NYC HEALTH + HOSPITALS

AUDIT COMMITTEE MEETING
AGENDA

October 15, 2018
10:30 A.M.
125 Worth Street,
Rm. 532
5th Floor Board Room

CALL TO ORDER

- Adoption of Minutes June 13, 2018 — Ms. Emily A. Youssouf

INFORMATION ITEMS

- Fiscal Year 2018 Draft Financial Statements and Related Notes — Mr. John Ulberg/ Mr. Jay Weinman
- Fiscal Year 2018 Report to the Audit Committee — Ms. Tami Radinsky, Partner Grant Thornton
- Audits Update — Mr. Chris A. Telano
- Compliance Update — Ms. Catherine Patsos

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: June 13, 2018
TIME: 11:00 A.M.

COMMITTEE MEMBERS
Gordon Campbell, Board Chair
Mitchell Katz, MD
Josephine Bolus, RN

STAFF ATTENDEES
Andrea Cohen, Acting General Counsel, Legal Affairs
Colicia Hercules, Chief of Staff, Chairman's Office
Paul Albertson, Vice President, Supply Chain
Yvette Villanueva, Vice President, Human Resources
Nicole Constantine, Director, Human Resources
Catherine Patsos, Compliance Officer
Diane Toppin, Senior Director, Medical & Professional Affairs
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President
Devon Wilson, Senior Director, Office of Internal Audits
Chalice Piña, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Graham Gulian, Chief Operating Officer, NYC H+H/Kings County
Anthony Saul, Chief Financial Officer, NYC H+H/Kings County
Juan Checo, Hospital Police Director, NYC H+H/Kings County
Nathalie Jacelon-Lews, Coordinating Manager, NYC H+H/Kings County
Elsa Cosme, Chief Financial Officer, NYC H+H/Gotham
Jose Santiago, Controller, MetroPlus

OTHER ATTENDEES
Grant Thornton: Tami Radinsky, Lead Engagement Partner; Lou Feuerstein, Relationship Partner; Steven Dioguardi, Senior Manager and Ganesh Narayan, Insurance Senior Manager.

JUNE 13, 2018
AUDIT COMMITTEE MEETING
MINUTES

An Audit Committee meeting was held on Wednesday, June 13, 2018. The meeting was called to order at 10:20 A.M. by Mr. Gordon J. Campbell, Acting Board Chair. He stated that there will be a vote to approve the minutes later, in the meantime he directed the meeting to Mr. Jay Weinman.

Mr. Weinman stated that each year before our audited financial statements, our auditors present to the Audit Committee some required communications. They will go over the auditors' responsibility, the responsibility of management and those responsible for governance. They will talk about the scope and timing of the audit. He asked the auditors of Grant Thornton to approach the table to present their audit plan and introduced themselves.

Mr. Campbell requested that it would be helpful to state what is different from the past since we have a new audit firm.

Grant Thornton introduced themselves as follows: Tami Radinsky, Lead Engagement Partner; Lou Feuerstein, Relationship Partner; Steven Dioguardi, Senior Manager and Ganesh Narayan, Insurance Senior Manager.

Ms. Radinsky began the presentation by reporting on their responsibilities:

- Performing the following audits of financial statements as prepared by management, with your oversight, conducted under US Generally Accepted Auditing Standards (GAAS) and, where applicable, under Government Auditing Standards:
  - NYC Health + Hospitals for the fiscal year ending June 30, 2018
  - HHC Accountable Care Organization Inc. annual financial statements for the fiscal year ending June 30, 2018
  - MetroPlus Health Plan's annual statutory financial statements for the fiscal year ending December 31, 2018
  - HHC Insurance Company's annual statutory financial statements for the fiscal year ending December 31, 2018
  - Annual Report of Ambulatory Health Care Facility (AHCF-1)
  - Annual Report of Residential Health Care Facility (RHCF-4)
  - Communicating fraud risks to you identified during our audit
  - Communicating specific matters to you on a timely basis

Those charged with governance are responsible for:

- Overseeing the financial reporting process
- Setting a positive tone at the top and challenging NYC Health + Hospital's activities in the financial arena
- Discussing significant accounting and internal control matters with management
- Informing us about fraud or suspected fraud, including its views about fraud risks
- Informing us about other matters that are relevant to our audit, such as:
  - Objectives and strategies and related business risks that may result in material misstatement
  - Matters warranting particular audit attention
  - Significant communications with regulators
  - Matters related to the effectiveness of internal control and your oversight responsibilities
  - Your views regarding our current communications

