the electronic medical record system with spending of approximately $22 million in 2014.

2013's major capital asset additions included:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional spending of approximately $45.7 million in 2013
- Construction continued on the major modernization of Harlem Hospital Center, with additional spending of approximately $44.1 million in 2013
- Construction continued on the major modernization of Henry J. Carter Center, with additional spending of approximately $143.0 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 approximately $153.0 million in 2013

The Corporation's 2016 capital budget projects spending of $286.3 million, which includes construction work on Rehab-Infrastructure projects, acquisition of medical equipment and electronic medical record (EMR) system. The 2016 capital budget is expected to be primarily financed by the Corporation's newly approved JP Morgan 2015 Equipment financing, City General Obligation and Transitional Finance Authority Bonds, and other 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, 2015, the Corporation has approximately $934 million in long-term debt financing relating to its capital assets, as shown with comparative amounts at June 30, 2014 and 2013 (in thousands of dollars):

		2015	2014	2013
Bonds payable	$	870,466	925,325	974,226
New York Power Authority (NYPA) financing		217	844	1,465
Equipment and renovation financing		135	540	998
Clinical bed financing		518	2,291	4,637
Henry J. Carter capital lease obligation		48,254	48,258	48,258
New Market Tax Credit		14,700	14,700	14,700
Total	$	934,290	991,958	1,044,284

At June 30, 2015, the Corporation's debt is 80.9% uninsured fixed and 19.1% 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 September 2, 2015, 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 Aa1/P-1, AA-/A-1+, and AA-/F1+ and Aa2/P-1, A+/A-1, and AA-/F1+, respectively. There are no statutory debt limitations that may affect the Corporation's financing of planned facilities or services.

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

Statements of Revenues, Expenses, and Changes in Net Position

Net patient service revenue – Increased $76.2 million from June 30, 2014 to June 30, 2015 due to recognition of risk pool revenue from MetroPlus. Net patient service revenue increased $419.0 million from June 30, 2013 to June 30, 2014 reflecting full year operations for Bellevue Hospital Center and Coney Island Hospital after temporary closings following Super Storm Sandy during fiscal year 2013. The following also contributed to the increase in net patient service revenue 1) increased UPL revenue of $76 million; 2) increased DSH Maximization of $103.9 million; and 3) patient service revenue increases from third parties of $114.0 million, and 4) other third-party retroactive settlement accruals of $120 million.

Appropriations from (remittances to) City of New York, net – Decreased $258.6 million from June 30, 2014 to June 30, 2015 mainly due to the fact that the 2014 malpractice and debt service of $126.9 million and $153.2 million are Due to The City as of June 30, 2015. Appropriations from (remittances to) City of New York increased $399.7 million from June 30, 2013 to June 30, 2014 mainly due to an agreement with The City that the Corporation would not reimburse the 2013 malpractice and debt service of $121.5 million and $150.4 million, respectively, and The City's agreement to fund collective bargaining settlements in the amount of $114.0 million. These were offset by an increase of $17.2 million in interest expense paid by The City for HHC.

Grants revenue – Increased $240.9 million from June 30, 2014 to June 30, 2015 due to recognition of $139.3 million of Interim Access Assurance Fund (IAAF) and $117.4 million of Delivery System Reform Incentive Payment (DSRIP) grant revenue. Grants revenue decreased $280.3 million from June 30, 2013 to June 30, 2014

due to the recording, in 2013, of FEMA and CDBG revenue in the amount of $256 million for Super Storm Sandy expenses. No additional FEMA and CDBG revenue was recorded during 2014. Additional revenue for IAAF was accrued for during 2014 in the amount of $15.5 million.

Other revenue – Increased $10.2 million primarily due to a $5.5 million increase in 340B program revenue. Other revenue remained consistent from June 30, 2013 to June 30, 2014.

Personal services – Increased $68.2 million, or approximately 2.8%, from June 30, 2014 to June 30, 2015 due to continued collective bargaining salary increases. Personal services increased $129.5 million, or approximately 5.4%, from June 30, 2013 to June 30, 2014 due to increase in collective bargaining estimates for 2014.

Other-than-personal services – Increased $38.9 million, or 2.5 % from June 30, 2014 to June 30, 2015, mainly due to a continued increase in pharmaceutical expenses of $28 million, and an increase in IT software maintenance expense of $17 million. Other-than-personal services increased $83.7 million, or 5.8%, from June 30, 2013 to June 30, 2014 due to costs related to increased pharmaceutical expenses of $19 million and increased use of temporary workers, including nursing of $32 million. Increased pollution remediation accruals of $9.1 million contribute to the increase from 2013.

Fringe benefits and employer payroll taxes – Increased $50.2 million or 6.7% from June 30, 2014 to June 30, 2015 mainly due to an increase in health benefits costs of $26.7 million or 5.1% and an increase in welfare benefits expense of $17.4 million or 16.7%. Increased $15.1 million from June 30, 2013 to June 30, 2014 primarily for FICA of $9.8 million or 7.1% for collective bargaining agreements.

Pension – Increased $60.6 million from June 30, 2014 to June 30, 2015 as determined by the New York City Office of the Actuary.

Postemployment benefits, other than pension – Decreased $239.3 million from June 30, 2014 to June 30, 2015 and decreased $94.8 million from June 30, 2013 to June 30, 2014 as determined by the New York City Office of the Actuary, and is mainly due to assumptions for healthcare actuarial gain experience, cost trends being updated to reflect recent past experience, and anticipated future experience, including the enactment of National Health Care Reform (note 10 to the financial statements).

Affiliation contracted services – Increased $71.5 million or 7.8% from June 30, 2014 to June 30, 2015 and $7.2 million or 0.8% from June 30, 2013 to June 30, 2014 primarily due to market adjustments and enhancement of services.

Investment income – decreased $0.6 million from June 30, 2014 to June 30, 2015 due to a decrease in interest income. Investment income increased $1.4 million from June 30, 2013 to June 30, 2014 as the Corporation recognized the market value adjustment of the bonds.

Capital contributions funded by City of New York – Decreased $197.3 million from June 30, 2014 to June 30, 2015 due to fewer continuing major modernization projects. Capital contributions funded by City of New York decreased $88.7 million from June 30, 2013 to June 30, 2014 due to completions of the past major modernization projects.

Corporation Issues and Challenges

The Corporation continues to adapt to the ever-increasing fiscal challenges placed on healthcare 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
- Continued penetration of managed care and accountable care in the market place
- Implementation of the International Classification of Diseases 10th Edition (ICD-10)

The Corporation has responded to these challenges by: 1) improving the patient experience and increasing MetroPlus members and increasing HHC's market share; 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, implement the conversion of its diagnostic and treatment centers into federally qualified health center look-alike, and Corporate re-branding. 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.

The International Classification of Diseases (ICD), 10th Edition will replace the current version (9th Edition) on October 1, 2015 as per the mandate of the United States Department of Health and Human Services. The ICD is a code set used internationally to report on diagnoses and inpatient procedures and was last updated 35 years ago. ICD-10 is a newer, more up to date, greatly expanded, and much more specific version of ICD-9. The documentation and coding requirements for ICD-10 are much more complex and if not done appropriately can potentially lead to loss of revenue for services provided. Significant effort was undertaken to minimize potential impacts to the Corporation. Patient information and billing information systems are ICD-10 compliant. Starting in September of 2013 and continuing through October 2015 education and training sessions were conducted for physicians and affected divisions, especially Health Information Management.

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, 2015 and 2014

(In thousands)

	2015				2014			
Assets	**Business-type Activities – HHC**	**Discretely Presented Component Unit-MetroPlus**	**Eliminations**	**Total**	**Business-type Activities – HHC**	**Discretely Presented Component Unit-MetroPlus**	**Eliminations**	**Total**
Current assets:								
Cash and cash equivalents (note 2)	$ 610,960	654,039	—	1,264,999	343,188	780,320	—	1,123,508
U.S. government securities (note 16)	—	93,309	—	93,309	—	71,396	—	71,396
Patient accounts receivable, net (notes 4 and 11)	634,811	—	(187,359)	447,452	693,151	—	(272,538)	420,613
Premiums receivable	—	232,925	(1,624)	231,301	—	168,518	(1,528)	166,990
Estimated third-party payor settlements, receivable (notes 4 and 11)	890,300	—	(167,900)	722,400	1,430,200	—	(110,830)	1,319,370
Grants receivable (note 13)	142,975	—	—	142,975	82,547	—	—	82,547
Supplies	20,909	—	—	20,909	19,796	—	—	19,796
Assets restricted as to use and required for current liabilities (notes 6 and 7)	49,068	—	—	49,068	46,873	—	—	46,873
Due from City of New York (note 8)	77,000	—	—	77,000	117,000	—	—	117,000
Other current assets	59,062	19,133	—	78,195	57,409	9,190	—	66,599
Total current assets	2,485,085	999,406	(356,883)	3,127,608	2,790,164	1,029,424	(384,896)	3,434,692
Assets restricted as to use, net of current portion (notes 6 and 16)	107,783	117,105	—	224,888	121,266	87,883	—	209,149
U.S. government securities (note 16)	—	156,559	—	156,559	—	43,010	—	43,010
Other receivable	10,661	—	—	10,661	10,661	—	—	10,661
Capital assets, net (note 5)	3,432,430	5,511	—	3,437,941	3,506,375	5,923	—	3,512,298
Total assets	6,035,959	1,278,581	(356,883)	6,957,657	6,428,466	1,166,240	(384,896)	7,209,810
Deferred Outflows of Resources								
Unamortized refunding cost	15,349	—	—	15,349	18,240	—	—	18,240
	$ 6,051,308	1,278,581	(356,883)	6,973,006	6,446,706	1,166,240	(384,896)	7,228,050
Liabilities								
Current liabilities:								
Current installments of long-term debt (note 7)	$ 51,442	—	—	51,442	50,669	—	—	50,669
Accrued salaries, fringe benefits, and payroll taxes	825,355	3,952	(1,624)	827,683	834,475	14,555	(1,528)	847,502
Accounts payable and accrued expenses (notes 12 and 16)	430,718	593,832	(355,259)	669,291	427,347	583,562	(383,368)	627,541
Estimated third-party payor settlement, payable (notes 4 and 11)	150,900	—	—	150,900	182,500	—	—	182,500
Estimated pools payable, net (notes 4 and 11)	452,300	—	—	452,300	711,600	—	—	711,600
Current portion of Due to City of New York, net (note 8)	309,405	—	—	309,405	449,941	(4,041)	—	445,900
Current portion of pension (note 9)	433,232	10,154	—	443,386	424,268	9,322	—	433,590
Current portion of postemployment benefits obligation, other than pension (note 10)	110,821	2,447		113,268	107,863	2,199	—	110,062
Other current liabilities	5,061	—	—	5,061	5,061	—	—	5,061
Total current liabilities	2,769,234	610,385	(356,883)	3,022,736	3,193,724	605,597	(384,896)	3,414,425
Long-term debt, net of current installments (note 7)	882,848	—	—	882,848	941,289	—	—	941,289
Due to City of New York, net of current portion (note 8)	477,514	—	—	477,514				
Long-term pension, net of current portion (note 9)	2,334,651	54,716	—	2,389,367	2,045,366	42,120	—	2,087,486
Postemployment benefits obligation, other than pension, net of current portion (note 10)	4,519,900	43,368	—	4,563,268	4,667,962	46,761	—	4,714,723
Total liabilities	10,984,147	708,469	(356,883)	11,335,733	10,848,341	694,478	(384,896)	11,157,923
Deferred Inflows of Resources								
Net differences between projected and actual earnings on pension plan investments and other changes	258,287	6,053	—	264,340	708,343	15,564	—	723,907
	11,242,434	714,522	(356,883)	11,600,073	11,556,684	710,042	(384,896)	11,881,830
Commitments and contingencies (note 11)								
Net position								
Net investment in capital assets	2,521,077	5,540	—	2,526,617	2,550,656	5,946	—	2,556,602
Restricted:								
For debt service	135,961	—	—	135,961	137,469	—	—	137,469
Expendable for specific operating activities	12,342	—	—	12,342	11,715	—	—	11,715
Nonexpendable permanent endowments	928	—	—	928	928	—	—	928
For statutory reserve requirements	—	117,105	—	117,105	—	87,883	—	87,883
Unrestricted	(7,861,434)	441,414	—	(7,420,020)	(7,810,746)	362,369	—	(7,448,377)
Total net deficit position	(5,191,126)	564,059	—	(4,627,067)	(5,109,978)	456,198	—	(4,653,780)
	$ 6,051,308	1,278,581	(356,883)	6,973,006	6,446,706	1,166,240	(384,896)	7,228,050

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, 2015 and 2014

(In thousands)

	2015				2014			
	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 11)	$ 5,729,197	—	(758,907)	4,970,290	5,653,009	—	(704,482)	4,948,527
Appropriations from (remittances to) City of New York, net (notes 1 and 11)	140,597	—	—	140,597	399,165	4,041	—	403,206
Premium revenue (note 13)	—	2,585,211	(20,204)	2,565,007	—	2,334,727	(19,129)	2,315,598
Grants revenue (note 13)	526,673	—	—	526,673	285,763	—	—	285,763
Other revenue	61,264	33	—	61,297	51,110	6	—	51,116
Total operating revenues	6,457,731	2,585,244	(779,111)	8,263,864	6,389,047	2,338,774	(723,611)	8,004,210
Operating expenses:								
Personal services	2,607,635	64,329	—	2,671,964	2,539,432	60,752	—	2,600,184
Other than personal services	1,566,345	2,385,522	(758,907)	3,192,960	1,527,445	2,169,538	(704,482)	2,992,501
Fringe benefits and employer payroll taxes	815,912	20,231	(20,204)	815,939	765,727	17,883	(19,129)	764,481
Pension (note 9)	285,111	6,879	—	291,990	224,500	4,932	—	229,432
Postemployment benefits, other than pension (note 10)	(40,299)	(1,097)	—	(41,396)	198,991	4,548	—	203,539
Affiliation contracted services	994,294	—	—	994,294	922,773	—	—	922,773
Depreciation (note 5)	291,729	2,424	—	294,153	302,859	2,606	—	305,465
Total operating expenses	6,520,727	2,478,288	(779,111)	8,219,904	6,481,727	2,260,259	(723,611)	8,018,375
Operating (loss) income	(62,996)	106,956	—	43,960	(92,680)	78,515	—	(14,165)
Nonoperating revenues (expenses):								
Investment income	1,979	905	—	2,884	2,536	1,761	—	4,297
Interest expense	(127,702)	—	—	(127,702)	(117,735)	—	—	(117,735)
Contributions restricted for specific operating activities	656	—	—	656	807	—	—	807
Total nonoperating (expenses) revenues, net	(125,067)	905	—	(124,162)	(114,392)	1,761	—	(112,631)
(Loss) income before other changes in net position	(188,063)	107,861	—	(80,202)	(207,072)	80,276	—	(126,796)
Other changes in net position:								
Capital contributions funded by City of New York, net	105,711	—	—	105,711	303,007	—	—	303,007
Capital contributions funded by grantors and donors	1,204	—	—	1,204	10,897	—	—	10,897
Total other changes in net position	106,915	—	—	106,915	313,904	—	—	313,904
(Decrease) increase in net position	(81,148)	107,861	—	26,713	106,832	80,276	—	187,108
Net deficit position at beginning of year	(5,109,978)	456,198	—	(4,653,780)	(5,216,810)	375,922	—	(4,840,888)
Net deficit position at end of year	$ (5,191,126)	564,059	—	(4,627,067)	(5,109,978)	456,198	—	(4,653,780)

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, 2015 and 2014

(In thousands)

