NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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125 Worth Street ▪ New York, NY ▪ 10013

BOARD OF DIRECTORS MEETING
THURSDAY, JULY 26, 2012

A~G~E~N~D~A

Call to Order - 4 pm	Dr. Stocker
1. Adoption of Minutes: June 28, 2012	
Chairman's Report	Dr. Stocker
President's Report	Mr. Aviles
>>Action Items<<	
Various Networks	
2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with Atlantic Dialysis Management Services, LLC to provide dialysis technical services to HHC patients in the following facilities: Coney Island Hospital, Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, North Central Bronx Hospital, Queens Hospital Center, and Woodhull Medical and Mental Health Center. The contract shall be for a period of five years with one, four-year option to renew exercisable solely by the Corporation, in an amount not to exceed $84 million for the entire term of nine years; AND further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity. *(Med & Professional Affairs/IT Committee – 07/19/2012)* *EEO / VENDEX:* Approved	Dr. Stocker
3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with Atlantic Dialysis Management Services, LLC for use and occupancy of space to provide chronic dialysis services at Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, and North Central Bronx Hospital. *(Capital Committee – 07/12/2012)* *VENDEX:* Approved	Ms. Youssouf
Southern Brooklyn/Staten Island Network	
4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with the Staten Island Inter-Agency Council for the Aging, Inc., for its continued use and occupancy of space to provide services to seniors at Sea View Hospital Rehabilitation Center and Home. *(Capital Committee – 07/12/2012)* *VENDEX:* Approved	Ms. Youssouf
South Manhattan Network	
5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with Eyes and Optics for use and occupancy of space to operate an optical dispensary at Gouverneur Healthcare Services. *(Capital Committee – 07/12/2012)* *VENDEX:* Pending	Ms. Youssouf
(over)	

Committee Reports ➢Capital ➢Finance ➢Medical & Professional Affairs / Information Technology ➢Strategic Planning	Ms. Youssouf Mr. Rosen Dr. Stocker Mrs. Bolus
Subsidiary Board Report ➢MetroPlus Health Plan, Inc.	Mr. Rosen
Facility Governing Body / Executive Session ➢Kings County Hospital Center ➢Dr. Susan Smith McKinney Nursing and Rehabilitation Center >>Old Business<< >>New Business<<	
Adjournment	Dr. Stocker

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (hereinafter the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 28th of June 2012 at 4:00 P.M. New York time, pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Michael A. Stocker
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Dr. Vincent Calamia
Dr. Christina L. Jenkins
Ms. Anna Kril
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Andrea Cohen was in attendance representing Deputy Mayor Linda Gibbs, Dr. Amanda Parsons was in attendance representing Commissioner Thomas Farley, Mary Harper was in attendance representing Commissioner Robert Doar and Dr. Gerald Cohen was in attendance representing Executive Deputy Commissioner Adam Karpati, each in a voting capacity. Dr. Stocker chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on May 24, 2012 were

presented to the Board. Then, on motion made by Dr. Stocker and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on May 24, 2012, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Dr. Stocker received the Board's approval to convene an Executive Session to discuss matters of quality assurance and personnel.

Dr. Stocker updated the Board on approved and pending Vendex and will report on the status of pending Vendex at the next Board meeting.

Dr. Stocker informed the Board that the survey by the Joint Commission on the Accreditation of Healthcare Organizations of Kings County Hospital Center went very well. He also stated that the next accreditation will take place at Sea View Hospital Rehabilitation Center & Home.

Dr. Stocker stated that HHC's Executive Committee met and approved submitting a letter of intent for an Accountable Care Organization. A motion was made to adopt the Executive Committee meeting minutes of June 12, 2012 and was unanimously approved by the Board.

PRESIDENT'S REPORT

Mr. Aviles' remarks were in the Board package and made available on HHC's

internet site. A copy is attached hereto and incorporated by reference.

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to rename the Department of Dentistry and Oral Surgery at Harlem Hospital Center the "Dr. James E. McIntosh Department of Dentistry and Oral Surgery."

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

3. Authorizing the President of the New York City Health and Hospitals Corporation to name in its entirety the new location of the former Goldwater Specialty Hospital and Nursing Facility, which will be constructed on the campus of the former North General Hospital, the "Henry J. Carter Specialty Hospital and Nursing Facility."

Mr. Aviles moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

4. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an extension to the affiliation agreements with the Physician Affiliate Group of New York, PC (PAGNY) for the provisions of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center, Morrisania Diagnostic and Treatment Center, Segundo Ruiz Belvis Diagnostic and Treatment Center, Jacobi Medical Center, North Central Bronx Hospital, Harlem Hospital Center, Renaissance Health Care Network Diagnostic and Treatment Center and Coney Island Hospital for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012, with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement; AND further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board

of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Dr. Stocker moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

5. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an amendment to the affiliation agreement with **New York University School of Medicine** for the provision of Health Services at **Woodhull Medical and Mental Health Center** and **Cumberland Diagnostic and Treatment Center** which terminates June 30, 2014, to include the provision of General Health Services at **Coler/Goldwater Specialty Hospital and Nursing Facility**, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; AND further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Mr. Robert Hughes, Executive Director, Coler/Goldwater Specialty Hospital and Nursing Facility, explained that the New York University School of Medicine ("NYU") would become the new affiliate effective July 1, 2012. He stated that to ensure a smooth transition and continuity, the Roosevelt Island Medical Associates employees will become employees of NYU at Coler/Goldwater. He also discussed the goals of the new affiliation with NYU, including regulatory surveys, participation in strategic planning and program development, participation in Breakthrough initiatives, as well as development of performance improvement activities.

Dr. Stocker moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

6. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an affiliation agreement with the State University of New York/Health Science Center at Brooklyn for the provision of General Care and Behavioral Health Services at Kings County Hospital Center for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A to provide the parties adequate time to conclude negotiations for a new agreement; AND further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Dr. Stocker moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

7. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical for use and occupancy of space to operate an optical store on the campus of Jacobi Medical Center.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

8. Authorizing the President of the New York City Health and Hospitals Corporation to execute a license agreement with the New York Legal Assistance Group for use and occupancy of space at Coler/Goldwater Specialty Hospital and Nursing Facility to provide pro bono legal services to patients and training to Corporation staff.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and

unanimously adopted by the Board.

RESOLUTION

9. Authorizing the President of the New York City Health and Hospitals Corporation to execute a license agreement with the New York City Department of Education for its continued use and occupancy of space to operate a Licensed Practical Nurse training program at Coler/Goldwater Specialty Hospital and Nursing Facility, Goldwater Campus.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

INFORMATION ITEM

Dr. Ross Wilson, Senior Vice President and Chief Medical Officer provided an overview on the current status of the Accountable Care Organization ("ACO") with respect to the role of HHC's Board and the direction of HHC. He stated that the Executive Committee is committed to applying for ACO status for HHC and the affiliation partners.

BOARD COMMITTEE REPORTS

Attached hereto is a compilation of reports of the HHC Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Woodhull Medical and Mental Health Center reviewed, discussed and adopted the facility's reports

presented.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:00 P.M.

Salvatore J. Russo
Senior Vice President/General Counsel and
Secretary to the Board of Directors

COMMITTEE REPORTS

Audit Committee – June 7, 2012
As reported by Ms. Emily A. Youssouf

Mr. Jim Martell, Lead Engagement Partner KPMG introduced the information item regarding the Fiscal Year 2012 Audit Plan. Mr. Martell joined the meeting via teleconference along with Maria Tiso, the Client Share Partner. Mr. Martell then stated that he would go through the highlights of this year's audit plan. He said that this year they met with the Audit Chairwoman being Emily Youssouf to get her views and concerns. They also met with Chief Internal Auditor Chris Telano, and also with Corporate Comptroller Jay Weinman and his group to get a flavor as to what's been on their radar screen and barometer in terms of audit issues. Mr. Martell stated that the audit plan is a plan, this is not something carved in stone, that it does take perhaps a turn here and there and if other things do occur whereby they need to change the plan they will. They will let the committee know that there has been a change in the actual plan itself. Mr. Martell stated that Ms. Fremont and Ms. Murray will do the bulk of the presentation.

Ms. Youssouf asked the KPMG team to introduce themselves: Camille Fremont, Senior Manager; Erin Murray, Engagement Manager; Benny Hadnott, Partner, Watson and Rice LLP. Mr. Hadnott stated that he has worked with Jim Martell on audits for a number of years and that he has a staff that participates in aspects of the audit, especially in the inventory accounts and they also come back and review audits and work on various areas, including assets, whatever Ms. Fremont asks them to do. He is very pleased to be with the team and he feels that he and his staff have been treated very well during the period they have been engaged with KPMG.

Ms. Fremont began her presentation by directing the committee to slide 2 where they have laid out the engagement team which consists of KPMG, minority business and women business enterprises firms. Ms. Fremont then directed them to slide 3 where they have laid out the deliverables that they issue in addition to the Corporation's financial statement audits. They also include various cost reports as well as the bond covenant compliance letter. They issue standalone audited financial statements for both of the insurance companies which have a December 31st year end as opposed to the Corporation's June 30th and they will issue a management letter at the end of the audit.

Ms. Fremont directed them to slide 5 where they laid out the responsibilities for the audit as it pertains to management, KPMG and the Audit Committee. She stated the Audit Committee's role is one of oversight and monitoring. Management's responsibilities include establishing and maintaining effective internal control as well as preparing the financial statements in conformity with general accepted accounting principles. KPMG's role is to express an opinion about whether the financial statements are presented fairly in all material respects in conformity with the generally accepted accounting principles and that KPMG has a requirement to communicate all required information to both management and Audit Committee throughout the audit.

Ms. Fremont continued on slide 6 where they laid out the financial statement audit timetable and as Mr. Martell indicated, they have met with various members of management in coming up with this timetable. For the first time in January and February they actually did some interim site visits to test internal controls throughout the year and then in April through June they've been holding various planning meetings. They reviewed the December 31st internal financial statements and are here to present the audit plan. Continuing into June and July, they will test the operating effectiveness of controls through additional site visits. They will also review the third parties as of March 31st and patient accounts receivable valuation process where they will utilize their computer assisted auditing tool to help them. Then in August and September they will start the final phase of the audit. Then they will be attending the Audit Committee meeting and reviewing the draft financial statement along with a draft management letter and performing all the required communications. Then they will once again be back in November to present the final management letter. Ms. Fremont stated that the due date of the financial statements has been accelerated by two weeks by the City to September 14th which will necessitate the audit moving up two weeks.

Mr. Martell stated that by pushing up the delivery date to the City by two weeks creates some additional work from management to supply them with the required work papers and the detailed financial statements in order to meet the deadline. Mr. Martell also stated that the New York City Audit Committee is looking to push up the presentation from NYCHHC to an earlier month.

Ms. Marlene Zurack, Senior Vice President & Chief Financial Officer stated that this has nothing to do with HHC; the City Audit Committee actually scheduled HHC for April and then was pushed to May. Ms. Zurack said that she offered to come in in December as soon as the Corporation had completed the national letter of review with this committee. She does not think this is a problem.

Ms. Youssouf asked KPMG to discuss the surprise visits that were discussed last year. Ms. Fremont responded that that was the interim site visits that they did in February. Those were surprise visits where two facilities were picked, they went out and looked to see if things such as cash disbursement controls were operating appropriately and some controls regarding accounts receivable – through that process they did not have any findings at that point in time so they were operating the way they would expect them to. Mr. Martell added that they were surprised they were not told at all that KPMG was coming. KPMG showed up on the doorstep on Monday telling them they were

looking at such and such and gave those samples and they provided the information. It does appear that the facilities have the process under control as it relates to procedures that are documented.

Ms. Youssouf stated that she was pleased to hear that.

Ms. Fremont continued with slide 7 where they have laid out what they consider some of the critical audit areas which include the valuation of third-party payers, receivables and liabilities. Also laid out are some significant areas of the audit which include the post-employment benefit obligations other than pension for the OPEB liability. They also looked at non routine transactions throughout the audit; there are no new accounting pronouncements for the current year. HHC entered into a transaction with North General that management is currently working through the accounting treatment for and the presentation with the financial statements. Management is also reviewing the Physician Affiliate Group of New York (PAGNY) agreement that was entered into to determine whether or not consolidation will be necessary within the Corporation's financial statements.

Ms. Youssouf asked that if it wouldn't normally be. Mr. Martell responded by stating that typically when you don't have ownership it's not, but under the accounting rules for variable interest entities it goes into a little more detail as it relates to control and so forth. There's some additional literature that will be required.

Ms. Youssouf stated that she did not think they controlled it but she's sure Finance will be able to sort it out with KPMG.

Continuing with her presentation Ms. Fremont stated that they also reviewed the information technology environment; they looked at such things as access controls and used their internal specialist to look over control over change management within the system.

Ms. Fremont continued with slide 8 where they laid out what they call their key map by audit area. This shows the risk that KPMG goes through during the audit by the level of risk. The highest ones are red and it shows how management, KPMG and Internal Audit work together in order to address the risks for the audit.

Ms. Youssouf asked to briefly explain timing cut off. Ms. Fremont stated that what that pertains to is to make sure revenue is recognized in the proper period. In terms of the accounts receivable and third-party payers and liabilities, to make sure it's being recognized in the proper period and what expenses were incurred in all.

Dr. Michael Stocker, Board Chairman asked if this refers to end of year. Mr. Fremont responded that this would be June 30th.

Ms. Youssouf asked that if in fact there was another area the board thought should be moved up, they would just have a discussion with management and KPMG. Ms. Fremont responded correct.

Ms. Zurack stated that in terms of this HHC is on a very aggressive timetable due to the weeks early for the City. She's asking KPMG to let her know what would be the last date HHC can reshuffle the priorities. Mr. Martell responded that KPMG has revised the calendar and they will share with HHC in terms of timing. Basically KPMG will start doing a lot of the third-party work now in the month of June, but July and August is going to be a lot more work. KPMG used to come in late July, now it will be in early July, but he expects draft financial statements by August 13th.

Ms. Zurack asked if the board wanted to escalate or elevate one of the green items or blue items, when KPMG would need to know so that KPMG does not go out and start the audit with the plan they have and have to do rework given the timetable. Mr. Martell responded that most of the stuff whether it's green and there is a concern at the board level, KPMG would just be adding additional work. The most time they would ask is a week's notice to revamp the audit approach.

Ms. Zurack asked that if it's a week from today or a week before the end of the audit. To which Mr. Martell responded that probably a week before they actually start their interim test work, their year-end test work, which would be in July. If they go in July 9th they would have to know by the end of June.

Dr. Boufford asked whether construction management might be moved up into the red zone that there may be certain vulnerable projects than others that could be targeted. Ms. Zurack stated that she thinks KPMG should define what they mean by construction management. Ms. Fremont stated that there are significant construction projects that are ongoing in the Corporation and KPMG will look at constructions in progress. They will look to make sure HHC is following proper procedure -- that it's signed off by the appropriate people and categorized in the right bucket; for example, tools and equipment and buildings and improvement. For KPMG, construction projects are somewhat routine. It is something that is purchased and continued to build, so it is elevated to a red in terms of the audit.

Ms. Zurack stated it is looked at how the dollars are spent and being recorded in the books, and whether or not the projects are managed well within the budget.

Mr. Martell stated that that it's correct. That they are not looking at the operational aspects of the project, they're looking at the change orders, making sure they're approved appropriately, the cash disbursements are approved appropriately, the bid process was completed appropriately, how the construction in progress being recorded, is there capitalized interest associated with it.

Ms. Youssouf asked if KPMG has an internal team who could look at construction projects. Mr. Martell responded absolutely.

Ms. Youssouf stated that that is something the Audit Committee members would like to discuss with KPMG and that she had a brief discussion with Ms. Zurack about this. Ms. Zurack stated that they're talking about a separate engagement on the consulting side.

Dr. Stocker asked if KPMG is actually looking at the management of the building, how to go through the process of construction. To which Mr. Martell responded absolutely, that he knows exactly what Dr. Stocker is talking about.

Dr. Stocker asked if KPMG does that. Mr. Martell responded yes they do that. They have a huge advisory practice in the real estate practice that does all that.

Ms. Youssouf stated that the committee will be discussing this with Ms. Zurack and will get back to them on that.

Ms. Fremont continued her presentation with slide 9 where they laid out for the committee how they utilize both the minority business enterprise, the women business enterprise and a member of the corporation's Internal Audit staff.

Ms. Fremont turned to slide 10 through 12 where they talked about some of their responsibilities throughout the audit as it pertains to fraud. They have a responsibility to conduct the audit in accordance with generally accepted auditing standards and plan to perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether caused by fraud or error. In order to do that, KPMG will identify certain progress that the Corporation is subject to and then will identify or respond. Some of those include testing the effectiveness of controls, making sure risk of management override of controls is minimal or not there. They will also look at and address revenue recognition back to the point of cutoff in the appropriate period. Then another key component to the fraud approach are the SAS 99 fraud interviews illustrated on slide 12.

Ms. Youssouf asked if the fraud risk states anywhere if the Corporation is spending large capital dollars. Ms. Fremont responded that the spending of money is not necessarily a fraud risk. It's about the Corporation not following the procedures and protocols. Those large spends would be caught in the cash disbursement.

Ms. Youssouf stated that the board has recently approved a number of capital spends and just wants to make sure that they are reviewed. To wish Ms. Fremont responded that there will be awareness with that throughout the audit.

Ms. Fremont continued by stating that on slide 12 there are the individuals within the Corporation that they plan to schedule SAS Fraud 99 interviews with. They include Madam Chairwoman, the Chairman of the Board Dr. Stocker, Marlene Zurack, Wayne McNulty, Chief Internal Auditor Chris Telano and others as they go through the process as well.

Ms. Fremont then stated that another thing that they have to consider throughout the audit on slide 13 is liquidity. That comes to KPMG through the Statement of Auditing Standards 59. The auditor has a responsibility to evaluate whether there is substantial doubt about the entity's ability to continue as a growing concern for a reasonable period of time. They have to look at certain key indicators, for instance the December 31, 2011 internal financial statements. Laid out are the five indicators that were looked at. The Corporation has a net asset deficiency and a loss from operation, as a result of that KPMG will perform certain audit procedures laid out on slide 14. KPMG will look at the 2013 budget and cash flow projections. KPMG will read the board and finance committee's meetings minutes, reports that have been issued if there are any restructuring reports then they will also look at the 2012 budget and compare that to the actual reports.

Ms. Youssouf asked what they meant by restructuring reports. Ms. Fremont responded that about one or two years ago the Corporation had a restructuring. Ms. Zurack added that Ms. Fremont is referring to the Road Ahead or any kind of cost containment or future plan to create savings or increase revenue.

Ms. Fremont continued and stated that they will also look at the working capital, days in account payable and the continued support from the City of New York which is an integral component for the preparation.

Ms. Zurack stated that she wants to make sure the committee is really clear on what's going here. On certain indicators related to the loss from operation and the net asset deficiency that would raise concern. She presents to this board and its various committees where the Corporation is currently as it relates to the current net asset deficiency and loss from operations. In HHC's favor, HHC tends to have decent cash and decent liquidity relative to HHC's peers in the health care industry in New York. But because of the loss from operations and the trend of the loss from operations, which is going up not down, there is this sort of secondary review that is being done. They are confirming that in fact HHC is taking action.

Committee member, Dr. Jo Ivey Boufford asked that how do those two categories relate to the issue of the uninsured and underinsured. How do you take into account that certain people would not be able to pay. Ms. Zurack asked if Dr. Boufford meant if they're comparing HHC to others. Dr. Boufford stated that if you look at the issue of net asset deficiency, loss from operation and you are seeing X number of patients, you play out the scenario, and you are collecting X minus whatever funding because of the nature of the patients. That's a characteristic of this kind built into the organization that ought to be flagged in a way other than from operations.

Mr. Martell stated that Ms. Zurack statement is correct. The reality is as they look at liquidity they look at the reasons why. The real question is how management is going to stay cash positive. The purpose of their report is to state to the readers of the report that you will be here next year. It does not go into the reasons why you won't be or the reasons why you will be. It goes into the reasons whether or not KPMG believes HHC has the financial strength to be in existence 367 days from the date of the year end.

Ms. Youssouf asked if they review management in respect of the people who are running various areas are competent and qualified. Mr. Martell responded that they review management's assumption as it relates to the financial reporting. They evaluate based on job function and obviously if it has an impact on the reporting they would inform the committee.

Ms. Fremont stated that KPMG has to get comfortable with the process that management goes through to come up the budget and also what the actual results will be. That's why a key component is looking at the 2012 budget and how it performed against that budget, which gives KPMG comfort that the appropriate assumptions are being utilized. So as KPMG goes through the third-party reviews as well as looked at what are the changing regulations, those reimbursement-type issues are caught up in the third-party receivables and liabilities.

Ms. Fremont continued to slide 15 where they point out the two new government accounting standards pronouncements that will be effective for the Corporation for fiscal year 2013. The first one is the codification of accounting and financial reporting guidance. This is basically what all the other not-for-profit organizations went through when the FASB codified all their accounting pronouncements. This will bring in all the authoritative literature in one spot in GASB so that HHC does not have to decide on adopting it or not; it will be all in one place. There is no change on how the corporation currently applies their accounting pronouncements.

Mr. Martell added that these two items don't affect 2012; they're there for information purpose only. This will be discussed next year in the planning budget.

Ms. Youssouf asked that although GASB 63 does not take effect until 2013 that she thought it had to be reported this year. Mr. Martell responded that he was not aware of it, but he will do some research and get back to her.

Ms. Zurack stated that her understanding was all we had to change was some of the wording on the presentation of the income statement. Her understanding is that GASB 62 did not affect the corporation at all. She asked Mr. Martell to confirm that. Mr. Martell responded that they will see if there are any changes.

Mr. Frement continued to slide 16 and 17 stating that these are included for information purposes and slide 18 lists the resources that are available to the Corporation.

Mr. Martell stated those are the details of the plan. As stated earlier they moved everything up two weeks so they will be visiting HHC earlier than normal. He envisions KPMG presenting to this committee somewhere in mid-September so that the New York City time frame can be met.

Dr. Boufford asked who management in this audit is, is there a mechanism for facilities engagement in sort of designing in the engagement of the auditors. KPMG mentioned that they do spot visits unannounced at facilities, but is there a kind of advisory group or group of executive directors involved or some group other than Central Office? Ms. Zurack responded that this is just an overview; this is a financial statement audit and that maybe at some other Audit Committee meeting we can present a flow chart and how the financial statements are prepared. The actual preparing of estimates and putting together financial statements are done exclusively by Central Office. However, they are done by data and transactions that are recorded at the hospital and diagnostic treatment centers and the nursing homes. That's why there is this field testing; the data being used is coming from the system.

Mr. Martell added that Ms. Zurack is correct, that what they consider the senior management team are the people at Central Office. The people out in the field at the facilities are there to assist us with reviewing the data which Central Office utilizes to come up with the estimates and the financial statement presentation.

Ms. Youssouf asked if there were any questions for the KPMG team and asked Mr. Martell if he had anything else to say. Mr. Martell responded no, he apologized he could not be present in person.

Ms. Youssouf asked Ms. Fremont if she had anything to say. She responded no, thanked the committee for the opportunity to be present again.

Mrs. Bolus thanked them for being present.

Ms. Youssouf moved onto the next information item: Chris Telano's internal audit update.

Mr. Telano saluted everyone and thanked Ms. Youssouf. Mr. Telano stated that today he had five reports to discuss. Regarding the first review, at the request of the Audit Committee, internal audit performs follow-up audits of reviews done by external agencies. This review was done at Sea View Hospital by the Social Security Administration; this was of the Representative Payee Program. This is simply bank accounts that are opened for the residents in which the Corporation controls as it was determined that the residents are not competent to handle their funds. Social Security found three issues – one relates to the funds being given to the proper parties when a resident expires, two is about the titling of the bank accounts and three relates to the receipts of expenses when petty cash is given to the resident to spend. Our review found that overall the same issues exist. Sea View continues to release the conserve funds to the family of the beneficiary or uses it to pay for the funeral. They believe that they are following Medicaid and a lower court ruling that is in contradiction with Social Security guidelines and Sea View management has been in touch with Social Security to resolve this issue. The accounts of the residents also were not titled properly, especially those who received physical checks; Sea View is working to correct that. Receipts for expenses incurred by the residents are not documented by proper support.

Mr. Telano asked if the committee wants the Sea View representatives to come up to the table. Ms. Youssouf responded by asking the other members of the committee if they had any questions about this particular audit.

Dr. Boufford responded by suggesting that it would be useful to know who the responsible person is and what the timetable is for corrective action in the report. In some instances the report says management will, in others it says the facilities will but it doesn't really say who's doing it and by when. She thinks it would be useful as an Audit Committee to record that a high level person or an executive is involved.

Ms. Youssouf thought that Dr. Boufford suggestion was a good one.

Mr. Telano continued by stating that the second audit performed was about patient revenue at Queens Hospital. Basically we found that there are no written procedures in the cashier's office and outpatient billing department pertaining to the time frame self-pay cash payments are posted. This issue will be resolved in a short period of time; perhaps three to six months because of the implementation of auto posting within the cashier's area. The second finding has to do with patients that are denied insurance, usually Medicaid, and they are referred to as self-pay. The system has a glitch in it which it does not send billings out to them; as a result, the facility does not always collect the monies. We found that the facility does not have a work around the system.

Ms. Youssouf asked for the representatives from Queens Hospital to come up to the table and introduce themselves. They introduced themselves as follows: Mr. Lekram Singh, Store Manager; Mr. Brian Stacey, Queens Network Chief Financial Officer; Ms. Nancy Moscoso, Operations Assistant Director and Mr. Robert Malone, Deputy Chief Financial Officer.

Mr. Telano continued by stating that the last issue is supposed to be resolved in April 2013 via the upgrading of the Siemens' financial system. Both of these issues that I'm discussing will be resolved as a result of systematic issues.

Ms. Youssouf asked if there is any way to do anything about this prior to April 2013 – it seems rather far away.

Mr. Stacey stated that the cash posting issue being addressed is already in terms of tightening up that time frame. As Mr. Telano said, there were a number over 30 days, which actually has been tightened up already. We have implemented some things from when cash is received to cash control to then actually post payment. We already started implementing that approach. Mr. Telano stated that on the other issue, they did request a report for self-paid write-offs. Ms. Moscoso stated that she has audited March and April, did a sample of the patients and she has audited it to make sure all those patients are recorded.

Dr. Stocker asked if they are being billed. To which Ms. Moscoso responded yes. Dr. Stocker asked to give him some idea of the size of that when they went back two months.

Mr. Stacey answered by stating that is probably seven hundred. Dr. Stocker asked if it was per month and Mr. Stacey said yes.

Dr. Stocker asked what kind of revenue he would expect to get out of it. Mr. Stacey said that on the self-pay side not very much. Most of the self-pay patients wind up in the fee scale because they are not Medicaid eligible; if it's self-pay they pay $15.

Ms. Youssouf asked that out of the few hundreds, are they all self-paying. Mr. Malone responded by stating that in this finding yes. The finding related to self-pay operation, which represents about two percent of our total outpatient payments.

Ms. Youssouf stated that the corporate bad debt policy is 100 percent self-pay that that was her question. Mr. Malone responded no.

Ms. Youssouf asked that since they are doing something manually prior to getting the system up, how much revenue you anticipate getting out of those few hundred a month. Mr. Malone answered by saying that on the self-pay population probably will get some patients that could come in on the fee scale, do fee scale application and will enable them to become part of our fee scale population. So that will secure the future visits that they pay the $15 a month or whatever amount.

Dr. Stocker asked that across the Corporation what do you raise on self-pay. Ms. Zurack responded that the entire self-pay collections, all services, are approximately $40 million a year. However, approximately $10 million of that is in the nursing homes for the net – their share of the social security check. Then she said she would say off the top of her head $13 million which is sort of in the category and the rest is on the inpatient side. This is for patients that came in and were not identified as self-pay initially which you have to go manually change the classification and there was a delay in changing the financial classifications on these patients. It's not the majority of self-pay patients just the ones that came in and they were not identified as self-pay. They might have been identified as something else, Medicaid say for example, erroneously, and after some investigation they find out they're self-pay going in and change each account. That's the standard work of the hospitals.

Ms. Moscoso added that it's not that they're behind, in some instances they were unaware that the patient came in Medicaid, was pending or something like that. Sometimes it was retroactively enrolled, in that instance once the Medicaid was put in the system with an effective date; the visits prior to the effective date will go to the self-pay side. In those instances, it's not all the time, there's a current statement balanced generated.

Ms. Youssouf asked if the bad debt number was on a monthly basis or on average. Mr. Stacey said that he did not know off hand.

Ms. Zurack added that she will translate what Mr. Malone was saying. If we were to look in the accounting system they would go at full charges, but the truth is 99 percent of these patients are eligible to be in the HHC option programs. Whereas, the patient has $400 in charges, once all the paperwork is done the real bad debt number is going to be $15. So the answer to what is in the bad debt file is going to be the number of charges.

Dr. Stocker asked that if this was done across all the facilities what it would be. Ms. Zurack asked if he meant the sum of the bad debts. Mr. Stocker said just what we would find, same practices, and different practices. Ms. Zurack stated that she did not know and Mr. Telano stated that he had not done anything. Ms. Zurack stated that whether or not they're not changing the financial class that she would have to get back to him.

Ms. Youssouf stated that it's probably something that we need to try to find out and have a best practice.

Ms. Zurack stated that Maxine Katz could not come to this meeting and she's the expert on all this practice. Ms. Zurack said that she will make sure that she does her due diligence and get back to the committee.

Ms. Youssouf said thank you and asked if there were more questions for Queens.

Mr. Telano stated that he will skip around since the Queens people are on the table. He will discuss the surprise count at the warehouse. He started off by saying that Mr. Singh and his staff should be commended for the controls that they have at the warehouse. We did a surprise count, we counted 90 items and 88 were correct and the total difference was approximately $140.

Ms. Youssouf said that was great.

Mr. Telano said that he just wanted to point out what an excellent job Mr. Singh and his staff did.

Dr. Stocker stated that they looked at a number of these items and he thinks they are the corporate champions.

Mr. Telano continued by stating that there are just two small issues, the lack of security cameras and also access to the system. There are a couple of individuals that should not have full access to the system.

Ms. Youssouf asked if those two items have been corrected.

Mr. Singh responded that the cameras are in the process of being installed and the two individuals came off the system.

Mr. Telano continued with the audit at Kings County – this was the start of the affiliation audits. The first one was Kings County Downstate.

Ms. Youssouf asked the representatives to come up to the table and introduce themselves. They introduced themselves as follows: Leo Johnson, Affiliate Administrator, Julian John, Chief Financial Officer, Ross Clinchy, Associate Dean for Administration at SUNY and Anthony Saul, Controller.