Management is responsible for:

- Preparing and fairly presenting the consolidated financial statements including supplementary information in accordance with US GAAP
- Designing, implementing, evaluating, and maintaining effective internal control over financial reporting
- Communicating significant accounting and internal control matters to those charged with governance
- Providing us with unrestricted access to all persons and all information relevant to our audit
- Informing us about fraud, illegal acts, significant deficiencies, and material weaknesses
- Adjusting the financial statements, including disclosures, to correct material misstatements
- Informing us of subsequent events
- Providing us with certain written representations

Audit Timeline

May - June 2018	Client acceptance	• Client acceptance • Issue engagement letter • Conduct internal client service planning meeting, including coordination with audit support teams such as IT and tax
May – June 2018	Planning	• Meet with management to confirm expectations and discuss business risk • Discuss scope of work and timetable • Identify current-year audit issues and discuss recently issued accounting pronouncements of relevance • Initial Audit Committee communications
June 2018	Preliminary risk assessment procedures	• Develop audit plan that addresses risk areas • Update understanding of internal control environment • Coordinate planning with management and develop work calendar
June – July 2018	Interim fieldwork	• Perform final phase of audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Review final "draft" reports and other deliverables
October 2018	Deliverables	• Present draft reports and audit results to the Audit Committee and management • Issue final audit reports and other deliverables
December 2018	Deliverables	• Present final management letter to the Audit Committee
December 2018 - January 2019	MetroPlus Health Plan	• Perform walk-throughs of business processes and controls • Perform control testing over significant business processes • Perform selective substantive testing on interim balances
February 2019 – March 2019	MetroPlus Health Plan	• Perform final phase audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Issue the final audit report and other deliverables
April 2019 – August 2019	Cost Report Certification and HHC Insurance Company	• Perform applicable audit procedures and issue auditor's reports on cost reports for the skilled nursing facilities (RHCF-4) and diagnostic and treatment centers (AHCF) • Perform HHC Insurance Company audit and issuance of audit report
Timing to be determined	HHC ACO, Inc.	• Perform HHC ACO, Inc. audit and issuance of audit report (2018)

Ms. Radinsky turned the meeting over to Mr. Dioguardi to explain the audit approach.

Planning – In this phase we will update an understanding of and document your operations, control environment, accounts and information technology systems.

Risk Assessment - We use our understanding of your internal control system and operations to identify the inherent audit risks and strengths of your operations and information systems. By performing our risk assessment, we customize our audit approach to focus our efforts on the key areas.

Evaluation & Testing of Controls - We will evaluate the design effectiveness, and when appropriate, the operating effectiveness of the corporate governance and information technology controls, as well as the controls over each significant activity/process. Based on the result of this evaluation, we will determine the extent of our substantive testing.

Substantive Testing - When appropriate, we will use audit software to perform substantive testing. This enables us to retrieve information directly from your data files, if needed, without affecting the integrity of the data.

Concluding & Reporting - We will provide management and the Audit Committee with the results of our audit, including best practices and internal control recommendations.

Significant Risks and other areas of focus

Areas of focus – Accounts receivable, related contractual and uncollectable allowances and net patient service.
Procedures:

- Review account reconciliations including completeness and accuracy testing of the aged patient trial balances
- Perform analytical procedures over key indicators such as days in accounts receivable, account write offs and aging of balances
- Perform detailed account balance testing
- Perform cut-off testing
- Review management's methodology for estimating allowances
- Perform medical record testing for existence (no confirmation procedures) and detail test of subsequent cash receipts
- Perform a hindsight analysis of the prior year accounts receivable balance by reviewing cash collections on prior year balances
- Perform cash to revenue proof to assist in the validation of the revenue balance

Mr. Campbell asked if this will include billing as well? To which, Mr. Gioguardi answered yes, we do billing from a controlled testing aspect over existence of a patient, in terms of when the patient came in and that the service provided was appropriately put into the billing system.

Mr. Campbell asked if this will include going back to the medical records and then back up to see that it is billed appropriately? This is something that the board is looking at very closely, we hope that you give it your just do.

Ms. Radinsky assured Mr. Campbell that they will and added that she is aware that the system is mostly centralized, but we will be doing site visits as well.

Mr. Campbell added that there are lessons to be learned and the more you recommend that better.

Mr. Gioguardi continued on with the presentation.