	2015 Business-type Activities – HHC	2014 Business-type Activities – HHC
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 6,036,538	5,565,689
Cash appropriations received from City of New York	479,930	322,176
Receipts from grants	466,245	508,696
Other receipts	53,276	63,409
Cash paid for personal services, fringe benefits, and employer payroll taxes	(3,530,016)	(3,323,160)
Cash paid for pension	(443,386)	(435,678)
Cash paid for other than personal services	(1,549,014)	(1,521,736)
Cash paid for affiliation contracted services	(966,376)	(933,394)
Net cash provided by operating activities	547,197	246,002
Cash flows from noncapital financing activity:		
Proceeds from contributions restricted for specific operating activities	657	808
Net cash provided by noncapital financing activity	657	808
Cash flows from capital and related financing activities:		
Purchase of capital assets	(261,154)	(442,120)
Capital contributions by grantors and donors	1,204	10,897
Capital contributions by City of New York	161,535	303,007
Cash paid for retainage and construction accounts payable	(1,851)	(947)
Payments of long-term debt	(49,599)	(40,633)
Interest paid	(143,486)	(125,104)
Net cash used in capital and related financing activities	(293,351)	(294,900)
Cash flows from investing activities:		
Purchases of assets restricted as to use	(885)	(4,690)
Sales of assets restricted as to use	11,727	32,064
Interest received	2,427	3,325
Net cash provided by investing activities	13,269	30,699
Net increase (decrease) in cash and cash equivalents	267,772	(17,391)
Cash and cash equivalents at beginning of year	343,188	360,579
Cash and cash equivalents at end of year	$ 610,960	343,188
Supplemental disclosure:		
Change in fair value of assets restricted as to use	$ (212)	(302)

(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, 2015 and 2014

(In thousands)

	2015 Business-type Activities – HHC	2014 Business-type Activities – HHC
Reconciliation of operating loss to net cash provided by operating activities:		
Operating loss	$ (62,996)	(92,680)
Adjustments to reconcile operating loss to net cash provided by operating activities:		
Depreciation	291,729	302,859
Provision for bad debts	479,172	636,517
Changes in assets and liabilities:		
Patient accounts receivable, net	(420,832)	(569,155)
Estimated third-party payor settlements, net	508,300	(579,600)
Estimated pools receivable (payable), net	(259,300)	414,700
Grants receivable	(60,428)	222,932
Supplies and other current assets	(2,766)	6,520
Accrued salaries, fringe benefits, and payroll taxes	(9,120)	104,794
Pension	(151,807)	(201,822)
Accounts payable and accrued expenses	3,371	23,443
Due to City of New York	376,978	(103,650)
Other liabilities	—	(16,813)
Postemployment benefits obligation, other than pension	(145,104)	97,957
Net cash provided by operating activities	$ 547,197	246,002

See accompanying notes to financial statements.

(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 six 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 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 obtained its license as a domestic captive insurance company from the New York State Department of Insurance on December 15, 2004 and commenced operations on January 1, 2005. The license was renewed on July 1, 2015. HHC Insurance underwrites medical malpractice insurance for the Corporation's attending physicians who specialize in the areas of Neurosurgery, Obstetrics, and Gynecology. HHC Insurance also provides access to the excess insurance coverage available in the New York State Excess Liability Pool (State Pool).

HHC Insurance issues primary professional liability policies to their insureds on a claims-made basis with policy limits of $1.3 million per incident and $3.9 million in the aggregate. With the existence of this insurance coverage, the insured is able to apply for excess coverage, in the amount of $1.0 million per incident and $3.0 million in the aggregate, provided by the Medical Malpractice Insurance Pool of New York (MMIP). HHC Insurance has been a participant in the excess program since 2007. 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.

- The HHC Physicians Purchasing Group, Inc. (HHC Purchasing), a public benefit corporation, was formed in 2003 to act as a purchasing group within the State. The business of HHC Purchasing is to obtain on behalf of its members, who are employees of HHC or HHC's affiliates, primary insurance for medical malpractice from HHC Insurance. HHC Purchasing was registered and approved for operations by the New York State Department of Insurance on August 31, 2005. The Corporation is the sole voting member of HHC Physicians.

- HHC Risk Services Corporation (Risk Services), 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. Risk Services did not conduct business (no policies were issued). Risk Services ceased operations as an insurance company in November 2011 and returned the insurance license to the State of Vermont in December 2011. It has been dormant since December 2011. Risk Services is in the process of dissolving. The dissolution papers were filed with the appropriate NYS agencies and are pending approval.

- During June 2012, HHC ACO Inc., a 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).

In October 2012, the Corporation formed the HHC Assistance Corporation (HHCAC), which is a membership not-for-profit corporation in which the Corporation is the sole member. 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 to be used for the construction of certain new facilities at the Harlem Hospital Center (note 7(i)). In 2015 HHCAC took on the function of the "Central Service Organization" in the HHC-led Participating Provider System under the New York State Department of Health's Delivery System Reform Incentive Payment ("DSRIP") program. In that capacity, HHCAC operates under the d/b/a "One City Health" and performs various functions on the Corporation's behalf to advance its participation in the DSRIP program.

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. Supplementary disclosures for MetroPlus are presented beginning with note 16 of the financial statements. The Corporation is the sole member and appoints a voting majority of the governing board of MetroPlus. 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 contractual agreements with the New York State Department of Health (DOH) to provide comprehensive medical services to Medicaid, Child Health Plus (CHP), Family Health Plus (FHP), HIV Special Needs Plan (HIV-SNP) recipients (members), and managed long-term care services under a partial capitation contract with the DOH. MetroPlus has contracted with CMS and the DOH to offer Medicare coverage to individuals, including those who are dually eligible for benefits under Medicare and New York State Medicaid. Beneficiaries have the option of selecting MetroPlus or the state of New York as their Medicaid coverage

provider. In October 2013, MetroPlus began offering Qualified Health Plans (QHP) with coverage beginning on or after January 1, 2014, also under a contract with the DOH. Such plans are the result of the Patient Protection and Affordable Care Act (ACA) signed into law in March 2010. Additionally, Corporation employees can elect MetroPlus healthcare coverage as part of their employee benefits.

MetroPlus and HHC Insurance issue separate statutory annual financial statements as of December 31, 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 eliminations column.

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 statement of net position at June 30, 2015 and 2014. Assets restricted as to use are stated at fair value, with unrealized and realized gains and losses included in investment income.

Donor-restricted net positions are used to differentiate resources, the use of which is restricted by donors, from resources of unrestricted assets on which donors place no restriction or that arise as a result of the operations of the Corporation for its stated purposes. Donor-restricted net positions represent contributions to provide healthcare services, of which $928,000 are held in perpetuity, as nonexpendable permanent endowments, at June 30, 2015 and 2014. 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 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 (note 3).

(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.

Included in net patient service revenue are adjustments to prior year estimated third-party payor settlements, estimated pools receivables and payables 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 an increase to net patient service revenue of $49.6 million and $172.8 million for the years ended June 30, 2015 and 2014, respectively.

(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, Net 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 $479.2 million in 2015 and $636.5 million in 2014.

The allowance for doubtful 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 collectibility. 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 doubtful accounts at June 30, 2015 and 2014 was approximately $452.8 million and $658.2 million, respectively.

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

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. Funds appropriated from The City are direct or indirect payments made by The City on behalf of the Corporation for:

- Settlements of claims for medical malpractice, negligence, other torts, and alleged breach of contracts, and payments by The City (note 11(e))
- Patient care rendered to prisoners, uniformed city employees, and various discretely funded facility-specific programs.
- 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 (note 5).
- Funding for collective bargaining agreements.

Reimbursement by the Corporation is negotiated annually with The City. In 2014, The City and the Corporation agreed that the Corporation would not reimburse the City for the 2013 malpractice and debt service of $121.5 million and $150.4 million, respectively. No similar transaction took place in 2015. The Corporation has agreed to reimburse The City for the following as remittances to The City:

- Medical malpractice settlements, negligence, and other torts up to an agreed-upon amount negotiated annually and paid by The City on behalf of the Corporation. In 2015 and 2014, the medical malpractice and general liability settlements paid by The City were $123.3 million and $126.9 million, respectively, and the Corporation has agreed to reimburse The City $123.3 million for 2015 and $126.9 million for 2014. 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 (note 11(e)).

  Debt service (interest and principal), negotiated annually, related to debt, which funded Corporation capital acquisitions and paid by The City on behalf of the Corporation. In 2015 and 2014, the debt service paid by The City were $147.9 million and $153.2 million, respectively, and the Corporation has agreed to reimburse The City $147.9 million for 2015 and $153.2 million for 2014. 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 substantially 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, Kings County Hospitals, 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.

The Corporation evaluates long-lived assets for impairment when circumstances suggest that the service utility or the usable capacity that upon acquisition was expected to be used to provide service of the capital asset may have significantly or unexpectedly declined. If circumstances suggest that assets may be impaired, an impairment charge is recorded on those assets based upon a method that most appropriately reflects the decline in service utility of the capital asset. No material charges to capital assets were recorded for the fiscal years ended June 30, 2015 and 2014.

(i) Custodial Funds

The Corporation holds funds for safekeeping, primarily cash held for the benefit of its long-term care patients, amounting to approximately $3.7 million and $3.8 million as of June 30, 2015 and 2014, respectively. These amounts are included in other current assets and accounts payable and accrued expenses in the accompanying statements of net position. At June 30, 2015 and 2014, 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 and other current assets in the accompanying statements of net position (note 12). 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 qualify as governmental entities (or affiliates of a governmental entity), not subject to federal income tax, by reason of the organizations being a state or political subdivision thereof, or an integral part of a state or political subdivision thereof; or, an entity all of whose income is excluded from gross income for federal income tax purposes under section 115 of the Internal Revenue Code of 1986. Accordingly, no provision for income taxes has been made in the accompanying financial statements.

(m) 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 (note 13).

(n) Net Position

Net position of the Corporation is 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 for debt service* consists of assets restricted, by each revenue bonds' official statement, for expenditures of principal and interest. *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). *Restricted nonexpendable net position* consist of 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*.

(o) 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 earn 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. The Corporation accrues for the employees' earned and accumulated vacation and sick leave.

(p) Reclassifications

Certain amounts have been reclassified from the prior year to conform with current year financial statement presentation.

(q) New Accounting Standards Adopted

In 2015, the Corporation adopted GASB Statement No. 72, *Fair Value Measurement and Application* (GASB 72). This guidance requires entities to expand their fair value disclosures by determining major categories of debt and equity securities within the fair value hierarchy on the basis of the nature and risk of the investment. The guidance only requires additional disclosures and did not have an impact on the financial statements.

(r) Fair Value

Management determines fair value of financial instruments as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Management utilizes valuation techniques that maximize the use of observable inputs (Levels 1 and 2) and minimize the use of unobservable inputs (Level 3) within the fair value hierarchy established by GASB. Financial assets and liabilities carried at fair value are classified and disclosed in one of the following categories:

Level 1: Fair value measurements using unadjusted quoted market prices in active markets for identical, unrestricted assets or liabilities.

Level 2: Fair value measurements using observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially that full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted market prices that traded less frequently than exchange-traded instruments.

Level 3: Fair value measurements using significant inputs that are not readily observable in the market and are based on internally developed models or methodologies utilizing significant inputs that are generally less readily observable.

(2) Cash and Cash Equivalents

Cash and cash equivalents include cash, certificates of deposit, and all highly-liquid debt instruments with original maturities of three months or less when purchased. The carrying amount of cash and cash equivalents approximates fair value due to the short-term maturity of the investments. 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, 2015 and 2014, 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 calculated using the prior year's cost reports. The following information measures the level of charity care provided during the years ended June 30 (in thousands):

		2015	2014
Charges foregone, based on established rates	$	938,461	968,399
Estimated expenses incurred to provide charity care		667,230	592,289

(4) Patient Accounts Receivable, Net and Net Patient Service 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.

Net patient service revenue for the years ended June 30, 2015 and 2014 is as follows (in thousands):

	2015		2014	
Medicaid	$ 1,436,363	25.1%	$ 1,495,122	26.4%
Medicare	664,399	11.6	680,663	12.0
Bad debt/charity care pools	614,698	10.7	609,647	10.8
Disproportionate share supplemental pool (DSH)	1,025,000	17.9	915,900	16.2
Other third-party payors that include Medicaid and Medicare managed care	1,197,299	20.9	1,190,921	21.1
MetroPlus	758,907	13.2	704,482	12.5
Self-pay	32,531	0.6	56,274	1.0
	$ 5,729,197	100.0%	$ 5,653,009	100.0%

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

	2015		2014	
Medicaid	$ 159,645	25.1%	$ 131,323	19.0%
Medicare	58,233	9.2	69,902	10.1
Other third-party payors, that include Medicaid and Medicare managed care	199,974	31.5	183,915	26.5
MetroPlus	187,359	29.5	272,538	39.3
Self-pay	29,600	4.7	35,473	5.1
	$ 634,811	100.0%	$ 693,151	100.0%

(Continued)

(5) Capital Assets

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

	2015	2014
Land and land improvements	$ 55,234	54,081
Buildings and leasehold improvements	4,287,073	4,258,355
Equipment	3,496,203	3,397,117
	7,838,510	7,709,553
Less accumulated depreciation	4,710,317	4,443,571
	3,128,193	3,265,982
Construction in progress	304,237	240,393
Capital assets, net	$ 3,432,430	3,506,375

Capital assets activity for the years ended June 30, 2015 and 2014 was as follows (in thousands):

	Land and land improvements	Buildings and leasehold improvements	Equipment	Construction in progress	Total
June 30, 2013 balance	$ 55,707	3,831,385	3,166,436	616,932	7,670,460
Acquisitions, net of transfers	6,889	498,586	330,311	(376,539)	459,247
Sales, retirements, and adjustments	(8,515)	(71,616)	(99,630)	—	(179,761)
June 30, 2014 balance	54,081	4,258,355	3,397,117	240,393	7,949,946
Acquisitions, net of transfers	1,266	36,406	133,201	63,844	234,717
Sales, retirements, and adjustments	(113)	(7,688)	(34,115)	—	(41,916)
June 30, 2015 balance	$ 55,234	4,287,073	3,496,203	304,237	8,142,747

Related information on accumulated depreciation for the years ended June 30, 2015 and 2014 was as follows (in thousands):

	Land and land improvements	Buildings and leasehold improvements	Equipment	Total
June 30, 2013 balance	$ 27,247	1,810,263	2,466,494	4,304,004
Depreciation expense	1,520	123,356	153,504	278,380
Sales, retirements, and adjustments	(3,873)	(44,958)	(89,982)	(138,813)
June 30, 2014 balance	24,894	1,888,661	2,530,016	4,443,571
Depreciation expense	1,558	134,188	155,983	291,729
Sales, retirements, and adjustments	(377)	(1,667)	(22,939)	(24,983)
June 30, 2015 balance	$ 26,075	2,021,182	2,663,060	4,710,317

In December of 2013, the Corporation surrendered the property formerly known as the Goldwater Specialty Hospital and Nursing Facility located on Roosevelt Island, New York to The City. The surrender of property to The City is consistent with the Corporation's bylaws, which empowers the Corporation to surrender real estate to The City when such property is no longer utilized for its corporate purpose. The Corporation recorded a loss on disposal of assets for the related land improvements, buildings, and leasehold improvements in the amount of $19.3 million and equipment in the amount of $3.4 million in 2014, which is included in depreciation expense on the statements of revenues, expenses, and changes in net position.

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, 2015 and 2014 was as follows (in thousands):

	2015	2014
Interest costs subject to capitalization	$ 11,102	10,495
Interest income	(1,529)	(1,614)
Capitalized interest costs, net	$ 9,573	8,881

The Corporation capitalized net interest costs on TFA debt and City General Obligation Bonds in both 2015 and 2014, 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 2015 and 2014 approximated $9.1 million and $7.4 million, respectively. In addition, the Corporation capitalized net interest costs of $0.5 million in 2015 and $1.5 million in 2014 related to its 2008 and 2010 Series bonds.

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 $11.7 million at June 30, 2015.