Mr. Telano stated that during our test work we wanted to confirm the accuracy of salaries by tracing this information to documentation. We found 9 out 31 in which we could not do that. Personnel forms, which indicate this information, were not current indicating the salaries that were on the books. In addition, we feel that the individual who is responsible for the payroll record keeping task is the only person that has intimate knowledge of the process and since the process is not written in a policy and procedure manual, we recommended that they create a manual in lieu of hiring a backup.

Ms. Youssouf asked that someone from the facility discuss the issue and is a manual in the process of being created and what are you doing in between. Mr. Johnson said that on the issue of the forms being outdated, the way the SUNY system is set up is when an employee is hired there's a form and if there's no transaction, which could be a year or ten years, there's no automatic update. The individual's salary would change over the years based on Cost of Living Adjustment (COLA) or discretionary. We have 3,000 employees and we don't have the resources every time we use COLA to actually put in paperwork to increase salaries like that. We do have salary history that we just started recently and we insured the audit team that would make payment accordingly. In the future that would be part of the documents that will be presented. Even if they had a form, say 10 years ago, it would be a lot easier to trace salaries today.

Ms. Youssouf asked if it's not automated at all and if they have this on a computer system. Mr. Johnson said that they just recently started. Mr. Saul added that this was through the state payroll system. When there's a cost of living increase through the collective bargaining agreement, it is applied by the Office of the Comptroller to everybody's paychecks across the system. We don't process pieces of paper on the campus to get those COLAs and so what we are saying is if we equate someone to say $50,000 a year nothing else happens to them except COLAs the salary history that's in the computer will show the changes year by year reflecting the collective bargaining agreement. There won't be a piece of paper changing that salary unless there's some other kind of transaction, changing FTE, in which case there will be a piece of paper processed reflecting that change.

Ms. Youssouf asked if our internal auditors have the ability to look at the system. Mr. Johnson responded yes, and just to add one thing. Out of fairness to Chris Telano and his team, some of our forms do have cross outs used by different areas. Sometimes the numbers will change and that is something we have gone out our way to correct. In the future, the form should be pretty clear. We are trying to eliminate cross outs.

Mr. Saul added that they have several PDFs instead so they are easier, but the transactions are all in the records in the payroll system in the State Comptroller's Office.

Mrs. Bolus asked if there was a backup should the system ever go down. To which Mr. Saul responded that the State Comptroller does. We don't manage the system on the campus; this is a state-wide system management.

Ms. Youssouf asked what about the policy and procedural manual that was mentioned. Mr. Johnson said that they were in the process and they agree with Chris' findings. They are going to write a policy and procedure manual.

Ms. Youssouf thanked them and directed Mr. Telano to discuss the next audit which is Coler-Goldwater.

Mr. Telano stated that in light of the follow-up audit done at Sea View regarding the records of the Payee Representative Program, we decided to roll that audit out at the skilled nursing facilities and we started with Coler. We just completed our audits of McKinney and Gouverneur. This is the result of the audit from Coler.

Ms. Youssouf asked for the representatives of Coler to come up to the table and introduce themselves. They introduced themselves as follows: Mercia Franklin, Chief Contracting Office; Gloria Ranghelli, Chief Financial Officer.

Mr. Telano stated that basically we came up with the same issues that came up at Sea View. The bank accounts with titles not in adherence to Social Security requirements. The conserve funds were not being sent back to Social Security when the residents are being sent over to Goldwater. The only unique finding was regarding the bank accounts. We found a $1,200 unresolved deposit that existed and a levy of $4,000 that the IRS applied, but the beneficiary had died and the account was closed but the money was given out of a primary account so the IRS owes us money.

Ms. Franklin said that they actually did not give them the money; they automatically took it not realizing that the account was not just for that one resident that it was a group account so we are trying to get it back.

Ms. Youssouf stated that seems to be a problem at the nursing homes in general and asked Chris Telano if there's a way to make it easier. Mr. Telano said that they wanted to do the review first, complete the reviews at McKinney and Gouverneur and come up with best practices.

He thinks that we have a lot of similar issues, when we're done with those audits we'll present a document indicating what should be done. One thing noteworthy is that Coler-Goldwater and Gouverneur and McKinney all have their bank accounts with Amalgamated. He thinks we should have some leverage with them because he understands there will be some push back in the title of some of these accounts. He's not sure we used that leverage in the past but now that everyone knows it.

Ms. Youssouf asked Ms. Zurack to respond to that. Ms. Zurack stated that we opened those accounts in Amalgamated as part of a program with the City Department of Finance because it's the only bank that has a branch on Roosevelt Island. So the City was asking to shore up that branch, otherwise there might have been no branch on Roosevelt Island and this was done a couple of years ago.

Ms. Youssouf asked if it's possible for Ms. Zurack to make a call. Ms. Zurack said yes that she would call.

Mr. Telano continued on with the briefing – the audits in progress. A quick summary of the New York City Office of the Comptroller overtime report that finally was issued in final on May 7th and on page 10 is a list of the follow-up audits and their progress.

Dr. Boufford asked if there were any title patterns on their overtime usage that could be subject to managerial issues. Mr. Telano responded that there did not seem to be in their review, and stated that that concludes his presentation.

Ms. Youssouf thanked Mr. Telano and directed Mr. McNulty to begin the Compliance Update.

Mr. McNulty saluted everybody and began his presentation by discussing compliance training. He noted that the Audit Committee ("Committee") was previously informed that, with regard to compliance training of HHC staff, the Office of Corporate Compliance ("OCC") was moving from the use of an outside vendor to an internally developed computer-based training program. He informed the Committee that at the present time all physicians, nurses and group 11 employees, as well as individuals designated by group 11 employees, receive compliance training. He further informed the Committee that the OCC was going to expand training to include all health professionals licensed under the Department of Education, as well as any individual who documents in the medical record and such documentation is used to support a claim submitted to Medicaid, Medicare or to a private payor. He told the Committee that the OCC developed a computer-based training ("CBT") module for physicians, noting that the module was in its final draft stage. He commented that the physician CBT module was disseminated to the members of the Executive Compliance Work Group ("ECW") as well as the members of the ECW Subcommittee on Compliance and Quality ("ECW Subcommittee"). Mr. McNulty stated that he anticipated this module would go live at some point in the following week. He added that the OCC looked forward to getting responses back from the ECW and the ECW Subcommittee, stressing that changes to the module would be made as necessary. He described the physicians' module by noting that it was about an hour long. He continued by discussing the content of the module, noting that it covered fraud and abuse, child abuse reporting, and professional responsibility. He informed the Committee that moving forward, training modules for the Board of Directors, health professionals and nurses, and for HHC managers, would be developed.

Ms. Youssouf asked how often everyone will be required to go through this training online. Mr. McNulty answered by stating that training was an annual requirement. He added that all new employees would also be required to undergo training.

Mr. McNulty continued with item number two of the compliance report agenda, the Corporate Compliance Work Plan. He stated that the OCC had initiated the assessment cycle review of each calendar year ("CY") 2011 Corporate Compliance Work Plan item. He explained that corresponding risk assessment and audit tools were completed and sent out to the subject matter and process experts. He expected to have the results back by June 20th. Mr. McNulty stated that the corresponding results would be reviewed and vulnerabilities and risks would be identified. He further stated that based on said results, the OCC would then determine whether or not an item would move to the mitigation stage, where a plan of correction would then be developed. Mr. McNulty provided that if a determination is made that an item poses either a low risk or no risk, said item would subsequently be closed and removed from the work plan.

Mr. McNulty asked the Committee if there were any questions with regard to OCC's review and assessment cycle.

Ms. Youssouf responded no, but she asked if Mr. McNulty if he would report back to the Committee on the final risk determination with regard to each item. Mr. McNulty replied that he would report back to the Committee as to the status of each item, including the details of any implemented mitigation plan.

Mr. McNulty continued on with the next item. He stated that each year the Federal Office of the Inspector General ("OIG") issues a work plan. He continued by stating that the OCC reviewed and assessed the OIG's fiscal year ("FY") 2012 Work Plan. He commented that OIG's FY 2012 Work Plan could basically be divided into seven (7) main categories. He explained that the OCC particularly focused on the Medicare Part A and Part B category, noting that this category was applicable to HHC. He added that the remaining six (6) categories in OIG's FY 2012 Work Plan were not directly related to HHC's operations. He further added that the OCC initiated an assessment of the Medicare Part A and B category of OIG's Work Plan and subsequently developed questions sets, which were disseminated to the relevant process and expert owners. He anticipated responses to these question sets by the end of June. He stated that, based on the

vulnerabilities and risks present with each item, the OCC would determine the scope of the HHC calendar year 2012 work plan. He added that the final assessment findings would be reported to the Committee in September.

Mr. McNulty continued with page five. He started by stating that the Office of the Medicaid Inspector General ("OMIG") released their fiscal year 2012 and 2013 work plan in May. He informed the Committee that the OCC was going to initiate an assessment of that work plan similar to the assessment currently under implementation for the OIG Work Plan. He stated that the OCC would report back to the Committee in September with an update up this matter.

Mr. McNulty continued with by discussing the OCC's staffing status. He announced that effective June 25, 2012 the OCC would be fully staffed. He informed the Committee that the vacant position in the South Brooklyn/Staten Island Health Care Network was filled, noting that the successful candidate was MetroPlus' current Chief Compliance Officer. He also informed the Committee that the OCC received staff training in May at the Health Care Compliance Association's regional annual conference in New York City. He told the Committee that the conference focused on compliance topics such as data mining, OMIG activities and their areas of focus, internal investigations, and anti-kickback and Stark Law. Mr. McNulty explained that training and education were essential to OCC staff, commenting that the OCC would explore other training opportunities. He further explained that information obtained by OCC staff during training would be shared with the ECW and the facility compliance committees.

Mr. McNulty continued to item number 7 – the development of data mining compliance activities. He informed the Committee that, as part of the OCC's strategic plan, it was investigating data mining tools and activities to identify areas of noncompliance and corporate vulnerability. He explained to the Committee that a large portion of HHC's current work plan was assembled by looking at OIG's Work Plan and OMIG's Work Plan. Mr. McNulty stressed that the OCC wanted to be more proactive by looking at HHC's financial system. He told the Committee that he had discussed data mining with Chief Financial Officer Marlene Zurack. He stated that Ms. Zurack recommended that the OCC staff undergo GPS training, which is Siemen's data warehouse. He informed the Committee that said training was scheduled to take place in July. He further commented that the use of this available information could be used to look at certain outliers and determine if HHC has risks and vulnerabilities.

Mr. McNulty continued to item number 8 on the compliance report agenda by informing the Committee that May 7 through May 12 was Corporate Compliance Week. He stated that this year's theme was "Think Compliance First." He informed the Committee that HHC president and Chief Executive Mr. Aviles sent out an informational email to the entire HHC workforce encouraging workforce members to report potential compliance issues and stressing HHC's prohibition of retaliation with regard to whistleblowers. He further informed the Committee that the OCC set up tables at HHC's various facilities and encouraged HHC staff members to report compliance issues through the OCC's confidential hotline. He told the Committee that HHC staff members were informed that HHC fully protects whistleblowers.

Mr. McNulty continued on with the last item, which was the Monitoring of Excluded Providers. He stated that there were no self-disclosures to report since the last time the Committee convened in April. He reminded the Committee that it was informed back in February about the OCC's discovery of a staff nurse at Woodhull Medical and Mental Health Center who was on the OMIG list of excluded individuals. He commented that the subject nurse was placed on OMIG's excluded list in early February and was discovered by HHC towards the end of February. He stated that the nurse was separated from services two days later after discovery. He reported that the government was made aware of the discovery and that the issue was resolved. Mr. McNulty explained that although HHC will not have to return any funds back to the Government, HHC will have to adjust its cost report.

Ms. Youssouf thanked Mr. McNulty. Mr. McNulty stated that that was the end of his report.

Ms. Youssouf then indicated that the Committee was going into Executive Session. (Executive session was then held).

After returning to public session Ms. Youssouf asked for a motion to approve the Internal Audits Plan. It was seconded and approved.

Capital Committee – June 7, 2012
As reported by Ms. Emily A. Youssouf

Alfonso Pistone, Assistant Vice President, Office of Facilities Development, informed the Committee that there would be five (5) action items on the agenda; including, a resolution to rename the Department of Dentistry at Harlem Hospital Center, a license agreement with the New York Legal Assistance Group for services to be provided at Coler-Goldwater, a license agreement with the Department of Education for space on the Goldwater campus to operate a Licensed Practical Nurse Program, a license agreement with GVS/Cohen Fashion Optical for space to operate an optical shop at Jacobi Medical Center (Jacobi), and a request for approval on a change order to complete work at Jacobi.

Mr. Pistone noted that in addition to these action items would be two information items; a status report on the major modernization at Gouveneur Healthcare Services, and a delay report regarding the Emergency Room Renovation project at Lincoln Medical and Mental Health Center.

This concluded his report.

Action Items

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to rename the Department of Dentistry and Oral Surgery at Harlem Hospital Center (the "facility") the "Dr. James E. McIntosh Department of Dentistry and Oral Surgery.

Denise Soares, Executive Director, Harlem Hospital Center, read the resolution into the record on behalf of Iris Jimenez-Hernandez, Senior Vice President, Generations+/Northern Manhattan Health Network. Ms. Soares was joined by James King, MD, and Sylvia White, Chief of Staff, Harlem Hospital Center.

Dr. King advised that Dr. McIntosh served the Corporation for forty (40) years, beginning in 1969 at Sydenham Hospital. Mr. McIntosh then went on to become the Director of Dentistry at Sydenham and then served for two (2) terms as Medical Board President at the facility, including during the time that the Sydenham facility was closed, which he worked tirelessly to prevent. Mr. McIntosh helped establish the Renaissance Healthcare Network before moving to Harlem Hospital Center, where he helped bring dentistry services to a departmental level. Under Dr. McIntosh's supervision, the Department of Dentistry increased visits from 6,000 to 27,000 annually. Dr. McIntosh created the Minority Specialty Program where over 30 African Americans were trained in dental specialties to provide services in underserved communities.

Ms. Youssouf thanked Dr. King for his impressive presentation and expressed pleasure in moving the item forward.

There being no questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a license agreement with the New York Legal Assistance Group (the "Licensee" or "NYLAG") for use and occupancy of space at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility") to provide pro bono legal services to patients and training to Corporation staff.

Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, read the resolution into the record on behalf of Lynda Curtis, Senior Vice President, South Manhattan Health Network. Mr. Hughes was joined by Dion Wilson, Assistant Director, Office of Facilities Development, later joined by Randye Retkin, New York Legal Assistance Group (NYLAG).

Mr. Hughes explained that NYLAG would provide assistance in the decanting of Goldwater Hospital, with issues relating to immigration, entitlements, family law, etc. He noted that their services would also allow for NYLAG staff to train Coler-Goldwater staff to identify which residents may need legal services. He advised that a NYLAG attorney would be on-site for one half day, once a week and would occupy approximately 150 square-feet of space, for six months. The organization would be paid $36,000 for their services.

Mrs. Bolus asked how many patients have been helped by NYLAG. Mr. Hughes advised that the relationship between Coler-Goldwater and NYLAG originated after the earthquake in Haiti, when NYLAG provided assistance to patients and residents who were Haitian, in efforts to gain them temporary protective status (TPS), they successfully filed 13 applications and received TPS for five (5) or six (6) individuals.

Alan Aviles, President, noting that Ms. Retkin was present, invited her to provide an overview of the relationship NYLAG has with other HHC facilities. Ms. Retkin advised that the organization's relationship with Coler-Goldwater had historically been related to immigration issues more than anything else, but moving forward they will be providing assistance having to do with patients being reintegrated into the community. She stated that NYLAG's relationship with other facilities has ranged from advanced planning, assistance with benefits, immigration, housing, and/or a wide variety of other services.

Ms. Youssouf noted that this relationship will be specifically related to the decanting of the facility, and Ms. Retkin confirmed.

Ms. Youssouf asked if the $36,000 was a flat rate or if it was related to a specific number of cases or some other factors. Ms. Retkin advised that the payment amount covers any and all services being that the organization can only handle so many cases. She noted that if something requiring additional help came up, staff from another facility would assist.

There being no questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation" or "Licensor") to execute a revocable license agreement with the New York City Department of Education (the "Licensee") for its continued use and occupancy of space to operate a Licensed Practical Nurse ("LPN") training program at Coler-Goldwater Specialty Hospital and Nursing Facility, Goldwater campus (the "Facility").

Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, read the resolution into the record on behalf of Lynda Curtis, Senior Vice President, South Manhattan Health Network. Mr. Hughes was joined by Nancy Doyle, Assistant Vice President, Workforce Development.

Mr. Hughes advised that the Goldwater campus had served as a site to the Licensed Practical Nurse (LPN) program since its inception in 2007. Since that time, four classes have graduated, with a fifth scheduled to graduate in June 2012. He noted that HHC hired 103 of 157 students that completed the program, 39 of whom were hired by Coler-Goldwater. Mr. Hughes explained that the program would occupy 7,100 square-feet of space at no fee, with the benefit of having the first opportunity to hire graduating LPNs. The term should not exceed one year, and the licensee was noted as being aware that the space will not be available when the facility is closed.

Mrs. Bolus inquired as to why graduates from the East New York LPN program are being hired as Patient Care Assistants (PCAs) and not LPNs. She said not only is that embarrassing for an individual who completed this program, but the individuals are functioning out of title.

Ms. Doyle advised that when the program began, there was robust funding from the State for training HHC staff. The current program is very different from that initial program. Funding for employee training has been stopped, but the Department of Education (DOE) has expressed significant support of the program, and desires to keep it running for as long as the facility is open at that location. Ms. Doyle advised that at this time employment is not promised to graduates due to changing circumstances but staff works with employees and graduates to help find them employment. Ms. Doyle advised that she would follow-up regarding Mrs. Bolus's concern regarding working out of title and would advise the Committee of her findings.

Ms. Youssouf asked where the program would be relocated to after the facility closes in 2013. Mr. Hughes advised that they have expressed a desire to remain on Roosevelt Island, possibly at the Coler campus but it has not yet been determined. Ms. Youssouf asked that the Committee be kept abreast of any decisions being that the partnership and program are beneficial to the Corporation. Mrs. Bolus agreed, and added that there may be space available at other HHC facilities.

There being no questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical (the "Licensee") for use and occupancy of space to operate an optical store on the campus of Jacobi Medical Center (the "Facility").

Diane Carr, Deputy Executive Director, North Bronx Health Network, read the resolution into the record on behalf of William Walsh, Senior Vice President, North Bronx Health Network. Ms. Carr was joined by Edward Baron, MD, Chief of Ophthalmology, North Bronx Health Network, Dion Wilson, Assistant Director, Office of Facilities Development, Miles Louis, Chief Executive Officer, General Vision Services and Karen Miller, Vice President, Cohen Fashion Optical.

Dr. Baron advised that the optical shop is capable of providing necessary services that are not currently available at the facility. He noted that these increased services may allow for the department to focus more on eye disease and would likely decrease appointment wait time. He explained that the facility, on a daily basis, has patients that ask what to do with the prescription they have received for glasses, and he believes that this optical store would make it easier for patients to fill prescriptions, and could also serve as a referral source for the facility.

Mrs. Bolus asked if there is a reporting system in place to note whether prescriptions have been filled. Dr. Baron said there is not a system in place, but the idea that there would be an on-site location to take care of that would undoubtedly increase the number of prescriptions filled.

There being no questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Request for approval from the Capital Committee for changes exceeding the $200,000 threshold for construction changes, in order to accomplish work needed to complete the following; Campus Site Improvements, Transportation Intermodal Facility at Jacobi Medical Center.

Diane Carr, Deputy Executive Director, North Bronx Health Network, read the change order into the record on behalf of William Walsh, Senior Vice President, North Bronx Health Network. Ms. Carr was joined by Beau Scelza, Director, and Christopher Gowrie, Associate Executive Director, North Bronx Health Network.

Ms. Carr provided before and after project photos to assist in describing the work being performed, and what the additional funding would be utilized for. She advised that the first change order request in the amount of $475,000 would be used to complete lobby renovations. She explained that funding for the work was derived from surplus funds from a Fire Alarm System project at the facility. The second proposed change order for $777,000 would allow for the completion of a pedestrian plaza and site improvements around the campus.

Ms. Youssouf asked if the projects had already been completed. Ms. Carr stated no, parts of the projects have been completed, but not those portions that requests are being made for. Ms. Carr explained that contracts that are already in place which provided exterior and interior work, but exterior work was all that was completed because of time constraints and therefore interior work needed to be completed. She noted that the project had received favorable bids at the time of award, and had benefited greatly from aggressive negotiations by the Construction Management firm, TDX, which allowed for holding prices firm for the proposed change order work as the base project was continuing. The savings from favorable bid results from the Fire Alarm System project and the firm price structure for the additional site work would allow the facility to incorporate these additional site improvements, which will provide for the installation of new lights, sidewalk repairs, and emergency telephones.

Ms. Youssouf asked if the facility was concerned about going over budget. Ms. Carr said no. Mr. Pistone added that cost was being held firm, and that TDX has confirmed the validity of that cost.

Mrs. Bolus asked whether lighting in the unmentioned lots was sufficient. Ms. Carr said either work had already been completed in those locations or would be part of a future project.

There being no questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the Construction Change Order.

Information Items:

Gouverneur Healthcare Services – Major Modernization

Mendel Hagler, Executive Director, Gouverneur Healthcare Services provided the status report. Mr. Hagler was joined by James Palace, Hunter Roberts Construction Group, and Steve Curro, Dormitory Authority of the State of New York.

Mr. Hagler noted that the Board had been informed of recent project delays and budget overruns and apologized for this news. He stated that construction at the facility is ongoing on floors two (2), three (3), four (4), five (5), six (6), seven (7), and eight (8), and the existing campus now includes the Ambulatory Care Pavilion and the 13th floor Sub Acute Care units. He advised that floors nine (9), ten (10), eleven (11), and twelve (12) would be turned over in the coming months, and finally on the first floor. Work would extend until late 2013 or early 2014, with forecasted completion expected for late 2014.

Mr. Hagler accepted responsibility for the issues associated with the project and again apologized to the Board, noting that he, along with the Dormitory Authority of the State of New York (DASNY), RMJM Hillier Architects, HHC Central Office, and the South Manhattan Network are all part of the project team.

Mr. Pistone added that as part of the team, he as well took partial responsibility for the project and advised that the Board would receive, from the Office of Facilities Development, a complete analysis on causes of the overrun and recommendations for the project moving forward.

Ms. Youssouf kindly noted both apologies but asked where the funding would be coming from for the $36 million variance. She asked whether funding had been approved by the Office of Management and Budget (OMB). Mr. Pistone said funding had not been secured but he has been in ongoing discussions with OMB and they are clearly supportive of the project. He advised that they were notified that there were anticipated over-runs and they have been continually kept abreast of the situation.

Ms. Youssouf expressed disappointment, on behalf of the Committee, in respect to where the project currently stands, and advised that the Committee looks forward to having detailed recommendations on how to change the procedure with regards to outside program and construction mangers so that these types of issues won't continuously happen.

Michael Stocker, MD, Chairman of the Board asked why previous reports had advised that the project was on budget, including times he had specifically asked whether the project was on budget.

Mr. Hagler advised that when status reports were given in 2010, after work on the Ambulatory Care Pavilion had begun, everything was still on target and the project team was still comfortable with progress. He stated that he provided the Board with any and all information that he had at the time he was presenting and when it was initially anticipated that there would be some delays and some budget difficulties the Board was informed. He said that every time he presented to the Board he gave them all the information that he had at the time, as current and accurate as he had.

Ms. Youssouf said that the team that he mentioned, including DASNY and outside construction groups, should be meeting and having serious discussions, including asking why the information provided to Mr. Hagler informed the Committee that the project was on time and on budget when that was not the case. Mr. Hagler said that when the project was presented as on time and on budget, that was the case, and it was not until work on the existing building began and the latent conditions started to appear that the team really started to see changes in the project cost and schedule.

Mr. Palace explained that in 2010, the project was at a stage when construction on the Ambulatory Care Pavilion was well underway and it was then, when renovation of the existing building began that things really started to change. There were failing risers, the existing façade couldn't support planned work, there was an unexpected amount of asbestos, there was a steam pipe explosion. He noted that destructive surveys are quite difficult in an occupied building so some of these issues and conditions were unforeseen.

Ms. Youssouf advised that she felt that surveys and even research on buildings built around the time of Gouverneur's existing facility should have provided significant information on what would be encountered. Mr. Palace noted that there was a thorough survey done but some assumptions were not made. It was determined that there was asbestos but not to the extent seen once the walls were opened up.

Dr. Stocker said that this information does not seem credible. If the building is inspected properly and we (HHC) know the age of the facility and have had possession of it for such a long time, there is no excuse why there would be so many unknown factors.

Mr. Curro advised that resources were not made available at the onset of the project to complete as thorough an investigation as necessary. He said the existing conditions survey that was performed was not completed as in depth as it should have been.

Ms. Youssouf asked what was meant by insufficient funding for preliminary investigations. Mr. Curro said that HHC leadership had not given enough money to perform a more thorough investigation. Mrs. Bolus asked if HHC leadership had been told that there was not enough money and Mr. Curro said that DASNY was given a budget to work with and that is what they used. Mrs. Bolus said that is not acceptable, if there was not enough money to do proper investigation, as needed, then somebody should have been told.

Dr. Stocker said that one of the most disturbing factors to him was that as the project budget was increased the contingency remained the same. He asked how that happened. Mr. Curro explained that the project started at $80 million and after schematic design it was increased to $159 million, at that time with a $14.5 million contingency. The next increase, to $182 million, was when HHC asked DASNY to take over construction of existing floors of the facility (initially planned to be completed by HHC). He noted that along with those increases funding was provided. He stated that at the time he believes HHC leadership was aware that there was no additional contingency but DASNY had a budget to work with and they were doing so. When it went from $182 million to $207 million DASNY was told that $14 million was for furniture, fixtures and equipment (FF&E) and $5 million was for a budget overrun, the remainder was for program changes. He noted that the budget now does contain an additional 10% contingency.

Ms. Youssouf stated that the project had gone from $81 million to $246 million and noted that all participants should be seriously concerned with what went wrong. She said it is mind boggling, and she was shocked and appalled that the project is so out of hand. She added that Dr. Stocker, OMB, and Sr. Management was not at all aware of how significant the problem was.

Dr. Stocker said this is a very bad time to have these cost overruns and that money could have been spent on a number of other important issues and services. Dr. Stocker asked if there were any way that the project could be downsized or if there were something that would be cut out of the scope.

Mr. Hagler said that the bulk of the cost went to infrastructure work, and that is complete. He said that cutting out a floor or two would not make a significant difference at this point. It is very difficult at this point to take anything out of the project.

Ms. Youssouf said she disagreed that infrastructure work at $50 million was the bulk of a $246 million project. Mr. Hagler apologized.

Dr. Stocker asked whether the Ambulatory Surgery Center was necessary and whether the original reasoning in constructing the Center was to decant Bellevue.

Mr. Hagler advised that at the time that the project was planned it was thought that services would increasingly be handled in an outpatient capacity and less in an inpatient capacity and it was thought that services provided by the Ambulatory Surgery Center would greatly support

Primary Care services. It was anticipated that Gouverneur would assist in decanting Bellevue since many Gouverneur patients were heading up to Bellevue, at that time Metropolitan Hospital was not a part of the South Manhattan Network. He noted that 85% of community hospital procedures are done in an outpatient capacity and therefore this service would be relevant.

Dr. Stocker advised that there is an Ambulatory Surgery Center at Metropolitan, which is currently part of the South Manhattan Health Network that has capacity, and asked why Bellevue would not send patients there. He suggested that it be reviewed whether or not the Ambulatory Surgery Center should still be part of the project.

Mr. Hagler stated that it is an integral part of the project and advised that all staffing of the unit would come from existing Gouverneur staff. Dr. Stocker asked that a study be performed that convinces the Board that there will be adequate utilization for the site.

Ms. Youssouf acknowledged that HHC is a large family, with multiple facilities throughout New York City and recommended that services not be duplicated unnecessarily. She advised that the Capital Committee would be looking at how to revamp what is going on with these major projects.

Mr. Hagler explained that when the project originated around 2005 the world was a different place, hospitals and operating rooms were primarily full, there was no breakthrough process to streamline decision making, things have changed greatly since the projects inception.

Ms. Youssouf noted that there were some disagreements and explanations that would not be solved by this debate and thanked Mr. Hagler.

Project Status Reports
Central/North Brooklyn Health Network
Generations+/Northern Manhattan Health Network*
Queens Health Network*
* Network contains project(s) that require a delay report

Generations+/Northern Manhattan Health Network

Peter Lynch, Office of Facilities Development, provided a brief delay report on the Lincoln Emergency Room Renovation project. Mr. Lynch was joined by Liny Liu, Senior Project Manager, Lincoln Medical and Mental Health Center

Mr. Lynch advised that the project originally fell behind schedule early on due to delays in receiving Certificate of Need (CON) and funding approvals but work is now in progress. The project commenced in 2011, this being the first of five phases, with an anticipated completion date of July 2013. He advised that the job was moving along well. Mr. Pistone added that there would be a need for additional funding and he would provide a written update for the committee. Ms. Youssouf asked what that mean. Mr. Pistone said that the project is over budget.

Dr. Stocker asked whether this was an in house project. Mr. Pistone said yes.

Equal Employment Opportunity (EEO) Committee – June 12, 2012
As reported by Rev. Diane Lacey

Assistant Vice President's Report

Manasses C. Williams, Assistant Vice President, Affirmative Action/EEO briefed the Committee on the Equal Employment Opportunity Commission (EEOC) new guidelines on the use of Arrest and Criminal Records in employment decisions.

2011-2012 M/WBE Program Annual Report Facility Update

The Assistant Vice President, Affirmative Action/EEO reported on the status of the Corporation's M/WBE Program. The report shows that there was a decrease in the overall M/WBE expenditures in the Corporation by $20,733,057.00 from $85,021,752.00 in 2011 to $64,288,695.00 in 2012.

Expenditures of MBEs decreased by $13,623,526.00 or 23.56% while expenditures on WBEs decreased by $7,109,531 or 26.15%. The overall utilization rate for MBEs decreased by 1.00%, from 8.30% in 2011 to 7.30% in 2012. WBE participation rates decreased by 0.37% from 2.65% in 2011 to 2.28 % in 2012, while the MBE participation rate decreased by 0.63% from 5.65% in 2011 to 5.02% in 2012.

Sharon Foxx, Sr. Management Consultant, reported on four conditionally approved contractors, Nouveau Elevator Industries, Inc., which had two underutilizations of minorities in Clericals Job Group 3 and in Crafts Job Group 1, Perkins Eastman Architects, PC which had two minority underutilizations in the Professional Job Groups 1 & 2 and eliminated the minority underutilization in Management Job Group 3 which it had in 2011. Sodexo Laundry Services, Inc., which also had four underutilizations of women in the Management Job Group 4,

Operators Job Group 1, Crafts Job group 1, and finally Service Workers Job Group 5. The third contractor Ms. Foxx reported was A&P Coat, Apron & Linen Supply, Inc. which had one underutilization for women in Managers Job Group 3.