Areas of focus – Estimate settlements due to third-party payers and net patient service revenue
Procedures:

- Review account reconciliations and roll-forwards and agree significant reconciling items to supporting schedules and documentation.
- Perform detailed account balance testing
- Review management's methodology for estimating amounts
- Review the financial statement presentation and disclosures

Mr. Weinman commented that those third-party include DSH and UPLs, things that are high value and required to be looked at extensively.

Areas of focus – Accrued liabilities reserves and contingencies
Procedures:

- Perform detail testing of management's calculations, including underlying inputs and data provided to specialists used in actuarial calculations for workers compensation, pension, OPEB, and self-insurance health liabilities
- Obtain and review outside actuarial reports used to determine pension and OPEB liabilities
- Assess for reasonableness the assumptions used in developing estimates
- Perform a search for unrecorded liabilities
- Test the completeness and accuracy of accounts payable aged trial balance
- Review payroll accruals for reasonableness

Areas of focus – Accounting Estimates
Planned procedures
The preparation of NYC Health + Hospital's financial statements requires management to make multiple estimates and assumptions that affect the reported amounts of assets and liabilities as well as the amounts presented in certain required disclosures in the notes to those financial statements. The most significant estimates relate to contractual allowances, the allowance for doubtful accounts, third-party liabilities, malpractice liabilities and actuarial estimates for the pension plan. Our procedures have been designed in part, to review these estimates and evaluate their reasonableness.

Ms. Radinsky commented that during our procedures if there are non-routine transactions, it will be high priority for us to look at.

Areas of focus – Financial Statement Disclosures
Planned procedures
Our procedures will also include an assessment as to the adequacy of NYC Health + Hospital's financial statement disclosures to ensure they are complete, accurate and appropriately describe the significant accounting policies employed in the preparation of the financial statements and provide a detail of all significant commitments, estimates and concentrations of risk, amongst other relevant disclosures required by accounting standards and industry practice.

Other Areas of Audit Focus
Perform substantive testing on key account balances as of June 30, 2018, as follows:

- Confirmation of cash and cash equivalents.
- Test significant fixed asset additions and disposals, as applicable.
- Test deferred revenue, as applicable.
- Obtain debt roll-forward and test payments throughout the year and compliance with debt covenants
- Review and testing the completeness of accounts payable and accrued liabilities.
- Perform an analytical review of revenues and expenses.
- Identify and test non-routine transactions to ensure appropriate accounting treatment.
- Independently confirm with internal and external legal counsel the potential exposure associated with outstanding claims, as applicable. Identify contingent liabilities or assets requiring accounting treatment or footnote disclosure.
- Perform fraud procedures
- Journal entry testing
- Review inter-company accounts
- Vendor testing

Ms. Radinsky stated that during their interim procedures, they will schedule meetings and interviews with Dr. Katz, Ms. Youssouf and Mr. Weinman and others to get a clear understanding on what is on their minds.

Mr. Gioguardi stated that the next item they will look at is Information Systems.
Our approach to testing the Organization's information technology systems is detailed as follows:

Phase 1: Understand and document business processes material to the audit
Our engagement team will:
- Meet with the Organization management to document our understanding of critical business processes and controls, and the technology used to support them.
- Document process flows, controls, and supporting technology relevant to audit objectives.

Phase 2: Assess information technology risks
- Our engagement team will identify information technology related risks and tailor our information technology review procedures to address those risks.

Phase 3: Identify information technology controls that support audit objectives
- General controls review – Review controls applicable to the overall processing environment.
- Applications review – Review specific business systems for application level and related controls.

Phase 4: Test technology related controls
- We will test the identified controls and determine their design and operating effectiveness, within the context of our audit scope and objectives. As a result of our test procedures, we will prepare observations and recommendations to improve existing information technology systems and associated controls and processes.

Mr. Weinman stated that what is going to be different from previous audits is the implementation of a new system for general ledger and accounts payable. This presents a new set audit procedure to make sure that that works properly.

Ms. Radinsky stated that if there were no questions regarding the audit process, she will direct the presentation to Mr. Feuerstein to discuss new standards that are applicable for this year and the future.

Mr. Feuerstein stated that there have been six GASBs issued that will impact the organization over next two to three years. There are only a couple of them that we have to worry about for 2018. One of them is GASB 83: Certain Asset Retirement Obligations. You will note that this not required until 2019, but because your financial statements are included with the City of New York, we have to make sure that our accounting policies are consistent between the two entities. It looks like they are going to adopt this obligation one year earlier.