The Corporation is developing an electronic medical records (EMR) system that has a six year implementation period with a budget of $764 million. Included within construction in progress is $115 million as of June 30, 2015 and $13.6 million has been expensed through other than personal services for the fiscal year ended June 30, 2015.

(6) Assets Restricted as to Use

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

	2015	2014
Under bond resolutions (a):		
Construction funds	$ 7,621	18,028
Capital reserve funds	87,103	86,847
Revenue funds	48,502	50,188
	143,226	155,063
New Market Tax Credit (b)	355	433
By donors for specific operating activities and permanent endowments (c)	13,270	12,643
Total assets restricted as to use	156,851	168,139
Less current portion of assets restricted as to use	49,068	46,873
Assets restricted as to use, net of current portion	$ 107,783	121,266

(a) Assets restricted as to use under the terms of the bond resolutions (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 construction funds are invested in an interest bearing negotiable order of withdrawal (NOW) account, which is fully collateralized. The capital reserve funds are invested primarily in a ten-year U.S. Treasury note and a three-year U.S. Treasury note. Security maturity date decisions are based on the final maturity of the specific Bond series, potential need for liquidity due to refunding, and/or an assessment of the current market interest rate conditions. The majority of the revenue funds are invested in U.S. T bills for the time period between a month and a maximum of twelve months. Investments are timed so that funds are available for required semiannual debt service payments. $0.1 million and $0.2 million were uninsured and uncollateralized at June 30, 2015 and 2014, respectively. Possible exposure to fair value losses arising from interest rate volatility is limited by the of investments in securities having maturities of less than one year and at most ten years and by intending to hold the security to maturity.

The current portion is related to the 2010 Series A bonds and the 2008 Series A, B, C, D, and E bonds payable in 2015.

(b) The New Market Tax Credit (NMTC) transaction required the execution of a loan agreement between HHC/NCF Sub-CDE, LLC and the Corporation. This agreement required the establishment of a National Community Fund (NCF) Fee Reserve Account, which HHC would use to pay interest or fees associated with the loan (note 7).

(c) The donor-restricted funds are invested in a certificate of deposit and an interest bearing commercial checking account at June 30, 2015 and 2014. $7.0 million was invested in a fully insured certificate of deposit at June 30, 2015 and 2014; the money market account is fully collateralized by the U.S. government securities held by a custodian in the Corporation's name.

The following presents the Corporation's fair value measurements for assets restricted as to use measured at fair value on a recurring basis as of June 30, 2015 and June 30, 2014:

		June 30, 2015		
		Fair value	Level 1	Level 2
U.S. government obligations and securities	$	127,492	28,202	99,290
Cash and cash equivalents		15,734	15,734	—
Total	$	143,226	43,936	99,290

		June 30, 2014		
		Fair value	Level 1	Level 2
U.S. government obligations and securities	$	130,048	33,191	96,857
Cash and cash equivalents		25,015	25,015	—
Total	$	155,063	58,206	96,857

Included within assets restricted as to use are Certificates of Deposit (CD's) of approximately $13.6 million and $13.1 million for 2015 and 2014 respectively.

The Corporation does not have any assets or liabilities based upon level 3 inputs.

(7) Long-Term Debt

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

		2015	2014
Bonds payable:			
2013 Series A Fixed Rate Health System Bonds – weighted average interest of 2.44%, payable in installments to 2023:			
Uninsured Bonds (a)	$	127,999	130,419
2010 Series A Fixed Rate Health System Bonds – weighted average interest of 3.89%, payable in installments to 2030:			
Uninsured Bonds (b)		474,179	505,993
2008 Series A Fixed Rate Health System Bonds – weighted average interest of 4.51%, payable in installments to 2026:			
Uninsured Bonds (c)		108,883	124,868
2008 Series B, C, D, and E Variable Rate Health System Bonds – subject to short-term liquidity arrangements, weighted average interest of 0.81% in 2014, payable in installments to 2031:			
Uninsured Bonds (d)		159,405	164,045
Total bonds payable		870,466	925,325
New York Power Authority (NYPA) financing (e)		217	844
Equipment and renovation financing (f)		135	540
Clinical bed financing (g)		518	2,291
Henry J. Carter capital lease obligation (h)		48,254	48,258
New Market Tax Credit (i)		14,700	14,700
Total long-term debt		934,290	991,958
Less current installments		51,442	50,669
Total long-term debt, net of current installments	$	882,848	941,289

Long-term debt activity for the years ended June 30, 2015 and 2014 were as follows (in thousands):

	June 30, 2014 balance	Additions	Reductions	June 30, 2015 balance	Amounts due within 1 year
Long-term debt:					
Bonds payable	$ 925,325	—	(54,859)	870,466	48,990
NYPA financing	844	—	(627)	217	217
Equipment and renovation financing	540	—	(405)	135	135
Clinical bed financing	2,291	—	(1,777)	514	442
Henry J. Carter capital lease obligation	48,258	—	—	48,258	1,658
New Market Tax Credit	14,700	—	—	14,700	—
	$ 991,958	—	(57,668)	934,290	51,442

	June 30, 2013 balance	Additions	Reductions	June 30, 2014 balance	Amounts due within 1 year
Long-term debt:					
Bonds payable	$ 974,226	—	(48,901)	925,325	46,795
NYPA financing	1,465	—	(621)	844	627
Equipment and renovation financing	998	—	(458)	540	405
Clinical bed financing	4,637	—	(2,346)	2,291	1,773
Henry J. Carter capital lease obligation	48,258	—	—	48,258	1,069
New Market Tax Credit	14,700	—	—	14,700	—
	$ 1,044,284	—	(52,326)	991,958	50,669

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 proceeds 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.

(Continued)

(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.

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 matured in 2014 bearing interest at 4.0%, $16,450,000 matured in 2015 bearing interest at 5.0%, and $11,820,000 matured 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, which is being amortized over the life of the 2013 Bonds.

The following table summarizes debt service requirements as of June 30, 2015 (in thousands):

		Principal	Interest	Total
Years:				
2016	$	640	5,286	5,926
2017		690	5,267	5,957
2018		675	5,244	5,919
2019		735	5,216	5,951
2020		745	5,186	5,931
2021–2023		108,560	8,603	117,163
Total		112,045	34,802	146,847
Unamortized premium on 2013 Bonds		15,954	—	15,954
	$	127,999	34,802	162,801

(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 bonds due February 15, 2030 with interest payable on February 15 and August 15.

Proceeds of the 2010 Bonds were used (i) to finance and reimburse the Corporation for the costs of its capital improvement program of $199,758,168; (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 not refunded); (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, 2015 (in thousands):

		Principal	Interest	Total
Years:				
2016	$	35,970	21,766	57,736
2017		37,705	19,955	57,660
2018		39,615	18,042	57,657
2019		41,565	16,067	57,632
2020		43,560	14,020	57,580
2021–2025		90,855	54,848	145,703
2026–2030		164,885	24,039	188,924
Total		454,155	168,737	622,892
Unamortized premium on 2010 Bonds		20,024	—	20,024
	$	474,179	168,737	642,916

(c) 2008 Series A Bonds

During 2009, 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.

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 for the costs of its capital improvement program of $99,367,379; (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.

On March 28, 2013, the Corporation refunded and defeased a portion of the 2008 Series A bonds maturing in 2014 and 2015 (note (a)).

(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 2008 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 letter of credit fees are 0.55% per annum for 2008 Series B and C and 0.70% per annum for 2008 Series D and E. The 2008 Series B and C letters of credit will expire in September 2019 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, 2015.

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 0.74% for 2015 and 0.81% for 2014.

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, 2015 (in thousands). The interest payments are based on the interest rate in effect at June 30, 2015:

	Principal	Interest	Total
Years:			
2016	$ 12,380	5,403	17,783
2017	12,800	5,079	17,879
2018	13,255	4,725	17,980
2019	13,720	4,321	18,041
2020	14,300	3,833	18,133
2021–2025	84,655	10,953	95,608
2026–2030	98,710	515	99,225
2031	17,390	4	17,394
Total	267,210	34,833	302,043
Unamortized premium on 2008 Bonds	1,078	—	1,078
	$ 268,288	34,833	303,121

(e) 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 10 years. Variable interest rates are based on NYPA's cost of money related to its outstanding debt in the prior calendar year. NYPA adjusts the variable rate effective January 1 each year. At June 30, 2015, approximately $0.2 million was due at 0.51% interest. The effective interest rate for 2015 was approximately 0.51%. The final payment is scheduled in 2016.

The following table summarizes debt service requirements as of June 30, 2015 (in thousands). The interest payments are based on the interest rate in effect at June 30, 2015:

		Principal	Interest	Total
Year:				
2016	$	217	—	217

(f) 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 to the contractor, 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, 2015 (in thousands):

		Principal	Interest	Total
Year:				
2016	$	135	4	139

(g) 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, 2015 (in thousands):

		Principal	Interest	Total
Year:				
2016	$	442	18	460
2017		76	1	77
	$	518	19	537

(h) 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 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 allowed 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 was 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 has been constructed to house skilled nursing (SNF) services. The Corporation renamed the site of the former North General Hospital to the Henry J. Carter site. The City financed 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. The interest rate for this obligation is 3.28%.

The following table summarizes debt service requirements as of June 30, 2015 (in thousands):

		Principal	Interest	Total
Years:				
2016	$	1,658	743	2,401
2017		9,600	4,166	13,766
2018		3,217	1,165	4,382
2019		3,217	1,060	4,277
2020		3,217	954	4,171
2021–2025		16,085	3,188	19,273
2026–2029		11,260	662	11,922
Total	$	48,254	11,938	60,192

(i) New Market Tax Credit (NMTC)

During the fall of 2012, the Corporation entered into a NMTC to fund construction of a new maternal postpartum unit at the Harlem Hospital Center. The transaction, structured under Section 45D of the Internal Revenue Code (IRC), involved a complex structure designed to meet IRC requirements.

The Corporation formed HHCAC, a New York not-for-profit corporation, the sole member of which is the Corporation. HHCAC was formed to assist the Corporation with various financial and other matters and initially to help finance the NMTC transaction. The Corporation capitalized HHCAC with $10.7 million, which was loaned to HHC/NCF Sub-CDE, LLC (the Sub-CDE), a Missouri limited liability company controlled by U.S. Bancorp Community Development Corporation (U.S. Bank).

Along with outside investors' capital, the Sub-CDE made two loans to the Corporation in the amounts of approximately $10.7 million and $4.0 million. Both loans are at interest rates of 1.217%. The principal on the two loans is not payable, and cannot be paid, until the end of the seventh year, at which time the principal on both loans are due ratably over the remaining 23 years of their term. US Bank may, however, exercise a put option to require the Corporation to purchase the entire equity in the Sub-CDE for $1,000 at the end of the seventh year. The larger of the two loans, through several intermediaries, is ultimately due to HHCAC. The smaller of the two loans would also become due to the Corporation or a controlled entity if the put option is exercised. If the put option is not exercised, then HHCAC could elect to purchase the equity in the Sub-CDE for its fair market value or it could elect to repay the smaller loan over the remaining 23 years at its stated interest rate.

The following table summarizes debt service requirements as of June 30, 2015 (in thousands):

		Principal	Interest	Total
Years:				
2016	$	—	179	179
2017		—	179	179
2018		—	179	179
2019		—	179	179
2020		324	181	505
2021–2025		2,876	790	3,666
2026–2030		3,056	609	3,665
2031–2035		3,248	418	3,666
2036–2040		3,451	214	3,665
2041–2044		1,745	27	1,772
Total	$	14,700	2,955	17,655

(j) Equipment Financing Agreement

On July 9, 2015, the Corporation entered into a $60 million Equipment Financing Agreement (the "Agreement") with JP Morgan Chase Bank for the purpose of financing medical, IT, and other equipment with useful lives ranging from 5 to 10 years. The Agreement is a drawdown loan, which allows the Corporation to make multiple draws (i.e. borrowings) up to June 30, 2016 for an aggregated not-to-exceed amount of $60 million. During this one year drawdown period, all borrowings will incur monthly interest expense based on an agreed upon variable rate formula. The Corporation may elect to convert all outstanding loans any time up until July 1, 2016 based on an agreed upon fixed rate formula with a final maturity no later than July 1, 2022. On July 9, 2015, the Corporation drew down $10 million at the initial interest rate of 0.9318%.

(8) Due to (from) City of New York

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

	2015	2014
FDNY EMS operations (a)	$ 177,025	140,461
Medical malpractice payable (b)	250,250	126,870
Other accrued expenses (c)	59,803	31,799
Utilities prepaid expenses (d)	(1,278)	(2,359)
Debt service (e)	301,119	153,170
Collective bargaining (f)	(77,000)	(117,000)
	$ 709,919	332,941

(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) Receivable represents final and reconciled utility costs due from The City. Estimated utilities payments made by the Corporation to The City during 2015 exceeded final and reconciled utilities bills, resulting in a prepaid expense of $1.3 million at June 30, 2015.

(e) Payable represents final and reconciled debt service costs. These debt service costs relate to debt incurred by The City, which funded HHC capital acquisitions.

(f) Receivable represents funding from The City for collective bargaining settlements.

(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 186,000 active municipal employees and 139,400 pensioners through $63.60 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 for the years ended June 30, 2015 and 2014 are approximately $2.167 billion and $2.081 billion, respectively. 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.

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the

NYCERS and additions to/deductions from NYCERS' fiduciary net position have been determined on the same basis as they are reported by NYCERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

NYCERS provides three main types of retirement benefits: service retirements, ordinary disability retirements (non-job-related disabilities) and accident disability retirements (job-related disabilities) to members who are in different "Tiers". The members' Tier is determined by the date of membership. Subject to certain conditions, members generally become fully vested as to benefits upon the completion of 5 years of service. Employees may be required to contribute a percentage of their salary to the pension plan based on their Tier, determined by their date of membership in the plan. Annual pension benefits can be calculated as a percentage of final average salary times number of years of service and changes with the number of years of membership within the plan.

Contribution requirements of the active employees and the participating New York City agencies are established and may be amended by the NYCERS Board. Employees' contributions are determined by their Tier and number of years of service. They may range between 0.00% and 7.46% of their annual pay. Statutorily-required contributions ("Statutory Contributions") to NYCERS, determined by the New York City Office of the Actuary in accordance with State statutes and City laws, are funded by the Employer within the appropriate fiscal year.

The Corporation's net pension liability, deferred inflows of resources, and pension expense is calculated by the Office of the Actuary, City of New York, and includes the information for MetroPlus. At June 30, 2015 and 2014, the Corporation reported a liability of $2.833 billion and $2.521 billion, respectively, for its proportionate share of the NYCERS net pension liability. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2012 and rolled forward to each respective fiscal year. The Corporation's proportion for the net pension liability for each fiscal year was based on the Corporation's actual contributions to NYCERS relative to the total contributions of all participating employers for 2015, and 2014 which was 14.030% and 13.991%, respectively.

(a) Actuarial Assumptions

The total pension liability in the June 30, 2013 actuarial valuation was determined using the following actuarial assumptions:

Inflation	2.5%.
Salary Increases	In general, merit and promotion increases plus assumed General Wage Increase of 3.0% per annum.
Investment Rate of Return	7.0%, net of pension plan investment expense. Actual return for variable funds.
Cost of Living Adjustment	1.5% and 2.5% for various Tiers.

Mortality rates and methods used in determination of the total pension liability were adopted by the New York City Retirement System (NYCRS) Boards of Trustees during fiscal year 2012. Pursuant to Section 96 of the New York City Charter, studies of the actuarial assumptions used to value liabilities of the five actuarially funded New York City Retirement Systems (NYCRS) are conducted every two years.

Mortality tables for service and disability pensioners were developed from an experience study of the Plan. The mortality tables for beneficiaries were developed from an experience review. For more detail see the reports entitled "Proposed Changes in Actuarial Assumptions and Methods for Determining Employer Contributions for Fiscal Years Beginning on and After July 1, 2011", also known as "Silver Books". Electronic versions of the Silver Books are available on the Office of the Actuary website (www.nyc.gov/actuary) under Pension information.