Finance Committee – June 12, 2012
As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack began her report by informing the Committee of the Corporation's cash on hand which is currently at 35 days compared to 43 days last month. The decrease is primarily due to a delay in the receipt of supplemental Medicaid payments that will lag until next fiscal year. As previously reported to the Committee, the days of having outstanding retroactive payments are changing significantly. Mr. Jay Weinman, Corporate Comptroller and his staff have done preliminary cash forecasts for next year that reflects a significant change in the cash flow than in recent year and will require extremely close monitoring of this issue and reporting the status of this situation to the Committee. The large surpluses that were rolled in previous years will no longer be available which was included in the reporting of the Financial Plan to the Committee.

Ms. Youssouf asked how significant is the decrease in cash expected to be. Ms. Zurack stated that the calculation has not been done in terms of the days; however, based on preliminary calculations, there will be instances whereby HHC will fall below $100 million which would translate to approximately eight days of cash on hand that would result in controlling vendor payments; aggressively pursuing receivables and keeping all parties informed of the status. Finance is planning to meet with the City and State on this issue. The Corporation will continue its efforts to increase revenues and reduce cost which from a budget perspective would impact the cash in a positive way.

Dr. Michael Stocker, Board Chairman asked if it is a timing issue. Ms. Zurack stated that for now it is a timing issue in that the COH has decreased from 43 days to 35 days and is expected to remain at that level by year-end due to a delay in the receipt of supplemental Medicaid that was projected to come in by year end but will be delayed until next FY. In light of that delay, it is important to inform the Committee of the anticipated change in the COH going forward given the magnitude of the change.

Mr. Rosen asked when was the last time HHC did seasonal borrowing. Mr. Larry Migdal, Deputy Chief Financial Officer stated that it was March 15, 1994.

Ms. Zurack stated that the seasonal borrowing issue would not be a viable alternative to resolving this issue. The solution has to be that the budget has to be aligned.

Mr. Migdal stated that in terms of seasonal borrowing, the President of the Corporation had to sign a promissory note to the City. Mr. Rosen stated that seasonal borrowing has to be repaid by the end of the year. However, it is a temporary solution that could be considered in terms of addressing timing issues.

Ms. Zurack stated that it is an option; however, in the past, HHC has worked with the City on advancing payments to HHC and HHC delaying payment to the City which has allowed HHC to balance as a result of those advancements and delays during tight cash time. However, it is important to reiterate that the solution is to align the budget; otherwise, there is no way to achieve a balanced budget without aligning expenses to revenues.

Mr. Rosen stated that during the fiscal crisis, the budget was balanced on an accrued basis but without federal guarantees meeting the payroll was unachievable.

Mr. Migdal responding to Dr. Stocker's comment, stated that in terms of the eight days of cash on hand at this time, it is difficult to project; however, those are seasonal trends whereby there are significant swings in cash which usually occurs in February and March due to the flow of funds from the City and State. However, over the years, throughout those flows, HHC has managed to get through by instituting various controls such as vendors' payables.

Mr. Weinman stated that HHC is averaging sixty days in its vendor payments. Some facilities are less some are more but generally those payments when necessary can be delayed. Mr. Rosen stated that there are measures that can be taken.

Ms. Andrea Cohen asked what have been the average days of cash-on-hand (COH) for the year and what the projected average is for next year.

Ms. Zurack stated that on average it has been thirty or more days and the projected is in the teens.

Mr. Migdal stated that in terms of dollars, HHC's cash flow has been from $450 million to $650 million on any given day which are healthy levels.

Ms. Zurack stated that it does not include any relief from the State and Federal governments.
Ms. Youssouf asked what the thirty five days would translate to in terms of total cash.

Ms. Zurack stated that it would be $573 million. Dr. Stocker asked how much uncertainty is there.

Ms. Zurack stated that a fairly conservative cash flow has been done and HHC is cautiously hopefully that there might be some improvement.

Dr. Stocker stated that if there are delays in payments from the Federal and State governments does HHC know how much leeway HHC has in terms of delaying payments and going to the City.

Ms. Zurack stated that HHC would know. Dr. Stocker stated that this issue comes as a surprise and is the first time this type of discussion has taken place since his appointment as Chairman of the Board.
Ms. Zurack stated that it is not the first time but rather the second time this type of issue has been reported to the Committee. The first time that HHC was faced with this type of situation, the supplemental Medicaid payments were late and HHC was very close to those levels at that time.

Ms. Youssouf stated that the situation then compared to now is that it was due to late supplemental payments compared to the current issue that relates to the budget and would require major reductions as opposed to delayed payments.

Ms. Zurack stated that this issue has been reported as part of the Financial Plan that was presented to the Committee.

Mr. Migdal stated that the key going forward is to engage the City and State as quickly as possible regarding this issue.

Ms. Zurack stated that the plan is to meet with the City's Office of Management and Budget (OMB) and the State Department of Health (SDOH) to review HHC's projected cash flow for next year which is expected to get them to move on certain items that are often not acted on. Three years ago, the status of HHC's cash flow became a part of the monthly reporting to the Committee and later began reported as cash on hand as opposed to the cash flow and was at the point when the supplemental Medicaid payments were significantly delayed. At which time, Finance in conjunction with Ms. Brown, Senior Vice President, Corporate Planning/HIV Services, Intergovernmental Relations and Community Health put forth an effort to get CMS to act on those payments. HHC's cash flow was sent to Albany and Washington on a regular basis. It was a period whereby pension and City payments were delayed.

Ms. Youssouf asked what type of emergency or catastrophic event could possibly eradicate HHC's cash balance.

Ms. Zurack stated that there was a time when the State took back $50 million from Woodhull for a retroactive rate decrease from capital reimbursement that created a major cash flow issue.

Mr. Migdal added that in the late 80's and 90's when the State was faced with a major financial crisis, the Medicaid checks were delayed which significantly impacted the cash flow.

Mr. Rosen stated that there will always be revenue issue, seasonal borrowing; however, what is important is that the funding agencies understand and respect what is being done to address the issue.

Ms. Zurack stated that it is important to be transparent in these types of situations which at this time the Committee is being informed as a forewarning of the anticipated decline in HHC's cash flow in February 2013.

Ms. Youssouf asked whether it is calendar or fiscal year. Ms. Zurack stated that it is FY 2013 cash flow issue. The average balances are significantly lower than the previous year. As Mr. Migdal mentioned historically, there are some extremely low days in February and March of each year that are alarming.

Ms. Youssouf asked if HHC is planning to have initial discussions with the City and State soon. Ms. Zurack stated that the plan is to meet with each entity as quickly as possible.

Dr. Stocker asked if there is a fundamental disconnect between expenses and revenues that might impact the cash flow.

Ms. Zurack stated that it raises the importance of revenue optimization that consists of two parts and timing is also important. For example, if it takes an extra twenty days to collect on a particular case due to staffing shortages, the Corporation knows when that money will be collected. Similarly with the processing of Medicaid applications by HRA, regardless of the time involved in the process, HHC know that it will eventually get the money.

Ms. Youssouf asked if there is an active internal team or committee that is actively reviewing long range planning to address this issue.

Ms. Zurack stated that there are two parts that are in parallel. First, there is a very active leadership team that is responsible for the restructuring that is designed to save HHC money on the expense side. It is a senior group lead by Mr. Aviles that meets regularly and there are some very active projects that have yielded savings which Mr. Aviles can address. The second part relates to internal control around the authorization of individual expenses which is headed by Mr. Martin, Corporate COO and is being addressed at a very micro level on the operating side. There are controls on OTPS, hiring, and affiliation contracts and are also expected to result in significant savings.

Mr. Aviles stated that this does highlight that there is a need to execute the restructuring plan elements that remain ahead, particularly this coming FY. There is a significant amount remaining totaling $155 million as targeted reductions for essentially cost containment.

Ms. Zurack asked Mr. Covino what the cumulative amount is for all of the cost containment projects to-date. Mr. Covino stated that the total is $1 billion.

Ms. Youssouf stated that from a financial perspective it is important to understand the level of the cash reduction and whether there would be a point whereby HHC would be at risk of having the State or the Federal governments take over due to a cash shortage given that in some city agencies that type of circumstance has occurred.

Ms. Zurack stated that there are two issues. At the recent Audit Committee, KPMG, HHC's independent auditing firm, presented the audit plan and the metric that would be used for establishing growing concerns. What is shown on an accrual basis is the significant loss from operations that has been trending in a negative direction over the past years. That trend triggers the accounting industry doing a growing concern review. HHC's liquidity has been very stable and not counter balances to the losses and accordingly, HHC passed the going concern review. If HHC's liquidity were to become problematic, it would affect HHC's credit rating and would trigger some major consequences. On the other side, in the State health law, the SDOH has the mechanism to step-in when hospitals hit major financial problems. It is not a specific trigger as previously mentioned; however, both of those circumstances would not happen and the City would not want that to happen. There is a layer of assistance that would occur before an outside entity steps in.
Mr. Aviles added that it is fairly unlikely that this type of action will occur given that it is apparent to the City that HHC is managing the problem in light of the reduction in FTES, $500 million reduction in expenses, and the plan going forward calls for further reductions. The State would be taking on the accountability for that execution if there were a mismanagement issue which is not the case in this instance.

Ms. Youssouf stated that the questions were being raised given that in some industries, there is an automatic trigger for those instances.

Mr. Rosen asked about the status of the adoption of the City's budget.

Ms. Zurack stated that on June 4, 2012, HHC had its City Council hearing. The Council was very supportive and HHC is requesting the restoration of $8.9 million in City funds which translates to $12.7 million in total funds for the restoration of child health clinics, rapid HIV testing and mental retardation and developmental disabilities (MRDD). In addition, in the past the council has restored HHC's subsidy reductions last year which totals $4.2 million for FY 12.

Mr. Rosen asked when the adoption will take place. Ms. Zurack stated that it is scheduled for the end of June 2012.

Key Indicators/Cash Receipts & Disbursements Reports

Mr. Larry Migdal reported that the Key Indicators report as of April 2012, utilization for acute discharges is down by 4.6% compared to last year for the same period. There is a slight improvement since January 2012 which was at 5%. The D&TC visits are down by 6.5%; skilled nursing facilities (SNF) days are down by 6.2% which has been trending downward during the year due to the transitioning underway at Coler/Goldwater hospital. The ALOS, all of the facilities are within the corporate average by .3 day with the exception of Coney Island and Lincoln, .4 day greater than the expected and .5 day less than the ALOS, respectively. The CMI is up slightly from last year and has reached a milestone of having a value greater than 1. FTEs are down by 297 compared to June 2011 but are 225 FTEs under the target. Over the past twelve months from April 2011 to April 2012 FTEs are down by 515. Receipts are $44 million better than budget and disbursements are $38 million under spent resulting in a positive net surplus of $82 million year to date. A comparison of the current actuals to the prior year for the same period, receipts are $352 million worse than last year due to the timing of DSH and UPL payments which are down by $225 million. Pools are down of which $90 million is due to timing whereas last year HHC received a quarterly supplementary payment in April compared to this year the payment was received in May 2012. Appeals and settlements are down by $31 million due to the FY 09 rate take back by the State. However, an additional UPL payment is expected of $434 million this month which will enable HHC to end the year with a projected cash balance of $465 million. Disbursements are $132 million worse than last year for the same period of which $67 million is due to the timing of City payments and $53 million due to an increase in fringes, health insurance and pension. Actuals versus budget YTD, inpatients receipts are down by $13 million while outpatient receipts are up by $28 million; all other revenues are up by $28 million. Disbursements personal services (PS) are $7.4 million over budget of which $3.8 million is due to overtime expenses and the

lag in the reduction of FTEs by 225. Other Than Personal Services (OTPS) expenses are under budget by $40 million due to the roll of Networks' surpluses from last year and also the lag in the start-up of IT projects.

Mr. Rosen asked Ms. Zurack if she had an announcement.

Ms. Zurack stated that while it is traditional for HHC to honor its retirees who move on to big and better things, that day marks a significant milestone for Mr. Migdal who is retiring after 34 years at HHC. Under his stewardship the Corporation in terms of financial systems, financial management, and financial reporting have move light years from a point and time in which HHC would get a qualified opinion from its independent auditing firm to the point where HHC had no material weaknesses. This is largely due to his leadership in his role as Corporate Controller and for those of us who know him are very familiar with the elegance and grace with which he conducts all business in the Corporation. His work papers are stellar and the only thing sharper than his pencil is his "wit." He applies the same standard to a schedule of a sentence in the English language which is very unusual for those in Finance. His editorial touch will be deeply missed in our financial statements. On a very personal note, this is a tremendous loss. He has been a true colleague, a mentor and a friend and certainly better days are ahead and he will be truly missed.

Mr. Aviles presenting Mr. Migdal with a plaque stated that it has been evidenced from some of Mr.
Midgal's pithy comments, he is one of HHC's financial historians and the Corporation will be losing a lot of institutional knowledge with his departure. Mr. Midgal has been indispensable in terms of his judgment and wealth of knowledge. From knowing and working with Mr. Midgal over the years, he is a profoundly descent individual. It is a pleasure to honor Mr. Migdal with this plaque that reads: "In recognition of Larry Migdal for thirty four years of dedication, service and leadership to the New York City Health and Hospitals Corporation, to new beginnings and happy memories."

Mr. Rosen added that it has been a pleasure working and knowing Mr. Midgal for a number of years and that the Committee would like to extend it thanks to Mr. Midgal for his years of dedication and service and to a long and health retirement.

Statement of Revenues and Expenses
For The Period Ended 3/31/2012 And 2011

Mr. Jay Weinman stated that the reporting would highlight some of the major changes in the Statement of Revenue & Expenses for the period ended March 31, 2012. Bringing to the attention of the Committee, bottom line, the Corporation's loss for FY 12 YTD is $596 million compared to $349 million last year. The major components of the decrease also related to cash are three items, $163 million decrease in DSH maximization, the $605 million allocation decreased to $307 million State fiscal year (SFY); $79 million decrease in supplemental Medicaid funds and $44 million additional reserve for HMO/GME. Appropriations decreased $26 million due to the increase in debt service. Premium revenue increased by $395 million due to several factors; $42 million for IGT; $229 million for pharmacy carve-in beginning in October 2012; $66 million and $55 million premium rate increases due to an increase in enrollment. Operating expenses, PS increased by $134 million, due to a shortfall in the reduction of FTEs and prior year labor settlements. OTPS increased by $294 million related entirely to MetroPlus pharmacy carve-in resulting in additional expenses and increase membership and rate increases. Benefits increased by $47 million or 6.1% related to an increase in health insurance. Post-employment benefits increased by $95 million. As previously reported expenses were increased to approximately $700 million from $630 million last year. Affiliation expense increased by $27 million or 4.3% a slight decrease from the previous quarter. Interest expense increased by $8 million due to an increase in interest on the debt service funding.

Ms. Youssouf asked for clarification of the increase in interest expense as part of the debt service funding.

Mr. Weinman stated that HHC is paying the debt service interest earned on the debt that was borrowed, the increase in TFA and GO debt.

Ms. Youssouf stated that the City has been doing a lot of refunding which would reduce the cost.

Mr. Weinman stated that there were some re-estimates at the beginning of the year on the interest and HHC reports those charges.

Ms. Zurack stated that Finance would research that issue and report back to the Committee; however, it could be that there were savings that were front loaded last year.

Ms. Youssouf stated that it would be helpful to understanding what those charges include given that the City recently did approximately $2 billion in refunding.

Ms. Zurack stated that the general sense is that it also relates to new projects so the principle increased for HHC and the City does cash flow borrowing. HHC is actively in the City's capital program. So if HHC draws a lot of cash it increases the debt service in addition to the interest rates there is also a principle amount.

Ms. Youssouf asked if HHC has increased the borrowing for some of its capital projects and whether there is more outstanding debt even with the steep decline in interest rates that would actually help HHC.

Ms. Zurack introducing Ms. Nini Mar, Assistant Director, Corporate Debt Financing stated that based on Ms. Mar's expertise she would address that question.

Ms. Mar stated that the charges are compiled by OMB and report by HHC; however, there are several modernization projects in their final stages, Harlem, Gouverneur and Goldwater north and other small reconstruction projects funded by TFA.

Ms. Zurack stated that Finance would prepare the specific data relative to Ms. Youssouf question but it appears that the principle is going up and the interest going down.

Medicaid Eligibility Inpatient Processing Report
Status of Converting Self-Pay Patients to Medicaid

Ms. Maxine Katz stated that the Medicaid eligibility report as April 2012 corporate-wide there continues to be a lag in application submitted compare to last year for the same period. Eligible decisions are slightly lower but the facilities have made significant progress in reducing the gap. The approval rate of applications submitted to Medicaid decisions is at 89% which is slightly better than last year for the same period at 87%. Although there are fewer applications submitted more of those applications are being approved. The decrease in applications submitted is primarily due to a decrease in discharges and a shift in payor mix, from Medicaid to Medicaid managed care. There are more patients with insurances coming to HHC facilities which decrease the pool of patients to pursue for eligibility. However, the Corporation is continuing its improvement efforts and a second pass on the value stream is scheduled to review all of the improvements activities that have been done to date to determine if the goals were achieved and the next step. The two models have shown improvements in terms of days to submit the application and getting a response to those submissions.

Ms. Youssouf asked when will it be decided which model will be used as best practice throughout the Corporation.

Ms. Katz stated that the plan is to make that determination by September 2012. There will be an event to determine which is best. Some of the facilities have implemented one of the models or some of the components of those models.

Mr. Rosen asked if steps are being taken to address the PCAP issue which has decreased compared to being close to 100% in prior years. Ms. Katz stated that PCAP is down and is under review and some of the issues are related to timing. Those factors in conjunction with the decrease in discharges and managed care companies including these women into managed care plans

Dr. Stocker stated that HHC has put a lot of effort in addressing this process that have resulted in some changes over the years; however, the question is whether it is beneficial to have the facilities present to the Committee the status of those processing efforts. In reviewing the Medicaid Eligibility report, Bellevue stands out so perhaps the facility can present their status to the Committee.

Mr. Aaron Cohen, Chief Financial Officer, South Manhattan Network stated that the facility is prepared to present to the Committee in September 2012.

Dr. Stocker confirming that Bellevue will present in September 2012 the facility's status of the Medicaid eligibility processing.

Mr. Rosen again extended well wishes to Mr. Midgal on his retirement.

<u>Medical & Professional Affairs /Information Technology Committee</u>
<u>May 24, 2012 - As reported by Dr. Michael Stocker</u>

Chief Medical Officer Report:

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer reported on the following initiatives:

Institute for Medical Simulation and Advanced Learning (IMSAL)

IMSAL hosted another very successful facilitator training program with the CMS group from the Harvard system. HHC was able to support this advanced training for another six members of our staff, to continue the expansion of expertise across more of our sites and hasten the facility based work of the IMSAL.

In addition, the first meeting of the re-vamped IMSAL Advisory Committee was convened this month, with the responsibility to advise on overall strategic direction for simulation training across our whole system, as well as new curriculum priorities.

Research

As part of the HHC-NYU partnership in the Clinical & Translational Science Institute (CTSI), we were pleased to announce the successful recipients of funding for HHC research projects after a competitive process. The recipients are:

- *L. Paladino MD (Kings County Hospital Center): The Rapidly Improving Stroke Symptoms (RISS) Study: A Pilot Observational study*.
- *H. Valsamis MD (Kings County Hospital Center): The Brooklyn Health and Hospitals Corporation TraumaticBrain Injury Network (BHHC TBraIN).*

Third Annual John Corser Symposium

The third Annual John Corser Bioethics Symposium *"An Ethics Journey from Global to Specific: Health Care Reform and Mediation at HHC"* was held on May 9, 2012 at Harlem Hospital Center with over 200 HHC leaders including physicians, nurses, chaplains and senior managers in attendance. Keynote speaker Bruce Vladeck, PhD, led the day with "The Ethics of the Affordable Care Act."

The symposium provided participants with an understanding of the new legislation dealing with health care reform affecting important end-of-life decision making, and ethical issues surrounding withdrawal of life sustaining treatments. Formal policy changes relating to the application of the Family Health Care Decisions Act, and the determination of brain death are being released following these discussions Corporate-wide for implementation, to align with the recent change in NYS policy from two assessments to one assessment to determine brain death.

HHC Walks to Raise Funds for the National Alliance for the Mentally Ill

On Saturday, May 12, 2012 HHC's Departments of Psychiatry and Central Office of Behavioral Health participated in a City-wide walk to raise funds for the National Alliance For the Mentally Ill, (NAMI) NYC Metro Chapter. NAMI is a national advocacy organization began by family members to create a voice for
improved research and care for those suffering from mental illness. HHC had six facilities and central office participate (Metropolitan Hospital Center, Harlem Hospital Center, Bellevue Hospital Center, Coney Island Hospital, Kings County Hospital Center, and Lincoln Medical and Mental Health Center). There were a total of 97 walkers raising over $15,000.

2012 Annual Behavioral Health Planning Session – June 7 at Draper Hall

The 2012 Annual Behavioral Health Planning Session will be held on June 7th at Draper Hall. This important meeting is the forum for the HHC discussion on the journey towards Behavioral Health managed care, with our experience to date with the BHO (Behavioral Health Organization), as well as our preparation for the next steps. Dr David Cutler, Otto Eckstein Professor of Applied Economics, Harvard University Department of Economics will be one of the keynote speakers.

HHC's Center for Teen Health Improvement

HHC has received grant funding from the Mayor's Young Men's Initiative (YMI) to improve services for teens and young adults, with an emphasis on improving sexual and reproductive health service quality and access for young men. This funding, which extends through fiscal year 2014, has enabled HHC to launch a system-wide improvement initiative focused on the health and development of young people in the populations that we serve. This work will be coordinated by the newly formed *Center for Teen Health Improvement* within the Office of Healthcare Improvement.

The goal of this Center is to improve the physical, psychological, and social well-being of young people. The aims are: 1) quality healthcare services for young people within HHC: a) "Teen Friendly" customer service practices to encourage young patients to openly communicate their needs, return for follow up care, and refer their peers; b) excellence in clinical service provision, in accordance with best practices in adolescent health care; 2) support for HHC's young patients in learning to make choices that promote long-term health; and 3) seamless partnerships with City-wide agencies that complement HHC in promoting youth development. Strategies include: 1) *Staff Training – a*ll clinical staff will be trained on clinical guidelines and skills, customer service, and issues in adolescent care; 2) *Systems Improvement* – a needs assessment will guide improvements to make HHC's services more appealing and accessible to young people. This may include updating clinic spaces, hours, equipment, and operating procedures; and 3) *Youth Engagement* – young people will be recruited and trained to help improve HHC's services for their peers. They will participate in provider training as model patients, educate their peers and communities about healthy behaviors and care-seeking, and promote HHC's services via outreach and technology. This work will improve participants' life and job skills, and build their self-esteem as they serve as important partners in healthcare improvement.

An announcement will go out the HHC facilities informing them of this new initiative and state how HHC staff can support and benefit from the Center for Teen Health Improvement such as: by joining our HHC professionals interested in care for young people – send us your

contact information and tell us where you work and what you do; we will inform you about relevant news, events, resources, opportunities; tell us what needs to be done – respond to our surveys, talk to us… we need your insights and ideas!; and take action – start or join workgroups to address specific improvement needs. Make a difference, be a leader, connect with your colleagues from around HHC!

Staff contacts are: Shoshanna Handel, MPH, *Director, Center for Teen Health Improvement.* Elet Howe, *Assistant Director, Center for Teen Health Improvement.* David Stevens MD, *Senior Director of Healthcare Improvement.*

MetroPlus Health Plan, Inc.

Dr. Van H. Dunn, Chief Medical Officer, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Dunn informed the Committee that the total plan enrollment as of April 24, 2012 was 427,245. The breakdown of plan enrollment by line of business is as follows:

Medicaid	359,414
Child Health Plus	17,131
Family Health Plus	36,295
MetroPlus Gold	3,084
Partnership in Care (HIV/SNP)	5,733
Medicare	5,588

For the first time in many months, MetroPlus had a decline in enrollment. From March to April MetroPlus dropped 675 members overall, 230 in Medicaid, 391 in Child Health Plus and 117 in Medicare. The reduction in Medicaid was due to a lower rate of applications, while the reduction in Child Health Plus was due to loss of eligibility. For Medicare, MetroPlus had 250 members disenrolled for failing to pay their premiums since January after a 90 day grace period. Dr. Dunn provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

Each month, data is shared with the Committee that reflects members that have disenrolled from MetroPlus and have transferred to Health First. In collaboration with HHC Finance, these transfers were studied, and 80% of those who transferred were no longer receiving care at HHC. A sample survey was done on those individuals who transferred. Eight hundred and fifty one members with valid phone numbers received outreach. Two hundred and forty two or 28% of those were reached. The two main reasons for members leaving MetroPlus and HHC were desire to receive care from providers not in our plan, and problems with accessing care. 76.6% reported leaving to go to a non-network provider. 17.9% left due to difficulties accessing care.

MetroPlus also conducted a survey of Medicare members that voluntarily disenrolled in January and February 2012. Of the members disenrolled, approximately 12% were reached and a disenrollment survey was completed. The main reason given for disenrolling was dissatisfaction with benefits offered by the Plan. MetroPlus is currently finalizing a renegotiation of provider contracts that should allow them some flexibility in offering enhanced value added benefits. Preliminary results for May show that MetroPlus will gain between 1,500 to 2,000 members.

On the other hand, MetroPlus will continue to face challenges in their ability to offer additional services to their Medicare population. Based on current federal legislation there will be a projected 19.28% base premium reduction in MetroPlus' Medicare Advantage rates over the next five years. The Affordable Care Act requires that counties such as those within New York City that are above the national fee-for-service (FFS) average reduces costs to 95% of FFS. Re-evaluated annually, county rates will be reduced over a maximum of six years to achieve these rate reductions.
The New York State Department of Health (SDOH) will be providing 2012-2013 rates in two phases. In Phase I (early May), plans can expect the April 1st base Medicaid and FHP medical rates. Regional trends are about 5% vs. 7% last year. This is before SDOH applies the legislative cuts from last year (it was a 2 year deal for managed care plans). These include a 1.7% trend reduction and a 2% overall reduction, leaving an approximately 1.3% trend. Separately, pharmacy rates are being reduced from the October carve-in to reflect an increase in the expected generic dispensing rate (from 72% to 77%) and an elimination of the funded carve-in transition period. An analysis of these new pharmacy rates reveals that MetroPlus will receive approximately 36 million dollars less in pharmacy revenue over the next year. In Phase II, MRT adjustments will be funded and include the carve-in of new populations and expenses, including low weight and disabled (SSI) babies, homeless recipients, and dental. All of these will come with incremental revenue and cost. SDOH is still developing those rates and those will probably not be available until mid-year. Chronic mediations that someone has been on for three months, look at prescriptions per member per month for those with chronic disease and monitor whether there has been a decrease in those being filled. Filled rates are monitored since formulary change to ensure all patients are receiving their appropriate medications – one of the major issues is that providers are not filling the 'prior authorization' required for non-formulary medications which we are addressing by outreach to both patients and providers.

On April 12, 2012, Governor Cuomo issued an Executive Order to establish a State-wide Health Exchange, an online marketplace where individuals and small businesses can choose among competing health insurance plans. The Governor stated that this will reduce cost of coverage for individuals, small businesses and local governments.

Chief Information Officer Report

Bert Robles, Chief Information Officer provided the Committee with updates on the following initiatives:

Meaningful Use (MU) Stage II

On February 23rd, the Centers for Medicare and Medicaid Services (CMS) released a Notice of Proposed Rule Making for Eligible Hospitals and Eligible Providers to meet Meaningful Use (MU) in the program's second stage. As presented to the Board previously, the Corporation has made steady progress towards Stage I MU for the HHC hospitals and HHC is currently meeting thresholds for all Stage I measures.

Stage II introduces the following significant changes to the program:

- Hospitals will have 16 core items and can pick two of four menu items were previously they had 14 and could choose five out of ten. Eligible providers will have 17 core and can pick three of five menu items.
- Most thresholds for MU will be increased. For example, patient demographics must be recorded for 80% of patients, where previously it was for 50%. The threshold for assessing smoking status is also up to 80% from 50% and the requirements for decision support rules are increased to five from one.
- Almost all Stage I menu requirements will be core including the requirement for *Summary of care at transitions,* syndromic surveillance, R\reportable lab results for public health, medication reconciliation, and providing educational resources to patients.
- The Summary of Care Document must be provided for at least 65% percent of transitions and referrals and would have to be electronically exchanged between the hospital and a provider that is not affiliated with the hospital and is using a different EHR vendor product. This proposed requirement may present particular difficulties for integrated delivery systems, where a large majority of referrals are within the system and using the same EHR. Professional Organizations such as the Greater New York Hospital Association (GNYHA), National Association of Public Hospitals (NAPH), the American Hospital Association (AHA) and the Hospital Association of New York State (HANYS) have identified this as an unreasonable request for their constituents. HHC concurs with their position.
- CMS proposes that at least ten percent of a hospital's patients would need to view or download information about their hospital stay, or electronically transmit their information to a third party. This requirement would make providers accountable for patients using computer technology. While GNYHA, NAPH, AHA and HANYS encourage electronic interaction with patients through the use of computer technology, they have found this requirement to be untenable. HHC concurs with their opinion.
- A new menu objective for Hospitals is to generate and transmit permissible discharge prescriptions electronically (eRx) for more than 10% of patients. This requirement could cost HHC an additional two million dollars annually for fees related to eRx and accelerate the planned implementation of eRx in the inpatient setting.
- A new objective for eligible providers would mandate that secure electronic messaging be used to communicate with more than 10 % of unique patients seen during the EHR reporting period. Although the requirement does not require the patient to respond, a requirement to electronically communicate with one out of ten patients may not be appropriate in many cases.

In addition to the new measures and thresholds, all hospitals will be required to submit quality metrics electronically in 2014.

The Notice of Proposed Rule Making also articulates the timetable where penalties will begin to be levied on providers who are not meaningful users. A one percent reduction in Medicare rates will commence in 2015 for Hospitals who have not attested to meaningful use by July 1 of 2014. Unexpectedly, eligible providers who elect to attest under the Medicaid Program will nevertheless be subject to Medicare Part B penalties if they have not attested by October 1, 2014. This is despite the fact that the Medicaid Program allows eligible providers to begin meaningful use as late as 2016, without reduction in incentive funding. Thus the program, on one hand recognizes that Medicaid eligible professionals may need more time to reach meaningful use and gives them until 2016 to start, but on the other hand penalizes what limited Medicare revenue they receive if they don't start by 2014.