There are two other June 30 2018 items, they will not have much of an impact.
GASB 85 - This is just question and answer regarding to previous GASB.
GASB 86 – It will only impact you if planning of refunding or irrevocably trust.

Ms. Radinsky asked if there were any questions regarding their presentation. She thanked the committee.

Mr. Campbell asked for a motion to adopt the minutes of the April 12th meeting. Motion was seconded.

Mr. Campbell then directed the meeting to Mr. Telano for Internal Audit update.

Mr. Telano began with the State Comptrollers Audit – Controls over Equipment. This audit began on December 2017 and it is still ongoing. Listed below are the eight sites they have visited, yesterday they indicated that they want to go to Sea View so that will make it nine.

1. NYC Health + Hospitals/Bellevue
2. NYC Health + Hospitals/Elmhurst
3. NYC Health + Hospitals/Jacobi
4. NYC Health + Hospitals/Harlem
5. NYC Health + Hospitals/Gotham Health, East New York
6. NYC Health + Hospitals/Gotham Health, Belvis
7. NYC Health + Hospitals/Gotham Health, Roberto Clemente
8. NYC Health + Hospitals/Gotham Health, South Queens

We had a meeting on June 7th, to discuss preliminary findings. One of the findings that they brought to our attention was that they physical counted ninety items and they were able to locate eighty-two in eight sites which is very impressive. H+H provide documentation on the missing items. The original cost of those eight items was almost $25,000 not including depreciation.

Mr. Campbell asked if there any other external audits going on. To which Mr. Telano responded that that is the only one.

Mr. Telano continued with the next audit – Audit of System-wide Review of Leased & Owned Vehicles. He asked Fred Covino, Paul Albertson and Roslyn Weinstein to approach the table.

This audit was suggested by the audit liaison from the Mayor's Office, George Davis. The audit was conducted at a very high level. We did not do specific testing looking for exceptions, we first evaluated what transpires at Central Office which is very impressive the way vehicles are being monitored. Then we went out to visit ten different sites to compare them to Central Office operations. We also sent questionnaires to every site and was provided with the listing of all the cars and a listing of their motor vehicle operators. The summary of 447 cars at the end of the year, including the facilities having a total 325, Central Office have 87 and the Inspector General (IG) have 35.

Central Office primarily leases vehicles, as Corporate Budget has provided them an analysis that is more fiscally responsible. The facilities purchased the vast majority of their vehicles and the cars for the IG were all purchased, as they required specialized equipment for those vehicles.

Mr. Campbell asked why the IG cars need sirens.

Dr. Katz responded that they said that they are part of law enforcement, and they follow-up with the FBI when money is taken or people are billing for things that they are not supposed to.

Mr. Covino commented that they had extensive discussions with the IGs Office to try to push for leases. H+H also clarified the breakdown of how many cars needed the specialized equipment and of note is that there were some time sensitivity to having the cars in operations in a timely manner.

Dr. Katz stated that due to this audit, he was made aware of the numbers of cars used by the IG's Office, and they have agreed to give up eight cars. Dr. Katz also stated that, Ms. Weinstein is in the process of reviewing the inventory of vehicles and present a plan to reduce the fleet. This review is only incidental to the audit, not that that was the purpose of the audit, but knowing about the number of cars, given our financial condition, it seems right that we should find ways to get by with fewer cars.

Mr. Telano continued, in conducting this review and visiting the facilities, we came to the conclusion that the control of the vehicles system-wide should be centralized and the policies and procedures be standardized for the following reasons:

a) No Centralized Procurement - Vehicles are purchased from numerous vendors. A review of eight of the facilities revealed that their vehicles were purchased from 46 different car dealers.
b) Excessive number of vehicles at the facilities – 132 are used for maintenance, or by specific departments such as Hospital Police and Behavioral Health. Although there are 193 vehicles used by the facility Transportation Departments, there are only 121 Motor Vehicle Operators (MVO) employed throughout the facilities. The reason for the abundance of vehicles is that the vehicles are purchased, and when they have reached their useful life expectancy, they remain in the fleet.

Mr. Campbell asked if they are purchased and not in use, why not get rid of them?

Ms. Weinstein answered that we are going to review the entire fleet and figure out those that are no longer working or available or does it make sense to use based on the number of MVOs drivers they have. I will also be working with Mr. Foley's office to communicate the process with the CEOs and each of the facilities transportation directors.