(b) Expected Rate of Return on Investments

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected real rates of return are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected real rates of return (RROR) by the target asset allocation percentage and by adding expected inflation. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized in the following table:

Asset Class	Target Asset Allocation	Arithmetic RROR by Asset Class	Portfolio Component Arithmetic RROR
U.S. Public Market Equities	32.60%	6.60%	2.15%
International Public Market Equities	10.00	7.00	0.70
Emerging Public Market Equities	6.90	7.90	0.55
Private Market Equities	7.00	9.90	0.69
Fixed Invoice (Core, TIPS, HY, Opportunistic, Convertibles)	33.50	2.70	0.90
Alternatives (Real Assets, Hedge Funds)	10.00	4.00	0.40
Portfolio Long-Term Average Arithmetic RROR	100.00%		5.39%

(c) Discount Rate

The discount rate used to measure the total pension liability as of June 30, 2015 and June 30, 2014, respectively, was 7.00%. The projection of cash flow used to determine the discount rate assumed that employee contributions will be made at the rates applicable to the current Tier for each member and that employer contributions will be made based on rates determined by the Actuary. Based on those assumptions, the NYCERS fiduciary net position was projected to be available to make all projected

future benefit payments of current active and nonactive NYCERS members. Therefore, the long-term expected rate of return on NYCERS investments was applied to all periods of projected benefit payments to determine the total pension liability.

The following presents the Corporation's proportionate share of the net pension liability calculated using the discount rate of 7.00%, as well as what the Corporation's proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.00%) or 1-percentage-point higher (8.00%) than the current rate (in billions):

		1% Decrease (6.00%)	Discount rate (7.00%)	1% Increase (8.00%)
Corporation's proportionate share of the net pension liability	$	3.927	2.833	1.830

(d) Deferred Inflows of Resources

At June 30, 2015 and 2014, the Corporation reported $264.3 million and $723.9 million, respectively, as deferred inflows of resources from the accumulated net difference between projected and actual earnings on NYCERS investments. The deferred inflows of resources at June 30, 2015 will be recognized in expense as follows:

	Amount
Year ended June 30:	
2016	$ (133,827)
2017	(133,827)
2018	(70,336)
2019	73,650
	$ (264,340)

(e) Annual Pension Expense

The Corporation's annual pension expense for fiscal years ending 2015 and 2014, which includes contributions toward the actuarially determined accrued liability, including the information for MetroPlus, were approximately $292.0 million and $229.4 million, respectively.

(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 10 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 (credit) expense of $(41.4) million, $203.5 million, and $300.0 million in 2015, 2014, and 2013 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 $13.1 million, $18 million and $15 million reduced OPEB expenses for 2015, 2014, and 2013, 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 2015, 2014, and 2013

composed the following, as calculated by the Office of the Actuary, City of New York, and includes the information for MetroPlus (in thousands):

		2015	2014	2013
Normal cost	$	227,986	241,316	244,614
Amortization of unfunded actuarial accrued liability over one year		(214,114)	(94,020)	264
Change in Assumptions		(110,701)	—	—
Amortization of unfunded actuarial accrued liability over 10 years		(115,952)	(115,952)	(115,952)
Interest at 4.0%		184,480	190,195	186,031
ARC		(28,301)	221,539	314,957
Less Corporation payments for retired employees' healthcare benefits and implicit rate subsidy credit		119,948	120,288	113,276
Net OPEB obligation increase		(148,249)	101,251	201,681
Net OPEB obligation – beginning of year		4,824,785	4,723,534	4,521,853
Net OPEB obligation – end of year		4,676,536	4,824,785	4,723,534
Less current portion of postemployment benefits obligation, other than pension		113,268	110,062	105,180
	$	4,563,268	4,714,723	4,618,354

The $110.7 million change in assumptions in the June 30, 2014 OPEB actuarial valuation for fiscal year 2015, are due to Welfare Fund contributions and Medicare Part B premiums. Welfare Fund contributions have been updated to reflect recent contribution rates. Recently negotiated amounts including scheduled increases for fiscal years 2015 through 2018 were reflected. A three-year trended average of reported annual contribution amounts for retirees was used in previous OPEB actuarial valuations. Medicare Part B premium reimbursement amounts have been updated to reflect actual premium rates announced for calendar years through 2015, as well as a legislated change to scheduled Income Related Monthly Adjustment Amounts (IRMAA).

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

The schedule below presents the results of OPEB valuations as of June 30, 2014 for fiscal year 2015, as of June 30, 2013 for fiscal year 2014, and as of June 30, 2012 for fiscal year 2013 (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, 2014	$ 3,688,064	—	3,688,064	2,138,008	172.5%
June 30, 2013	3,732,883	—	3,732,883	2,105,660	177.3%
June 30, 2012	3,544,019	—	3,544,019	2,083,349	170.1

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, 2014 and 2013 and the frozen entry age actuarial cost method was used in the 2012 OPEB actuarial valuations as the basis for the 2015, 2014, and 2013 ARC calculations, respectively. The change in Unfunded Actuarial Accrued Liability due to the change in actuarial methods is being amortized over a closed 10-year period using level dollar amortization. The portion of the Unfunded Actuarial Accrued Liability related to previous accumulated deficiencies in funding and any actuarial gains or losses due to experience are being amortized over a closed one-year period.

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 9.0% and is gradually reduced to an ultimate rate of 5% after 8 years. The complete set of actuarial assumptions and methods used in the June 30, 2014 OPEB actuarial valuation are contained in the Report on the Tenth Annual Actuarial Valuation of Other Postemployment Benefits Provided under the New York City Health Benefits Program (the Tenth OPEB Report). The Tenth OPEB Report was prepared as of June 30, 2014 in accordance with GASB Statements No. 43 and 45 for the fiscal year ended June 30, 2015 by the New York City Office of the Actuary and is dated September 17, 2015.

(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).

Long-term acute care is also reimbursed under PPS. For outpatient services, Medicare payments are based on service groups called ambulatory payment classifications (APCs).

Medicare provides PPS reimbursement for psychiatric units on a per diem basis, recognizing the intensity of care provided to the patients. The Corporation also 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 comorbidities.

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 2010 to 2012.

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, 2017. Medicaid pays for inpatient acute care services on a prospective basis using a combination of statewide and hospital specific 2010 costs per discharge adjusted to meet state budget targets and 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, long-term acute care, 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 comorbidities and length of stay.

Commercial insurers, including Health Maintenance Organization (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. 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 was effective for hospital ambulatory surgery services 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 was effective as of October 2010. APG payment for nonhospital based chemical dependency and mental health clinic services was 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, is changing 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.

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) Medicare Recovery Audit Contractor Program (RAC)

Federal and state governments have implemented a variety of audit programs to review and recover potential improper payments to providers from the Medicare and Medicaid programs. In 2012, CMS resolved technical issues delaying implementation of the Medicare Recovery Audit Contractor (RAC) program at hospitals receiving Prospective Interim Payments and each of the Corporation's hospitals

has seen an increased level of activity under the RAC program. These RAC requests have focused primarily on medical necessity of inpatient admissions and hospital coding practices. In addition, the Corporation has continued to receive inquiries from other Medicare and Medicaid auditors and reviewers. The Corporation has cooperated with each of these audit requests and implemented programs to track and manage their efforts.

Effective October 1, 2013, CMS adopted a policy known as the "Two-Midnight" rule. The "Two-Midnight" policy specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. CMS adopted the policy due to concern with auditor determinations regarding appropriate inpatient admission criteria as well as the growing use of "observation" status at hospitals. On January 31, 2014, CMS issued a notice creating a "Probe and Educate" period delaying enforcement of the "Two-Midnight" rule until September 30, 2014 and later extended the delay to December 31, 2015. During this period, Medicare administrative contractors (MACs) will select claims for review of policy compliance in order to provide guidance to providers, and RACs are precluded from conducting reviews for medical necessity under the "Two-Midnight" rule.

(c) Budget Control Act

The Budget Control Act of 2011 (the Budget Control Act) mandated significant reductions and spending caps on the federal budget for fiscal years 2012 through 2021. The Budget Control Act also created a requirement for Congress to enact recommendations of a bipartisan "super committee" achieving at least $1.2 trillion in deficit savings over a 10-year period by January 1, 2013, otherwise $1.2 trillion of across the board reductions known as the "sequester" would be triggered. The super committee failed to produce recommendations and after passing the American Taxpayer Relief Act to provide a two month delay, Congress was unable to reach an agreement to avoid imposition of the sequester. As a result, Medicare reimbursement was reduced by 2% effective April 1, 2013, known as Sequestration. The Sequestration period was extended by legislation until 2024.

(d) Delivery System Reform Incentive Payment (DSRIP) Program

In April 2014, the federal government approved a New York State Medicaid waiver request to reinvest $8 billion in federal savings to support implementation of transformative reforms to the State's healthcare system. Delivery system reforms will primarily be implemented through $7.4 billion of DSRIP Incentive payments for community-level collaborations to achieve programmatic objectives with a goal of reducing avoidable hospital use by 25% over five years. Additionally, $500 million was awarded through an Interim Access Assurance Fund (IAAF) to ensure the financial viability of critical safety net providers during the period prior to DSRIP implementation.

The IAAF, part of the DSRIP program, is a grant program authorized under the recently approved $8 billion Medicaid 1115 waiver. Its purpose is to assist safety net hospitals in severe financial distress and major public hospital systems to sustain key healthcare services as they participate with other providers to develop proposals for systems of integrated services delivery to be funded and implemented under the DSRIP. The Corporation was awarded a total of $152.4 million for IAAF and received an initial distribution, net, of $35.5 million for IAAF in 2014 and the balance of the award

during 2015. The Corporation recorded $15.5 million of grant revenue as of June 30, 2014 and $136.9 million as of June 30, 2015..In June 2015, the New York State Department of Health (NYSDOH) announced DSRIP valuation awards, which represent the total potential amount that each Performing Provider System (PPS) is eligible to earn in performance payments over the five years of the DSRIP program. OneCity Health, the HHC-led PPS received a valuation of $1.2 billion (note 1).

As the DSRIP program requires, HHC serves as fiduciary or lead partner for a coalition of Medicaid provider and social services organizations referred to as a Performing Provider System (PPS). The HHC-led PPS is referred to as OneCity Health and the constellation of partner organizations was finalized via a NYSDOH-mandated attestation process that began in December, 2014. Since April 2014, HHC has dedicated significant effort to enterprise-level and PPS-level preparation for participation in the DSRIP program, and in execution of NYSDOH required organizational and project planning essential to implementing and managing DSRIP program efforts. Notable activities include the establishment of PPS governance structures and the operationalization of an HHC subsidiary dedicated to DSRIP implementation and management.

OneCity Health PPS governance structures include an Executive Committee, three sub-committees to the Executive Committee, and four Hub Steering Committees, for each of four OneCity Health Hubs corresponding to each of the boroughs Bronx, Brooklyn, Queens and Manhattan. All governance approvals are made by the Executive Committee, and HHC has the final approval authority in its role as fiduciary of the PPS. The OneCity Health PPS Central Services Organization (CSO) is charged with supporting HHC and all PPS partners in implementing all aspects of the DSRIP program. The CSO Board is comprised of HHC leadership plus a minority (<25%) of outside members. Since the establishment of the CSO, the CSO team of HHC employees has advanced the planning and implementation work of the PPS by completing a complex partner readiness assessment of our over 200 partner organizations, over 1,000 sites of care and over 10,000 individual providers; performing initial project planning for the eleven selected DSRIP projects; and committing to a high-level DSRIP budget and flow of funds, which was approved by our PPS Executive Committee and included in our DOH-required State Implementation Plan submitted in August, 2015.

In June, 2015 HHC received a DSRIP payment from NYSDOH in the amount of $333.4 million and subsequently remitted two required IGT payments to fund the non-federal share of the DSRIP program performance payments. The first IGT payment to NYSDOH was $166.7 million and the second was for $55.6 million; both payments were made in June, 2015. The net amount of these transactions, $111.1 million, was recorded as grant revenue for the fiscal year ended June 30, 2015 based on meeting the eligibility requirements.

(e) 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 $123.4 million for 2015 and $126.9 million for 2014. 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 (note 8(b)). Accordingly, no provision has been made in the accompanying financial statements for unsettled claims, whether asserted or unasserted.

(f) 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 $40.1 million in 2015 and $38.3 million in 2014 and included in other than personal services in the accompanying financial statements.

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, 2015 (in thousands):

		Amount
Years:		
2016	$	22,192
2017		19,685
2018		19,292
2019		18,843
2020		14,741
2021–2025		59,922
Total minimum payments required	$	154,675

(12) Accounts Payable and Accrued Expenses

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

		2015	2014
Vendors payable	$	258,450	254,504
Per diem nurses payable		65,311	61,921
Accrued interest		12,870	13,773
Affiliations payable		30,206	17,435
Affiliations vacation accrual		37,493	28,318
Pollution remediation liability		10,691	21,659
Other		15,697	29,737
	$	430,718	427,347

(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 and recognized as grant revenue during 2014. In addition, New York City allocated $183 million in Community Development Block Grant (CDBG) funds to support operational expenses not covered by FEMA. Grant receivable for CDBG reimbursement is $372,000 at June 30, 2015 and $11 million at June 30, 2014.

During 2015, the Corporation received over $33 million in reimbursement from FEMA for Sandy related expenditures which was recorded as grant revenue.

(14) Incentive Payments for Meaningful Use of Electronic Health Records

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). These provisions were designed to increase the use of EHR technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement, or upgrade certified EHR technology; but providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional incentive payments.

During the years ended June 30, 2015 and 2014, the Corporation recognized revenue of approximately $13.3 million and $47.2 million, respectively, of HITECH incentives from the Medicare and Medicaid programs that is related to the Corporation meeting the requirements of the Meaningful Use Incentive program. The Corporation elected to recognize the revenue associated with the EHR incentive payment under the grant model and included such amounts in grants revenue in the accompanying consolidated statements of revenues, expenses, and changes in net position. The amount of the EHR incentive revenue recorded was based on the amounts received, which is subject to audit by CMS or its intermediaries and amounts recognized are subject to change.

(15) Correctional Health Services

On August 9, 2015, the Corporation, via a Memorandum of Understanding (MOU) with The City of New York, assumed from the New York City Department of Health and Mental Hygiene (DOHMH) its contracts for the provision of medical, mental health and dental services for the inmates of correctional health facilities maintained and owned by the City of New York (Correctional Health Services (CHS)) with Corizon Health, Inc., Correctional Medical Associates of New York, PC, and Correctional Dental Associates of New York (collectively, "Corizon"); Damian Family Care Centers, Inc. (Damian), and other smaller contracts for the duration of their terms for the nine contracts. Included is the understanding that the Corporation will also assume the transfer of staff from DOHMH otherwise engaged in the performance of correctional health functions, together, with the transfer of all real and personal property, as used by DOHMH in its provision of correctional health services. The total fiscal year 2016 budget for CHS is $153.9 million which is funded by the City of New York.

(16) MetroPlus

(a) Cash and Cash Equivalents

Cash and cash equivalents consist principally of money market funds. MetroPlus considers all highly liquid investments with original maturities of three months or less to be cash equivalents.

(b) U.S. Government Securities

U.S. government securities consist of U.S. Treasury bills, U.S. Treasury notes, and U.S. Treasury zero-coupon strips. Such securities are stated at fair value, with unrealized and realized 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
2015	U.S. Treasury bills, notes, bonds, and strips	$ 249,868	93,309	156,559
2014	U.S. Treasury bills, notes, bonds, and strips	$ 114,406	71,396	43,010

The following presents MetroPlus fair value measurements for U.S. government securities measured at fair value on a recurring basis as of June 30, 2015 and June 30, 2014:

		June 30, 2015		
	Fair value	Level 1	Level 2
U.S. Treasury bills, notes, bonds, and strips	$ 249,868	19,402	230,466

		June 30, 2014		
	Fair value	Level 1	Level 2
U.S. Treasury bills, notes, and bonds	$ 114,406	21,179	93,227

MetroPlus does not have any assets or liabilities based upon level 3 inputs.