Enterprise Business Intelligence (BI) Initiative

EITS is embarking on one of the most critical initiatives for HHC- establishing an Enterprise Business Intelligence (BI) strategy. BI is widely viewed as a key strategic imperative for the success of information driven organizations. With the explosion of information technology in healthcare and the accelerated pace of health care reform, we are grappling with enormous amounts of data and an incredible pace of change that requires new and sophisticated ways to allow us to timely and effectively analyze and model.

At its core, BI is about decision making. BI converts enormous volumes of data into meaningful analytics and metrics about HHC's current business and clinical operations. It identifies evolving patterns that allow us to be more responsive to changing conditions and therefore, make more informed decisions. Some of the key objectives of the BI initiative will be to:

- Strengthen data and information governance

- Integrate data from diverse systems to enable advanced, comprehensive analytics to drive clinical, financial and operational improvement
- Streamline the data reporting process flow and improve efficiency and service levels
- Deploy meaningful reporting, dashboards and alerts for various user levels that track and monitor key performance indicators
- Provide both retrospective and predictive forecasting capabilities to answer not only what happened but why did it happen.
- Enable self-service reporting analytics and the ability to drill down into key performance indicators for better evidence-based decision-making.

Our goal in deploying this Business Intelligence and Analytics strategy is to greatly enhance our ability to execute on our corporate objectives and mission.

Patient Centered Medical Home (PCMH)

EITS is working in partnership with Medical and Professional Affairs on another of HHC's most critical strategic initiatives- the implementation of Patient Centered Medical Home (PCMH). Presently, HHC has a primary care population of more than 477,000 adult and pediatric patients.

The primary goal of the PCMH initiative is to improve patient outcomes through improved care management and care coordination. All of our acute care facilities and diagnostic and treatment centers, 17 separate sites in all, have received designation as Patient-Centered Medical Homes (PCMH) by the National Committee for Quality Assurance (NCQA) and awarded each the highest, Level 3, PCMH Recognition. HHC is in the process of PCMH designation for 22 community health centers and extension clinics. If all of our primary care sites ultimately receive Level 3 NCQA Recognition status, HHC will ultimately qualify for at least $15 million annually in enhanced Medicaid reimbursement rate increases.

IT Asset Management

EITS' Service Management Office is in the process of developing and implementing IT Asset Management for the division.

IT Asset Management is a set of business practices that leverage financial, contractual and inventory functions to support life cycle management and decision making for the IT environment. This is especially critical for EITS as budget dollars shrink and demand for IT services increases. There are multiple benefits of implementing this type of program for EITS. They include but are not limited to: accurate budgeting, cost and risk reduction and increased asset utilization. Presently, the Service Management Office team is implementing Asset Management at the Jacobi Data Center with implementation at both Queens and South Manhattan Networks targeted for the end of this Fiscal Year. The remaining networks (North Bronx, Generations+, North &Central Brooklyn and South Brooklyn Networks) will be completed by the end of this calendar year. Successfully implemented, IT Asset Management will enable EITS to support user demands quickly while rationalizing the cost of services.

Action Items:

Resolution authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A;
AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

The resolution was moved for the full Board of Directors approval.

Resolution authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Microsoft Corporation to provide a care plan information system. The contract shall be for a period of five years with two, consecutive, one-year options to renew exercisable solely by the Corporation, in an amount not to exceed $11.43 million for the five year term, and an amount not to exceed $2.3 million annually for the two, consecutive, one-year options to renew, for a total of up to $16.1 million for seven years.
AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

The resolution was moved for the full Board of Directors approval.

Information Items:

Readmissions

Presenting to the Committee was Dr. Ross Wilson, Senior Vice President, Corporate Chief Medical Officer. Readmissions are an easy target as a reflection of waste in health care systems in that percentages of readmissions are regarded as preventable. Certain payer groups such as Centers for Medicare and Medicaid Services (CMS) and others have latched on to this as readmission is a reflection of poor care. Dr. Wilson put on the table that no real readmissions are preventable, some of them actually reflect the deterioration the chronic status of a patient or that they have other socio or other needs that need to be met. Dr. Wilson further added that of the preventable readmissions we need to do better.

CMS has introduced the readmissions reduction program which is basically a financial penalty starting in 2013 for patients who are readmitted within 30 days of discharge with heart failure (HF), pneumonia and acute myocardial infarction (AMI) – any site of readmission, any cause for readmission. CMS has been reporting this data for some time but now the penalty has started to be introduced which amounts to around 3% of our Medicare revenue in a financial year associated with these readmission cases. The 30 day readmission maker is not a very good marker it just happens to be the one we have. Early readmissions in the first seven days often reflect the fact that what was cared for in the hospital could have been improved, either the medication stabilization or the discharge plan etc. Readmissions after 14 days up to 30 days can be due to any number of reasons that may or may not be preventable. CMS will base the financial penalty on a three year rolling average of performance of July 1, 2008 to June 30, 2011 and compare this rolling average against our 2012 performance.

Dr. Wilson provided the Committee with a slide that drives CMS and all payers. The horizontal axis displays the readmission rates by State for Medicare patients and the vertical axis is the Medicare reimbursement per enrollee. The slide demonstrates that the readmission rates and cost per enrollee increases (linear relationship) with some outliers. CMS's view is if you can drive down the readmission rate you can predominately project a reduction in the payment per enrollee which is how they financially determine the penalty.

Dr. Wilson then provided the Committee with HHC specific data for Calendar Year 2011. The total percentage of readmissions across the entire HHC system has fallen with some variations for which there are conjecture seasonal components operating in February as noted by the high increase but the overall direction is declining. In order to try to understand our problem better we are focusing on different groups of readmissions: psych readmissions slightly declines towards the end of CY 2011. Dr. Wilson noted that each month, HHC facilities receive a readmission report for HF, AMI, and pneumonia. In addition we report on total readmissions and readmissions in psychiatry. Behind the reports the medical record number for each one of the readmissions is provided so that each clinical department can actually review the records and see what the learning points are behind the readmission.

In response to Dr. Stocker's question regarding benchmarks, Dr. Wilson noted that the only real case-mix or risk adjusted benchmark is the one provided by CMS. They correct for age, some social-demographics and the corrected diagnoses within the Medicare population of our facilities. So it is not Medicare diagnosis or the co-morbidities per patient it is actually more about the complexity of the whole Medicare population that each facility treats. There is a lot of argument about whether this is in fact a valid risk adjustment or not, however, it is the one we have to use. So when Medicare readjusts these raw figures we have to wait 24 to 30 months to get the Medicare figures as they use the rolling three year data. Separately we are going to start to look at what the risk adjustment algorithm looks like for our populations because when we risk adjust Coney Island Hospital it looks different when we risk adjust Lincoln Medical and Mental Health Center – the impact on raw figures changes quite a bit between the two sites.

The next slide that Dr. Wilson presented to the Committee demonstrated heart failure (HF) readmissions in CY 2011 for Jacobi Medical Center and Coney Island Hospital and looks at two subsets of patients. The slide illustrates that in CY 2011 Jacobi managed to continue a significant reduction in HF readmissions, while it bounces around but the overall trajectory is significant over the 12 month period. At Coney Island there is a mirror image of deterioration of HF readmissions, due to the fact that the Coney Island population is bigger, older and has different co-morbidities and when we risk adjust the Coney Island figure it may not look as quite bad as this. However, it is important to note that many of HHC sites have made substantial improvements in HF and pneumonia readmissions.

Dr. Wilson then provided the Committee with several slides in his presentation that demonstrates how CMS sees readmissions (which are public domain information) based on Medicare data from July 1, 2007 and June 30, 2010. In comparing the rate of readmission for HF between Bellevue Hospital Center, Woodhull Medical and Mental Health Center and New York University on the basis that they share some the same medical staff, the first thing one sees on this slide is that the National benchmark or National average is 24.8% which is the risk adjustment figure. Figures of 20% are good performance. The number of Medicare patients tracked for Bellevue was 171 patients, Woodhull 150 patient versus 973 patients at NYU which shows that in terms of the Medicare population we treat relatively few compared to the Medicaid population particularly related to the voluntary sector. There is a big consequence of this because if you look at Bellevue's rate of 29.8% and Woodhull's rate of 32.1%, both are worse than the US National rate versus NYU at 22.9% which is no different than the US National rate – the fewer patients you have the broader the 'bar' will be as illustrated on the chart and yield a higher rate than the US National rate. A larger number of patients reduce the scale of the rates. Statistically there is a better performance at NYU than Bellevue for

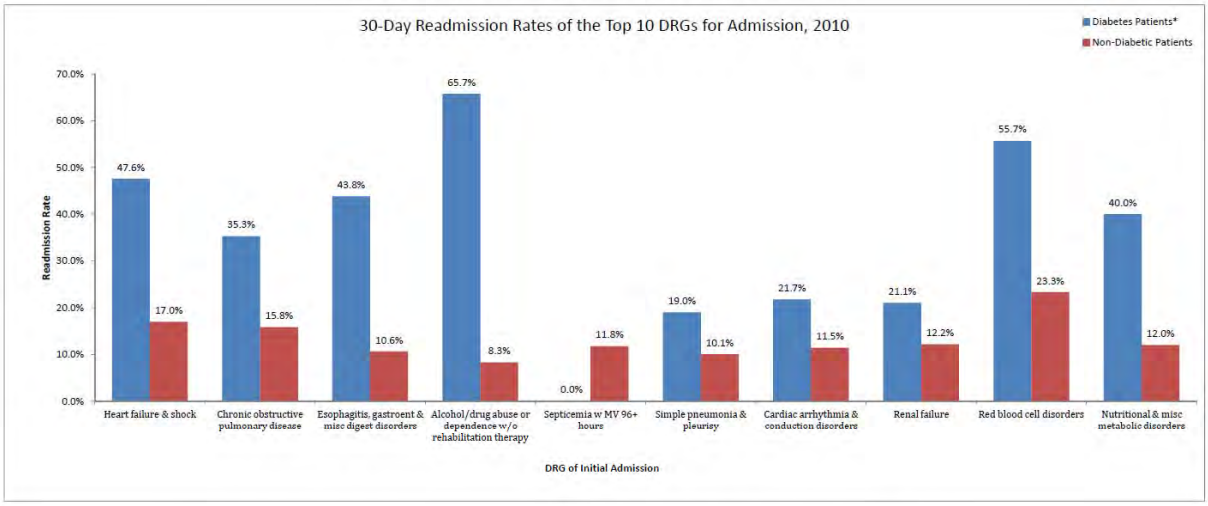
Medicare patients with heart failure readmission. Current preliminary figures show that there is significant improvement at Bellevue. Since readmissions rates are both a financial and clinical problem, it is an indicator in the Affiliation agreements so there is a bonus for reducing to a level that gets us into the black.

Data on the death rate for heart failure patients are for the same time period and same population of patients. The US National 30-day death rate for heart failure patients is 11.3%. Both Bellevue (10.5%) and Woodhull (9.8%) are no different than the US National average, while NYU at 6.9% is better than the National rate. While we have a higher readmission rate, based on mortality data we are no different from the National average. One can speculate as to why that is the case – is it that our care of these patients are fine but they have more social needs and are harder to discharge, or NYU patients are less sick than ours, or treat them better – but we don't know the answer to these speculations. What we do know is that in terms of mortality rate for heart failure our performance is consistent with the National rate.

Dr. Wilson then provided the Committee with the other HHC hospital's data on readmissions rates as follows: Jacobi at 28.1%, Metropolitan at 27.9% - both no different than National rate; Lincoln at 30.3%, Coney Island at 31.0%, Elmhurst at 29.5% and Kings County at 30.8% - all slightly worse than the National rate. The last slide in Dr. Wilson's presentation illustrates the causes of readmissions using Harlem's data as an example, for all payers, all causes and unadjusted. The blue bars on the graph are for diabetic patients and the red bar's non-diabetic patients. For heart rate failure the diabetic population has two and one half times the readmission rate than the non-diabetic population. For chronic obstructive pulmonary disease (COPD) the diabetic population's readmission rate is double that of the non-diabetic population. The table below provides the rates for other top diagnoses. Dr. Wilson notes that this level of granular data illustrates that we need to evaluate the diabetic population and see what we might have to do differently or separately.

Harlem Hospital Center

30-Day Any Hospital, All Payer, All Cause, Unadjusted Readmissions



State Rank based on Volume of Initial Admissions	DRG Name	Diabetes Patients* Hospital Readmission Rate	Diabetes Patients* NYS Readmission Rate	Non-Diabetic Patients Hospital Readmission Rate	Non-Diabetic Patients NYS Readmission Rate
1	Heart failure & shock	47.6%	25.2%	17.0%	17.5%
2	Chronic obstructive pulmonary disease	35.3%	26.0%	15.8%	15.5%
3	Esophagitis, gastroent & misc digest disorders	43.8%	14.3%	10.6%	9.2%
4	Alcohol/drug abuse or dependence w/o rehabilitation therapy	65.7%	21.0%	8.3%	14.3%
5	Septicemia w MV 96+ hours	0.0%	18.8%	11.8%	14.0%
6	Simple pneumonia & pleurisy	19.0%	16.0%	10.1%	10.5%
7	Cardiac arrhythmia & conduction disorders	21.7%	15.5%	11.5%	10.9%
8	Renal failure	21.1%	22.5%	12.2%	15.4%
9	Red blood cell disorders	55.7%	30.2%	23.3%	17.2%
10	Nutritional & misc metabolic disorders	40.0%	16.6%	12.0%	11.8%
	Overall Readmission Rate	**27.0%**	**25.5%**	**9.9%**	**10.5%**

Source: December 1, 2009 - December 31, 2010 SPARCS Data (excludes obstetrics, neonatal, rehabilitation and transfers)
*Includes all diabetic patients (patients with a primary or secondary diagnosis of diabetes melitus (ICD-9 250.X or 648.0))

Mr. Aviles inquired as to how transparent is CMS about the algorithm they use for risk adjustment. Dr. Wilson responded that no, CMS doesn't share their algorithm, only the information on the principles they have taken into account and the statistical reference of the external agency that is doing this for them to give us the confidence that it is a credible process. We cannot replicate the data so I cannot tell you how is diabetes weighted, but I can tell you that homelessness is not weighted, nor ethnicity. Dr. Wilson believes that the algorithm that CMS uses is not particularly sensitive to the population we serve, but generalizations that have to pertain to the whole country.

ED Dash Board

Presenting to the Committee was Dr. Ross Wilson, Senior Vice President, Corporate Chief Medical Officer.

The Clinical Information Systems division led the design, build and implementation of documentation screens and whiteboard functionality in the Emergency Departments (EDs) of ten acute care hospitals across HHC as part of pre-ICIS work and to help resolve disparate use of data in the EDs. The Clinical Information
Systems team engaged numerous stakeholders within central office and within each acute care hospital across HHC in 2011 to complete the ICIS: ED project.

The project transformed hospitals that relied on a patient flow driven by paper charts to one where patients can be electronically tracked via real-time updates triggered by electronic clinical documentation. There are currently three ED Dashboards that are live in 10 acute care hospitals and one dashboard that is not yet live with all users. The Dashboard includes the following components.

- Volume and Throughput Metrics Dashboard: displays monthly volume & throughput performance
- Operational Dashboard: displays overall status of the ED in near-real time
- ED Trends Dashboard: displays historical trending information on the volume and throughput metrics
- Corporate Overview Dashboard: displays a snapshot of all HHC hospitals specific to wait times

The benefits of the Dashboard include:

- Value to Patients: Patients can be tracked electronically via real-time updates to electronic clinical documentation to ensure the appropriate level of care is provided at the appropriate time.
- Value to Clinicians: Clinicians can assess the patient care demands placed on care teams in near-real time and assign new patients to the most available team.

Value to Administration: Hospital administrators are able to use concrete data to identify bottlenecks in patient flow and base decisions such as modifying staffing levels to reduce long wait-times.

Medical & Professional Affairs/Information Technology Committee
June 14, 2012 – As reported by Dr. Michael Stocker

Chief Medical Officer Report:

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer reported on the following initiatives:

Annual Behavioral Health Planning Event

On Thursday June 7, 2012 The Office of Behavioral Health held its Annual Planning Event entitled *Innovate and Collaborate: Planning for Managed Behavioral Healthcare.* During the program three Facility performance awards were given to Harlem Hospital Center for their improvement in HHC Behavioral Health (BH) key indicators, North Central Bronx Hospital for their performing the highest in a set of psychiatric inpatient core measures and Queens Hospital Center for best in overall performance with the BH key indicators. The event had over 185 participants including executive, administrative, and clinical staff and leaders. President Aviles set the stage for the need to plan for the changing healthcare environment which will include enrolling those with mental and substance use conditions into managed care. The range of speakers began from a macro level with drilling down into the provider and consumer changes in the care delivery system needed. The afternoon included an interactive discussion using the audience participation system so that all participants voices could be heard in designing our strategy in addressing managed care readiness. Written proceedings are available and all the presentations are on the Office of Behavioral Health website through the Intranet.

Radiology

Following discussions at the Quality Assurance Committee of the Board, the Chiefs of Radiology have been working together with Central Office staff to implement a policy to provide attending level, final read (interpretation) of CT scans for all patients within 30 min, 24 hours per day, 7 days per week. In addition, the attending that reads the study must be available for consultation with the treating physician should further discussion of the study be necessary. This will spread to include non-routine CXR and MRI. Coverage on nights, weekends and holidays may be provided by the active members of the department currently on the medical staff or through the contracted services of an outside vendor, or re-rostering of current Affiliate staff. Currently 8 hospitals have available real time, final reads and the remaining expect to have real time interpretations in the next two to three months.

Clinical Council Chairs

On Monday, June 4th the Chairmen and Chairwomen of the clinical councils met to review the strategic directions of HHC and discuss how their councils could contribute. Mr. Aviles opened the meeting with a summary of current challenges and opportunities. The response was a very positive one, with agreement to help lead the quality and cost improvements of the triple aim.

NYS Department of Health (NYSDOH) Award

The Patient Safety Center of the NYSDOH awarded to HHC a grant covering the services of the internationally recognized experts in medication safety – The Institute for Safe Medication Practices (ISMP). That award will cover a conference to take place July 10th at Metropolitan hospital and will be attended by Directors of Pharmacy, Medical Directors and Chief Nursing Officers, Directors of Quality and Risk Managers. The speakers from ISMP will share their experience and expertise based on their national database of events with attendees, focusing on some of the most common medications associated with errors and adverse outcomes such as anticoagulants and narcotic analgesics. In addition, they will return on 3 additional days to each HHC Network for an on-site discussion of issues of greatest interest to the attendees. One area of particular focus of the ISMP faculty will be to review and comment on the Root Cause Analysis process for medication errors at each network.

NYS Hospital-Medical Home (H-MH) Demonstration Program Award

HHC will be submitting an enterprise-wide application for the New York State Department of Health Hospital-Medical Home (H-MH) Demonstration Program. The H-MH Demonstration Program will make up to $250 million available over the next three years to NYS teaching hospitals to support transition of their outpatient training sites to Patient-Centered Medical Home (PCMH). An initial July 2, 2012 application submission is followed by award notifications in August 2012. Successful applicants will then be required to submit a work-plan describing selected residency training enhancements, care integration initiatives, inpatient safety projects and performance measures. If successful, HHC is estimated to receive approximately $28 million of the $102 million to be disbursed in the first year of the demonstration, based on a formula derived from Medicaid volume and number of primary care residents receiving training at our facilities. Continued funding will be dependent upon meeting certain milestones, including achieving Level 2 or 3 NCQA PCMH re-certification by December 2013.

MetroPlus Health Plan, Inc.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee.
Dr. Saperstein informed the Committee that the total plan enrollment as of May 25, 2012 was 433,003. Breakdown of plan enrollment by line of business is as follows:

Medicaid	364,979
Child Health Plus	16,704
Family Health Plus	36,792
MetroPlus Gold	3,096
Partnership in Care (HIV/SNP)	5,778
Medicare	5,654

Dr. Saperstein informed the Committee that 5,788 members were added to the plan this month. This gain represents MetroPlus' largest addition of members for a one month period in 2012. Their largest growth was in Medicaid.

Dr. Saperstein also provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.
This month, MetroPlus added 224 new enrollees in Medicare, with the largest growth in our Advantage (Dual- Eligible) product.

The New York State Department of Health (SDOH) released utilization data for the Managed Care Pharmacy Carve-In that became effective on October 1, 2011. The data, a comparison of the three months before the carve-in and the most current three months post implementation, reveal that statewide, utilization is up and costs are down. MetroPlus' cost in the three months prior to the implementation was $76.80 per member per month (PMPM). MetroPlus' costs for the first three months of 2012 were $59.75 PMPM. Due to these declines in cost, seen also by other plans, the state's actuary, Mercer, has recommended significant decreases to the Pharmacy capitation. Essentially, the MRT cost savings has been realized for this benefit.

The SDOH has provided a draft of the Phase 1 pharmacy rate change analysis. The total rate change for Medicaid in NYC was -7.1%. The total rate change for FHP in NYC was -11.5%. The release of this data solidifies our initial analysis which found that MetroPlus will receive approximately 3 million dollars less in pharmacy revenue per month, retroactive to April 1st, 2012.

The 2013 Medicare bids were due to CMS on June 4, 2012. Cost savings allowed us to add benefits in our Medicare Advantage (Dual), Select (Dual) and Platinum (Straight Medicare) lines of business. We were able to reduce co-payments and deductibles and include some value added benefits such as an over-the-counter non-prescription benefit card and a gym membership at NYC Parks & Recreation sites.

Unfortunately, MetroPlus' historical utilization especially in pharmaceuticals was very high in our Medicare HIV/PIC Special Needs Plan (SNP). In addition, CMS reduced their risk intensity and their rates were dramatically reduced. Changes to the HIV SNP product were made to account for this reduction and include an increase in co-payments and reduction in some benefits. These changes affect the 300 members in their HIV/PIC SNP and may make this product more difficult to market and add membership in 2013.

As Dr. Saperstein reported earlier this year, as of July 2, 2012, all Medicaid managed care plans will be required to cover dental services for their enrollees. The MetroPlus dental implementation is going well. MetroPlus has contracted with Healthplex to administer dental benefits for all their MetroPlus Medicaid and Medicaid SNP members. Also as of July 2, 2012, MetroPlus Family Health Plus, Child Health Plus, and Medicare Advantage members will have management of their dental benefits transition from DentaQuest to Healthplex.

Also part of Dr. Saperstein's report earlier this year, mandatory enrollment for Managed Long Term Care begins on July 2, 2012. The MetroPlus application is complete and they are eagerly awaiting the SDOH's response. MetroPlus has learned that the SDOH is moving slowly in awarding these new licenses but they are prepared to offer services as soon as their license is effective.

MetroPlus is also in the process of meeting with all network and facility leadership in regards to their strategic initiatives to grow the Medicare product. Dr. Saperstein will continue to keep the Committee updated on their progress.

Action Itmes:

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC") for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A to provide the parties adequate time to conclude negotiations for a new agreement;
AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

The resolution was moved for the full Board of Directors consideration.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an extension to the Affiliation Agreements with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH") for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012 with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement;
AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

The resolution was moved for the full Board of Directors consideration.

Information Item:

Presenting to the Committee was Michael Keil, Director, IT Service Management Office and Glenn Manjorin, IT Disaster Recovery/Business Continuity. They informed the Committee that the foundation for a Business Continuity program is comprised of several components as outlined below:

- Establishing a Disaster Recovery (DR) testing methodology to apply repeatable procedures throughout all IT infrastructure.
- Identifying and preparing for the threats and vulnerabilities at our facilities. Availability Risk Analysis (ARA).
- Understanding the Operationally Critical Business processes and the IT resources required. Business Impact Analysis (BIA).

- Establishing a DR recovery prioritization chart with Recovery Time Objectives (RTO) & Recovery Point Objectives (RPO).
- Conducting periodic tests to ensure the quality of the program meets the needs of the organization.

Availability Risk Assessment (ARA) reviews were completed HHC's 11 acute care facilities and its two data centers in October 2011. ARAs are an on-site physical review of each facility with a focus of determining potential points of failure, identifying external threats due to forces of nature, mankind, etc, and identifying local Infrastructure threats, highways, rail etc. Results of the ARAs identified 248 risks at the 11 hospitals and two data centers: seven (7) risks required capital investment - work is in progress to quantify the costs and prioritization of projects will follow; of the 241 remaining risks, 56% are \completed to date (134), 36% are to be completed by the end of calendar year 2012 (87), and 8% are to be completed by the end of calendar year 2013 (20). All mitigation plans in place have been identified.

A business impact analysis (BIA) was conducted of HHC's various business process flow (s). The BIA utilized industry standards and SunGard comparative value model in which we identified and surveyed SMEs from each process. A sampling approach representative and diverse to represent HHC process environment was used with a 41% participation rate. The survey was developed and reviewed within a workshop approach jointly by HHC and SunGard. The "return to operations" (RTO) was determined by several factors including financial impact and current mitigation factors resulting in a minimized exposure. The goals of the BIA process shows impacts over time on HHC clinical and administrative processes, process recovery priorities, and technology recovery needs. They provided the Committee with a slide that demonstrated the businesses processes and the related hospital functions that were analyzed.

The distribution of time-critical applications shows 30.5% of the applications with an under 24 hour RTO; Original preliminary findings stated 44% which was higher than the norm. These final findings are more in line with industry standards. Tier One applications that need to RTO in less than four hours include: Bed Tracking – Teletrac; Whiteboard; Allscripts Sunrise Record Manager (SRM); HMED; QCPR; Cisco Call Manager / Telephone Systems; Ensemble; Openlink; Unity Patient Management & Scheduling; and Webterm. The Tier Two applications that need to RTO between four hours and 24 hours include examples such as: ACU Manager; Picis (Ingenix); Canopy; 3M Health Data Management (HDM); MedRec Resources Dictation System; TalkStation (TalkTech); Voice Recognition; Groupwise Email; Quest Interface; PACS – AGFA IMPAX; PACS – SECTRA; and OPUS ISM Pharmacy Management System.

The findings of the BIA were: seventeen key business processes were identified for sampling; received a survey response rate of 41%; over 100 Interviews held with multiple individuals/groups; 49 hospital departments were represented; 131 systems/applications clearly identified for RTO/RPO; and 80 applications were discovered that were not in the EITS management purview.

Next steps for the Business Continuity Program's Disaster Recovery (DR) Program includes: solicitation has been awarded to AVALUTION for the Enterprise Wide IT/BCP Program which is a consulting firm that will analyze data from the ARA and BIA projects; present to ARA prioritized plan to the HHC Capital Committee; Business Impact Analysis (BIA) - complete the recovery prioritization chart and validate recovery time & recovery point objectives through testing and make changes; continued testing on QuadraMed expanding to more interfaces, multiple domains, etc.; and continued DR planning with iCIS planning team for new EMR.

SUBSIDIARY BOARD REPORT

HHC Capital Corporation – May 24, 2012
As reported by Dr. Michael Stocker

Summary of HHC Bond Issuances, Low Interest Rate Environment and HHC's Variable Rate vs. Fixed Rate Bond Allocation

Ms. Linda DeHart, Assistant Vice President of the Debt Finance and Corporate Reimbursement indicated that the current par amount of bonds outstanding as of April 30, 2012 is $1.002 billion, the majority of which are fixed rate bonds. 17% of HHC's outstanding bonds are variable rate with a weekly re-set. HHC's Bond Counsel and Financial Advisor recommend that no more than 20% of HHC's portfolio be variable rate. This has benefitted the Corporation as rates on the variable rate bonds have been at historic lows.

2010 HHC Health System Bond Construction Fund and Disbursement History

Paulene Lok reported that of the approximate $200 million construction fund for the 2010 series bonds, $143.5 million remains unspent as of May 1, 2012. Disbursements are at a slower pace when compared to previous bond issuances. Ms. Youssouf asked if the Board can see a list of projects and equipment which are to be funded with the bonds and a spending schedule. Mr. Pistone indicated that his office would provide these items.

Financing Source of HHC's Capital Program and Average Debt Service

Nini Mar presented a slide which showed that only 32% of HHC's capital program is financed with health systems bonds issued by the Corporation. Of the total par outstanding of $3.2 billion, $2.2 billion represents bonds issued by the City of New York and the NYS Dormitory Authority. The average annual debt service, which includes principal and interest, is $250 million.

New Business

Ms. Zurack indicated that a new Operating Procedure ("OP") concerning the Corporation's Banking activities will be distributed to the Board for its review and welcomes any suggestions. One of the advantages of the new OP will allow the HHC Capital Corporation more flexibility to finance its capital program on a "just-in-time" basis rather than issuing bonds several years in advance of spend down; which incurs negative arbitrage, whereby bond interest expenses exceeds interest earnings on construction funds.

Ms. Zurack also informed the Board of the fact that Finance has been meeting with its senior underwriting banking firms to discuss bond refunding opportunities given the current low interest rate environment. Preliminary analysis show potential present value savings of up to $17 million. The optimal time for the re-financing activity to occur is in late December to early January given that the HHC bonds targeted for refunding have a call date of February 15th. Based on recent discussions with Mr. Bert Robles, Senior Vice President & CIO and Dr. Lou Capponi, Chief Medical Informatics Officer, HHC is likely to issue new money bonds to fund the preliminary cost of acquiring a new medical records system concurrent with the re-financing.

***** *End of Reports* *****

ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
JUNE 28, 2012

SUPREME COURT DECISION ON THE CONSTITUTIONALITY OF THE ACA

This morning, the Supreme Court of the United States issued its long anticipated decision about the constitutionality of the Affordable Care Act (ACA). The Court -- by a 5 to 4 margin -- ruled that the ACA was constitutional. The liberal wing of the court -- Associate Justices Elena Kagan, Ruth Bader Ginsberg, Sonia Sotomayor and Stephen G. Breyer -- were joined by Chief Justice John G. Roberts, Jr. in upholding the law, including the individual mandate provision that virtually all Americans buy health insurance.

Importantly, the majority ruled that the provision was constitutional under the taxing power granted to Congress. They reasoned that the financial penalty for an individual not procuring health insurance was considered a tax. Notably, there were not enough votes -- only 4 -- to validate the individual mandate under the constitution's commerce clause, which has historically been the preferred vehicle for expanding federal power.

It should be noted that the court did narrow the reach of an ACA provision that required states to comply with new eligibility requirements for Medicaid or risk losing their Medicaid federal funding. The Court held that the provision is constitutional as long as states would only lose **new** Medicaid funds if they didn't comply with the new requirements, rather than lose the funding for their existing programs. To quote Chief Justice Roberts: "What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding."

It should be highlighted that Associate Justice Anthony M. Kennedy, who is often the swing vote on the Court, sided with the conservative wing of Associate Justices Antonin Scalia, Clarence Thomas and Samuel Anthony Alito, Jr. in voting to invalidate the entire ACA.