Mr. Telano continued, and stated that we noted that Central Office Transportation Department (and Correctional Health) utilizes a Global Fleet Management Service (ARI) to manage the preventive maintenance of their fleet. The facilities are not using ARI for vehicle maintenance to reduce the risk of inflated prices for parts and labor. Instead, the facilities are using outside vendors that do not always have contracted prices. In addition, some facilities are using mechanics that are not in close proximity to their sites. For example, Queens and Harlem use repair shops located in Brooklyn. ARI offers an open network with access to over 600 repair vendors within the five boroughs.

One of the reasons they have some many vehicles is because they are old, 260 of them are age from 1989 to 2012. The maintenance expenses are very high due to the age of the cars.

The disposal of the cars is not always done, the policies and procedures are not that strict so that everyone knows what the rules are. For example, at Kings County Hospital, a 2005 Freight RV has been stationed and not utilized since 2012.

The current Automobile Policy (OP 170-2) was established in 1997. It needs to be updated to reflect the operations currently practiced within Central Office Transportation.

The last item for this audit is the oversight of placards, this item was brought to the City Council in the creation of a special investigation unit and they were going to focus on placards as one of their areas of interest. We decided to include it in our audit and we found that there was a difference between the list maintained by Central Office Transportation and what we can physically locate at the sites. Due to the difference, there will be a periodic review and that should take care of itself.

Mr. Telano continued on to the next audit Volunteer Services at Kings County. He asked for the representatives to approach the table. They introduce themselves as follows: Graham Gulian; COO; Anthony Saul, CFO; Nicole Constantine, HR Director; Juan Checo, Hospital Police; Natalie Jacelon-Lewis, Coordinating Manager.

This audit was requested by Ms. Youssouf during the risk assessment for Fiscal Year 2018. During our review of background checks, we found that they were not done on a timely basis as 12 volunteers began working up to 77 days prior to obtaining results from the State Central Register Child Abuse search. Two volunteers have been active since October 2015 to April 2016 without having a background check at all and there was identification missing within the files.

Systems access was not disabled for inactive volunteers. Two of the inactive volunteers logged into the Active Directory after their end date. One of them logged into QuadraMed, this presented a possible breach which I forwarded to Corporate Compliance. They concluded that although a violation occurred, they could not determine if a breach occurred because the computer is located an area where anyone can use it.

Ms. Patsos commented that in that area, certain individuals are permitted to use someone else's credentials to get information from QuadraMed.

The Behavioral Health Department uses pre-signed black access forms to access the Network and QuadraMed. The volunteers are given the pre-signed form and they can check off any box they want.

The ID cards for 12 volunteers were still active 112 to 646 days after their separation date. One of the ID cards was used to swipe in 2,106 times during the 6 month period after the volunteer's separation date. Hospital Police determined that the volunteer's supervisor had retrieved the card and was using it in error to enter over 30 different areas within the facility.

The personnel information of the volunteers was not properly input to the PeopleSoft Human Resources database.

Mr. Saul thanked Mr. Telano for this audit and stated, one of things we noticed that we were not following the same process for employees as we use for volunteers. The process for employees is to notify IT, HR and Hospital Police to deactivate the account. Now we have implemented the same process for the volunteers.

In terms of the register not being on time, it partly an error in finance and the other one was trying to facilitate students that were coming into the Behavioral Health Program. In terms of finance, we have this program CABE, the majority of those individuals are vendors and they get paid through GHX. We found out that there were some volunteers included there and we did not steer them to the volunteer department to get assessed correctly, we have now corrected it.

In terms of the students coming into the Behavioral Health, because we were notified late in terms of them starting the program, we allowed them to start while we wait for the verification stage. We have implemented the process of no exceptions, that when they come in, they get processed and until the verification is received they do not start.

In terms of reconciliation to the system within PeopleSoft, every individual that has access to the facility needs to be reported. Previously, the volunteer department kept their active register. They were working with HISS to upload the data and all the data was not uploaded correctly and we did not timely reconciled it. Now we reconcile it on a monthly basis, we run the report and correct any discrepancy.

Ms. Villanueva commented that this is not unique to Kings County, I did conduct an audit of all the volunteers about 46 records across the system and we found similar issues. With the volunteers, we are required to do a preliminary criminal background check, which is the simplest form in H + H, it is not the same as the employees. We do not fingerprint them, it is a quick check. The issue we are having in the volunteers department, when it comes to the processing and background checks is that there are things unique like the Child Registry to Behavioral Health that is a requirement. If you are going to have someone like a volunteer in that service that does take some time to get a response.