(c) Premiums Receivable and Premium Revenue

Premiums earned are recorded in the month in which members are entitled to service. Medicaid and HIV Special Needs Plan (HIV-SNP) premiums are based upon several factors, including age, aid category, and health status 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 DOH represents a substantial portion of MetroPlus' premium revenues, and is subject to audit and adjustment by the DOH.

Medicare premiums are based on rates approved by CMS; premium revenues received from CMS represent a portion of MetroPlus' Medicare premium revenues. Premiums earned include Individual and Small Business Health Options Program (SHOP) Qualified Health Plan (QHP) revenues. QHP premiums are based on various plan types and coverage levels selected by the enrollee for individual and small business plans offered through the New York State Marketplace. In addition to premiums from enrolled QHP members, MetroPlus receives premium subsidies from CMS for Individual QHP members, under the Advanced Premium Tax Credit program (APTC) provided under the ACA.

Advanced premium tax credits received from CMS represent of substantial portion of MetroPlus' Qualified Health Plan premium revenues. MetroPlus also began receiving QHP Cost-Sharing Reduction (CSR) payments from CMS, which are recorded as deposit liabilities, and offset by payments to providers on behalf of the QHP member. These deposits are available to fund member deductibles, copayments, and coinsurance costs incurred by certain enrolled Individual QHP members. Receipts and payments for the CSR program are accumulated and the net amount is reported as a receivable or liability. Under the ACA, the United States Department of Health and Human Services (HHS) will initiate a settlement of the net CSR due, following the end of the coverage year.

With the implementation of the Exchange, the DOH began disenrolling FHP members from all managed care plans in New York State, at their respective annual renewal dates. MetroPlus FHP members qualifying for expanded Medicaid coverage were moved to the MetroPlus Medicaid line. MetroPlus FHP members not qualifying for Medicaid, had the option to select a QHP offered by any managed care plan in New York State. By March 2015, all MetroPlus FHP members were disenrolled from FHP.

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, 2015 and 2014 was as follows:

	2015	2014
Medicaid	81%	76%
Medicare	4	4
Child Health Plus	1	1
Family Health Plus	1	5
HIV-SNP	10	11
Qualified Health Plans	3	3
	100%	100%

(d) Assets Restricted as to Use

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

		2015	2014
MetroPlus statutory reserve investments	$	117,105	87,883

MetroPlus statutory reserve investments are required by the DOH regulations for the protection of MetroPlus enrollees, and are maintained at 5% of the health care services expenditures projected for the calendar year 2015. The statutory reserve is calculated in accordance with the regulations.

The statutory reserve account of $117.1 million and $87.9 million at June 30, 2015 and 2014, respectively, is invested in U.S. government securities with original maturities of one year or less. The account is in the form of an escrow deposit, maintained in a trust account under a custodian arrangement approved by the NYS Department of Financial Services.

The following presents MetroPlus statutory reserve investments' fair value measurements for assets measured at fair value on a recurring basis as of June 30, 2015 and June 30, 2014:

		June 30, 2015		
		Fair value	Level 1	Level 2
U.S. government Treasury Bills	$	117,105	29,205	87,900

		June 30, 2014		
		Fair value	Level 1	Level 2
U.S. government Treasury Bills	$	87,883	—	87,883

MetroPlus does not have any assets or liabilities based upon level 3 inputs.

(e) Change in Claims Payable

Accounts payable and accrued expenses include MetroPlus claims payable of $504.5 million and $561.7 million at June 30, 2015 and 2014, 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):

		2015	2014
Balance, July 1	$	561,692	489,055
Less drug rebates receivable		(9,156)	(2,794)
Net balance		552,536	486,261
Incurred related to:			
Current year		2,349,090	2,130,092
Prior years		(40,448)	(3,251)
Total incurred		2,308,642	2,126,841
Paid related to:			
Current year		1,893,421	1,667,086
Prior years		482,109	393,480
Total paid		2,375,530	2,060,566
Net balance at June 30		485,648	552,536
Plus drug rebates receivable		18,885	9,156
Balance, June 30	$	504,533	561,692

Net reserves for unpaid claims and claim adjustment expenses attributable to insured claims of prior years decreased by $40.4 million in 2015 and by $3.3 million in 2014. These changes are generally the result of ongoing analysis of recent loss development trends that include expected healthcare cost

and utilization. In 2015, the changes also reflect the impact of prior year net reserves for risk programs under the ACA, including the permanent risk adjustment, temporary reinsurance and temporary risk corridor programs.

(f) Risk Sharing Agreement with HHC

In July of 2000, MetroPlus and HHC entered into an agreement whereby all medical risk was shifted to HHC for most Medicaid, FHP, Child Health Plus and HHC members who select primary care physicians associated with HHC or contracted with MetroPlus based upon a percentage of the premium collected for those members (86% and 88% in risk years 2015 and 2014 respectively). HHC is also entitled to 100% of the onetime maternity and newborn supplemental payments for those members. After the end of the calendar year risk period, both parties settle the net amount remaining after payment of all capitated and fee-for-service medical expenses. This risk sharing agreement was expanded in 2011 to shift the prescription drug risk cost component for most Medicaid and FHP members from MetroPlus to HHC, for 97.5% of the prescription drug premium collected for those members. The risk sharing agreement provides for annual settlement within six months of the end of each risk period or later as mutually agreed upon.

MetroPlus assumes full risk for operations, including paying medical claims and providing administrative services to its members and providers, and other services required by contract with HHC, the State of New York, and CMS for its business lines.

As of January 2013, MetroPlus and HHC entered into an agreement to share surpluses generated under the aggregated Medicare Part C lines of business operated by MetroPlus for each year of the agreement. Surpluses, defined as the excess of expected costs of HHC medical claims for Part C, over actual HHC medical claim costs for Part C, will be shared at the rate of one quarter to three quarter between MetroPlus and HHC, respectively. Surplus payments are only made if the MetroPlus Medicare line of business has a positive net income for the claim year. To date, there have been no surplus sharing provisions.

(g) Operating Leases

MetroPlus leases equipment and office space under various operating leases. Total rental expense for operating leases was approximately $8.5 million in 2015 and $7.2 million in 2014 and included in other than personal services in the accompanying financial statements.

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, 2015 (in thousands):

		Amount
Years:		
2016	$	8,608
2017		8,376
2018		9,254
2019		8,755
2020		8,846
2021–2025		28,202
Total minimum payments required	$	72,041

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of The City of New York)

Schedule of the Corporation's Contributions
NYCERS Pension Plan
(Unaudited)
June 30, 2015, 2014, and 2013
(Dollar amounts in thousands)

		2015	2014	2013
Contractually required contribution	$	443,386	435,678	426,284
Contributions in relation to the contractually required contribution		443,386	435,678	426,284
Contribution deficiency (excess)	$	—	—	—
HHC covered-employee payroll	$	2,166,797	2,081,328	2,103,054
Contributions as a percentage of covered-employee payroll		20.46%	20.93%	20.27%

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of The City of New York)

Schedule of the Corporation's Proportionate Share of The Net Pension Liability

NYCERS Pension Plan

(Unaudited)

June 30, 2015, 2014, and 2013

(Dollar amounts in thousands)

	2015	2014	2013
HHC proportion of the net pension liability	14.030%	13.991%	13.991%
HHC proportionate share of the net pension liability	$ 2,832,753	2,521,076	3,228,173
HHC covered-employee payroll	2,166,797	2,081,328	2,103,054
HHC proportionate share of the net pension liability as a percentage of its covered-employee payroll	130.73%	121.13%	153.50%
Plan fiduciary net position as a percentage of the total pension liability	73.12%	75.32%	67.18%

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 years ended June 30, 2015 and 2014, and the related notes to the financial statements, which collectively comprise the Corporation's basic financial statements, and have issued our report thereon dated October __, 2015. 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*.

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 the 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 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.

October __, 2015

KPMG

cutting through complexity

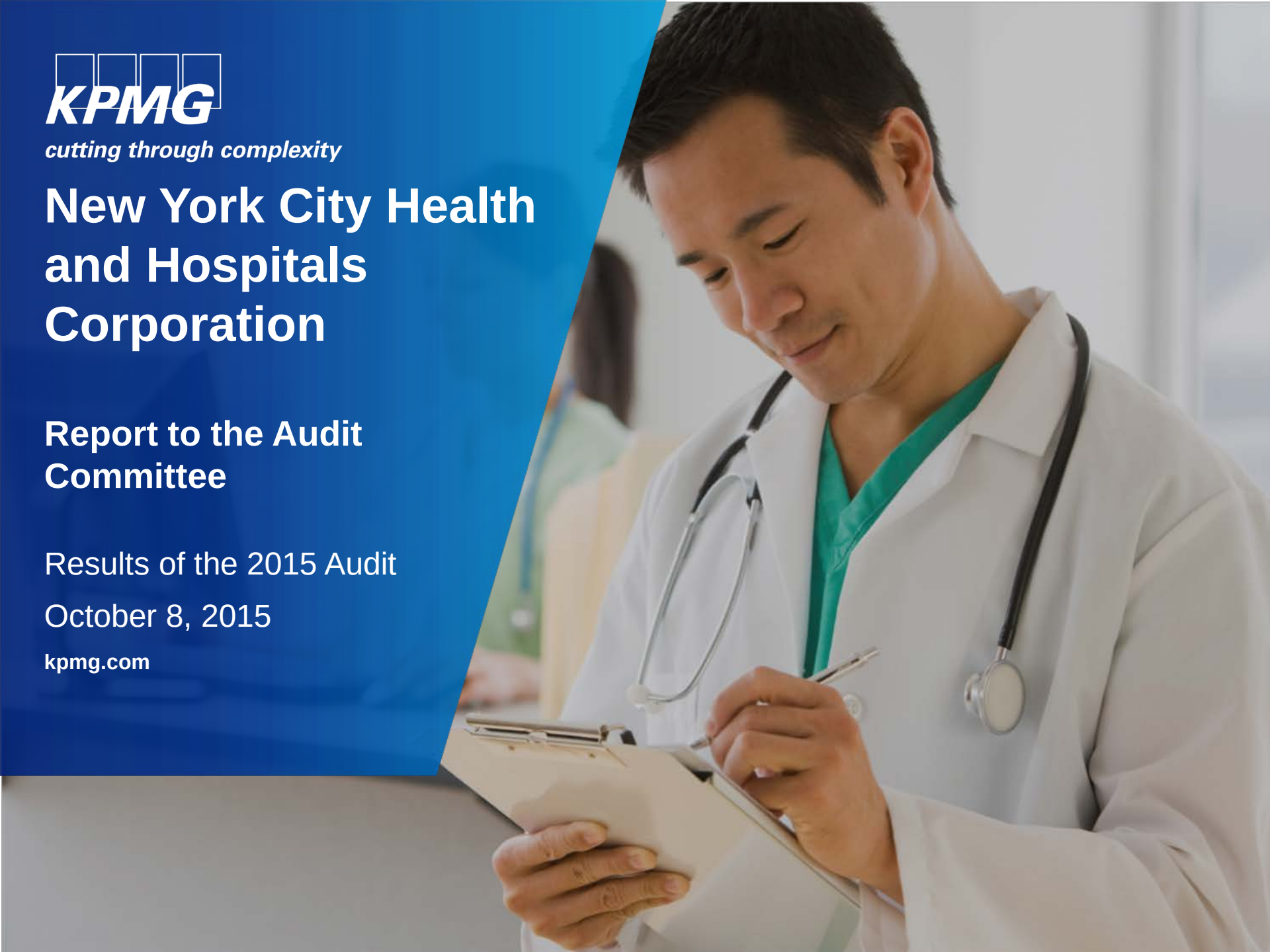
New York City Health and Hospitals Corporation

Report to the Audit Committee

Results of the 2015 Audit

October 8, 2015

kpmg.com



Agenda

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With You Today

- Maria Tiso, Lead Engagement Partner
- Jim Martell, Healthcare Industry Resource Partner
- Joe Bukzin, Engagement Senior Manager
- Bennie Hadnott, Partner, Watson Rice

Deliverables

- Auditor's report on the financial statements
- Required Communications (Clarified Statements on Auditing Standards (AU-C) section 260)
- Management Letter (AU-C section 265) – in progress to be issued in November 2015
- Various Regulatory Reports (cost reports) – to be issued in 2016
- MetroPlus Health Plan (Calendar year end) – to be issued in 2016
- HHC Insurance Company, Inc. (Calendar year end) – to be issued in 2016
- HHC ACO, Inc. – in progress

Required communications

Required communications	Application to New York City Health and Hospitals Corporation
Auditor's Responsibility Under Auditing Standards Generally Accepted in the U.S. (GAAS)	■ Management responsibilities are: – Adopting sound accounting policies. – Establishing and maintaining effective internal control over financial reporting (ICFR), including controls to prevent, detect and deter fraud. – Fairly presenting the financial statements, including disclosures, in conformity with generally accepted accounting principles (GAAP). – Identifying and ensuring that New York City Health and Hospitals Corporation complies with laws and regulations applicable to its activities, and for informing the auditor 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 New York City Health and Hospitals Corporation's financial reporting • Acknowledgement of their responsibility for the design and implementation of programs and controls to prevent, deter, and detect fraud; and • Affirmation that the effects of any uncorrected misstatements aggregated by the auditor are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation
Auditor's Responsibility Under Auditing Standards Generally Accepted in the U.S. (GAAS) (continued)	■ 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 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 ICFR as a basis for designing audit procedures, but not for the purpose of expressing an opinion on the effectiveness of the entity's ICFR – Communicating to management and the Audit Committee all required information, including significant matters – Communicating to the Audit Committee and management 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
	■ Audit Committee responsibilities are: – Role is one of oversight and monitoring. – Must rely on senior management, external auditors, and internal auditors. – Appoint, approve and review external audit function.

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation

Summary of Audit Results	■ We intend to issue an unmodified audit opinion on the financial statements.
	■ There was one corrected audit adjustment during 2015 relating to the valuation of due to third party payors, net of $20.2 million related to third party issues (i.e. Medicaid IPRO liability accrual for $16.5 million and a reduction to a RAC receivable of approximately $3.7 million), which resulted in a reduction to net patient services revenue.
	■ There was one post closing adjustment to reclassify $300 million from current to non-current liabilities for amounts due to the City related to debt service and malpractice.
	■ We are unaware of any material errors, fraud and illegal acts that would result in a significant misstatement of the financial statements.
	■ **New Accounting Pronouncement**
	  ■ There was one new accounting pronouncement adopted that had an impact on the financial statements
	  ■ GASB 72, Fair Value Measurement and Application, which required the Corporation to expand their fair value disclosures.
	■ **Accounting Estimates**
	  ■ The significant accounting estimates affecting the financial statements include:
	  ■ Valuation of patient accounts receivable
	  ■ Valuation of estimated third party settlements, net and estimated pools receivable, net
	  ■ Valuation of pension plan liability under GASB 68 (In Progress)
	  ■ Valuation of post-retirement benefits other than pension (OPEB) liability
	  ■ Valuation of MetroPlus incurred but not reported (IBNR) liability
	  ■ Amounts are reasonably stated within the financial statements

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation
Summary of Audit Results (continued)	■ **Significant Accounting Transactions** ■ The following significant transactions occurred during fiscal year 2015: ■ **Interim Access Assurance Fund (IAAF)** grant funds of approximately $116.9 million received of which $136.9 million has been recorded as grant revenue in 2015. ■ **DSRIP** ■ In 2015, HHC Assistance Corporation (HHCAC) took on the function of the "Central Service Organization" in the HHC led Participating Provider system (PPS) under the DSRIP program. HHCAC operates under the d/b/a "One City Health." ■ In June 2015, the NYSDOH announced DSRIP valuation awards which represent the total amount that each PPS is eligible to earn in performance payments over 5 years of DSRIP Program. One City Health received $111 million, net of IGT payments which was recorded in grant revenue. ■ **Upper payment limit** balance (inpatient/outpatient) recorded as a third party payor receivable of $890 million at June 30, 2015 (approximately $1.4 billion at June 30, 2014). The Corporation received approximately $1 billion on the prior year receivable during 2015. ■ **Electronic medical records system** ■ The Corporation is in the process of implementing EMR system over a 6 year implementation period. The first network to go live (Queens) is scheduled for April 2016. The Corporation has capitalized costs included within construction in progress of $115 million and recorded $13.6 million as expenses for the fiscal year ended June 30, 2015. ■ **FEMA** ■ During 2015, the Corporation received $33 million in reimbursement from FEMA for Sandy related expenditures which was recorded as grant revenue.