In New York State, an estimated 90,000 people -- childless adults with incomes between 100% and 133% of federal poverty level -- will be eligible for Medicaid as a result of the ACA mandated Medicaid expansion starting in 2014. In addition, an estimated 160,000 young adults in the state already have insurance as a result of the ACA requirement that Health plans allow parents to keep their children under age 26 without job-based coverage on their family coverage. An estimated total of 1.2 million New Yorkers will gain health insurance coverage as a result of the ACA, when fully implemented.

HHC MEETS GAP-CLOSING TARGET FOR FISCAL YEAR 2012

In Fiscal Year 2012, HHC's Restructuring and Cost Containment initiatives achieved a total annual savings of over $480 million from our baseline, which exceeded our target for the current fiscal year. In fact, these programs have netted HHC over one billion dollars in

savings over the last three years. In Fiscal Year 2013, we are projecting another $294 million in gap-closing activities through a combination of Restructuring, Cost Containment and State and Federal Actions. Although achieving this coming fiscal year's gap-closing targets will be extremely challenging, our senior leadership team is committed to keeping HHC's financial plan on course.

HHC HOSPITALS MEET STAGE 1 CRITERIA FOR 90 DAY PERIOD TO QUALIFY FOR ENHANCED FEDERAL FUNDING

At this time HHC has hit a major milestone in our ongoing use of Health Information Technology to improve patient care and outcomes. All HHC hospitals have now successfully completed the attestation process for Meaningful Use of Electronic Health Records by meeting the Stage 1 criteria for 90 consecutive days. As a result, HHC has already begun to receive enhanced federal funding and will eventually receive approximately $120 million in incentive monies under the hospital program and another $70 million under the Eligible Provider Category.

When the meaningful use regulations were released, HHC facilities were already positioning themselves to meet the mandates of the Centers for Medicare and Medicaid Services Meaningful Use program. However, there were many additional steps to be completed, including 24 major software upgrades and significant changes in clinical documentation and workflow. Successful achievement of Stage 1 is a significant milestone. It represents the outstanding collaboration between our clinical staffs, Finance, and Enterprise Information Technology Services who have worked together to make this a reality. HHC's success in achieving meaningful use further emphasizes the importance of a close working relationship between information technology and the business units of our healthcare organization.

The designation of Meaningful Use reflects HHC's continued commitment to enhance patient safety and the quality of care. HHC will maintain meaningful use measures under Stage 1 for the next 18 months and is actively looking ahead to meet the Stage 2 requirements in the latter part of 2013.

$8.8 MILLION STATE HEAL GRANTS WILL SUPPORT EXPANSION OF AMBULATORY CARE SERVICES FOR THREE HHC FACILITIES

On June 15th, Governor Andrew M. Cuomo announced that HHC will receive $8.8 million in healthcare grants from New York State to expand ambulatory care services in dentistry, geriatrics, psychiatry and ophthalmology at three hospitals. The grants will fund projects to renovate and expand dental and oral surgery clinics at Harlem Hospital in Manhattan; geriatric and psychiatric clinics at Lincoln Hospital in the Bronx; and ophthalmology and dental practices at Woodhull Hospital in Brooklyn, including the addition of a pediatric dentistry service.

The funding is part of $301.1 million in grants made available through New York State's Health Care Efficiency and Affordability Law (HEAL NY). The HEAL NY grants will help 40

hospitals and nursing homes across the state improve primary and community-based care, eliminate excess bed capacity, and reduce over-reliance on inpatient care in hospitals and nursing homes.

HHC COLLABORATES WITH ORASURE TO OPEN TRADING AT NASDAQ IN RECOGNITION OF NATIONAL AIDS TESTING DAY

As part of National HIV Testing Day on yesterday morning, June 27, HHC Senior Vice President LaRay Brown joined Douglas A. Michels, President and CEO of OraSure, maker of the rapid HIV test used most often in our facilities, and Frank J. Oldham Jr., President and CEO of the National Association of People with AIDS at the opening bell of the NASDAQ Marketsite in Times Square.

According to the Centers for Disease Control and Prevention, those who do not know they are HIV positive are unknowingly responsible for up to 70 percent of the 50,000 new HIV infections that occur each year. HIV Testing Day is a national campaign to encourage testing for HIV and promote the benefits of knowing one's HIV status.

HHC has tested more than 1.12 million New Yorkers for HIV since 2005, the year the public hospitals and health centers began offering HIV screening as a routine part of medical care for patients ages 13 to 64. In seven years, HHC has diagnosed 11,490 HIV positive individuals. Ninety percent of those who test positive are linked to care within 90 days, improving their health and the health of the community.

LEADER DEVELOPMENT PROGRAM LAUNCHED TO SUPPORT AND ENHANCE HHC'S INVALUABLE WORKFORCE

On June 13th, the kick-off to the 2012 Corporate-Wide Leader Development Program was held at Metropolitan Hospital in Draper Hall. Over 160 senior HHC leaders participated in the half-day workshop where the Program was introduced. The Leader Development Program is a primary component of our multi-year Workforce Development Strategic Plan. The Program will bring 125 high-potential middle managers through five full-day learning intensives conducted by the Advisory Board Company. Thirty-six senior managers have been trained to coach the program participants between workshops and will also attend the five intensives. Managers were nominated for the program by their facility senior executives.

As you know, this year, under the leadership of Senior Vice President Caroline Jacobs, we have begun to implement a comprehensive workforce development plan to better support our employees who want to acquire more skills relevant to a fast-changing healthcare environment and to help build leadership skills at every level of our organization. Through this and other programs, we will foster and support continuous learning, reward innovation and promote and sustain a culture of teamwork, mutual respect, and accountability.

The leader development learning intensives begin on July 10 and end in March 2013. Each intensive will focus on a different aspect of leadership. Topics include: Management Intensive, Instilling Accountability, Facilitating Effective Teamwork, Problem Solving and Critical Thinking, and Impact Through Influence. Workshops on Breakthrough, HHC's performance improvement system, and Budget/Finance for Managers will also be required. The coaches will help the participants apply the principles they've learned between sessions. A second cohort of 125 managers will be enrolled into the program in spring 2013.

CIR/SEIU AND 1199 SEIU COLLABORATES WITH HHC IN MEDICATION SAFETY GRAND ROUNDS

On June 5th, the HHC Labor-Management Patient Safety Committee comprised of HHC, CIR/SEIU, and 1199 SEIU, held the first of six Medication Safety Multi-Disciplinary Grand Rounds at Jacobi Medical Center. The Grand Rounds *Improving Medication Safety Through Effective Teamwork and Communication* was supported by a Federal Mediation and Conciliation Service (FMCS) grant. Presenters included Mei Kong, RN, AVP for Patient and Employee Safety; Dr. Abdul Mondul, Associate Medical Director and Patient Safety Officer, Lincoln Hospital; Dr. Nelly Pakh, member of 1199; and Dr. Marian Irizarry, second year pharmacy Resident and member of CIR/SEIU.

Program objectives included: understanding the impact of medication errors, particularly those involving opioids for the effective management of pain; learning tools for empowering all members of the team to become actively involved in preventing medication errors; identifying ways to engage patients and families in medication management and safety; and integrating teamwork concepts, knowledge, skills and attitudes, as taught in the TeamSTEPPS program, to improve patient safety.

Over 120 participants, including attending physicians, residents, nurses, pharmacists, nurse practitioners, and administrators attended the session. Every participant received and learned how to use, our new Pain Management Guide.

The Grand Rounds will be replicated at Bellevue, Coney Island, Harlem, Lincoln, and Metropolitan hospitals over the next three months.

ANNUAL HHC BEHAVIORAL HEALTH CONFERENCE HELD

On Thursday June 7th, the Office of Behavioral Health held its annual event entitled *Innovate and Collaborate: Planning for Managed Behavioral Healthcare*. During the program Facility Performance awards were given to Harlem Hospital for improvement in HHC Behavioral Health Key Indicators, North Central Bronx Hospital for performing the highest in a set of Psychiatric Inpatient Core Measures and Queens Hospital Center for best in overall performance with the Key Indicators. The event had over 185 participants including executive, administrative, and clinical staff and leaders.

Our speakers, including Harvard Professor David Cutler -- a healthcare advisor to Presidents Clinton and Obama -- addressed the need to plan for the changing healthcare environment which will include enrolling those with mental and substance use conditions into a patient-centered comprehensive managed care model of service delivery. The afternoon discussion about addressing managed care readiness included audience participation, allowing many voices to be heard as we design our strategy. All the presentations are available to HHC staff on the Office of Behavioral Health website through the Intranet.

PATIENT-CENTERED MEDICAL HOME LEARNING SESSION

On May 30, the Office of Ambulatory Care Transformation sponsored *HHC's PCMH Implementation Journey Year 1 – A Learning Session* at Jacobi's Conference Center. More than 175 participants across the Corporation who are actively involved in enhancing primary care services and transforming facility practices into medical homes attended the session.

I welcomed the audience and outlined HHC's strategic goals, including the redesign of ambulatory care with the implementation of Patient Centered Medical Homes and Health Home Programs as building blocks towards establishing and achieving designation for an HHC Accountable Care Organization.

Dr. Ross Wilson, Senior Vice President for Quality, gave the key note address, anchoring the platform for ambulatory care transformation to the triple aim: better care for our patients, better health outcomes for our communities, and both at lower costs. A comprehensive plan for communicating the PCMH initiative at HHC was launched at the session by Joe Schick, Executive Director of the Office of Special Projects, who introduced a short video reflecting some of the innovative strategies being developed to engage our workforce and spread the excitement about the PCMH program's benefits for our patients.

The session also featured HHC best practices. Dr. Debra Brennessel, Ambulatory Care Director, presented Queens Hospital Center's approach to collaborative care plan development and Theresa Watson, Assistant Director Ambulatory Care, presented Harlem Hospital's approach to performance improvement at the PCMH team level. Workshops and table top exercises followed to spread some of the best practices shared through these presentations. The session was capped off by an overview of HHC's application development strategy for meeting the new and more stringent NCQA standards in order to sustain HHC's PCMH Level 3 certification going forward.

HHC HEALTH HOME PROGRAM PLANNING SOFT-LAUNCH

HHC's Health Home program will commence with a soft launch in Brooklyn and Bronx in mid-July. HHC has selected a group of 200 patients with complex healthcare needs to whom we will reach out, with the goal of enrolling as many as possible within a month. These patients were selected for a variety of characteristics, including existing connections

to HHC physicians or departments, risk scores, and managed care affiliations. The goals of the launch are to:

- Test the Health Home care pathways that have been developed across the sites
- Test the forms and paperwork processes that have been designed for the program
- Gain insight into the requirements of patients with various risk scores
- Set baseline goals for outreach and enrollment targets
- Analyze and refine processes based on front-line staff and managerial feedback

Outreach and engagement will initially be conducted by staff at Woodhull, Kings County and Lincoln, who are currently working on COBRA programs as community follow-up workers. These staff members will receive training at the beginning of July to orient them to the new forms and outreach processes. MetroPlus will begin the outreach by mailing out initial welcome letters to the 200 patients. A toll-free line, operated by MetroPlus, has been set up to be used by Health Home patients 24/7, to reach a care coordinator at all times. This line will allow staff to potentially divert unnecessary hospitalizations and ED visits, and redirect patients to more appropriate forms of care.

The Manhattan/Queens Health Homes are scheduled to have a soft launch beginning in August, which will follow a similar timeline. Existing COBRA, CIDP and TCM patients are expected to transition to the Health Home beginning in mid-September, with all patients being converted by December. Contracts have not yet been signed with our prospective community-based organizations partners, so all patients who are engaged and enrolled during the soft launch will receive their care coordination services at an HHC Health Home, starting with those sites where COBRA and CIDP staff are already based.

NOTICE OF INTENT FILED TO SEEK ACCOUNTABLE CARE ORGANIZATION CERTIFICATION FOR HHC

HHC has submitted a letter of intent to CMS to participate in the Medicare Shared Savings Plan for accountable care. The final application is due by the end of August, with a proposed start date of January 1, 2013, if successful. The first meeting of the Board of Directors of HHC ACO Inc, a newly formed subsidiary of HHC, occurred on June 26 at which time the Board passed a series of resolutions to facilitate the implementation of our ACO, including proceeding with the application to CMS.

RHIO POISED TO ENTER NEW AGREEMENT WITH NYeC

Several NYS regional health information organizations (RHIOs), including the Interboro RHIO of which HHC is a member, are collaborating with the New York eHealth Collaborative (NYeC) and New York State Department of Health on the development and implementation of statewide health information exchange (HIE) services. To facilitate this development, NYeC has provided the opportunity for RHIOs to transfer their existing HIE software infrastructure to NYeC which will absorb the cost of further standardized development of the software applications.

The standardization and consolidation of the technical infrastructure for the existing downstate RHIOs offers an opportunity to eliminate redundant technology and reduce the total cost of supporting a common HIE infrastructure. The health information exchange goals of the Interboro RHIO and NYeC are well aligned with HHC's goals of building robust care management/care coordination capabilities across care settings both within the HHC network and with external partners. Currently, the Interboro RHIO and NYeC are in the final stages of completing a Transition Services Agreement, which will initiate the first phase of Interboro's shift to the shared technology model. Both parties expect the agreement to be signed shortly.

FEDERAL PRESCRIPTION DRUG USER FEE ACT

On Tuesday, the Senate passed bipartisan legislation that would extend for five years authority for the Food and Drug Administration (FDA) to assess user fees on prescription drugs and medical devices. Last week, the House passed the bill by a voice vote. President Obama is expected to sign the bill. Importantly for HHC and the nation's hospitals, the package includes provisions aimed at mitigating prescription drug shortages. The bill will require drug manufacturers to provide FDA with early notification of discontinuations or other situations that could lead to potential shortages, and will expedite FDA approval of manufacturing changes that would help prevent or mitigate shortages.

It also includes improved public record keeping of drug shortage lists and requires the FDA to issue updated guidance on repackaging, which could modify current practices to allow hospital systems to share shortage drugs among facilities.

The pharmaceutical industry backed the legislation which includes accelerated approval provisions. The bill also includes a provision to extend market exclusivity on some new antibiotics by an extra five years. Manufacturers had sought preferred status for antibiotics to help spur new research and development efforts.

ACTION NOT TAKEN BY NY STATE LEGISLATURE ON INDIGENT CARE FUNDING REFORM

The State Legislature concluded their session last week without taking action to change how New York State distributes Indigent Care funds to hospitals. In order to conform with Federal changes made in the Affordable Care Act, New York must remove bad debt from the equation and direct more of these funds to high Medicaid hospitals when calculating a hospital's indigent care funding, or the State risks larger than estimated cuts to Disproportionate Share Hospital funding. Draft legislation was shared with the Legislature in the waning days of the session but it was deemed that there was not adequate time to review the proposal before the scheduled close of session. We estimate that HHC could lose approximately $2.3 billion between FFY 2104 and FFY 2021 due to reductions in DSH funding. These cuts could be substantially larger if New York State does not act to change the formula before the cuts are scheduled to begin in October 2013.

NURSE MIDWIFE AT GOUVERNEUR PLAYS LEADING ROLE IN UN MISSION TO IMPROVE MATERNITY CARE IN CHINA

Dewan Duan, a Certified Midwife at Gouverneur Healthcare, is now in China as part of a United Nations program to reduce maternal death and disability rates through increased use of certified midwives. Ms. Duan has devoted her career to improving the maternal health of low-income women in China and those who are recent immigrants seen at Gouverneur in Lower Manhattan.

Dewan Duan, a Certified Midwife with a Master of Public Health degree from Columbia University, also earned her medical degree and Ph.D. in China and has been working with the United Nations Fund for Population Activities (UNFPA) H4+ program to improve maternal health in countries with high maternal mortality.

The UNFPA China and Chinese Maternal and Child Health Association have launched a pilot program in Hunan province that incorporates the formal inclusion of a midwifery curriculum and certification in medical education systems that Ms. Duan recommended. At the same time, the program will promote natural delivery in selected hospitals by working with health providers and clients. Ms. Duan is helping to develop a midwifery education curriculum for China to strengthen China's capacity to train skilled healthcare professionals.

TWENTY HHC DOCTORS RECOGNIZED IN NEW YORK MAGAZINE'S BEST DOCTORS ISSUE

The Best Doctors 2012 edition of New York Magazine this month includes twenty doctors from HHC Hospitals including Bellevue, Elmhurst, Harlem, Jacobi, Kings County and Queens Hospital. These outstanding physicians practice everything from cardiac and pediatric surgery to child and adolescent psychiatry. It's really terrific to have some of our physicians receive this kind of recognition. We also recognize that they are just a small sample of the many, many more talented and outstanding physicians at HHC who are leading change, and working to provide quality and compassionate care to our patients every day. I know the Board joins me in congratulating all those recognized on this list.

Dr. Mark Adelman, Vascular Surgery, Bellevue Hospital Center
Dr. Michael Attubato, Interventional Cardiology, Bellevue Hospital Center
Dr. John Coppola, Cardiovascular Disease, Bellevue Hospital Center
Dr. I. Marc Galanter, Addiction Psychiatry, Bellevue Hospital Center
Dr. Howard Ginburg, Pediatric Surgery, Bellevue Hospital Center
Dr. John Golfinos, Neurological Surgery, Bellevue Hospital Center
Dr. Karen Hendricks-Munoz, Neonatal-Perinatal Medicine, Bellevue Hospital Center
Dr. Alec Megibow, Diagnostic Radiology, Bellevue Hospital Center
Dr. H. Leon Pachter, Surgery, Bellevue Hospital Center
Dr. J. Thomas Roland, Otolaryngology, Bellevue Hospital Center
Dr. Joseph Sanger, Nuclear Medicine, Bellevue Hospital Center

Dr. David Zagzag, Pathology, Bellevue Hospital Center
Dr. Susan Zweig, Endocrinology, Diabetes & Metabolism, Bellevue Hospital Center
Dr. A. Reese Abright, Child and Adolescent Psychiatry, Elmhurst Hospital Center
Dr. Farzan Filsoufi, Thoracic & Cardiac Surgery, Elmhurst Hospital Center
Dr. Ian Holzman, Neonatal-Perinatal Medicine, Elmhurst Hospital Center
Dr. Ilene Fennoy, Pediatric Endocrinology, Harlem Hospital Center
Dr. Norman Ilowite, Pediatric Rheumatology, Jacobi Medical Center
Dr. Scott Miller, Pediatric Hematology-Oncology, Kings County Hospital Center
Dr. M. Margaret Kemeny, Surgery, Queens Hospital Center

RESOLUTION TO NAME NEW HHC FACILITY AFTER HENRY "HANK" CARTER

On today's agenda, you will hear a resolution, which I will ask Lynda Curtis to read as Senior Vice President of the South Manhattan network, regarding the naming of the HHC facility that will rise on the site of the former North General Hospital in Harlem in honor of HHC's good friend and longtime benefactor Hank Carter. Pending the board's approval, the new HHC facility will be named the Henry J. Carter Specialty Hospital and Nursing Facility.

The new facility, about which this board has often heard, will become home for many current residents of Goldwater Memorial Hospital, which itself is part of the city's economic development master plan and will be reconceived as a Cornell University-led high-tech research center.

Relocating Goldwater to the modernized new site in Harlem will bring several distinct benefits, but none will be more positive for residents than the ongoing involvement and support provided by Hank Carter, whose gifts and donations to Coler-Goldwater over the past 39 years have resulted in a computer lab, a rehabilitation gymnasium, assistive and mobility equipment, specially outfitted buses and thousands of state-of-the-art wheelchairs, all of which have provided our residents with greater independence, greater comfort, and the opportunity to learn and grow. The value of Hank's generosity exceeds $25 million, but for residents and staff the greater gifts are the constant and unwavering devotion of Mr. Carter and the opportunity afforded to live life more fully, and those, of course, are priceless.

HHC has no greater friend than Hank Carter and Wheelchair Charities, Inc., Hank's philanthropic organization, which will celebrate its 40th birthday next May. As we plan our move to the new facility, the Community Advisory Board, the Medical Board of Coler-Goldwater, and the facility's staff have all fully endorsed the naming. We could not honor a more fitting and a more beloved individual than Hank Carter, and I ask the Board to join me in recognizing his contributions through approval of this resolution.

HHC IN NEWS HIGHLIGHTS

Broadcast

C-sections and obese children, Dr. Denise Infante, Gouverneur, Telemundo Ch. 47-TV, 6/20/12

Heat related deaths, Dr. Fernando Jara, Lincoln Hospital, WCBS -TV, 6/21/12

Heatwave, Dr. Fernando Jara, Lincoln Hospital, Telemundo Ch.47-TV; Noticias Ch 41-TV, 6/20/12

Nurse Protest, Jacobi and Kings County, News 12 Brooklyn -TV, 6/21/12

Patient says thank you to EMS and Lincoln Hospital, Jose Polanco, RN, News 12 Bronx – TV, 6/13/12

Palliative Care Certification, Dr. Abdul Mondul, Lincoln Hospital, News 12 Bronx -TV, 5/30/12

Teaching Patients to Speak Up For Themselves, Mei Kong, HHC, Hospitals & Health Networks (Video), 5/30/12

Print and Online

Gouverneur midwife going to China as part of U.N. program

> From Chinatown to China, Dewan Duan, CNM, Gouverneur and Bellevue, Crain's Health Pulse, 6/11/12
>
> Gouverneur Health Associate Executive Director promoting OB/GYN service, Dewan Duan, CNM, Gouverneur and Bellevue, The Epoch Times, 6/8/12
>
> Gouverneur Health Associate Executive Director promoting OB/GYN service, Dewan Duan, CNM, Gouverneur and Bellevue, Sing Tao Daily, 6/8/12
>
> (Also covered in Sino Television, NTD Television, World Journal, China Press, Ming Pao Daily, and in a dozen Chinese media including Sina News and Sohu.)

Bronx woman thanks EMS workers, firefighters and nurses who gave her new lease on life, Lincoln Hospital, New York Daily News, 6/14/12

Lincoln Medical Center's Palliative Care team earns advanced certification honor, Dr. Abdul Mondul, Lincoln Hospital, New York Daily News, 5/31/12

Best Doctors 2012, New York Magazine, 6/11/12

HHC continues to improve diabetic patient health outcomes, Nurse.com, 6/4/12

Staff recognized for efforts in Haiti, Dr. Jean-Daniel Desrosiers, Queens Hospital Center, Queens Chronicle, 5/31/12

Harlem physical therapists open a clinic entirely for kids, David Simon, Chief, Rehabilitation Therapy, Harlem Hospital, New York Daily News, 6/7/12

Will you be cancer free?, Harlem Hospital, Harlem News Group, 5/24/12

Lincoln unit is certified, Lincoln Hospital, Bronx Times, June 7-13, 2012

N.J. hospitals adapting to larger patients, Antonio Martin, COO, HHC, The Record/NJ, 6/22/12

Med Mal Litigation in New York: Time to Change the Status Quo, HHC, New York Law Journal, HHC, 6/14/12

Docs have the Rx for slay raps, Dr. Sheldon Teperman, Jacobi, New York Post, 6/25/12

Fascinating pictures from America's oldest public hospital show how far treatment has come in just 60 years, Bellevue Hospital, The Daily Mail, London, 6/15/12

Growing Bolder with Age: Tips to Remain Active As You Get Older, Dr. Malay Das, Lincoln Hospital, The Bronx Free Press, 5/23/12

Lincoln's psych bed shortage syndrome, Lincoln Hospital, Crain's Health Pulse, 6/5/12

Bidders scramble for health IT contracts, HHC, Crain's Health Pulse, 6/12/12

WPA murals back where they belong, Sea View Hospital Rehabilitation Center and Home, Staten Island Advance, 6/20/12

RESOLUTION APPROVED, June 28, 2012

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an extension to the Affiliation Agreements with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH") for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012 with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreements with PAGNY at Lincoln, Morrisania, Belvis, JMC, NCB, Harlem, Renaissance, and CIH will expire on June 30, 2012; and

WHEREAS, prior to the expiration date, the Corporation recognizes the need to revise the current agreements to provide for improved contract management and service delivery; and

WHEREAS, the Corporation and PAGNY have met to discuss and to clarify principles of a new agreement; and

WHEREAS, it is necessary for the President to have the managerial flexibility to insure that the rights of the Corporation remain protected during the negotiation process; and

WHEREAS, a summary of the financial terms of the extension is set forth in Attachment A, and

WHEREAS, the respective Community Advisory Boards of Lincoln, Morrisania, Belvis, JMC, NCB, Harlem, Renaissance and CIH have been consulted and apprised of such proposed general terms and conditions; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that PAGNY continues to provide General Care and Behavioral Health Services at Lincoln, Morrisania, Belvis, JMC, NCB, Harlem, Renaissance and CIH.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") is hereby authorized to negotiate and execute an extension to the Affiliation Agreement with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH") for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012 with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement; and

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

ATTACHMENT A

Summary of the Financial Terms and Conditions for Contract Extension between the New York City Health and Hospitals Corporation ("the Corporation") and the Physician Affiliate Group of New York, P.C. ("PAGNY") for the Provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH")

- Affiliate reimbursement will be cost-based, not to exceed departmental spending limits
- All changes to budget must be approved by the Joint Oversight Committee (JOC) at the facility and Central Office approval as per policy
- The Corporation retains the right to bill all patients and third-party payers for services rendered, except that the Affiliate will continue to bill for its direct patient care activities (Part B) through the Faculty Practice Plan at Lincoln, JMC (for outpatient Medicaid services only), NCB (for outpatient Medicaid services only), Harlem and CIH
- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement

Proposed Contract Costs
FY 2013 Three Month and Six Month Funded Options

Facility	Contract Budget 3 Month	Contract Budget 6 Months	Contract Budget Annualized
Lincoln Medical and Mental Health Center	$20,040,862	$40,081,725	$80,163,449
Morrisania Diagnostic and Treatment Center	$569,648	$1,139,296	$2,278,592
Segundo Ruiz Belvis Diagnostic and Treatment Center	$148,645	$297,289	$594,578
Jacobi Medical Center	$24,149,322	$48,298,644	$96,597,287
North Central Bronx Hospital	$8,987,180	$17,974,360	$35,948,720
Harlem Hospital Center	$16,623,568	$33,247,137	$66,494,273
Renaissance Health Care Network Diagnostic and Treatment Center	$864,599	$1,729,199	$3,458,397
Coney Island Hospital	$16,206,561	$32,413,123	$64,826,246
Total*	**$87,590,385**	**$175,180,771**	**$350,361,542**

* The Board previously approved an affiliation agreement in June 2011 for PAGNY at Metropolitan Hospital Center that included a six-month extension until 12/31/12 at an annual rate of $55,381,355.

APPROVED: June 28, 2012

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has for some years entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreement with Coler-Goldwater expires on June 30, 2012; and

WHEREAS, the Corporation's Board of Directors at its June 2011 meeting approved a three-year agreement, effective July 1, 2011, to permit NYUSOM to provide health services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center; and

WHEREAS, NYUSOM has agreed to continue to provide the services previously supplied by the prior affiliate, Roosevelt Island Medical Associates, P.C. starting July 1, 2012; and terminating on June 30 2014; and

WHEREAS, a summary of the terms and conditions of the amendment to the current Affiliation Agreement with NYUSOM is set forth in Attachment A; and

WHEREAS, the respective Community Advisory Boards of Coler-Goldwater have been consulted and apprised of such proposed general terms and conditions; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that NYUSOM begin to provide General Care Health Services at Coler-Goldwater.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") is hereby authorized to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A; and,

BE IT FURTHER RESOLVED that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Attachment A

Summary of the Proposed Contract Amendment Between the New York City Health and Hospitals Corporation ("the Corporation") and New York University School of Medicine (NYUSOM) for the Provision of Services at Coler-Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater")

General Terms and Synopsis:

The proposed contract amendment covers a two-year term commencing July 1, 2012. The proposed contract amendment is for the provision of direct patient care services, administration of the provision of services, supervision of post-graduate trainees and students, administration and provision of rehabilitation therapy services and technical services to support the operations at Coler-Goldwater. The proposed contract amendment will compensate NYUSOM on a non-workload basis. The proposed contract amendment includes newly created pay-for-performance indicators with financial incentives attached. The pay-for-performance indicators were jointly created with medical staff leadership to address patient safety and the effective management in these facilities.

Anticipated Goals and Achievements

- Successful regulatory surveys
- Patient safety initiatives
- Participation in strategic planning and program development
- Participation in the relocation of Coler-Goldwater operations
- Development of performance improvement activities
- Participation in HHC Breakthrough activities
- State of the art technology advances, including electronic medical record migration
- A pay for performance program that aligns incentives with quality outcomes and other business objectives

Financial Terms

Proposed Contract Amendment Costs
FY 2013 – FY 2014

Contract Year	Coler-Goldwater
FY 2013	$27,500,000
FY 2014	$27,500,000
TOTAL	$55,000,000

- As in the current Affiliation Agreement, proposed payment to NYUSOM is based on costs.

- The costs reported assume no material change in patient volume or services provided and no additional impact from managed care programs or other third-payer developments

- Any change to the budget must be approved by JOC and the Corporation as per policy.

- The Corporation retains the right to bill all patients and third-party payers for services rendered.

- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement.

Performance Indicators

A pay-for-performance program will be implemented that address patient safety and effective management. An incentive up to $498,000 in incremental compensation to the Affiliate will be provided annually if all goals are met

Pay-for-performance indicators subject to incentive include:

- ✓ Informed Consent
- ✓ Consultation/Specialty Referral Request
- ✓ Consultation/Specialty Referral Response
- ✓ Influenza Vaccine Administration
- ✓ Pneumococcal Vaccine Administration

Transfers and Referrals

- Patients will be transferred and referred to other facilities when the required services are not available, if a third-party payer does not authorize reimbursement or at the patient's request.

- If a service is not available, such transfers and referrals will be made to other HHC facilities.

- Transfers and referrals to non-HHC facilities will only be made with the approval of the Executive Director or his/her designee and if an agreement with the receiving facility is in place.

- Transfer and referral activity will be monitored monthly.

APPROVED: June 28, 2012

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC") for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A to provide the parties adequate time to conclude negotiations for a new agreement;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreement with SUNY/HSCB, to provide General Care and Behavioral Health services expires on June 30, 2012; and

WHEREAS, it is necessary for the President to have the managerial flexibility to insure that the rights of the Corporation remain protected during the negotiation process; and

WHEREAS, a summary of the financial terms of the extension is set forth in Attachment A, and

WHEREAS, the Community Advisory Board of KCHC has been consulted and apprised of such proposed extension; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that SUNY/HSCB continue to provide General Care and Behavioral Health Services at KCHC.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation is hereby authorized to negotiate and execute an Affiliation Agreement with State University of New York/Health Science Center at Brooklyn, for the provision of General Care and Behavioral Health Services at Kings County Hospital Center, for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; to provide the parties adequate time to conclude negotiations for a new agreement; and;

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

ATTACHMENT A

Summary of Financial Terms and Conditions for Contract Extension

KINGS COUNTY HOSPITAL CENTER

Fiscal Year	Annualized Cash Rate
FY 2013	$18,932,602

- Affiliate reimbursement will be cost-based, subject to line item reconciliation
- All changes to budget must be approved by the facility and Central Office as per policy
- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement

APPROVED: June 28, 2012

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical (the "Licensee") for use and occupancy of space to operate an optical store on the campus of Jacobi Medical Center (the "Facility").