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation
Summary of Audit Results (continued)	■ The following subsequent event disclosures are included within the notes to the financial statements: ■ Line of Credit - Equipment Financing Agreement ■ On July 9, 2015, the Corporation entered into a $60 million equipment financing agreement with a bank for the purpose of financing medical, IT and other equipment. The Corporation drew down $10 million on the line of credit on July 9, 2015. ■ Correctional Health Services (CHS) ■ On August 9, 2015, the Corporation via a memorandum of understanding with the City of New York, assumed from the NYC Department of Mental Hygiene its contracts for the provision of medical, mental health and dental services for the inmates of correctional health facilities maintained and owned by the City of New York. The total fiscal 2016 budget for CHS is $159.3 million which is funded by the City of New York. ■ Liquidity Considerations

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation
Significant Accounting Policies	■ New York City's Health and Hospital Corporation's significant accounting policies are summarized in note 1 to the financial statements
Quality of Accounting Principles	■ Accounting principles have been consistently applied and appropriate disclosures are included in the financial statements.
Management Judgments and Accounting Estimates	■ Significant accounting estimates affecting New York City Health and Hospitals Corporation financial statements are noted in the summary of audit results (slide 6). ■ We evaluated management's significant judgments and estimates as part of our audit, and found them to be reasonable in the context of the financial statements taken as a whole.
Audit Misstatements	■ There was one corrected audit adjustment noted in the summary of audit results (slide 6). ■ There were no material uncorrected financial statement misstatements.

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation
Disagreements with Management	■ There are no unresolved disagreements.
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 New York City Health and Hospitals Corporation auditors.
Difficulties Encountered in Performing the Audit	■ We encountered no significant difficulties in dealing with management during the performance of our 2015 audit.
Material Written Communications	■ Material written communications between management and KPMG include: – Engagement letter – Management representation letter – Management letter
Significant or Unusual Transactions	■ See slide 6.
Significant Deficiencies and Material Weaknesses in Internal Control	■ There were no material weaknesses or significant deficiencies identified.

Required communications (continued)

Required communications	Application to New York City Health and Hospitals Corporation
Other Information in Documents Containing Audited Financial Statements	■ Not applicable, as the financial statements are not included in other documents, except for when New York City Health and Hospitals Corporation includes them in a bond offerings.
Material Errors, Fraud and Illegal Acts	■ Planned audit procedures performed, including inquiries of senior management and the Office of the Inspector General.
Changes to Initial 2015 Audit Plan	■ There were no significant changes to the initial 2015 audit plan
Management Cooperation	■ Received full cooperation. ■ Full access to books and records.
Independence	■ In our professional judgment, we are not aware of any relationships between KPMG and New York City Health and Hospitals Corporation, that may reasonably be thought to bear on our independence.
Related Party Transactions	■ Related party transactions with The City of New York are disclosed.
Evaluation of non-gaap policies and practices	■ Amounts for non-GAAP policies and practices were deemed not material to the financial statements of the organization.
Litigations, Claims, & Assessments	■ None other than normal course of business.
Noncompliance with Laws and Regulations	■ None that came to our attention.

Next steps

- Finalize concurring partner review
- GASB 68 Pension Review
- Finalize testwork on consulting costs
- Finalize subsequent event procedures required until issuance
  - Inquiries with management
  - Down to date legal letter inquiry updates
  - Inspection of subsequent minutes, if any
- Management representation letter
- Final debt covenant calculations
- Responses to the management letter observations and status of prior year observations

KPMG resources

KPMG's Audit Committee Institute (ACI)

Established in 1999

- KPMG's commitment to communicating with Audit Committee members and other participants in the financial reporting process
- www.kpmg.com/aci
- Publications of the ACI
  - Audit Committee Insights – www.kpmginsights.com
  - Audit Committee Quarterly – http://www.kpmg.com/aci/quarterly.htm
  - Audit Committee Institute Roundtables – www.kpmg.com/aci/roundtables.htm
  - ACI Website: www.kpmg.com/aci
  - ACI mailbox: auditcommittee@kpmg.com | ACI hotline – 1-877-KPMG-ACI

Healthcare Publications

- KPMG Insiders: Healthcare – www.kpmginsiders.com
- Healthcare Business Briefing

Independent Auditors' Report

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

We have audited, 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, 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 years ended June 30, 2015 and 2014, and the related notes to the financial statements, which collectively comprise the Corporation's basic financial statements, and have issued our report thereon dated October __, 2015. Our report included an emphasis of matter paragraph regarding the Corporation's implementation of Governmental Accounting Standards Board (GASB) Statement No. 72, *Fair Value Measurement and Application*. Our opinion was not modified with respect to this matter.

In connection with our audit, nothing came to our attention that caused us to believe that the Corporation failed to comply with the terms, covenants, provisions, or conditions of Section 811(c) of Article VIII of the General Resolution adopted November 19, 1992, relating to the New York City Health and Hospitals Corporation Health System Bonds, 2008 Series A, B, C, D, and E, 2010 Series A, and 2013 Series A, insofar as they relate to accounting matters. However, our audit was not directed primarily toward obtaining knowledge of such noncompliance. Accordingly, had we performed additional procedures, other matters may have come to our attention regarding the Corporation's noncompliance with the above-referenced terms, covenants, provisions, or conditions of the General Resolution, insofar as they relate to accounting matters.

This report is intended solely for the information and use of the board of directors and management of the Corporation and Manufacturers and Traders Trust Company and is not intended to be and should not be used by anyone other than these specified parties.

October __, 2015

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

AUDIT COMMITTEE OF THE HHC BOARD OF DIRECTORS

Corporate Compliance Report

October 8, 2015

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Agenda

I. Compliance with the Deficit Reduction Act of 2005

1) Pursuant to the Deficit Reduction Act ("DRA") of 2005, the New York City Health and Hospitals Corporation ("HHC") is required, as a condition of its participation in the Medical Assistance Program ("Medicaid"), to establish written policies and procedures that inform its employees[1], contractors, agents, and other persons about the following[2]:

- HHC's internal policies covering the prevention and detection of fraud, waste, and abuse;
- the Federal False Claims Act and any similar law under the State of New York (the "State") that governs false claims and statements; and
- whistleblower protections under Federal and State laws.

2) To comply with this mandate the Office of Corporate Compliance disseminated to all workforce members and contractors an overview of the DRA and HHC's policies and procedures designed to prevent and detect fraud, waste, and abuse. Additionally, workforce members and contractors were provided with a summary of the Federal False Claims Act and similar State laws, as well as Federal and State whistleblower laws.

3) The OCC also reviewed all Central Office and Facility employee handbooks to ensure that, as required by the DRA, said handbooks contain information related to the DRA. All handbooks were compliant with the same.

4) HHC has, without limitation, the following policies in place to detect and prevent fraud, waste and abuse:

A. HHC's Corporate Compliance Plan

The overall breadth of HHC's Corporate Compliance Program (the "Program") is best reflected in its Corporate Compliance Plan (the "Plan"). Specifically, the Plan outlines and explains the structural and operational elements of the Program, highlighting HHC's development and/or adoption of written policies and procedures covering compliance, including, without limitation, HHC's Operating Procedure 50-1 - *Corporate Compliance Program* ("OP 50-1"), which details the structure of the Program; HHC's Principles of Professional Conduct ("POPC"), which establishes HHC's prohibition of fraudulent billing and other improper business practices; and HHC's A Guide to Compliance at the New York City

[1] For purposes of sections A-D of this memorandum, the term "employee" shall mean all HHC employees, personnel, affiliates, medical staff members, volunteers, trainees, and other individuals whose conduct is under the direct control of HHC (collectively hereinafter referred to as "workforce members").
[2] *See* 42 U.S.C. § 1396a [a][68][A-C]

Health and Hospitals Corporation ("Guide to Compliance")[3], which provides a summary of important compliance issues and compliance standards and expectations at HHC. The Plan, OP 50-1, the POPC, and the Guide to Compliance may all be accessed through HHC's Intranet under the Office of Corporate Compliance ("OCC") at http://compliance.nychhc.org/, or by way of HHC's public website at http://www.nyc.gov/html/hhc/html/about/About-PublicInfo-Compliance.shtml. You may also contact your facility Compliance Officer or the OCC - by phone at (646) 458-7799 or by e-mail at COMPLIANCE@nychhc.org - to obtain copies of the same.

The Plan also underscores HHC's commitment to routinely identify potential areas of corporate risks and vulnerabilities, and to perform self-evaluations and audits of its operations and practices, which are required under New York's mandatory compliance program regulations.[4]

B. HHC Operating Procedure ("OP") 50-1- Corporate Compliance Program

As evidenced by its internal operating procedures[5], HHC has implemented a Program that satisfies the mandatory provider compliance program regulations promulgated by the New York State Department of Social Services.[6] Additionally, the Program also adopts the principles set forth in the United States Sentencing Commission 2014 Guidelines Manual pertaining to effective compliance and ethics programs. The Program is responsible for, among other things, aggressively identifying, directing, and addressing corporate-wide and local compliance activities and concerns. The following are some key highlights of the Program:

- the appointment of a Corporate Compliance Officer ("CCO") charged with the oversight and implementation of the Program;
- the creation of an annual Corporate Compliance Work Plan ("WorkPlan") designed to proactively address compliance vulnerabilities;
- the institution of a confidential process and toll-free hotline (1-866-HELP-HHC) to receive complaints;
- the implementation of corporate-wide training and education regarding corporate compliance issues;
- the requirement that the CCO report, at least quarterly, HHC compliance activities to the Chairperson of the Board of Directors ("BOD"), the Chairperson of the Audit Committee of the BOD, and HHC's President and Chief Executive;

[3] *See* HHC's A Guide to Compliance at New York City Health and Hospitals Corporation (revised: July 2014)
[4] *See* 18 N.Y.C.R.R. § 521.3[c][6]; *see also* HHC's Corporate Compliance Plan (Updated 11/09/11), p.35
[5] *See* HHC Operating Procedure (OP) 50-1 - Corporate Compliance Program
[6] *See* 18 N.Y.C.R.R. Part 521

- the requirement that all HHC workforce members report violations of OP 50-1, as well as of all applicable laws, rules, codes and regulations (collectively "Laws"), to the CCO;
- the investigation of allegations regarding: (i) violations of applicable Laws and HHC OP 50-1; and (ii) allegations of intimidation and retaliation; and
- the prohibition of intimidation and retaliation against any person who, acting in good faith, engages in the Program.

C. HHC's Principles of Professional Conduct ("POPC")

The POPC is a guide to direct HHC workforce members to conduct official business in an ethical and lawful manner. Some examples of violations of professional conduct are:

- improper billing practices;
- accepting gifts from a vendor;
- inappropriate patient referrals;
- breaches of patient confidentiality; and
- failure to adhere to HHC policies concerning patient care.

D. HHC's A Guide to Compliance at the New York City Health & Hospitals Corporation

The Guide to Compliance defines the terms *compliance, fraud, waste*, and *abuse*. The Guide to Compliance also describes the goals of HHC's Program, the consequences of non-compliance with applicable Laws and internal policies, and the responsibilities of each workforce member with regard to compliance. In addition to the foregoing, the Guide to Compliance provides information regarding the following compliance subjects:

- Federal and State False Claims Acts;
- HHC's policy on retaliation; and
- instructions on how to report a compliance issue.

II. Monitoring of Excluded Providers

1) There have been no reports of excluded providers since the last time the Audit Committee convened in September 2015. The OCC is presently awaiting the results of HHC's September 2015 review of excluded providers.

III. Outline of Calendar Year 2015 ("CY2015") Corporate-wide Risk Assessment: *Status Report*

1) As reported in September, the OCC started its CY2015 Corporate-wide Risk Assessment (the "Risk Assessment") process in May 2015.[7] The Risk Assessment results will be used, in pertinent part, by the OCC to develop the fiscal year 2016 ("FY2016") New York City Health and Hospitals Corporation ("HHC") Corporate Compliance Work Plan ("FY16 Work Plan").

Status Update:

2) In September, the OCC reported the following with regard to the Risk Assessment process:

- Over a period of approximately three weeks in July and early August, the OCC organized and conducted in Central Office and at the various HHC Health Networks a total of 19 Compliance Committees meetings to discuss corporate-wide and facility specific risks. Subsequently, three additional compliance meetings were conducted in late August and early September, bringing the total of risk assessment compliance meetings conducted corporate-wide to 22. During these meetings, risk assessment and scoring processes were conducted and completed. All identified risks were prioritized taking into account, among other things, the potential impact of a given risk, the likelihood of risk occurrence, and the presence of internal controls to mitigate identified risks.

- The compliance committee/risk scoring meetings took place at the: (i) **South Manhattan Health Network** (Bellevue; Metropolitan; Coler and Carter; and Gouverneur – six meetings with two combined meetings at the Coler site covering Coler and Carter and two meetings at the Metropolitan site); (ii) **North and Central Brooklyn Healthcare Networks** (Cumberland; Dr. Susan Smith McKinney; East New York; Woodhull; and Kings County – six separate meetings with two meetings at Woodhull); (iii) **Generations+/Northern Manhattan Healthcare Network** (Lincoln Medical and Mental Health Center, Harlem Hospital Center, Segundo Ruiz Belvis Diagnostic & Treatment Center, Morrisania Diagnostic & Treatment Center, Renaissance Healthcare Network – one collective meeting held at Harlem); (iv) **North Bronx Healthcare Network** (Jacobi Medical Center and North Central

[7] Risk may be described as "a measure of the extent to which an entity is threatened by a potential circumstance or event, and is typically a function of: (i) the adverse impacts that would arise if the circumstance or event occurs; and (ii) the likelihood of occurrence." (NIST, U.S. Dep't of Commerce, *Guide for Conducting Risk Assessments* (Special Publication 800-30) Information Security, September 2012, at 6); In simpler terms, "[r]isks are events or conditions that may occur and, if they do occur, would have a harmful effect" on HHC. (HCCA Professional's Manual, Risk Assessment Chapter, ¶ 40,105, at 41,001).

Bronx Hospital – one collective meeting held at the Jacobi site); (v) **Queens Healthcare Network** (Elmhurst Hospital Center and Queens Hospital Center – one collective meeting held at the Queens Hospital site); (vi) **Southern Brooklyn/Staten Island Network** (Coney Island Hospital; and Sea View Hospital Rehabilitation Center – two separate meetings held); (vii) the **Executive Compliance Workgroup ("ECW") –** held at Central Office; (viii) **the ECW Subcommittee on Compliance and Quality** – held at Central Office; (ix) **the HIPAA compliance meeting** – two separate meetings held at Central Office and webconference; and (x) **HHC Health and Home Care** – held at Central Office.

3) Since the last time the Audit Committee convened, the OCC conducted the following risk assessment/compliance committee meetings: (i) **OneCity Health/Delivery System Reform Incentive Payment ("DSRIP") Program Compliance Committee** – one meeting held at Central Office; (ii) **the HHC ACO, Inc. Compliance Committee** – one meeting held at Central Office; and (iii) **the World Trade Center Health Program Compliance Committee** – one meeting held at Central Office. Follow up ECW and World Trade Center Health Program compliance committee meetings have been scheduled. Once these last two meetings have taken place, the Risk Assessment process will be finalized.

IV. Compliance Training

Regulatory Requirements

1) Pursuant to 18 NYCRR § 521.3(c)(3) "Compliance Program Required Provider Duties", a provider of services' (such as HHC) compliance program shall include certain elements including that which specifically addresses the *"training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation."* In addition, this section of the law details further requirements noting that *"such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member".*

Overview of HHC Compliance Training

2) Workforce member compliance training is developed by the OCC and separated into three courses namely "OCC General Compliance and Fraud, Waste & Abuse Training" for "Physicians", "Healthcare Professionals", and "General Workforce Members" and cover the core areas of an effective compliance program as it relates to their various roles within HHC. An additional course titled "OCC General Compliance and HIPAA Training" was developed for the HHC Board of Directors and currently undergoing the final stages of quality and product testing prior to Board Member assignment and dissemination..

- Generally, training for all HHC employees and Board Members is provided electronically through the Corporation's PeopleSoft Enterprise Learning Management System ("ELM"). Courses include an array of media such as videos from key regulatory entities and electronic display of HHC policies and procedures and memoranda. Various other training methods including live training and secure file email distribution are utilized for those without access to ELM.

- Training is required on a periodic basis (no less than biennially) for all healthcare professionals, physicians, workforce members (*i.e.* employees, affiliates, and other personnel who are identified by the OCC as requiring training based on one's role or function), and members of the Board of Directors.

Content of Training

3) All training courses developed by the OCC provide information on key Federal and State regulatory requirements including, without limitation, the Federal False Claims Act, Stark and Anti-Kickback Laws, Civil Monetary Penalties Law, the Deficit Reduction Act of 2005, the New York City Conflicts of Interest Law and the Emergency Medical Treatment Active Labor Act ("EMTALA"). All courses also cover topics including medical record documentation, corporate records management policies and procedures, general compliance issues, fraud, waste, and abuse, and accountable care organizations ("ACOs") compliance-related activities, as well as HHC's own ethical and business standards found in its Principles of Professional Conduct and Code of Ethics. The courses also cover New York Social Services Law (18 NYCRR Part 521) requirements for an effective compliance program, and provides and overview of HHC's Corporate Compliance and Ethics Program.

4) Healthcare Professionals and Physicians training courses, in addition to the aforementioned topics applicable to all, also provide, without limitation, information on the following topics:

- The Elder Justice Act and related required reporting requirements;
- Child Abuse identification and reporting;
- Professional Misconduct reporting; and
- Patient rights laws and requirements specific to facility types such as Diagnostic and Treatment Centers and Skilled Nursing Facilities.

5) The Board of Directors training course, in addition to the aforementioned topics applicable to all, also provides, without limitation, information on the following topics specific to one's role as a Board Member:

- The fiduciary responsibilities of Board Members under the Public Authorities Accountability Act of 2005 and Reform Act of 2009 (collectively "PAAA");
- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

- Responsibilities as Board Member as it relates to the oversight of HHC's operations under the Medicare and Medicaid program regulations;
- Board member responsibility as it relates to the oversight of the provision quality services; and
- Board Member guidance provided by the U.S. Department of Health and Human Services Office of Inspector General ("OIG").

Current Status

1) As of **7/14/15** the compliance training completion rates were as follows:

- PHYSICIAN MODULE: 56% completion
- HEALTHCARE PROFESSIONALS: 69% completion
- GENERAL WORKFORCE MEMBER: Not assigned during this timeframe

2) As of **10/1/15** the compliance training completion rates were as follows:

- PHYSICIAN MODULE: 63% completion
- HEALTHCARE PROFESSIONALS: 76% completion
- GENERAL WORKFORCE MEMBER: no numbers at this time as the course was recently assigned on or about September 5-10, 2015.

V. Delivery System Reform Incentive Payments ("DSRIP") Compliance Program – Status Update

Background of the Delivery System Reform Incentive Payments ("DSRIP")

1) As previously reported to the Audit Committee in June 2015, the federal government recently agreed to allow the State of New York (the "State") to reinvest nearly half of the savings generated through Medicaid Redesign Team ("MRT") reforms.[8] The majority of funds used by the State for reinvestment activities has been allocated for the Delivery System Reform Incentive Payments ("DSRIP") program.

[8] In April 2014 the State of New York (the "State") finalized an agreement with the federal government to allow the State to reinvest $8 billion of the $17.1 billion in savings generated through Medicaid Redesign Team ("MRT") reforms. Of this, $6.42 billion was allocated for Delivery System Reform Incentive Payments ("DSRIP") program, which is the main vehicle that the State will utilize to implement the savings generated through the MRT reforms. "DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years." (citing New York State Department of Health, Frequently Asked Questions (FAQs), New York MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan).

Repurposing of a HHC Wholly Owned Subsidiary to Function as a Centralized Service Organization

2) On December 18, 2014, the HHC Board of Directors (the "Board") approved via formal resolution the following Corporation actions as it relates to DSRIP:

- the submission of an application to the New York State Department of Health ("SDOH") to participate in DSRIP;
- the execution of agreements with designated participants; and
- the repurposing of the wholly owned HHC subsidiary the HHC Assistance Corporation to function in the capacity of a centralized service organization ("CSO")(d/b/a One City Health Services) for the purpose of providing technical assistance to a single HHC-led Performing Provider System ("PPS"). As part of the resolution, the Board directed that the activities of the CSO under the DSRIP program be subject to HHC's compliance, procurement, and internal audit programs. HHC will serve as the PPS Lead, or fiduciary, of the PPS.

Office of Medicaid Inspector General Compliance Requirements for PPS Leads

3) In its April 6, 2015 guidance to PPS leads, the Office of the Medicaid Inspector General ("OMIG") provided the following:

- To satisfy Department of Social Services compliance program regulations, HHC, as a PPS Lead, is required to "dedicate resources toward implementing a compliance program that will assist in preventing and identifying Medicaid payment discrepancies related to DSRIP payments."[9] In simple terms, HHC is required to "[f]ollow the money."[10] To meet these requirements, "PPS Leads must dedicate resources and develop systems to take all reasonable steps to ensure the Medicaid funds that are distributed as part of the DSRIP program are not connected with fraud, waste and abuse."[11]
- OMIG further advised that PPS Leads should focus risk identification strategies on "the current phase of the DSRIP program and payments made to it."[12]

[9] New York State Department of Health Office of the Medicaid Inspector General Delvery System Reform Incentive Payment ("DSRIP") Program, DSRIP Compliance Guidance 2015-01, Special Considerations for Performing provider System ("PPS") Leads' Compliance Program. [DSRIP CG 2015-01, April 6, 2015].
[10] *Id.*
[11] *Id.*
[12] *Id.*at p.2.

4) As noted above, in April 2015, OMIG issued guidance outlining the eight elements PPS leads must comply with to maintain an effective compliance program as required to participate in the Medicaid program. On September 1, 2015, OMIG revised its guidance on this topic. Pursuant to OMIG's latest guidance, the following are special considerations, by element, that HHC must consider as a PPS Lead, with a comparison of the April 2015 guidance and the September 1, 2015 guidance:

- ***ELEMENT # 1*** – *Initial Guidance* - The establishment of policies and procedures that outline compliance expectations pertaining to DSRIP, including a mechanism for the reporting of compliance issues to HHC's Chief Corporate Compliance Officer ("CCO"), who is the PPS Lead Compliance Officer.[13] This may be accomplished with direct reports to the PPS Lead Compliance Officer or through "compliance liaisons within the [PPS] network."[14]

  THIS GUIDANCE REMAINS UNCHANGED

- ***ELEMENT # 2*** – *Initial Guidance* - The CCO must be an employee of HHC - the PPS Lead - and report directly to HHC's Chief Executive Officer (or other senior administrator) and report to the HHC's governing body at least quarterly.

  The CCO should consider the distribution of DSRIP funds and the department of Health (DOH) requirements set out in the DSRIP Measure Specification and Reporting Manual.

  GUIDANCE REMAINS UNCHANGED

- ***ELEMENT # 3*** - *Initial Guidance* - The provision of training and education directly to the workforce members of the HHC (as PPS lead) and indirectly to performing providers within the PPS Network. HHC can meet its obligations here by supplying training materials to the PPS providers or by implementing a control process that allows HHC to validate that said training took place. Training and education should cover DSRIP compliance expectations, the performing provider's role in DSRIP projects, and the procedure for reporting compliance violations as related to DSRIP funds.

  THIS GUIDANCE REMAINS UNCHANGED

- ***ELEMENT # 4*** – *Initial Guidance* - The establishment of a confidential reporting methodology to HHC's CCO.

[13] *See id*. at p. 2, Special Considerations by Element
[14] *Id.*

THIS GUIDANCE REMAINS UNCHANGED

- ***ELEMENT # 5*** – *Initial Guidance* – HHC's disciplinary policies must facilitate the good faith reporting of DSRIP-related compliance issues and it must cover the performing providers within the PPS Network.

THIS GUIDANCE REMAINS UNCHANGED

- ***ELEMENT # 6*** – *Initial Guidance* - The PPS Lead is required to perform a risk assessment on the distribution and use of DSRIP funds. Additionally, the PPS Lead should audit/monitor how PPS partners are using DSRIP funds. OMIG provides that "[t]his plan may coincide with DOH requirements for measuring performance and reporting on the flow of funds related to DSRIP projects."

NEW GUIDANCE

HHC must develop and implement a system for routine identification of compliance risk areas specific to their provider type (i.e. PPS Lead). Risks specific to HHC (as PPS Lead) during this phase of the DSRIP program include partners performance and progress toward DSRIP milestones. The PPS Lead's system should include a plan for auditing/monitoring network partners' performance toward meeting DSRIP milestones.

- ***ELEMENT # 7*** – *Initial Guidance* - PPS Leads are required to respond to compliance issues, such as: (i) the misuse of DSRIP funds; and (ii) the false representations to obtain DSRIP funds. The PPS Lead must establish an auditing program that reaches and has the capability of assessing how network partners are utilizing DSRIP funds.

NEW GUIDANCE

HHC must develop and implement a system for responding to compliance issues that are raised. HHC should consider its own willful misuse of DSRIP funds, or false statements made by a PPS Lead or its network providers to obtain DSRIP funds, as examples of compliance issues. Social Services Law § 363-d and 18 NYCRR Part 521 require reporting compliance issues to DOH and OMIG. HHC's system must include a prompt corrective action and refunding overpayments. HHC (as PPS lead) will need to work with its network performing providers to support compliance with this requirement.

- ***ELEMENT # 8*** – *Initial Guidance* - The development of whistleblower protection policies must be undertaken. The PPS Lead will require assistance from the PPS partners to enforce this requirement.

  THIS GUIDANCE REMAINS UNCHANGED

DSRIP and Privacy-Related Matters

5) The New York State Department of Health ("DOH"), Office of Health Insurance Programs, requires that all PPS Leads receiving Medicaid data containing Protected Health Information ("PHI") originating from DOH ("DOH Medicaid Data") assess the need for two factor authentication when accessing DOH Medicaid Data whether it be for employee use within the PPS Lead's IT systems or when providing downstream entities (PPS Performing Providers and PPS Lead's contractors) access to DOH Medicaid Data through the PPS Lead's IT systems. This assessment requirement also applies to the Performing Providers and contractors if they desire to utilize DOH Medicaid Data, shared by the PPS Lead, on their IT systems.

Additional DSRIP Compliance Considerations

6) The following are additional State/OMIG Compliance-related Funds Flow Reporting Requirements as it relates to DSRIP:

- PPS are asked to report the amount of DSRIP performance payments paid by the PPS Lead to its network providers using the Funds Flow module in the DSRIP Quarterly Report. The instructions for the Implementation Plan indicated that "the quarterly reports will require you (the PPS) to submit your actual distribution of funds to these provider categories on a quarterly basis" and that the "quarterly submissions of actual funds distribution will ultimately be required at the provider level".

- For the purposes of the DSRIP program, the Independent Assessor ("IA") will be evaluating that funds have been disbursed by the PPS Lead to its network partners in accordance with the Special Terms and Conditions ("STCs") of the DSRIP waiver, which requires that non-safety net providers are eligible to receive DSRIP payments totaling no more than 5 percent of the total DSRIP Project Plan valuation.

- A separate but related New York State requirement managed by OMIG requires that any enrolled Medicaid provider or entity that receives $500,000 or more from Medicaid during a 12 month period must adopt and implement a compliance program that meets the requirements of New York Social Services Law § 363-d and the corresponding regulations found at 18 NYCRR part 521. These requirements are outlined above in DSRIP payments count toward the $500,000 payment threshold and

OMIG will require the payment information made by the PPSs at the provider level. OMIG has requested the PPS payment data.

- SDOH determined that it is most efficient for DOH to provide to OMIG the quarterly validation data that is provided by the PPS to the IA, instead of having OMIG contact the PPS directly to obtain the information. The data from the four quarterly reports submitted by the PPS, will cover all DSRIP payments earned by participating entities between October 1 and September 30 for each of the years covered under the DSRIP waiver and will include those payments made directly from the PPS Lead to its network partners. OMIG will use this data, in conjunction with the information for all Medicaid Fee-for-Service (FFS) and Medicaid Managed Care payments, to determine which Medicaid providers are required to adopt and implement a compliance program.

Corporate Governance Requirements

7) As a wholly owned subsidiary of HHC, OneCity Health is a public benefit corporation and is subject to the Public Authorities Accountability Act of 2005 and the Reformation Act of 2009 (hereinafter collectively "PAAA"). Some of these requirements include, without limitation:

- The establishment of a governance committee made up of independent members
- The establishment of an audit committee made up of independent members.

8) The OCC is working with OneCity Health Leadership, the Office of Legal Affairs ("OLA"), and OLA's outside counsel Katten Muchin and Rosenman, LLP, to address any applicable PAAA governance requirements.

Establishment of a DSRIP Compliance Committee

9) The OCC has established a compliance committee to focus on DSRIP compliance issues, which will be co-chaired by Christina Jenkins, M.D., Senior Assistant Vice President, HHC/Chief Executive Officer of One City Health Services, and Wayne A. McNulty, Esq., CIPP, CHC, Senior Assistant Vice President and Chief Corporate Compliance Officer, OCC. In addition to the aforementioned co-chairs, DSRIP Committee members include the following individuals:

- Jeremy Berman, Esq.
  Deputy Counsel,
  Office of Legal Affairs

- Linda DeHart
  Assistant Vice President,
  Corporate Reimbursement

- Sal Guido
  Senior Assistant Vice President/
  Acting Chief Information Officer
  Enterprise Information Technology Services

- Lauren Johnston, RN
  Senior Assistant Vice President/
  Corporate Chief Nursing Officer
  Medical and Professional Affairs

- Patricia Slesarchik
  Assistant Vice President
  Labor Relations

- Kevin Rogan
  Senior Executive Corporate Compliance Officer
  OCC

- Ross Wilson, MD,
  Senior Vice President, Quality/
  Corporate Chief Medical Officer

The DSRIP compliance committee shall meet as frequently as necessary to carryout DSRIP-related compliance activities but in no event shall said committee meet less than semi-annually.

10) On October 1, 2015, the DSRIP Compliance Committee convened to assess, score and prioritize DSRIP-related risks. This process, which in pertinent part satisfies one of the eight elements of the mandated DSRIP compliance program **(*see* Paragraph 4, Element # 6 above)**, will be utilized to develop a DSRIP Work Plan.