WHEREAS, in April 2010, the Board of Directors authorized the President of the Corporation to enter into a license agreement with the Licensee to operate optical stores at Bellevue Hospital Center, Harlem Hospital Center, Lincoln Medical & Mental Health Center, and Metropolitan Hospital Center; and

WHEREAS, the services and products provided have proved to be beneficial to patients; and

WHEREAS, Jacobi Medical Center desires to have the Licensee operate an optical store on its campus and has adequate space to accommodate the Licensee's needs; and

WHEREAS, the Licensee shall provide optical services, including but not limited to filling new prescription eyeglasses, examining eyes, low vision screening, prescribing and fitting contact lenses, and selling contact lens supplies.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical (the "Licensee") for use and occupancy of space to operate an optical store on the campus of Jacobi Medical Center (the "Facility").

The Licensee shall be granted the use and occupancy of a total of approximately 675 square feet of space on the ground floor of Building No. 1 (the "Licensed Space"). The Licensee shall pay a total annual occupancy fee of approximately $40,500, or $60 per square foot. The occupancy fee shall be escalated by 3% per year. The Facility shall provide hot and cold water, electricity, heating, air conditioning and routine security to the Licensed Space. The Licensee shall be responsible for its own housekeeping, repairs and maintenance.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any and all claims arising by virtue of its use of the Licensed Space and shall also provide appropriate insurance naming each of the parties as additional insureds.

The license agreement shall not exceed five (5) years without further authorization from the Board of Directors and shall be revocable by either party upon thirty (90) days notice.

APPROVED: June 28, 2012

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a license agreement with the New York Legal Assistance Group (the "Licensee" or "NYLAG") for use and occupancy of space at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility") to provide *pro bono* legal services to nursing home residents and training to Corporation staff.

WHEREAS, in March 2011, the Board of Directors authorized the President of the Corporation to enter into a license agreement to provide training and legal services at Bellevue Hospital Center, Elmhurst Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Woodhull Medical & Mental Health Center; and Harlem Hospital Center; and

WHEREAS, the Licensee is a not-for-profit provider of *pro bono* legal services to, among others, patients in need of attorney counseling in various areas of the law, including, but not limited to, immigration, domestic relations, child support and custody, and benefit entitlements; and

WHEREAS, the Licensee's program includes the training of Corporation staff to assist the Licensee in recognizing patients in need of legal services; and

WHEREAS, the Facility desires to utilize the Licensee's services and has adequate space to accommodate its program needs.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a license agreement with the New York Legal Assistance Group (the "Licensee" or "NYLAG") for its use and occupancy of space at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility") to provide *pro bono* legal services to nursing home residents and training to Corporation staff.

The Licensee shall be granted the part-time use of approximately 150 square feet of office space on the Facility's Goldwater and Coler campuses (the "Licensed Space"). The Licensed Space shall be used by one of the Licensee's attorneys to train Facility staff and provide legal services to Facility nursing home residents. The Facility shall provide utilities, housekeeping, maintenance, and reasonable security to the Licensed Space. The Corporation shall pay the Licensee the sum of $36,103 for services provided over a six (6) month period.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the Licensed Space and its provision of services in such space. The Licensee shall also provide appropriate insurance, naming both parties to the license agreement and the City of New York as insureds.

The term of the license agreement shall not exceed six (6) months without further authorization of the Board of Directors of the Corporation. The license agreement shall be revocable by either party on fifteen (15) days notice.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation" or "Licensor") to execute a revocable license agreement with the New York City Department of Education (the "Licensee") for its continued use and occupancy of space to operate a Licensed Practical Nurse ("LPN") training program at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility").

WHEREAS, in May 2007, the Board of Directors of the Corporation authorized the President to execute a license agreement with the Licensee which by its terms expires August 31, 2012; and

WHEREAS, the Corporation continues to have a need for Licensed Practical Nurses and the Office of the Mayor continues to provide funding for the LPN training program; and

WHEREAS, the Licensee's program provides training to Corporation staff and community residents; and

WHEREAS, the Facility has space available on the 4th floor of Goldwater to accommodate the Licensee's program needs.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with the New York City Department of Education (the "Licensee") for its continued use and occupancy of space to operate a Licensed Practical Nurse ("LPN") training program at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility").

The Licensee shall be granted the continued use and occupancy of approximately 7,100 square feet of space on the 4th floor of Goldwater (the "Licensed Space"). In lieu of an occupancy fee, the Corporation shall receive the benefit of the program's graduates filling LPN positions at its facilities.

The Licensor shall provide hot and cold water, electricity, heating, air conditioning, and security to the Licensed Space. The Licensor shall also be responsible for housekeeping and routine maintenance. The Facility shall be reimbursed up to $45,000 per year for the expense of providing these services.

The term of the agreement shall not exceed one (1) year without further authorization by the Board of Directors of the Corporation and shall be revocable by either party on thirty (30) days prior notice. The agreement shall contain an option to renew for one (1) year exercisable by the Licensee without further approval of the Board of Directors. The Licensee has been informed that space on the Goldwater campus will no longer be available in the Fall of 2013.

APPROVED: June 28, 2012

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to rename the Department of Dentistry and Oral Surgery at Harlem Hospital Center (the "Facility") the "Dr. James E. McIntosh Department of Dentistry and Oral Surgery".

WHEREAS, the administration of Harlem Hospital Center has recommended that the Department of Dentistry and Oral Surgery be renamed in honor of Dr. James E. McIntosh, former Chair of the Department of Dentistry and Oral Surgery; and

WHEREAS, Dr. James E. McIntosh started his services to the New York City Health and Hospitals Corporation in 1969 as a dental resident at Sydenham Hospital; and

WHEREAS, he worked his way up through the ranks and in the 1970s he became the Director of Dentistry and served two terms as Medical Board President at Sydenham Hospital; and

WHEREAS, Dr. McIntosh came to Harlem Hospital Center in 1984 when the Department of Dentistry was a division under General Surgery. He brought dentistry to the departmental status. The present dental clinic in the Women's Pavilion opened in 1984 and the first year there were 6,000 dental visits. In the next ten (10) years this would increase to 27,000 dental visits; and

WHEREAS, in 1988, in cooperating with Columbia University School of Dental and Oral Surgery, he started the minority specialty program. This program trained over 30 minority specialists. During his career Dr. McIntosh trained over a hundred minority general dentists who mostly returned to underserved areas of the country to practice; and

WHEREAS, Dr. McIntosh served the community by providing strong compassionate leadership to the Department of Dental and Oral Surgery until his retirement in 2000; and

WHEREAS, the Facility has met the requirements for renaming a portion of a facility as set forth in the Corporation's Operating Procedure 100-8, dated December 15, 2004; and

WHEREAS, the renaming is supported by the Facility's Community Advisory Board, the Medical Board, and the Executive Director of Harlem Hospital Center as required by Operating Procedure 100-8.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation"), be and hereby is authorized to rename the Department of Dentistry and Oral Surgery at Harlem Hospital Center (the "Facility") the "Dr. James E. McIntosh Department of Dentistry and Oral Surgery."

The President of the Corporation is hereby authorized to notify all private and public agencies and organizations involved and interested in the affairs of said department of the said renaming.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to name in its entirety the new location of the former Goldwater Specialty Hospital and Nursing Facility, which will be constructed on the campus of the former North General Hospital, the Henry J. Carter Specialty Hospital and Nursing Facility.

WHEREAS, the Corporation has committed to the relocation of the Goldwater Campus and will now accommodate the residents of Goldwater in new and renovated and modernized buildings that will be sited on the former campus of North General Hospital, the new facility shall be named in honor of Henry J. (Hank) Carter; and

WHEREAS, Hank Carter has been a philanthropist and activist for the independence and ability to live life to the fullest for those whose physical mobility and capabilities are limited and require wheelchairs, and has, through his extraordinary faith, generosity of spirit, and bountiful donations improved the mobility and expanded the reach and scope of thousands of Goldwater residents; and

WHEREAS, through their deep and abiding commitment over nearly 40 years, Mr. Carter and Wheelchair Charities, Incorporated, have funded on behalf of Goldwater Hospital and HHC a vast array of resources, including an extensive computer laboratory, a gymnasium and rehabilitation facility, specialized hospital beds, transport vans, and thousands of the finest wheelchairs manufactured in order to help residents be able to participate in life beyond the walls of the facility; and

WHEREAS, Mr. Carter's gifts and donations have totaled more than $25 million in value and changed the lives of thousands, and over the years, Hank Carter has become a cherished and beloved presence in the Goldwater community; an inspiration and source of hope to residents and staff; and a friend of inestimable magnitude to all of HHC; and

NOW, THEREFORE, BE IT RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to name the HHC facility to be sited on the campus of the former North General Hospital the Henry J. Carter Specialty Hospital and Nursing Facility.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Atlantic Dialysis Management Services LLC ("Atlantic") to provide dialysis technical services to HHC patients in the following facilities: Coney Island Hospital, Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, North Central Bronx Hospital, Queens Hospital Center, and Woodhull Medical and Mental Health Center. The contract shall be for a period of five years with one, four-year option to renew exercisable solely by the Corporation, in an amount not to exceed $83 million for the entire term of nine years.

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

WHEREAS, the Corporation seeks to enter into a contract to provide all nursing services, supplies, equipment and maintenance of equipment required for the provision of dialysis technical services and

WHEREAS, a Negotiated Acquisition ("NA") was issued on October 3, 2011 in accordance with the Corporation's operating procedures; and

WHEREAS, the selection committee evaluated the proposal using criteria specified in the NA, and the committee recommended that Atlantic Dialysis Management Services, LLC be awarded the contract; and

WHEREAS, Atlantic Dialysis Management Services, LLC is a company that provides management services to affiliated companies licensed under Article 28 of the Public Health Law but Atlantic Management Dialysis Services LLC is not itself licensed under Article 28 of the Public Health Law; and

WHEREAS, to perform under the proposed contract the company engaged must be either licensed under Article 28 of the Public Health Law or be a medical professional corporation; and

WHEREAS, Atlantic Dialysis Management Services LLC will assign the proposed contract to an entity or entities licensed under Article 28 of the New York Public Health Law or another entity legally entitled to engage doctors, nurses and other medical professionals provided that such entity(ies) are affiliates of the Licensee and that

the Corporation receives satisfactory assurances that the financial strength of the Licensee will continue to stand behind the Licensee's performance under the license agreement; and

WHEREAS, facilities will monitor contract quality measures to ensure quality of patient care; and

WHEREAS, the savings, over the life of the contract, are projected to exceed $146 million; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Senior Vice President/Corporate Chief Medical Officer, Division of Medical & Professional Affairs.

Now, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to negotiate and execute a contract with the Atlantic Dialysis Management Services LLC to provide dialysis technical services to HHC patients in the following facilities: Coney Island Hospital, Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, North Central Bronx Hospital, Queens Hospital Center, and Woodhull Medical and Mental Health Center. The contract shall be for a period of five years with one, four-year option to renew exercisable solely by the Corporation, in an amount not to exceed $83 million for the entire term of nine years.

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

Executive Summary
Proposed Contract with Atlantic Dialysis Management Services, LLC

We are proposing to enter into a contract with Atlantic Dialysis Management Services, LLC (ADMS) to provide all nursing services, supplies, equipment and maintenance of equipment required for the provision of dialysis services in the following facilities: Coney Island Hospital, Harlem Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, North Central Bronx Hospital, Queens Hospital Center, and Woodhull Medical and Mental Health Center. Currently Bellevue Hospital Center and Elmhurst Hospital Center have active dialysis contracts. Upon expiration a thorough review will be conducted which may lead to them being added to the contract

A Negotiated Acquisition ("NA") was issued on October 3, 2011, in accordance with the Corporation's operating procedures and the submitted proposal was evaluated by a selection committee and rated using criteria specified in the NA. The selection committee recommended that Atlantic Dialysis Management Services, LLC be awarded the contract. ADMS will assign the proposed contract to an entity or entities licensed under Article 28 of the New York Public Health Law or another entity legally entitled to engage doctors, nurses and other medical professionals provided that such entity(ies) are affiliates of ADMS and that the Corporation receives satisfactory assurances that the financial strength of ADMS will continue to stand behind the assigned entity(ies).

The contract shall be for a period of five years with one, four-year option to renew exercisable solely by the Corporation, in an amount not to exceed $83 million for the entire term of nine years. In addition, the resolution requests authorization for the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

These funds will be utilized to provide payment to the vendor for the acute dialysis treatments and for those HHC patients requiring chronic dialysis who are not eligible for any form of insurance. New patients requiring dialysis will be accepted to ADMS' program upon discharge from acute care, regardless of their ability to pay. HHC will reimburse the vendor for those patients who are found to not be eligible for any insurance after all efforts have been exhausted.

The vendor will assume all costs of the provision of dialysis services. The vendor will purchase existing capital equipment at its current depreciated value and will provide and maintain all equipment needed for patient care. The savings over the life of the contract, inclusive of the costs listed above, are projected to exceed $146 million.

When a facility's medical staff determines that urgent or emergency treatment is required, ADMS will provide such treatment within agreed upon response parameters. The vendor will be responsible for all regulatory and quality standards as required by CMS and will provide data regularly to the Corporation for quality and performance improvement.

Currently Newtown Dialysis d/b/a/ Broadway Dialysis (owned by principals of ADMS) has a license agreement with Elmhurst Hospital Center and provides chronic dialysis services. This agreement was originally signed in 2005 and most recently renewed in 2010. Elmhurst Hospital Center and Newtown Dialysis are satisfied with their arrangement.

Dialysis Outsourcing Financial Analysis

Conclusion: Over a nine year period, the corporation would incur costs of up to $83 million to provide contracted dialysis services to chronic and acute patients at Coney Island, Harlem, Jacobi, Kings County, Lincoln, Metropolitan, North Central Bronx, Queens and Woodhull Hospitals. Over the same period, the Corporation would realize combined cost savings and rental income of $230 million for total net savings of $147 million. In addition to contracting out existing services, the proposal includes the creation of a new chronic service at North Central Bronx Hospital to serve referrals from the North Bronx Network.

Assumptions

A cost-benefit analysis for contracting out dialysis services at nine HHC hospitals was conducted using Institutional Cost Report (ICR) data for HHC Fiscal Year 2010, which is the most recently completed ICR. Total costs at the nine facilities were $47.9 million, of which $14.4 million are fixed costs that the facilities would continue to bear. The facilities' FY 2010 revenue for outpatient dialysis, adjusted to reflect a recent increase in Medicaid rates, was $9.6 million, resulting in a Total Net Cost of $38.3 million, and Net Variable Costs of $23.9 million, without considering revenue associated with inpatient treatments.

Payment for inpatient dialysis treatments is included in the per case DRG reimbursement rates; therefore in this analysis there is no revenue loss associated with contracting out inpatient dialysis services. There is however, an additional cost to pay a vendor to provide the inpatient treatments. Contract costs for inpatient treatments are estimated using rates negotiated with the vendor.

Acute Treatment Type	Year 1 Rate	Est. Percentage of Workload
Routine	$412.50	72%
Bedside	$434.50	18%
Off Hours	$467.50	10%
Average Blended Rate	$421.96	

In addition, in order to ensure continuing access to care for all patients, the analysis assumes that HHC will pay the vendor to provide outpatient treatments to patients who cannot be enrolled in any insurance program. As a worst case scenario, the outpatient "uninsurable" population is estimated at 15 percent of patients. Vendor payments for outpatient treatments are estimated using a flat rate of $235.00 negotiated with the vendor.

Projected Vendor Payments *(current dollars)*

Service		Treatments	Total Cost
Inpatient Total		16,335	$6.9 million
Outpatient	Current Chronic Services	43,267	
	Projected North Bronx	7,488	
	Total Outpatient	50,755	
Outpatient Uninsured (15%)		7,613	$1.9 million
Total			$8.8 million

Rates will be inflated annually by the inflation trend factor applied to NYS Medicaid rates. For this analysis the trend factor is very conservatively assumed to be 3% per year.

HHC savings will be offset by retaining staff currently employed to provide dialysis services at the nine facilities until they attrit out or are redeployed to existing vacancies. The nine facilities employ a total of 146 FTES. Approximately 20 percent are in Tech titles – the titles primarily used by most vendors – and the balance are predominately nurses. The vendor is projected to hire 50 percent of the Techs and 5 percent of the nurses and other staff during each implementation phase. Those staff not hired by the vendor are assumed to attrit out over the three years following implementation at their facility.

Title	Current FTEs	Projected Vendor Hires	Attrition/ Redeployment
Tech	31.5	14.0	17.5
Nurse	96.0	5.0	91.0
Other	18.5	0.0	18.5
Total	146.0	19.0	127.0

It is anticipated that the vendor will lease space for outpatient dialysis services at each of the four facilities currently offering chronic dialysis and at NCB for the new North Bronx Chronic Service. Projected rental income is based on a market rate appraisal and negotiations with the vendor.

(current dollars) Facility	Square Footage	Market Rate Rent	Total Rental Income
Metropolitan	5,015	$50.00	$0.3 million
KCHC	9,500	$54.00	$0.5 million
Lincoln	5,998	$40.00	$0.2 million
Harlem	9,260	$50.00	$0.5 million
NCB	7,000	$40.00	$0.3 million
Total			$1.7 million

* All costs and revenues, excluding rental income, are assumed to inflate by 3% per year.

** This analysis does not include any income associated with the potential lease or sale of existing HHC dialysis equipment to the vendor or any other party.

Central Office Finance, June 27, 2012

(financial analysis narrative & assumptions 6-27-12.docx, dialysis analysis summary by fy 6-27 -12.xlsx)

Dialysis Outsourcing Contract
(with rental income)

Source: Central Office Finance
June 27, 2012

Current (FY10 ICR) Cost	
Total Cost	47,922,939
Collections	(9,612,249)
Net Loss	38,310,690
Fixed Cost	(14,367,094)
Net Variable Costs	**23,943,596** = FY 10 Potential Savings

(assume 3% annual cost inflation)

Contract Costs (Estimated at Negotiated Rate)	
Inpatient Acute Services	6,892,671
Outpatient Chronic Services	1,857,754
(assumes 15% uninsurable population)	
Total Annual Contract Cost (All Facilities)	**8,750,424**

(assume 3% Medicaid Trend Factor)

	1	2	3	4	5	6	7	8	9	Total FY13-FY21
Fiscal Year	**FY 13**	**FY 14**	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**FY 21**	
Total Contract Costs**	**3,826,234**	**8,008,331**	**9,283,325**	**9,561,825**	**9,848,680**	**10,144,140**	**10,448,464**	**10,761,918**	**11,084,776**	**82,967,694**
Savings										
Dialysis Costs Savings	9,432,533	23,212,496	27,757,190	28,589,906	29,447,603	30,331,031	31,240,962	32,178,191	33,143,537	245,333,451
Dialysis Space Rental Income Potential	379,958	1,158,003	1,746,670	1,746,670	1,746,670	1,746,670	1,746,670	1,746,670	1,746,670	13,764,652
Staff Redeployment Costs	(4,652,884)	(10,849,280)	(8,957,949)	(4,101,743)	(579,460)	0	0	0	0	(29,141,315)
Total Savings	**5,159,608**	**13,521,220**	**20,545,912**	**26,234,833**	**30,614,813**	**32,077,701**	**32,987,632**	**33,924,861**	**34,890,207**	**229,956,788**
Net Contract Savings	**1,333,374**	**5,512,890**	**11,262,586**	**16,673,008**	**20,766,133**	**21,933,561**	**22,539,168**	**23,162,943**	**23,805,431**	**146,989,094**

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title:	Enterprise-wide dialysis services
Project Title & Number:	Enterprise-wide dialysis services
Project Location:	346 Broadway, Room 1136, New York, NY 10003
Requesting Dept:	Division of Medical and Professional Affairs, Office of Patient Centered Care
Successful Respondent:	Atlantic Dialysis Management Services, LLC
Contract Amount:	Not to exceed $83 million for the entire term of nine years. In addition, the resolution requests authorization for the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.
Contract Term:	Five years with one, four-year option to renew exercisable solely by the Corporation
Number of Respondents: (If sole source, explain in Background section)	One
Range of Proposals:	Cost per acute treatment from $412.50 – $467.50 Cost per chronic treatment is $235.00
Minority Business Enterprise Invited:	**X Yes** If no, please explain:_____
Funding Source:	**X General Care** _ Capital _ Grant: Explain _____ _ Other: Explain _____
Method of Payment:	_ Lump Sum _ Per Diem _ Time and Rate **X Other** Deliverables
EEO Analysis:	Approved
Compliance with HHC's McBride Principles?	**X Yes** _ No
Vendex Clearance	**X Yes** _ No _ N/A __Pending

(required for contracts In the amount of $50,000 or more awarded pursuant to an RFP or as a sole source, or $100,000 or more if awarded pursuant to an RFB.)

Background *(include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):*

The cost for dialysis incurred annually across the Corporation far exceed the revenue collected. Equipment is beyond its expected life use and water treatment systems need to be replaced. There are currently no funds available for required capital improvements. Fixed staffing costs and overhead prevent this from improving. CMS regulations are increasingly stringent and voluminous. The vendor has the required expertise and experience to achieve and exceed the standards, to provide the state of the art equipment, cost effective supply chain management, excellent patient outcomes and access to all regardless of their ability to pay.

Atlantic Dialysis Management Services, LLC (ADMS) will provide all personnel services, supplies, equipment and maintenance of equipment, required for the provision of chronic and acute dialysis services in the following facilities: Harlem Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center, Kings County Hospital Center, North Central Bronx Hospital and acute dialysis services for: Coney Island Hospital, Jacobi Medical Center, Queens Hospital Center, and Woodhull Medical and Mental Health Center. Currently Bellevue and Elmhurst have active dialysis contracts. Upon expiration a thorough review will be conducted which may lead to them being added to this contract These services will be available seven (7) days a week, twenty-four (24) hours a day, 365 days a year. Such Dialysis services shall include hemodialysis, and may include continuous renal replacement therapy (CRRT) and continuous cycling peritoneal therapy (CCPD). ADMS will enter into a license agreement with the Corporation for chronic services performed within an HHC facility. The license agreement will require ADMS to pay the market rate rent to the Corporation for the use of the space. The rent charged will meet all Stark Safe Harbor requirements.

When the Facility's medical staff determines that urgent or emergency treatment is required during regular operating hours, ADMS will provide such treatment within two (2) hours of notification of the Facility's request, including travel and set-up time. For non-urgent cases presenting during regular operating hours, ADMS shall provide treatment within six (6) hours of the Facility's request, including travel and set-up time.

New Patients requiring dialysis will be accepted to ADMS' program upon discharge from acute care, regardless of their ability to pay. HHC will reimburse the vendor for those patients who are found to not be eligible for any insurance after all efforts have been exhausted.

Contract Review Committee

Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):

Yes, February 29, 2012 CRC Approval

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:

Timetable has been adjusted from all sites starting simultaneously to a phased in process across the sites in concert and cooperation with the vendor and the NYSDOH Certificate of Need process.

Overall hospitals included in contract has been increased, and expansion of chronic dialysis capacity was added.

Selection Process *(attach list of selection committee members, list of firms responding to RFP, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection):*

Committee Members:

Chairperson

Lauren Johnston	Senior Assistant Vice President, Office of Patient Centered Care

Members

Gary Briefel, MD	Director of Nephrology, KCHC
Dona Green	Senior Assistant Vice President, Corporate Planning
Jeremy Berman	Senior Council, Legal Affairs
Joseph Quinones	AVP, Contract Administration & Control
Linda Dehart	AVP, Debt Finance/Corp Reimbursement Services
Mikey Bocachica	Deputy CFO, Lincoln
Steven Alexander	Chief Operating Officer, Bellevue
Eve Borzon	Chief Operating Officer, Woodhull
Elizabeth Smith Ware	A.D.N, Lincoln

List of Firms Responding to the NA:

Atlantic Dialysis Management Services, LLC

List of Firms Evaluated:

Atlantic Dialysis Management Services, LLC

Firm Selected:

Atlantic Dialysis Management Services, LLC

Describe the process used to select the proposed contractor, the selection criteria, and the justification for the selection:

In order to solicit the appropriate vendors the Negotiated Acquisition (NA) process was utilized. There was an evaluation and the vendor met all qualifications of the solicitation. Due diligence was done and negotiation team was successful in negotiating the proposed contract.

Costs/Benefits:

Why can't the work be performed by Corporation staff:

The costs incurred annually across the Corporation are not covered by the revenue collected. Equipment is beyond its expected life use and water treatment systems need to be replaced. Fixed staffing costs and overhead prevent this from improving. CMS regulations are stringent and voluminous. The vendor has the required expertise and experience to achieve and exceed the standards.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

N/A

Contract monitoring (include which Senior Vice President is responsible):

Ross Wilson, MD - Senior Vice President/Corporate Chief Medical Officer, Division of Medical and Professional Affairs

Lauren Johnston, FACHE – Senior Assistant Vice President, Office of Patient Centered Care

Equal Employment Opportunity Analysis *(include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):*

Received By E.E.O. January 23, 2012
Date

Analysis Completed By E.E.O February 24, 2012 *Date* Manasses C. Williams *Name*

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Suite 401, New York, NY 10013 Tel: 212-788-3380 Fax: 212-788-3689
nyc.gov/hhc

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Beth R. Brooks, MS, Asst. Director
Office of Patient Centered Care

FROM: Manasses C. Williams

DATE: February 24, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Atlantic Dialysis Management Services, LLC (ADMS)**, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____ Project: Enterprise Dialysis Services

Submitted by: Office of Patient Centered Care

EEO STATUS:

1. [X] Approved

2. [ ] Approved with follow-up review and monitoring

3. [ ] Not approved

COMMENTS:

MCW:srf

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Room 527, New York, NY 10013 Tel: 212-788-3300 Fax: 212-267-6905
nyc.gov/hhc

Office of Legal Affairs

MEMORANDUM

To: **Lauren Johnston**
Medical & Professional Affairs

From: **Karen Rosen** (KR)
Assistant Director

Date: **June 15, 2012**

Subject: **VENDEX Approval**

For your information, on June 15, 2012 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Atlantic Dialysis Management Services.

cc: Norman M. Dion, Esq.

Atlantic Dialysis Management Services, LLC

Key Personnel

J. Ganesh Bhat, M.D.
Dr. Bhat received his M.B.B.S. and M.D. degrees from University of Mysore in India. He completed a Residency in Internal Medicine at Government Wenlock Hospital, Mangalore, India, Kasturba Medical College Hospital, Manipal, India and Methodist Hospital in Brooklyn. He completed his fellowship training in nephrology at NYU Medical Center. He was awarded a post doctoral fellowship for two years by New York State Kidney Disease Institute to continue research at NYU Medical Center. Dr. Bhat is a diplomate of American Board of Internal Medicine and Nephrology. He has earned numerous honors and awards most notably, the Government of India's Ministry of Health Merit Scholarship.

Dr. Bhat has been affiliated with most major medical and educational institutions in the New York area for over three decades. He has been intimately involved with post graduate medical education and has served on the panels of several training programs in the area. His past faculty appointments included NYU School of Medicine and State University of New Health Sciences Center in Stonybrook. Currently he holds faculty appointment at Albert Einstein School of Medicine. He has held various administrative and leadership positions in different hospitals in New York including interim Chairman of Medicine and Medical Director at North Shore University Hospital at Forest Hills. He has an avid interest in research and has published numerous papers in the fields of kidney diseases. He is considered an expert on health care economics in general and End Stage Renal Disease (ESRD) program in particular and has been sought after speaker on this issue nationwide.

Dr. Bhat is co-founder of Atlantic Dialysis Management Services, a New York based dialysis chain providing high quality dialysis services to patients with ESRD. He is currently serving as director on Kidney Care Council, a Washington D.C. based industry group working with the government to improve quality of care for patients on dialysis. Dr. Bhat was appointed as Chancellor of Xavier University School of Medicine in Oranjestad, Aruba in 2008. He is also a trustee of the Xavier University Foundation in Aruba.

In recognition of his long and dedicated service to the people of New York State, Governor David Paterson appointed him to prestigious New York State Public Health Council in 2010. His appointment was confirmed by the State Senate and he served on the Establishment Committee and Health Personnel Committee of the Public Health Council. He was re-appointed by Governor Paterson to the newly formed New York State Public Health and Health Planning Council for a full six year term to expire in 2016. Dr. Bhat

Nirmal K. Mattoo, M.D.
Dr. Mattoo received his M.D. degree from the University of Delhi, India in 1968. He completed his residency training in internal medicine at Queens General Hospital (LIJ division) and completed his fellowship in nephrology at Elmhurst Hospital Center in Queens, New York. Dr. Mattoo is certified by the American Board of Internal Medicine and Nephrology.

Dr. Mattoo is co-founder of Atlantic Dialysis Management Services, a New York based dialysis chain providing high quality dialysis services to patients with ESRD. He is the former Chief Executive Officer and Chief Medical Director of Wyckoff Heights Medical Center in Brooklyn, New York. Prior to that leadership position, he has served as Chief of Nephrology and President of the Medical Staff. Dr. Mattoo is published in nephrology and has been an active teacher in the Hospital's residency programs. Dr.

Mattoo is a founding partner in Mattoo and Bhat Medical Associates, PC, one of the largest group practices in New York City devoted exclusively to nephrology practice.

Dr. Mattoo is deeply involved in the Indian community in the U.S. He has been president of the American Association of Indians in America. In 1998, he co-edited Ananya, a collection of essays on Indian culture and contributions published on the 50th Anniversary of Indian Independence. The book was critically well-received and widely distributed throughout the country. Dr. Mattoo is also President of the Center for India Studies at SUNY Stonybrook in Long Island.

Edward Dowling
Edward "Buzz" Dowling former president and continued advisor to Atlantic Dialysis Management Services, LLC. Mr. Dowling has held a number of key, senior level positions within New York State such as the Deputy Director and Associate Director at the Division of Health Planning, Deputy Director at the NYS Health Planning Commission, and Assistant Commissioner at the NYS Department of Social Services.