Compliance Staffing for DSRIP Purposes

11) The hiring process for an Executive Compliance Officer within the OCC, whose sole purpose and focus shall be DSRIP-related compliance activities, has commenced. Vacancy Control Board approval was recently obtained. Accordingly, the official posting for this position is expected to take place early next week.

VI. HHC ACO, Inc., Compliance Activities – Update

Background

Formation of HHC subsidiary to carry out accountable care activities

1) As previously reported to the Audit Committee in June 2015, the HHC ACO, Inc., a wholly owned HHC subsidiary, was selected by CMS to participate in the Medicare Shared Savings Program (MSSP) for a three-year term that began on January 1, 2013.[15] Under the MSSP, the ACO is accountable for improving the quality of care for approximately 13,000 Medicare fee-for-service beneficiaries who receive primary care at HHC. In both 2013 and 2014, the ACO met quality reporting standards and achieved a 7% reduction in Medicare expenditures for its population.

HHC ACO, Inc. participants

2) As of June 2015, the following entities and their employed providers will perform functions or services related to the ACO's activities:

- Coney Island Medical Practice Plan, P.C.
- Downtown Bronx Medical Associates, P.C.
- Harlem Medical Associates, P.C.
- Icahn School of Medicine at Mount Sinai
  Icahn School of Medicine at Mount Sinai, doing business as
  the Mount Sinai Elmhurst Faculty Practice Group
- Metropolitan Medical Practice Plan, P.C.
- New York University School of Medicine
- NYC Health & Hospitals Corporation
- Physician Affiliate Group of New York, P.C.

Overview of Accountable Care Organizations

3) Pursuant to the Patient Protection and Affordable Care Act ("PPACA"), "the Centers for Medicare & Medicaid Services (CMS) finalized the Medicare Shared Savings Program (MSSP) …. to help doctors, hospitals, and other health care providers better coordinate care for Medicare

[15] On June 12, 2012 the HHC Board of Directors by way of resolution approved the formation of HHC ACO, Inc. ("HHC ACO"), a wholly owned subsidiary public benefit corporation in order to establish an Accountable Care Organization to meet the purposes and goals of the Medicare Shared Savings Program. The following individuals have since been designated to key leadership roles at HHC ACO: (i) the Chief Executive Officer of the HHC ACO is Ross Wilson, M.D., who also serves as HHC's Senior Vice President, Quality/Corporate Chief Medical Officer; (ii) the Medical Director of the HHC ACO is Nicholas Stine, M.D.; and (iii) the Director of Operations of the HHC ACO is Megan Cunningham

patients through [ACOs]." [16] "ACOs are groups of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that agree to work together to coordinate care for the Medicare Fee-For-Service patients they serve."[17] The goal of an ACO is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. This improves patient outcomes and reduces overall cost of care. [18]

4) ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including doctor's offices, hospitals, and long-term care facilities.[19]

Achievement of Quality Performance Standard

5) ACOs cannot share in savings unless the quality performance standard for that year is realized. The 2014 ACO quality standard consists of 33 quality measures, which can be separated into four key categories:[20]

- Patient/caregiver experience - 7 measures;
- Care coordination/patient safety - 6 measures;
- At-risk population - 5 measures and 2 composites consisting of an additional 7 measures; and
- Preventive Care – 8 measures.

Note that, the quality performance standards are expected to change in 2015.

The HHC ACO

6) The HHC ACO participates in the MSSP. Although the HHC ACO currently focuses on Medicare fee-for-service patients, the HHC ACO will drive broader transformation to a higher-

[16] (CMS Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications, June 30, 2014, prepared by RTI International, accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf)
[17] *Id.; see also* 42 CFR §425.10 and 42 CFR § 425.20
[18] *See* http**://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html**, (last accessed on June 8, 2015); *see also* 42 CFR § 425.10.
[19] The Goals of an ACO are to: (i)"deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers receive different, disconnected payments"; (ii) maintain "a patient-centered focus . . . ."; and (iii) develop "processes to: (a) promote evidence-based medicine; (b) promote patient engagement; (c) internally and publicly report on quality and cost; and (iv) and coordinate care. (CMS Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications, *supra*, note 16)
[20] *Id.*

performance health system, serving and ultimately benefiting all HHC patients. All of the entities and providers that are part of the HHC ACO must agree to comply with the MSSP Regulations, which set forth the HHC ACO's requirements with respect to governance, operations, performance and compliance.

Accuracy of HHC ACO Data

7) The entities and providers that are part of the HHC ACO must ensure that any information documented in patient records and business applications is accurate, complete and truthful, including:

- Quality measure documentation; and
- Beneficiary notification tracking.

Participant information must remain updated

8) The entities and providers that are part of the HHC ACO must keep all required job licenses, registrations and/or certifications up to date. Providers must keep their National Provider Identifier (NPI) up to date and must notify CMS of any changes within 30 days.

HHC ACO Restrictions

9) There are two key ACO Restrictions that entities and providers of the HHC ACO must abide by:

- *Patient inducement* - The entities and providers that are part of the HHC ACO must not give or offer any gifts or other remuneration to patients as inducement for receiving items or services at HHC.
- *Patient avoidance* - The entities and providers that are part of the HHC ACO are prohibited from avoiding at-risk patients, including those patients who:
  - Have a high risk score and/or more than one chronic condition(s);
  - Are considered high cost due to hospital/ED utilization;
  - Are dual eligible; or
  - Have a disability, or mental health or substance abuse disorder.

Additional Regulatory Requirements

10) In addition to MSSP Regulations, entities and providers that are part of the HHC ACO must comply with all applicable laws, including Federal criminal law and the following:

- **False Claims Act.** This generally prohibits the knowing submission of false or misleading claims to the federal government (31 U.S.C. § 3729[a][2]).

- **Anti-Kickback Statute.** This generally prohibits the knowing and willful exchange of remuneration for the referral of patients for items or services covered by federal health care program (42 U.S.C. §1320a-7b[b]).

- **Civil Monetary Penalties Law.** This authorizes the imposition of penalties upon one who knowingly presents or causes to present an improper claim for a medical service (42 U.S.C. § 1320a–7a)

- **Stark Law (Physician Self-Referral Law).** This prohibits referrals by physicians to any entity with which the physician has a financial relationship that does not fit within any permitted exception (42 U.S.C. §1395nn).

Records Retention

11) ACO's are required to retain records related to the MSSP program for a period of ten years. Also, if there is a dispute, such as a termination or allegation of fraud, the ACO should retain the medical records for an additional six years from the date of any resulting final resolution. Note that, Records Management is a risk item that is already present on part of the OCC's Work Plan.[21]

Data Use Agreements and Compliance

12) Subject to beneficiaries' rights to opt-out of data sharing, CMS may share beneficiary data with ACOs for activities such as quality assurance/quality improvement and population based activities. However, in order to receive such data, ACOs must sign a Data Use Agreement and must require all participants (and associated providers/suppliers) to comply with the terms of the Data Use Agreement.[22] ACOs will also likely be considered a business associate of the participants to the extent that they require protected health information from the participants.[23] ACOs could, therefore, be subject to HIPAA fines and penalties for impermissible disclosures of protected health information. HIPAA Privacy and Security issues are already part of the OCC Work Plan.

[21] 42 CFR 425.314
[22] 42 CFR 425.710
[23] 76 Fed. Reg. 67846

Development of an ACO Compliance Plan

13) All ACOs, including HHC ACO, are required to establish and periodically update (to reflect changes in applicable laws) a compliance plan that encompasses several required elements. The development of a compliance plan serves the following key purposes:[24]

- Identifies and helps to prevent unlawful and unethical conduct;
- Provides a centralized source for distributing information on healthcare statutes and other program directives related to fraud, waste and abuse; and
- Fosters an environment that encourages employees and others to anonymously report potential problems.

14) The structure of an ACO's compliance plan may be determined by, among other things, the following factors:[25]

- The size of an ACO; and
- The business structure of an ACO.

Required Elements of an Effective ACO Compliance Program

15) To constitute an effective ACO compliance plan, the following five (5) elements are required:

- ***ELEMENT # 1*** - The appointment of a "designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO governing body."[26];
  - **Note**: Attorneys can serve as compliance officers of an ACO, however, legal counsel for the ACO and the compliance officer of the ACO must be different individuals.[27] According to the enforcement agency commentary, this is necessary "in order to ensure independent and objective legal reviews and financial analyses of the organization's compliance efforts and activities by the compliance officer."[28] ACO's, *however,* can utilize the

[24] *See* 76 FR 67,802, 67,952 [2011]
[25] 76 FR 67,802, 67,952 [2011]
[26] 42 CFR § 425.300 [a][1];
[27] (*See* 76 FR 67,802, 67,952 [2011]
[28] *Id.*

existing organization's compliance officer *provided that* the compliance officer *is not legal counsel* to the ACO or existing organization and *reports directly* to the *governing body* of the ACO.[29]

- Wayne A. McNulty, HHC's Sr. AVP/CCO has being appointed CCO of HHC ACO.

- ***ELEMENT # 2*** - The development and implementation of "mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance."[30]

  - **Note**: "ACOs should consider implementing a system for identifying and addressing possible violations when designing their compliance plan."[31] Potential ACO risks include failure to comply with, among other things, the following:

    - ✓ Physician self-referral prohibition;
    - ✓ Civil monetary penalties (CMP) law;
    - ✓ Federal anti-kickback statute;
    - ✓ Medicare laws and regulations relevant to ACO operations; and
    - ✓ Record retention requirements under 42 CFR § 425.314[b].

Other potential risks include the following:

- ✓ Failure to record accurate specific financial and quality measurement data;
- ✓ Improper coding;
- ✓ Presence of beneficiary and provider complaints;
- ✓ The engagement or practice of avoiding at risk beneficiaries; and
- ✓ Failure to adhere to ACO governance requirements.

[29] *See* 42 CFR § 425.300 [b][1]); *see also* (76 FR 67,802, 67,952-3 [2011]).
[30] 42 CFR § 425.300 [a][2]
[31] 76 FR 67,802, 67,953 [2011]

- ***ELEMENT # 3*** - "A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer."[32]

  - **Note**: The ACO compliance program shall be constituted in a manner that "allows for the prompt and thorough investigation of possible misconduct by ACO participants, ACO providers/suppliers, other individuals or entities performing function or services related to ACO activities, corporate officers, managers, employees, and independent contractors, as well as early detection and reporting of violations . . . ."[33] Anonymous reporting mechanisms should be available to report suspected problems related to the ACO.[34]

- ***ELEMENT # 4*** - The provision of "[c]ompliance training for the ACO, the ACO participants, and the ACO providers/suppliers."[35]

  - **Note**: Compliance training is necessary to ensure that ACO participants, ACO providers/suppliers, and contractors are aware of potential compliance risks and how to report compliance concerns.[36] ACO compliance training should cover the legal obligations of every ACO participant, ACO providers/suppliers, and contractor "with respect to the ACO's operations and performance, as well as the requirements of the compliance program and the manner in which [the] ACO is implementing such requirements."[37]

  - **Note**: All current HHC compliance training modules have an entire section devoted to ACO compliance.

- ***ELEMENT # 5:*** A requirement for the ACO to report "probable violations of law to an appropriate law enforcement agency."[38];

[32] 42 CFR § 425.300 [a][3]
[33] *See* 76 FR 67,802, 67,953 [2011]
[34] *See id* at 67,952
[35] 42 CFR § 425.300 [a][4].
[36] 76 FR 67,802, 67,952 [2011].
[37] *See* 76 FR 67,802, 67,953 [2011].
[38] 42 CFR § 425.300 [a][5]

- **Note**: The following guidance may be used to determine what violations must be reported:
  - ✓ Utilize the Medicare self-referral disclosure protocol for potential violations of the physician self-referral statute.[39]
  - ✓ Utilize the Office of the Inspector General guidance with regard to those activities that may rise to the level of a violation that may require reporting.[40]

16) As underscored above, the HHC ACO has established a compliance plan that satisfies the aforementioned five elements.

Updating the ACO Compliance Plan

17) ACO Compliance Plans must: (1) satisfy applicable law; and (2) be periodically updated "to reflect changes in the law and regulations."[41] The HHC ACO, Inc. Compliance Plan will be reviewed over the next month with ACO leadership, the OCC, and OLA; said Compliance Plan will be accordingly updated, supplemented, and/or amended as appropriate.

Reporting Compliance Issues

18) The entities and providers that are part of the HHC ACO are encouraged to report compliance issues related to the HHC ACO, including any suspected violation of law, in one of the following ways:

- By anonymously reporting through HHC's confidential Compliance Helpline at **1-866-HELP-HHC (1-866-435-7442)**;
- By e-mailing COMPLIANCE@nychhc.org;
- By following the link to Report Fraud or Abuse on the HHC Office of Corporate Compliance intranet site at http://compliance.nychhc.org; and/or
- By sending a letter through postal mail (or if you are located at HHC or one of its facilities, by interoffice mail) addressed to:

New York City Health and Hospitals Corporation/HHC ACO, Inc.

[39] *See* 76 FR 67,802, 67,953 [2011]
[40] *See id.*
[41] 42 CFR § 425.300 [b][2]

Office of Corporate Compliance
160 Water Street, Suite 1129
New York, NY 10016

Present Compliance Activities

19) The OCC has included the HHC ACO's operations as part of its CY2015 Risk Assessment process.

20) The OCC has enrolled ACO participants who are members of HHC's medical staff into its Healthcare Professional and Physician Compliance Training Modules. Both modules consist of, among other things, fraud, waste and abuse and general compliance training on ACO compliance consistent with that outlined in the forgoing paragraphs.

21) The OCC is presently developing audit and monitoring plans with regard to the HHC ACO.

22) The OCC will work with the HHC Inspector General and other law enforcement officials as necessary and when appropriate with regard to meeting its reporting requirement if a circumstance arises where a probable violation of law regarding ACO operations exists.

Establishment of a HHC ACO Compliance Committee

23) The HHC ACO established a Compliance Committee to address ACO compliance-related activities. Said Compliance Committee will be co-chaired by Wayne A. McNulty, Esq., CIPP, CHC, Senior Assistant Vice President/Chief Corporate Compliance Officer, and Megan Cunningham, JD, Senior Director of Operations, Accountable Care Organization. In addition to the co-chairs, the following individuals will serve as members of the HHC ACO Compliance Committee:

- Salvatore J. Russo, Esq.
  Senior Vice President/General Counsel
  Office of Legal Affairs

- Nicholas Stine, MD
  Chief Medical Officer
  HHC ACO, Inc.,

- Ross Wilson, MD
  Senior Vice President, Quality/
  Corporate Chief Compliance Officer

Additionally, Kevin Rogan, Senior Executive Corporate Compliance Officer, OCC, will serve as the recording secretary of the committee.

HHC ACO Calendar Year 2015 Corporate-Wide Risk Assessment, Identification, and Scoring Exercise

24) On Thursday, September 17, 2015, the HHC ACO Compliance Committee convened to perform ACO-related risk assessment, scoring, and prioritization activities. The results of said risk assessment and the discussions had during the compliance committee meeting, will be utilized, in pertinent part, to develop the HHC ACO Work Plan and updated Compliance Plan.

Changes to the MSSP

25) The Centers for Medicare & Medicaid Services ("CMS") published a final on June 9, 2015 that addresses changes to the Medicare Shared Savings Program ("MSSP"), including provisions relating to beneficiary notification, patient attribution, and financial benchmarking. HHC ACO updated its agreements, policies, and procedures in accordance with new requirements.

Renewal Application

26) HHC ACO recently submitted a renewal application to extend its participation in the MSSP from 2016 to 2018. CMS will issue its decision on the application later this year.

Expansion of network partnerships

27) HHC ACO will expand network partnerships to broaden primary care population and capacity during this next MSSP cycle. This expansion will begin with Community Healthcare Network, a Federally Qualified Health Center that provides primary care, mental health and social services for diverse populations in underserved communities throughout New York City.

Future Updates

28) The Audit Committee will be provided with an HHC ACO compliance update in December 2015.