William D. Cundiff
Bill joined the ADMS family in 2008 as its Vice President of External Relations and Regulatory Affairs with responsibilities in areas of compliance and the performance of corporate, legal, and regulatory compliance services related to the ADMS development of facilities; business development to undertake the identification, valuation and initial due diligence process of potential acquisition targets and joint venture partners. In addition, he maintains full strategic responsibility for organizational development and responsible for counseling the executive and senior management groups on all aspects of the ADMS business including sales, marketing, employment law, business development, drafting, negotiating and reviewing contracts and providing counsel where appropriate.

Starting in the mid 1990s, Bill has held positions as President and/or Chief Operating Officer in a series of medical schools located the Netherland-Antilles, England and West Africa. Prior to that, Bill spent a number of years with Fortune 100 companies such as the DeVry Corporation, Time Warner/HBO and Capital Cities/ABC. Possessing a law degree from the Touro College Law Center, Bill also holds a Masters in Business Administration in Finance and Analysis and Bachelor's degrees in both Accounting and Computer Science.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with Atlantic Dialysis Management Services LLC (the "Licensee") for use and occupancy of space to provide chronic dialysis services at Harlem Hospital Center, Kings County Hospital Center, Metropolitan Hospital Center, Lincoln Medical and Mental Health Center and North Central Bronx Hospital (the "Facilities").

WHEREAS, the Corporation, through a Negotiated Acquisition, solicited proposals from qualified vendors to manage inpatient and outpatient dialysis services at the Facilities;

WHEREAS, the Licensee, a New York-based manager of dialysis services provided by related entities licensed under Article 28 of the New York State Public Health Law, submitted a proposal, was deemed to have met the solicitation's requirements by the Corporation's Selection Committee, and has been approved for contract award by the Corporation's Contract Review Committee;

WHEREAS, by a separate resolution presented in conjunction with this one, the President seeks authorization to enter into a service agreement with the Licensee to govern the provision of both chronic and acute dialysis services to the patients of the Facilities;

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a revocable license agreement with Atlantic Dialysis Management Services, LLC (the "Licensee") for use and occupancy of space to provide chronic dialysis services at Harlem Hospital Center, Kings County Hospital Center, Metropolitan Hospital Center, Lincoln Medical and Mental Health Center and North Central Bronx Hospital (the "Facilities").

The Licensee shall be granted use and occupy of approximately 9,260 sq. ft. of space on the 4th floor of the New Patient Pavilion at Harlem Hospital Center, approximately 8,970 sq. ft. of space on the 6th floor of the "C" Building at Kings County Hospital Center, approximately 5,015 sq. ft. of space on the 14th floor of the Main Hospital building at Metropolitan Hospital Center, approximately 5,998 sq. ft. of space on the 7th floor at Lincoln Medical and Mental Health Center, and approximately 6,825 sq. ft. on the 6th floor at North Central Bronx Hospital (the "Licensed Space"). The Licensee shall pay an occupancy fee, based on the fair market value of the space, of $50.00 per sq. ft. at Harlem, or $463,000 per year; $54.00 per sq. ft. at Kings County, or $484,380 per year; $50.00 per sq. ft. at Metropolitan, or $250,750 per year; $40.00 per sq. ft. at Lincoln, or $239,920 per year; and $40 per sq. ft. at NCB or $273,000 per year. The occupancy fee will increase by 10% every five years. The license agreement may be amended, upon the mutual consent of the Corporation and the Licensee, to expand the area licensed at each of Lincoln and NCB to bring the total at each Facility to up to 9,000 sq. ft. and the occupancy fee shall be increased accordingly at $40 per sq. ft.

The Facilities shall provide building security, heat, air conditioning and ventilation, electricity, internet access, structural maintenance, disposal of medical waste and access to the space twenty-four (24) hours a day, seven (7) days per week. The Licensee shall provide its own housekeeping perform non-structural repairs and maintenance, and maintain and repair the mechanical systems installed for use in the operation of a dialysis clinic.

The Licensee will provide acute dialysis services to the Facilities' inpatients in space controlled by the Corporation and not licensed to the Licensee under the proposed license agreement.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any and all claims arising by virtue of its use of the licensed space, and shall provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

The license agreement shall not exceed five (5) years without further authorization from the Board of Directors and shall be revocable by either party on one hundred and eighty (180) days prior notice. If the Corporation terminates the license agreement without cause prior to the end of the allowed five year period, the Corporation shall reimburse the Licensee for its un-depreciated, verifiable, reasonable out-of-pocket expenses incurred to prepare the licensed spaces for its intended use and for reasonable expenses actually incurred to wind-down the operation prematurely. The Licensee shall have an option to extend the term of the license agreement for an additional four (4) years with the approval of the Corporation's Board of Directors.

The Licensee may assign the license agreement to an entity or entities licensed under Article 28 of the New York Public Health Law or another entity legally entitled to engage doctors, nurses or other medical professionals provided that such entity(ies) are affiliates of the Licensee and that the Corporation receives satisfactory assurances that the financial strength of the Licensee will continue to stand behind the Licensee's performance under the license agreement.

The Facilities shall provide building security, heat, air conditioning and ventilation, electricity, internet access, structural maintenance, removal of hazardous waste and access to space twenty-four (24) hours a day, seven (7) days per week. The Licensee shall provide its own housekeeping, perform non-structural repairs and maintenance, and maintain and repair mechanical systems installed for use in the operation of a dialysis clinic.

The Licensee will indemnify and hold harmless the Corporation and the City of New York from any and all claims arising by virtue of its use of the licensed space, and will provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

The license agreement will not exceed five (5) years without further authorization from the Board of Directors and shall be revocable by either party on one hundred and eighty (180) days prior notice If the Corporation terminates the license agreement without cause prior to the end of the allowed five year period, the Corporation shall reimburse the Licensee for its un-depreciated, verifiable, reasonable out-of-pocket expenses incurred to prepare the licensed spaces for their intended use and for reasonable expenses actually incurred to wind-down the operation prematurely.

RELATED SERVICES:

Pursuant to a companion resolution, the Corporation will contract with the Licensee to accept referrals from the Facilities of their outpatients to receive chronic dialysis services and for the Licensee to provide acute dialysis services to the Facilities' inpatients. The Facilities will provide the space for the Licensee to use in performing dialysis services on the Facilities' inpatients whether it be at bedside, in the Emergency Department, in an Intensive Care unit or at a location within the hospital equipped to provide dialysis services to patients who can be brought from their beds to such location. Such service agreement will require the Licensee to assure the quality and timeliness of the services, stipulate that the Licensee will accept all of the Facilities' patients regardless of their ability to pay, and set forth the rate at which the Facilities will compensate the Licensee for services rendered to inpatients. Chronic services provided to outpatients will be billed to third party payors when insurance is available.

Facility	Sq. Ft.	Price/Sq. Ft.	Annual Occupancy Fee
Harlem	9,260	$50	$463,000
Kings County	8,970	$54	$484,000
Lincoln	5,998	$40	$239,920
Metropolitan	5,015	$50	$250,750
North Central Bronx	6,825	$40	$273,000

Atlantic Dialysis Management Services, LLC

Key Personnel

J. Ganesh Bhat, M.D.
Dr. Bhat received his M.B.B.S. and M.D. degrees from University of Mysore in India. He completed a Residency in Internal Medicine at Government Wenlock Hospital, Mangalore, India, Kasturba Medical College Hospital, Manipal, India and Methodist Hospital in Brooklyn. He completed his fellowship training in nephrology at NYU Medical Center. He was awarded a post doctoral fellowship for two years by New York State Kidney Disease Institute to continue research at NYU Medical Center. Dr. Bhat is a diplomat of American Board of Internal Medicine and Nephrology. He has earned numerous honors and awards most notably, the Government of India's Ministry of Health Merit Scholarship.

Dr. Bhat has been affiliated with most major medical and educational institutions in the New York area for over three decades. He has been intimately involved with post graduate medical education and has served on the panels of several training programs in the area. His past faculty appointments included NYU School of Medicine and State University of New Health Sciences Center in Stonybrook. Currently he holds faculty appointment at Albert Einstein School of Medicine. He has held various administrative and leadership positions in different hospitals in New York including interim Chairman of Medicine and Medical Director at North Shore University Hospital at Forest Hills. He has an avid interest in research and has published numerous papers in the fields of kidney diseases. He is considered an expert on health care economics in general and End Stage Renal Disease (ESRD) program in particular and has been sought after speaker on this issue nationwide.

Dr. Bhat is co-founder of Atlantic Dialysis Management Services, a New York based dialysis chain providing high quality dialysis services to patients with ESRD. He is currently serving as director on Kidney Care Council, a Washington D.C. based industry group working with the government to improve quality of care for patients on dialysis. Dr. Bhat was appointed as Chancellor of Xavier University School of Medicine in Oranjestad, Aruba in 2008. He is also a trustee of the Xavier University Foundation in Aruba.

In recognition of his long and dedicated service to the people of New York State, Governor David Paterson appointed him to prestigious New York State Public Health Council in 2010. His appointment was confirmed by the State Senate and he served on the Establishment Committee and Health Personnel Committee of the Public Health Council. He was re-appointed by Governor Paterson to the newly formed New York State Public Health and Health Planning Council for a full six year term to expire in 2016.

Nirmal K. Mattoo, M.D.
Dr. Mattoo received his M.D. degree from the University of Delhi, India in 1968. He completed his residency training in internal medicine at Long Island Jewish Medical Center and completed his fellowship in nephrology at Elmhurst Hospital Center in Queens, New York. Dr. Mattoo is certified by the American Board of Internal Medicine and Nephrology.

Dr. Mattoo is the former Chief Executive Officer and Chief Medical Director of Wyckoff Heights Medical Center in Brooklyn, New York. Prior to that leadership position, he has served as Chief of Nephrology and President of the Medical Staff. Dr. Mattoo is published in nephrology and has been an active teacher in the Hospital's residency programs. Dr. Mattoo is a founding partner in Mattoo and Bhat Medical Associates, PC, one of the largest group practices in New York City devoted exclusively to nephrology practice.

Dr. Mattoo is deeply involved in the Indian community in the U.S. He has been president of the American Association of Indians in America. In 1998, he co-edited Ananya, a collection of essays on Indian culture and contributions published on the 50th Anniversary of Indian Independence. The book was critically well-received and widely distributed throughout the country. Dr. Mattoo is also President of the India Center at Stony Brook University in Long Island.

Edward Dowling
Edward "Buzz" Dowling former president and continued advisor to Atlantic Dialysis Management Services, LLC. Mr. Dowling has held a number of key, senior level positions within New York State such as the Deputy Director and Associate Director at the Division of Health Planning, Deputy Director at the NYS Health Planning Commission, and Assistant Commissioner at the NYS Department of Social Services.

William D. Cundiff
Bill joined the ADMS family in 2008 as its Vice President of External Relations and Regulatory Affairs with responsibilities in areas of compliance and the performance of corporate, legal, and regulatory compliance services related to the ADMS development of facilities; business development to undertake the identification, valuation and initial due diligence process of potential acquisition targets and joint venture partners. In addition, he maintains full strategic responsibility for organizational development and responsible for counseling the executive and senior management groups on all aspects of the ADMS business including sales, marketing, employment law, business development, drafting, negotiating and reviewing contracts and providing counsel where appropriate.

Starting in the mid 1990s, Bill has held positions as President and/or Chief Operating Officer in a series of medical schools located the Netherland-Antilles, England and West Africa. Prior to that, Bill spent a number of years with Fortune 100 companies such as the DeVry Corporation, Time Warner/HBO and Capital Cities/ABC. Possessing a law degree from the Touro College Law Center, Bill also holds a Masters in Business Administration in Finance and Analysis and Bachelor's degrees in both Accounting and Computer Science.

Dialysis Outsourcing Financial Analysis

Conclusion: Over a nine year period, the corporation would incur costs of up to $83 million to provide contracted dialysis services to chronic and acute patients at Coney Island, Harlem, Jacobi, Kings County, Lincoln, Metropolitan, North Central Bronx, Queens and Woodhull Hospitals. Over the same period, the Corporation would realize combined cost savings and rental income of $230 million for total net savings of $147 million. In addition to contracting out existing services, the proposal includes the creation of a new chronic service at North Central Bronx Hospital to serve referrals from the North Bronx Network.

Assumptions

A cost-benefit analysis for contracting out dialysis services at nine HHC hospitals was conducted using Institutional Cost Report (ICR) data for HHC Fiscal Year 2010, which is the most recently completed ICR. Total costs at the nine facilities were $47.9 million, of which $14.4 million are fixed costs that the facilities would continue to bear. The facilities' FY 2010 revenue for outpatient dialysis, adjusted to reflect a recent increase in Medicaid rates, was $9.6 million, resulting in a Total Net Cost of $38.3 million, and Net Variable Costs of $23.9 million, without considering revenue associated with inpatient treatments.

Payment for inpatient dialysis treatments is included in the per case DRG reimbursement rates; therefore in this analysis there is no revenue loss associated with contracting out inpatient dialysis services. There is however, an additional cost to pay a vendor to provide the inpatient treatments. Contract costs for inpatient treatments are estimated using rates negotiated with the vendor.

Acute Treatment Type	Year 1 Rate	Est. Percentage of Workload
Routine	$412.50	72%
Bedside	$434.50	18%
Off Hours	$467.50	10%
Average Blended Rate	$421.96	

In addition, in order to ensure continuing access to care for all patients, the analysis assumes that HHC will pay the vendor to provide outpatient treatments to patients who cannot be enrolled in any insurance program. As a worst case scenario, the outpatient "uninsurable" population is estimated at 15 percent of patients. Vendor payments for outpatient treatments are estimated using a flat rate of $235.00 negotiated with the vendor.

Projected Vendor Payments *(current dollars)*

Service		Treatments	Total Cost
Inpatient Total		16,335	$6.9 million
Outpatient	Current Chronic Services	43,267	
	Projected North Bronx	7,488	
	Total Outpatient	50,755	
Outpatient Uninsured (15%)		7,613	$1.9 million
Total			$8.8 million

Rates will be inflated annually by the inflation trend factor applied to NYS Medicaid rates. For this analysis the trend factor is very conservatively assumed to be 3% per year.

HHC savings will be offset by retaining staff currently employed to provide dialysis services at the nine facilities until they attrit out or are redeployed to existing vacancies. The nine facilities employ a total of 146 FTES. Approximately 20 percent are in Tech titles – the titles primarily used by most vendors – and the balance are predominately nurses. The vendor is projected to hire 50 percent of the Techs and 5 percent of the nurses and other staff during each implementation phase. Those staff not hired by the vendor are assumed to attrit out over the three years following implementation at their facility.

Title	Current FTEs	Projected Vendor Hires	Attrition/ Redeployment
Tech	31.5	14.0	17.5
Nurse	96.0	5.0	91.0
Other	18.5	0.0	18.5
Total	146.0	19.0	127.0

It is anticipated that the vendor will lease space for outpatient dialysis services at each of the four facilities currently offering chronic dialysis and at NCB for the new North Bronx Chronic Service. Projected rental income is based on a market rate appraisal and negotiations with the vendor.

(current dollars) Facility	Square Footage	Market Rate Rent	Total Rental Income
Metropolitan	5,015	$51.50	$0.3 million
KCHC	9,500	$51.50	$0.5 million
Lincoln	5,998	$40.00	$0.3 million
Harlem	9,260	$51.50	$0.5 million
NCB	7,000	$40.00	$0.3 million
Total			$1.5 million

* All costs and revenues, excluding rental income, are assumed to inflate by 3% per year.

** This analysis does not include any income associated with the potential lease or sale of existing HHC dialysis equipment to the vendor or any other party.

Central Office Finance, June 13, 2012
(financial analysis narrative & assumptions 6-13-12.docx, dialysis analysis summary by fy 6-13 -12.xlsx)

SAVITT PARTNERS

June 19, 2012

Dion Wilson
Director
Office of Facilities Development Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: Appraisal of Renal Dialysis unit at Harlem Hospital

Dear Dion,

Pursuant to your request, on Wednesday, March 28, 2012, I visited the referenced Renal Dialysis unit which was in the final stages of construction, to establish its fair market value (FMV) rent, based on the information that you provided to me and knowledge of area rental values and the condition of the premises. The evaluation is subject to the following assumptions:

- The hospital will soon open a 25 chair outpatient Renal Dialysis unit
- The square footage of the unit is approximately 9,260 Gross Internal (net useable)
- General office/retail space in the surrounding East Harlem community leases at a rent of approximately $55 per square foot through the Madison Avenue retail corridor.

The Renal Dialysis unit currently in the finishing stages of construction, is located within the Harlem Hospital complex, specifically within the hospital's new building. It will occupy space on the 4th floor. The Harlem Hospital complex is readily accessible by the number 2 and 3 subway lines at 135th Street and Lenox Avenue and by bus routes running East/West and North/South through that intersection. There is no building parking but there are 2 public parking facilities nearby, as well as street parking.

The proposed Renal Dialysis unit which will be completed summer/fall of 2012 with occupancy 3rd to 4th quarter of 2012 represents what we believe is a dialysis unit designed and built in accordance with all regulatory agency requirements and to a building standard consistent with new construction and within an institutional location. The unit will have the ability to treat and monitor up to 25 dialysis patients, on an outpatient basis, at a given time and will be further capable of accommodating the lengthy time periods required for each patient's care. While treating patients, the unit will also provide staff with opportunities to carry out administrative tasks. The unit will take advantage of the efficiencies of the hospital's electric, common areas, cleaning services, IT and telephone services etc.

The unit as previously mentioned comprises 9,260 internal useable square feet. There is no common area mark up typical of commercial space leased outside of an institutional setting. It consists of 25 Renal Dialysis stations to receive patients on an outpatient basis inclusive of 2 isolation areas of a larger than typical size. There will be ample storage for both dry and wet

supplies needed to operate the unit. However, storage will be housed in the main MLK building and not in the unit.

The space is divided into 2 separate and distinct treatment modules. The 2 isolation areas are in one of the modules. There is a common reception and waiting area serving the entire space. The unit, while brand new, has not yet been equipped with furnishings, equipment, supplies, communication system, dialysis machines, tanks, etc, so its setup and to some degree its efficiency cannot yet be determined.

The method of measurement used to calculate the available square footage within the institution gives us an accurate reading, leading to a truer measure of the useable square footage than in a traditional office space. A traditional office space generally suffers a loss factor of 30% or greater, meaning that a 12,000 sf requirement necessitates approximately 17,143 sf to achieve the same net square footage result.

Space in medical offices found in this area typically is in or competes with retail/commercial space in residential buildings. Rents range from approximately $30 RSF for office locations to upwards of $60 RSF for spaces considered and used as retail. There is average to above average retail in the area, benefitting from the hospital's location and its population, keeping the retail pricing firm. The low end spectrum of the market should typically be in the older, un-renovated or minimally renovated office or residential buildings. They would typically not be built for medical but for general office use and not provide full building services. Such offices would generally be found on side street locations. However, the size of the unit being evaluated for this report is typically not found in these buildings due to size limitations. The high end spectrum of the market would be in the larger and recently renovated buildings providing full service amenities such as concierge service with 7 day, 24 hour access.

Alternately, the spaces would be retail spaces leased to either retail users or non-retail users taking advantage of retail street presence and increased visibility. Medical offices in these buildings would be to code, be in good to excellent condition, with enhanced plumbing, electric and HVAC systems, and in many instances would also have substantial fixture improvements within the space (millwork, plumbing fixtures and cabinetry). These building spaces, while used for medical offices, would also be quite suitable for general office and specifically retail purposes but for the specific build-out needed for medical. Most medical offices, in general, unless built within the last 6-7 years or recently renovated, will not meet current ADA or other municipal code requirements, and unless nothing but a cosmetic face lift is contemplated, would require structural changes, permits, filings, etc. to meet code.

These proposed Renal Dialysis unit, however, is specific to the hospital's use as an outpatient dialysis unit, which makes it somewhat more difficult to compare to spaces found within the general community. In addition, there is little or no value placed on common areas so our evaluation only considers the space within the demised premises. Accordingly, we value the space at approx $35/sf net of any services and any additional physical space add, to account for common area within the premises or common area needed for access to the premises.

In addition to the base rent of $35, which we previously described as net, you would add in approximately $3.50/sf for utility services but would credit $2.25/sf for cleaning services, since the tenant will be responsible for this, and as much as $5/sf for IT and telephone services depending on the level of sophistication provided. In addition to these services, the tenants occupying the spaces do not have to maintain service contracts or maintenance of AC, communications or office equipment etc. That can be value-added into the cost of the space as well. Accordingly, we value the space at a gross rent of approx $44sf with services provided, which would be consistent with general office tenants.

It has been our experience that a build out of a Renal Dialysis unit, complete with the extensive plumbing, technical equipment, maintenance and regulatory agency compliance required to provide dialysis services equates to $350 per square foot. This figure would be broken down to approximately $250/sf for unit build out and approximately $100/sf for FF&E (furniture, fixtures, and equipment). While this sum describes the build out costs for the intended use, it also includes base building work performed to include, but not be limited to HVAC installation and equipment, electrical, plumbing and other building conditions that would be required and calculated in the total fit-out costs. On a 10 year lease, fully amortized and with an interest rate factor on the money used for the build out, this comes to $40 per square foot. Coupled with a market rent of approximately $40 per square foot for the area, the result would be a rent of $80 per square foot for a built dialysis space that is operational and current to code.

However, while the unit is new and has an anticipated occupancy several months away, it must be noted that significant design flaws exist that contribute to a less than ideal flow for this space as used for a dialysis unit. More importantly, the attraction to the space by an operator is limited because of the inability to treat the proper number of patients without a significant reworking of the space and the time lost to do so. Specifically, the unit has been built as two (2) separate operating sections and the unit's ultimate function requires additional construction costs to streamline its use. Alternately, the build out in its current configuration requires some duplicity in staffing, thereby increasing the unit's operating costs. The isolation room will be reduced to one and the extra space, we assume, will be reconfigured for additional chairs. We estimate the construction costs to reconfigure and/or complete the spaces to be at $30/sf. FF&E will be provided for an paid for by the operator. Additionally, it has been determined that the prospective tenant will be responsible for the cost to complete the unit's construction and fully equip and furnish the unit. Accordingly, we believe the rent for this newly built outpatient dialysis unit is approximately $50 per square foot.

In the event I can be of any further assistance to you, please do not hesitate to call me.

Very truly yours,

Michael Dubin
Partner
Savitt Partners LLC

SAVITT PARTNERS

June 13, 2012

Dion Wilson
Director
Office of Facilities Development Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: Appraisal of dialysis unit at Kings County Hospital Center

Dear Dion,

Pursuant to your request, on Wednesday, March 28, 2012, I visited the referenced Renal Dialysis unit to establish the fair market value (FMV) rent of the existing dialysis unit, based on the information that you provided to me, knowledge of area rental values and the condition of the premises. The evaluation is subject to the following assumptions:

- The hospital operates a 24 chair outpatient Renal Dialysis unit
- The square footage of the unit is approximately 8,970 Gross Internal (net useable) RSF
- General medical space in the surrounding Wingate/Crown Heights community leases at a rent of approximately $21 per square foot on average.

The Renal Dialysis unit is located within the Kings County Hospital Center, which is readily accessible by the number 2 subway line at Winthrop Street and by bus routes running along Clarkson, New York, and Nostrand Avenues. Building parking is limited and there is surface street parking available.

The Renal Dialysis unit is located on the hospital's 6th floor. It consists of 17,940 gross useable square feet. It is divided equally between inpatient and outpatient services. For the purpose of this report only the outpatient portion and any common areas used for outpatient treatment are described. The outpatient portion of the unit comprises approximately 8,970 gross useable square feet. The central corridor that accesses the entire Renal Dialysis unit houses the entrance to both spaces and shares a common waiting room. There are staff lockers, an office, and phone alcove in the common area here but it could not be determined who the users are.

The outpatient portion consists of 24 dialysis stations (chairs), 1 private exam room, 1 staff locker room with toilet, 2 additional toilets, 3 doctor's offices, 1 private exam room and reception. There are also storage rooms. The outpatient unit is set up as 3 open units; 2 with six chairs each and the third with twelve chairs. The large unit has 2 nurse's stations with a smaller nurses/staff monitoring station in each of the others. This space was built with a proper design for outpatient dialysis services and is of the correct size to maximize a unit's efficiency.

The adjacent but connected inpatient portion has larger storage areas and the water treatment room, pump room, and other private offices. It is assumed that some storage, the water treatment and pump rooms service both portions of the premises. The square footage for the space, therefore, must be adjusted to account for this by an estimated 1,000 square feet. HVAC appears to be provided by the main building systems.

The method of measurement used to calculate the available square footage within the institution gives us an accurate reading, leading to a truer measure of the useable square footage than in a traditional office space. A traditional office space generally suffers a loss factor of 30% or greater, meaning that a 9,000 sf requirement necessitates approximately 12,800 sf to achieve the same net square footage result.

Space in medical offices found in this area typically is in or competes with retail/commercial space in residential buildings. Rents range from approximately $19 RSF - $26 RSF. The low end spectrum of the market should typically be in the older, un-renovated or minimally renovated offices or residential buildings. They would typically have been converted to small spaces found on the ground floor of residential buildings and would not provide full building services. Such offices would generally be found on side street locations. However, the size of the unit being evaluated for this report is typically not found in these buildings due to size limitations and use. Renal Dialysis is considered invasive to building systems and accordingly is not always welcomed as a tenant. Tenants may also pay a premium to Landlord for the use. The high end spectrum of the market would be in the larger and recently renovated buildings providing more services. These spaces are more limited in this location.

More commonly, the spaces would be retail spaces leased to either retail users or non-retail users taking advantage of retail street presence and increased visibility. Medical offices in these buildings would be to code, be in good to excellent condition, with enhanced plumbing, electric and HVAC systems, and in many instances would also have substantial fixture improvements within the space (millwork, plumbing fixtures and cabinetry). These building spaces, while used for medical offices, would also be quite suitable for general office and specifically retail purposes but for the specific build-out needed for medical. Retail will garner higher rents. Most medical offices, in general, unless built within the last 6-7 years or recently renovated, will not meet current ADA or other municipal code requirements, and unless nothing but a cosmetic face lift is contemplated, would require structural changes, permits, filings, etc. to meet code.

Retail Space in a hospital zone typically garners a rent premium based on its proximity to a hospital. The added population and street traffic is a financial benefit most tenants of the space are willing to pay for.

This dialysis unit, however, was developed and is specific to the hospital's use, as an outpatient facility which makes it somewhat more difficult to compare to spaces found within the general community. In addition, there is little or no value placed on common areas so our evaluation only considers the space within the demised premises. Accordingly, we value the space at approx $22/sf net of any services and any additional physical space add, to account for common area within the premises or common area needed for access to the premises.

In addition to the base rent of $22, which we previously described as net, you would add in approximately $3.50/sf for utility services, as much as $5/sf for IT and telephone services depending on the level of sophistication provided, but would credit $2.25/sf for cleaning services since the tenant will be responsible for this. In addition to these services, the tenants occupying the spaces do not have to maintain service contracts or maintenance of AC, communications or office equipment etc. That can be value-added into the cost of the space as well. Accordingly, we value the space at a gross rent of approx $27/sf with services provided, which would be consistent with general office tenants found within the general community.

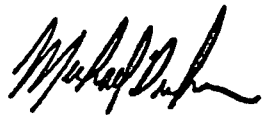
It must be noted that the unit is 10 years old and presents in an above average in condition. The infrastructure and equipment must be evaluated when determining this build out and FF&E component to establish an ultimate rental value.

It has been our experience that a build out of a dialysis unit, complete with the extensive plumbing, technical equipment, maintenance and regulatory agency compliance required to provide dialysis services equates to $350 per square foot. This figure would be broken down to approximately $250/sf for the unit build out and approximately $100/sf for FF&E (furniture, fixtures, and equipment). While this sum describes the build out costs for the intended use, it also includes base building work performed to include, but not be limited to HVAC installation and equipment, electrical, plumbing and other building conditions that would be required and calculated in the total fit-out costs. On a 10 year lease, fully amortized and with an interest rate factor on the money used for the build out, this comes to $40 per square foot for a newly constructed and equipped space. Coupled with a market rent of approximately $50 per square foot for the area with services and utilities, the result would be a rent of $70 per square foot for a built dialysis space that is operational and current to code.

It is important to note, however, that while this is a well functioning dialysis unit for outpatient use, it is also a 10 year old installation with equipment of the same age. As such, the useful life of the installation has been significantly amortized and the equipment is in need of upgrades, repair or replacement. Accounting for this, therefore, it would be proper to recognize that the value of this unit would be reduced by as much as $20 per square foot for any potential tenant or licensee, which would be charged with the obligation to upgrade, repair, replace and modernize both the space, equipment and infrastructure. Accordingly, we place the value of this unit at approximately $54 per square foot for the built dialysis unit in its current condition and configuration.

In the event I can be of any further assistance to you, please do not hesitate to call me.

Very truly yours,



Michael Dubin
Partner
Savitt Partners LLC

SAVITT PARTNERS

June 13, 2012

Dion Wilson
Director
Office of Facilities Development Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: Appraisal for a proposed dialysis unit at Lincoln Hospital, 234 East 149th Street, Bronx, NY 10451

Dear Dion,

Pursuant to your request, on Wednesday, May 16, 2012, I visited the referenced hospital community to canvass and establish the fair market value (FMV) rent for the proposed dialysis unit, based on the information that you provided to me and knowledge of area rental values. The evaluation is subject to the following assumptions:

- The hospital will house a soon to be built outpatient Renal Dialysis unit
- The square footage of the unit is approximately 5,998 Gross Internal (net useable) RSF
- General medical space in the surrounding community leases at a rent of approximately $25-32 per square foot on average. Retail along Morris Avenue and 149th Streets rent at approximately $100 per square foot on average.
- The unit is proposed to be located on the hospital's seventh floor.
- The proposed unit will be built and financed by the designated tenant/vendor.

The Renal Dialysis unit is slated to be located on the 7th floor within Lincoln Hospital in space that is currently being used as a storage facility. Lincoln is readily accessible by the number 2, 4, 5 A, B, C and D subway lines. Building parking is available and there is limited surface street parking. There is also a municipal parking facility nearby.

The size of the space should be able to treat and monitor up to 18 dialysis patients at a given time and is further capable of accommodating the lengthy time periods required for each patient's care. The actual number of chairs is still to be determined. While treating patients, the unit will also provide staff with opportunities to carry out administrative tasks. The unit will take advantage of the efficiencies of the hospital's electric, common areas, cleaning services, IT and telephone services etc. The method of measurement used to calculate the available square footage within the institution gives us an accurate reading, leading to a truer measure of the useable square footage than in a traditional office space. A traditional office space generally suffers a loss factor of 30% or greater, meaning that a 5,998sf requirement necessitates approximately 8,580sf to achieve the same net square footage result.

Space in medical offices found in this area typically is in or competes with retail/commercial space in residential buildings. Rents range from approximately $23 RSF - $32 RSF. The low end spectrum of the market should typically be in the older, un-renovated or minimally renovated offices or residential buildings. They would typically have been converted to small spaces found on the ground floor of residential buildings and would not provide full building services. Such offices would generally be found on side street locations. However, the size of the unit being evaluated for this report is typically not found in these buildings due to size limitations and use. Renal Dialysis is considered invasive to building systems and accordingly are not always welcomed as Tenants. Tenants may also pay a premium to Landlord for the use. The high end spectrum of the market would be in the larger and recently renovated buildings providing more services. These spaces are more limited in this location.

More commonly, the spaces would be retail spaces leased to either retail users or non-retail users taking advantage of retail street presence and increased visibility. Medical offices in these buildings would be to code, be in good to excellent condition, with enhanced plumbing, electric and HVAC systems, and in many instances would also have substantial fixture improvements within the space (millwork, plumbing fixtures and cabinetry). These building spaces, while used for medical offices, would also be quite suitable for general office and specifically retail purposes but for the specific build-out needed for medical. Retail will garner higher rents. Most medical offices, in general, unless built within the last 6-7 years or recently renovated, will not meet current ADA or other municipal code requirements, and unless nothing but a cosmetic face lift is contemplated, would require structural changes, permits, filings, etc. to meet code.

Retail Space in a hospital zone typically garners a rent premium based on its proximity to a hospital. The added population and street traffic is a financial benefit most tenants of the space are willing to pay for. The area seems to house medical offices in ground floor spaces of local apartment buildings. Morris Avenue and 149th Street are heavily trafficked retail corridors. The retail spaces command a premium and there is little vacancy. Most of the office space in the area aside from the previously described residential buildings area found on the 2nd – 4th floors of these retail spaces. In addition, there is little or no value placed on common areas so our evaluation only considers the space within the demised premises. Accordingly, we value the space at approx $28/sf net of any services and any additional physical space to account for common area within the premises or common area needed for access to the premises.

In addition to the base rent of $28, which we previously described as net, you would add in approximately $3.50/sf for utility services, $2.25/sf for cleaning services and as much as $5/sf for IT and telephone services depending on the level of sophistication provided. In addition to these services, the tenants occupying the spaces do not have to maintain service contracts or maintenance of AC, communications or office equipment etc. That can be value-added into the cost of the space as well. Accordingly, we value the space at a gross rent of approx $40/sf with services provided, which would be consistent with general office tenants found within the general community. These additional costs can be adjusted based on actual services provided. For example, cleaning costs can be deducted if provided by tenant/vendor, as well as electric costs if metered or submetered directly.

It has been our experience that a build out of a dialysis unit, complete with the extensive plumbing, technical equipment, maintenance and regulatory agency compliance required to provide dialysis services equates to $350 per square foot. This figure would be broken down to approximately $250/sf for the unit build out and approximately $100/sf for FF&E (furniture, fixtures, and equipment). These build out costs, hard and soft construction costs and FF&E expenses will be borne by the tenant/vendor.

In the event I can be of any further assistance to you, please do not hesitate to call me.

Very truly yours,

Michael Dubin
Partner
Savitt Partners LLC

SAVITT PARTNERS

June 19, 2012

Dion Wilson
Director
Office of Facilities Development Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: Appraisal of dialysis unit at Metropolitan Hospital

Dear Dion,

Pursuant to your request, on Wednesday, March 28, 2012, I visited the referenced property to evaluate the fair market value (FMV) rent of the newly built dialysis unit, based on the information that you provided to me, knowledge of area rental values and the condition of the premises. The evaluation is subject to the following assumptions:

- The hospital will soon open a 12 chair Renal Dialysis unit
- The square footage of the unit is approximately 5,015 Gross Internal (net useable) RSF
- General office/retail space in the surrounding community leases at a rent of approximately $70 per square foot through the Upper East Side corridor of York Avenue through Lexington Avenue to 96th Street.

The Renal Dialysis unit is located within the Metropolitan Hospital complex, which is readily accessible by the number 6 subway lines at 96th Street and Lexington Avenue and by bus routes running East/West along 96th Street and North/South along First through Lexington Avenue. There is no building parking but there are public parking facilities nearby, as well as on street surface parking.

The proposed dialysis unit represents what we believe is a dialysis unit efficiently designed and built in accordance with all regulatory agency requirements and to a building standard consistent with an institutional location. The unit will have the ability to treat and monitor up to 12 dialysis patients, on an outpatient basis, at a given time and will be further capable of accommodating the lengthy time periods required for each patient's care. While treating patients, the unit will also provide staff with opportunities to carry out administrative tasks. The unit will take advantage of the efficiencies of the hospital's electric, common areas, cleaning services, IT and telephone services etc provided.

The 14th floor Renal Dialysis unit consists of 5,015 internal useable square feet. There is no common area mark up typical of commercial space which would be leased outside of an institutional setting.

The newly constructed unit consists of 12 dialysis stations, including one (1) isolation space. There are 3 restrooms - one staff, one patient, and one for the isolation room. Outside of the unit there is a family waiting area large enough to accommodate 8 visitors, that also contains a restroom for the visitors. The unit has a private exam room and one nurse's station currently set up with 7 chairs in this working area to monitor the patients.

The unit is fully built, equipped with the new dialysis equipment in place, general equipment, furniture and phones. It has never been operational and is ready to receive its first outpatients.

The unit benefits from its own, designated HVAC unit exclusive to the dialysis unit. The ceilings are finished to 8ft. There are floor drains throughout the space fitted into concrete floors that have been painted and textured.

Besides the family waiting area there is an RO (reverse osmosis) water treatment room, a storage room of approximating 10x18 and an administrative office area, all located outside of the Renal Dialysis unit but included within the square footage measurements for this evaluation.

The method of measurement used to calculate the available square footage within the institution gives us an accurate reading, leading to a truer measure of the useable square footage than in a traditional office space. A traditional office space generally suffers a loss factor of 30% or greater, meaning that a 5,000 sf requirement necessitates approximately 7,200 sf to achieve the same net square footage result.

Space in medical offices found in this area typically is in or competes with retail/commercial space in residential buildings. Rents range from approximately $40 RSF for office locations to upwards of $90 RSF for spaces considered retail. The low end spectrum of the market should typically be in the older, un-renovated or minimally renovated office or residential buildings. They would typically not be built for medical but for general office use and not provide full building services. Such offices would generally be found on side street locations. However, the size of the unit being evaluated for this report is typically not found in these buildings due to size limitations and use. Renal Dialysis is considered invasive to building systems and accordingly are not always welcomed as Tenants. Tenants may also pay a premium to Landlord for the use. The high end spectrum of the market would be in the larger and recently renovated buildings providing full service amenities such as concierge service with 7 day, 24 hour access.

Alternately, the spaces would be retail spaces leased to either retail users or non-retail users taking advantage of retail street presence and increased visibility. Medical offices in these buildings would be to code, be in good to excellent condition, with enhanced plumbing, electric and HVAC systems, and in many instances would also have substantial fixture improvements within the space (millwork, plumbing fixtures and cabinetry). These building spaces, while used for medical offices, would also be quite suitable for general office and specifically retail purposes but for the specific build-out needed for medical. Retail will garner higher rents. Most medical offices, in general, unless built within the last 6-7 years or recently renovated, will not meet current ADA or other municipal code requirements, and unless nothing but a cosmetic face lift is contemplated, would require structural changes, permits, filings, etc. to meet code.

There is an interesting real estate dynamic, however for this location. Commercial spaces south out of 96th street along the First and Second Avenue corridors benefit from the higher end of the described rental rates. Spaces north of 96th Street, in the same north-south corridor do not have the same concentration of retail or office space and have disproportionately lower rents due in part to the lack of foot traffic. Rents would fall by as much as 20% ($30-$70 respectively)

This proposed dialysis unit, however, is specific to the hospital's use, as an outpatient facility which makes it somewhat more difficult to compare to spaces found within the general community. In addition, there is little or no value placed on common areas so our evaluation only considers the space within the demised premises. Accordingly, we value the space at approx $38/sf net of any services and any additional physical space add, to account for common area within the premises or common area needed for access to the premises.

In addition to the base rent of $37.75, which we previously described as net, you would add in approximately $3.50/sf for utility services, but would credit $2.25/sf for cleaning services since the tenant will be responsible for this, and as much as $5/sf for IT and telephone services depending on the level of sophistication provided. In addition to these services, the tenants occupying the spaces do not have to maintain service contracts or maintenance of AC, communications or office equipment etc. That can be value-added into the cost of the space as well. Accordingly, we value the space at a gross rent of approximately $44/sf with services provided, which would be consistent with general office tenants found within the general community.

It has been our experience that a build out of a dialysis unit, complete with the extensive plumbing, technical equipment, maintenance and regulatory agency compliance required to provide dialysis services equates to $350 per square foot. This figure would be broken down to approximately $250/sf for the unit build out and approximately $100/sf for FF&E (furniture, fixtures, and equipment). While this sum describes the build out costs for the intended use, it also includes base building work performed to include, but not be limited to HVAC installation and equipment, electrical, plumbing and other building conditions that would be required and calculated in the total fit-out costs. On a 10 year lease, fully amortized and with an interest rate factor on the money used for the build out, this comes to $40 per square foot. Coupled with a market rent of approximately $44 per square foot for the area, the result would be a rent of $84 per square foot for a built dialysis space that is operational and current to code.

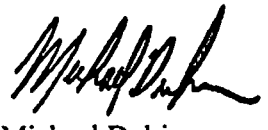
However, while the unit is new, plumbed and equipped, it appears to have been designed improperly for its most efficient dialysis use. There are areas of the unit's build out and design that will cause the ultimate tenant or licensee to undertake additional construction costs or other overhead or operating costs that would not otherwise exist had the unit been built according to that user's plans. Specifically, most users expect an outpatient unit to house approximately 25 chairs for optimum efficiency. The limited size of this unit causes an operator to spread its costs over a smaller operation even though the staffing requirements remain fairly constant. Further, this unit is built without a central distribution for the acid and base materials, resulting in either additional construction retrofit or an additional personnel function. Finally, these deficiencies in size and design will have an impact on a prospective tenant's or licensee's interest in operating the unit. Accordingly, we will reduce the rental value by $30 per square foot, bringing the rental

value to approximately $54 per square foot for a built dialysis unit equipped and current to code but with these shortcomings. It should be noted that if the prospective operator chose to reimburse HHC for the FF&E component, the rental value can be further reduced on a straight dollar per dollar basis.

Further, we have been advised that the FF&E will be addressed separately. As such, the original cost of approximately $200,000.00 as amortized will be paid for by the prospective tenant and the rent shall be reduced accordingly. Therefore, on a 10 year amortization with 10% of the term for this equipment having been used, the cost of $180,000.00 divided by the square footage of 5,015 gross square feet further reduces the actual rental value by $4, bringing it to $50/sf.

In the event I can be of any further assistance to you, please do not hesitate to call me.

Very truly yours,



Michael Dubin
Partner
Savitt Partners LLC

SAVITT PARTNERS

June 13, 2012

Dion Wilson
Director
Office of Facilities Development Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: Appraisal for a proposed dialysis unit at North Central Bronx Hospital ("NCB"), 3423 Kossuth Avenue at 210th Street, Bronx, N.Y., 10467

Dear Dion,

Pursuant to your request, on Wednesday, May 16, 2012, I visited the referenced hospital community to canvass and establish the fair market value (FMV) rent for the proposed dialysis unit, based on the information that you provided to me and knowledge of area rental values. The evaluation is subject to the following assumptions:

- The hospital will house a soon to be built outpatient Renal Dialysis unit
- The square footage of the unit is approximately 6,825 Gross Internal (net useable) RSF
- General medical space in the surrounding community leases at a rent of approximately $25 per square foot on average. Retail along Jerome Avenue and East Gun Hill Road rents at approximately $60 per square foot on average.
- The proposed unit will be built and financed by the designated tenant/vendor.
- The Renal Dialysis unit is slated to be located on the 6th Floor within NCB.

NCB is located off of East Gun Hill Road at 210th Street. It is readily accessible by the number 4 and D subway lines. Building parking is limited and surface street parking is available.

The size of the space should be able to treat and monitor up to 20 dialysis patients at a given time and is further capable of accommodating the lengthy time periods required for each patient's care. The actual number of chairs is still to be determined. While treating patients, the unit will also provide staff with opportunities to carry out administrative tasks. The unit will take advantage of the efficiencies of the hospital's electric, common areas, cleaning services, IT and telephone services etc. The method of measurement used to calculate the available square footage within the institution gives us an accurate reading, leading to a truer measure of the useable square footage than in a traditional office space. A traditional office space generally suffers a loss factor of 30% or greater, meaning that a 6,825sf requirement necessitates approximately 9,750sf to achieve the same net square footage result.

Space in medical offices found in this area typically is in or competes with retail/commercial space in residential buildings. Rents range from approximately $20 RSF - $35 RSF. The low end spectrum of the market should typically be in the older, un-renovated or minimally renovated

offices or residential buildings. They would typically have been converted to small spaces found on the ground floor of residential buildings and would not provide full building services. Such offices would generally be found on side street locations. However, the size of the unit being evaluated for this report is typically not found in these buildings due to size limitations and use. Renal Dialysis is considered invasive to building systems and accordingly is not always welcomed as a Tenant. Tenants may also pay a premium to Landlord for the use. The high end spectrum of the market would be in the larger and recently renovated buildings providing more services. These spaces are more limited in this location.

More commonly, the spaces would be retail spaces leased to either retail users or non-retail users taking advantage of retail street presence and increased visibility. Medical offices in these buildings would be to code, be in good to excellent condition, with enhanced plumbing, electric and HVAC systems, and in many instances would also have substantial fixture improvements within the space (millwork, plumbing fixtures and cabinetry). These building spaces, while used for medical offices, would also be quite suitable for general office and specifically retail purposes but for the specific build-out needed for medical. Retail will garner higher rents. Most medical offices, in general, unless built within the last 6-7 years or recently renovated, will not meet current ADA or other municipal code requirements, and unless nothing but a cosmetic face lift is contemplated, would require structural changes, permits, filings, etc. to meet code.

Retail Space in a hospital zone typically garners a rent premium based on its proximity to a hospital. The added population and street traffic is a financial benefit most tenants of the space are willing to pay for. The hospital competes with Montefiore Medical Center with one of its campuses located on an adjacent street. Much of the campus medical spaces are connected and leased to that institution or private practices that benefit from the later. Accordingly, there is little available office space. The area seems to be dotted with medical offices in ground floor spaces of local apartment buildings and ground floor units in private homes. In addition, there is little or no value placed on common areas so our evaluation only considers the space within the demised premises. Accordingly, we value the space at approx $28/sf net of any services and any additional physical space to account for common area within the premises or common area needed for access to the premises.

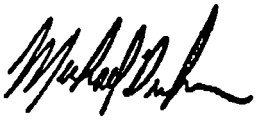
In addition to the base rent of $28, which we previously described as net, you would add in approximately $3.50/sf for utility services, $2.25/sf for cleaning services and as much as $5/sf for IT and telephone services depending on the level of sophistication provided. In addition to these services, the tenants occupying the spaces do not have to maintain service contracts or maintenance of AC, communications or office equipment etc. That can be value-added into the cost of the space as well. Accordingly, we value the space at a gross rent of approx $40/sf with services provided, which would be consistent with general office tenants found within the general community. These additional costs can be adjusted based on actual services provided. For example, cleaning costs can be deducted if provided by tenant/vendor, as well as electric costs if metered or submetered directly.

It has been our experience that a build out of a dialysis unit, complete with the extensive plumbing, technical equipment, maintenance and regulatory agency compliance required to provide dialysis services equates to $350 per square foot. This figure would be broken down to

approximately $250/sf for the unit build out and approximately $100/sf for FF&E (furniture, fixtures, and equipment). These build out costs, hard and soft construction costs and FF&E expenses will be borne by the tenant/vendor.

In the event I can be of any further assistance to you, please do not hesitate to call me.

Very truly yours,



Michael Dubin
Partner
Savitt Partners LLC

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Room 527, New York, NY 10013 Tel: 212-788-3300 Fax: 212-267-6905
nyc.gov/hhc

Office of Legal Affairs

MEMORANDUM

To: **Lauren Johnston**
Medical & Professional Affairs

From: **Karen Rosen** (KB)
Assistant Director

Date: **June 15, 2012**

Subject: **VENDEX Approval**

For your information, on June 15, 2012 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Atlantic Dialysis Management Services.

cc: Norman M. Dion, Esq.

Proposal for:
Atlantic Dialysis Management Services to provide Dialysis Services for HHC

Board of Directors Meeting

July 26, 2012

The Context

- Ongoing financial threats to HHC budget
- Although dialysis is an important clinical service for our patients, we currently are losing $24m* annually providing the service
- Also, we are currently unable to provide outpatient dialysis services to all patients who need the service
- Capital needs for current facilities continue to increase

* Based on FY2010 actual costs

Ensuring Access

Vendor to provide:

- Dialysis treatment for all ambulatory patients, regardless of insurance status
- a fully licensed and compliant site within our facilities, with HHC nephrologist as Medical Director
- 24 hour, 7 day per week acute dialysis service for inpatients

Maintaining Quality

- For inpatients and outpatients health care will continue to be managed by HHC physicians, and their dialysis supervised by our nephrologists
- Care will be provided in a manner that meets or exceeds all required standards
- ADMS has been successfully providing dialysis services at Elmhurst Hospital Center for 6 years
- 80% of US hospitals have elected to outsource their dialysis services
- Internally and externally reported indicators will be monitored and publically available

Financial Projections

9 year forecast

Total Projected Contract Cost

Acute dialysis fee for service payments	$65m
Chronic patients ineligible for any insurance*	$18m
Total Projected Contract Cost	**$83m**

Total Projected Savings

Dialysis cost avoided	$245m
Rental income from licensed space	$14m
HHC staff costs over 5 years**	($29m)
Total contract cost (per above)	($83m)
Total Projected Savings	**$147m**

* includes a provision for payment to vendor for up to 15%

** assumes 127 FTEs to be attrited over 5 years

License for Chronic Dialysis

- Licensed space in which to provide
  - Article 28 process to be followed
- Vendor to build new units
- Current equipment to be replaced by vendor, including water systems as needed

Annual License fees:

Facility	sq ft	cost per sq ft
KCHC	8970	$54.00
MHC	5015	$50.00
HHC	9260	$50.00
LMMHC*	5998	$40.00
NCB*	6825	$40.00

•*LMMHC and NCB sites are shell space which will be built out by the vendor
•KCHC is most efficiently developed and built. Other sites require further modifications to increase efficiency and productivity

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with Atlantic Dialysis Management Services LLC (the "Licensee") for use and occupancy of space to provide chronic dialysis services

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Atlantic Dialysis Management Services LLC ("Atlantic") to provide dialysis technical services to HHC patients

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation" or "Licensor") to execute a revocable license agreement with the Staten Island Inter-Agency Council for the Aging, Inc. (the "Licensee"), for its continued use and occupancy of space to provide services to seniors at the Sea View Hospital Rehabilitation Center and Home (the "Facility").

WHEREAS, in June 2007, the Corporation's Board of Directors authorized the President to execute a license agreement with the Licensee; and

WHEREAS, the Licensee's services will enhance the quality of life for the Facility's patients; and

WHEREAS, the Facility continues to have space available to accommodate the Licensee's needs.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with the Staten Island Inter-Agency Council for the Aging, Inc. (the "Licensee"), for its continued use and occupancy of space to provide services to seniors at the Sea View Hospital Rehabilitation Center and Home (the "Facility").

The Licensee shall continue to have use and occupancy of approximately 200 square feet of space on the first floor of the Administration Building and, subject to availability, occasional use of the Fireside Room also located in the Administration Building (the "Licensed Space"). The Licensee shall pay an occupancy fee of $3,600 per annum or approximately $18.00 per square foot.

The Facility shall provide structural maintenance and utilities to the Licensed Space. The Licensee shall provide housekeeping and general maintenance. The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the Licensed Space and shall also provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

The License Agreement shall be revocable by either party on sixty (60) days prior notice, and shall not exceed a term of five (5) years without further authorization by the Board of Directors of the New York City Health and Hospitals Corporation.

EXECUTIVE SUMMARY

LICENSE AGREEMENT
INTER-AGENCY COUNCIL FOR THE AGING
SEA VIEW HOSPITAL REHABILITATION CENTER AND HOME

The President seeks the authorization of the Board of Directors of the Corporation to execute a revocable license agreement with the Staten Island Inter-Agency Council for the Aging, Inc, ("IAC"), for its continued use and occupancy of space to provide services to seniors on the campus of Sea View Hospital Rehabilitation Center and Home ("Sea "View")

The IAC is an advocacy group established to identify and address the needs of the borough's elderly. The IAC is comprised of over sixty (60) organizations with a mission to facilitate and promote programs for senior citizens. The IAC advocates for the financial, educational, housing, health care, social and transportation needs of Staten Island's elderly population.

The IAC encourages seniors to recognize that they are productive members of a society that appreciates and respects the significance of their life experiences. The IAC has established committees, consisting of seniors, their families, representatives from various organizations providing services to seniors, and caregivers, to provide a forum for discussion and an action platform for policies and programs affecting the elderly. The committees are as follows:

Education: Promotes awareness of educational opportunities available to seniors. For example, the committee co-sponsors a program with the College of Staten Island offering college-level courses.

Housing: Focuses on the need for affordable senior housing.

Legislative: Monitors political developments and lobbies for legislation in support of seniors.

Natural Supports: Assesses the service needs of caregivers, family, and other support systems.

Senior Center and Social Activities: Provides a networking forum for managers of senior centers where cultural programs and social activities for seniors can be planned and discussed.

Transportation: Addresses the transportation requirements of the borough's seniors.

The IAC, working in conjunction with the staff of Sea View and the larger Staten Island Community, will provide services that will enhance the quality of life for the facility's patients.

The IAC will continue to have use and occupancy of approximately 200 square feet of space on the first floor of the Administration Building and, subject to availability, occasional use of the Fireside Room in the Administration Building. The IAC will pay an occupancy fee of $3,600 per annum, or approximately $18.00 per square foot.

Sea View will provide structural maintenance and utilities to the licensed space. The IAC will provide housekeeping and general maintenance. The IAC will indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the licensed space and will also provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

The license agreement shall be revocable by either party on sixty (60) days prior notice, and shall not exceed a term of five (5) years without further authorization by the Board of Directors of the Corporation.

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
125 Worth Street, Room 527, New York, NY 10013 Tel: 212-788-3300 Fax: 212-267-6905

Office of Legal Affairs

MEMORANDUM

To: **Pedro Irizarry**
Sea View Hospital Rehabilitation Center & Home

From: **Karen Rosen** (KR)
Assistant Director

Date: **June 26, 2012**

Subject: **VENDEX Approval**

For your information, on June 26, 2012 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Staten Island Inter-Agency Council for Aging, Inc

cc: Norman M. Dion, Esq.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with Eyes and Optics (the "Licensee") for use and occupancy of space to operate an optical dispensary at Gouverneur Healthcare Services (the "Facility").

WHEREAS, in April 2008 the Board of Directors authorized the President to enter into a license agreement with the Licensee which by its terms expires July 31, 2012; and

WHEREAS, the Facility operates an Ophthalmology and Eye Clinic, performing an array of vision screenings, diagnostic tests and ophthalmic procedures for its patient population; and

WHEREAS, the Licensee's optical dispensary augments available ophthalmology and eye clinic resources for the Facility's patient population by providing an on-site ophthalmic dispensary; and

WHEREAS, the optical dispensary has been a beneficial addition to the Facility's programs and the Facility desires to continue to provide space for the Licensee's operation.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with Eyes and Optics (the "Licensee") for use and occupancy of space to operate an optical dispensary at Gouverneur Healthcare Services (the "Facility").

The Licensee shall have the continued use and occupancy of approximately 100 square feet of space on the third floor of the Facility (the "Licensed Space"). The Licensee shall pay an occupancy fee of $45 per square foot, or approximately $4,500 per year. The occupancy fee represents the fair market value of the space. The cost of electricity shall be included in the occupancy fee. The occupancy fee shall be escalated by 3% per year.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the Licensed Space and shall also provide appropriate insurance naming each of the parties as additional insureds.

The term of this agreement shall not exceed five (5) years without further authorization of the Board of Directors of the Corporation. The License Agreement shall be revocable by either party on ninety (90) days notice.

EXECUTIVE SUMMARY

LICENSE AGREEMENT
EYES AND OPTICS
GOUVERNEUR HEALTHCARE SERVICES

The President of the New York City Health and Hospitals Corporation seeks authorization from the Board of Directors to execute a revocable license agreement with Eyes and Optics for use and occupancy of space to operate an optical dispensary at Gouverneur Healthcare Services ("Gouverneur").

Gouverneur operates an Ophthalmology and Eye Clinic, performing an array of vision screenings, diagnostic tests and ophthalmic procedures for its patient population. The Eyes and Optics optical dispensary augments available ophthalmology and eye clinic resources for Gouverneur's patient population by providing an on-site dispensary where patients are able to fill prescriptions for eye glasses, protective goggles, contact lenses and other related products. Eyes and Optics offers a range of moderate-to-low cost options for children and adults and its product lines are available for customers at all income levels.

Eyes and Optics shall have the continued use and occupancy of approximately 100 square feet of space on the third floor of the Facility (the "Licensed Space"). The Licensee shall pay an occupancy fee of $45 per square foot, or approximately $4,500 per year. The occupancy fee represents the fair market value of the space. The cost of electricity shall be included in the occupancy fee. The occupancy fee shall be escalated by 3% per year.

Eyes and Optics will indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the licensed space and will also provide appropriate insurance naming each of the parties as additional insureds.

The term of this agreement shall not exceed five (5) years without further authorization of the Board of Directors of the Corporation. The license agreement shall be revocable by either party on ninety (90) days notice.

SAVITT PARTNERS

May 23, 2012

Mr. Dion Wilson
Director
Office of Facilities Development, Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: Fair Market Value/appraisal of Eyes & Optics within Gouverneur Healthcare Services Facility located at 227 Madison Street, New York, NY 10002
On behalf of NYC Health & Hospitals Corporation

Dear Dion:

Pursuant to your request, on Tuesday, May 22, 2012, the referenced location was inspected in order to assess the Fair Market Value (FMV) of the designated retail space. This assessment is inclusive of the value of the tenant improvements and specified operating expenses such as utilities, housekeeping, security, service contracts, repairs and maintenance, etc. As the owner is designated as a not for profit (501C3) real estate taxes may not be applicable, however this expense will also be considered when evaluating the value of the space in order to provide a comprehensive FMV. This appraisal will assess the estimated value of the base rent inclusive of the tenant improvements and operating expenses. This evaluation is subject to the following:

- The Eyes and Optics space is appropriately zoned for the use (retail) within the space.
- The premises are located within the medical facility on the ground floor.
- This evaluation is for the purpose of establishing the FMV to lease/license the referenced property and considers numerous factors including but not limited to location, market conditions, market area comparables, lease terms and conditions, as well as tenant improvements.

There are two variables that must be considered in this evaluation which are in fact weighted greater than other variables. These unique factors are location and use.

The location of the space provides the tenant with an immediate and "captured' client base according to the facility operator. Eye wear prescriptions generated by the non-affiliated ophthalmology and optometry physicians within the medical facility generate 90% of the client base for this tenant. The community medical center also benefits by providing this amenity to the patients; the convenience of access to a retailer that can fill the prescription immediately. The proposed retail operation compliments the physician practices with an optical modality. The balance of the Eyes and Optics patient base comes from the existing customer referral and not walk-in street traffic.

It would be inappropriate and unjustifiable to evaluate the value of the referenced space as retail. Despite the obvious benefit of the readily available retail client base the space does not have the one most important value to be considered retail, street presence. Therefore the space must be assessed as commercial property with a retail build out and operation. Our assessment of the value of the tenant improvement for an optical, retail operation within the hospital at this specific location would be that it is dramatically less than the cost for a typical store front optical store. The space is open (minimal walls or partitions) with extensive space for display cases, both free standing and mounted on the unit's walls.

Another important factor is the value of the space for medical use. It is our experience that space within built medical facilities is valued at a premium simply due to the fact that it is a finite resource which is in demand. Allocation of medical space for ancillary use is a primary cause for concern for medical facility administrators. This is the case even when the organization can garner a higher rent for the space. This assessment takes into consideration the value of this space for medical facility operations.

It is apparent that proximity within the medical facility complex is attractive to this tenant and benefits the facility's patients as well. The provision of tenant services that are uncommon for retail facilities, i.e., 24-7 access, even if not utilized and the provision of full time services such as HVAC, repairs and maintenance, security, etc. must also be factored in this evaluation. However, when assessing the value the fact that the client base is limited to foot traffic within the medical facility impacts the success of the tenant. The tenant has no opportunity to promote their presence and the average pedestrian walking by the building would not be aware of this retail operation.

The referenced medical space is located on the ground floor away from the main entrance of the medical center. When assessing the FMV for this space we took into consideration the referenced factors and used comparables for medical space, hospital space and retail space within the immediate market where available to establish benchmarks for market rents. The proposal offers the licensee a full service building with amenities typically provided only by hospitals and full service medical office buildings and not retail properties. Typical retail operations are triple net, with the tenant absorbing all of the related operational expenses. However, this opportunity provides the tenant with comprehensive services which will be reflected in our evaluation.

Market conditions for each use were established for comparison. Medical space, specifically physician, private offices garners rents at $35 - $55 per RSF. Retail rents are $75-$100 per RSF. Asking rents in this market remained flat in 2011but landlord concessions are still negligible. Although these areas have medical offices, the lack of product, i.e., rental opportunities has maintained a stable rental market.

CONCLUSION

The ability to access the space and the provision of services without interruption is an amenity that benefits this retail tenant. This retail tenant, however, remains viable only as long as an eye care practice remains present at the premises. The minimal expense for tenant improvements was a variable that was evaluated as well.

Not all of the locations that were inspected for this report were handicapped accessible. To reiterate 24-7 security is a valuable and an attractive amenity provided by the landlord. All of the lavatories throughout the facility are ADA compliant. The corridors are also wheelchair accessible.

For the purpose of this appraisal, we shall assume that all operating expenses, i.e., security, refuse removal, utilities, repairs and maintenance, service contracts, etc. are provided by the landlord

In conclusion this analysis finds that the FMV for this space is essentially a hybrid due to the location of the space, proposed use and lack of opportunity to promote a true retail operation. However, it also provides the retailer with an immediate client base.

It is our professional opinion that the value of the referenced space is **$40 - $45** per RSF. It would not be appropriate to provide a tenant with a construction concession of rent abatement given the size of the unit.

It would be appropriate for the tenant to negotiate an escalation provision to the base rent/fee of 2.75% to 3% commencing in the second year of the license agreement. These would be commercially fair and reasonable terms based on the data and information assessed in this report.

In the event I can be of any further assistance to you, please do not hesitate to call me.

Very truly yours,

Michael Dubin
Partner