Dr. Katz asked who is it required by?

Ms. Villanueva answered that it is required by the State, the Office of Mental Health (OMH), if anyone is in that service whether is a student or a volunteer, or an employee, and they must go through certain checks. Some facilities want Child Registry checks on all of their employees, some want it on Pediatrics, some on other services like the emergency room and that is kind of unique to the facilities. This is something we are discussing with them and challenging them with support from the legal department and from Dr. Charles Barron at Elmhurst just to determine if we need to have it done in all of the areas that is currently being required. It is creating an issue of over processing, while reducing H+H exposure to risk, we need to be conscious of over processing of our volunteers and employees.

Dr. Katz added that we want a sensible balance, we want to make sure that people are not going to harm our patients. On the other hand a check is no proof of anything other than what happened before they come into the facilities. I would rather we spend our efforts and money on training and supervising when they are with us. That seems to matter quite a lot more, than to be spending time and money on the past. Of course, we have to uphold whatever is required by law.

Ms. Villanueva stated that I do foresee that there will be standardization across the system. We are working with the CEOs and the Risk Management department, we want to make sure we are addressing their concerns. But it is very clear that we are over processing. Now that the Volunteer Department is under the Human Resources, we are trying to standardize including the background investigation standards making clear for them as to what they should do and should not do because they need guidance.

Dr. Katz asked if we know what other the facilities require, i.e. NYU, Columbia, what is considered the community standard?

Ms. Villanueva responded that we looked into that and we are quite extensive with what we require.

Mr. Campbell stated that he agrees with Dr. Katz in regards to standardization and he asked what is the timeline? To which Ms. Villanueva answered that they are looking at September.

Mr. Campbell requested that Ms. Villanueva comes back to the committee when the standardization is final.

Mr. Telano stated that that concludes his presentation.

Mr. Campbell directed the meeting to Catherine Patsos for the Corporate Compliance report.

Ms. Patsos started off with monitoring of Excluded Providers – Part of the Federal and State requirements, we have to make sure that we check and screen for excluded providers. During the period of April 1, 2018 and May 31, 2018, we identified one provider who is a Physician Affiliate Group of New York (PAGNY) affiliate physician at Harlem who had limitations placed on his license restricting him from being able to prescribe certain controlled substances and also requiring him to be monitored by a licensed board-certified physician during his period of probation. We have informed PAGNY and are in consult with Legal Affairs and Dr. Wright, Chief Medical Officer at Harlem.

Privacy Incidents and Related Report – Between April 1, 2018 and May 31, 2018, there were 20 privacy complaints, 6 were found to be violations, 5 were not substantiated, 5 were not in violation, 3 are still under investigation and 1 was a request for guidance.

The 3 that were found to be breaches are at Coney Island, Lincoln and Bellevue. In Coney Island, laboratory specimens for 5 patients went missing. They have added new procedures to transport and log specimens to and from the laboratory to better track the movement of specimens so that does not happen again. At Lincoln, one patient was given the incorrect discharge papers, which were returned to Lincoln. At Bellevue, one patient was mistakenly given

documentation of another patient, unfortunately we are not able to contact that patient. Notifications were sent out in all cases to the affected individuals.

OCR Inquiries Regarding Potential and/or Determined Privacy Incidents – There was one inquiry from the Office of Civil Rights (OCR) regarding the incident which occurred at Harlem which was reported at the last Audit Committee meeting involving the stolen laptop from the Audiology Department. The OCR requested additional information about the breach, including short-term and long-term remediation efforts and our policies and procedures and other internal controls documentation which were sent on May 29th.

Also, at the last meeting involving the stolen laptop from the Audiology Department, the OCC reported that it would be working with Enterprise Information Technology Systems (EITS) to develop a policy and procedure for documenting and securing biomedical devices that enter the Systems and connect to the System's network, as well as devices that do not connect to the System's network. The OCC and EITS are currently working on such a policy, and expect to have it completed before the next Audit Committee meeting.

Compliance Reports – For the period April 1, 2018 through May 31, 2018, there were 51 compliance reports, none of which were classified as Priority A, 13 were classified as Priority B and 38 were classified as Priority C reports.

Review and Updating of Compliance Policies and Procedures – We are still working on the Operating Procedures regarding the Federal and State False Claims Acts and Federal and State Laws Related to the Commission of Health Care Fraud. However, I am pleased to inform you that the Emergency Treatment and Active Labor Act has been signed by Dr. Katz and is currently in effect.

Status Update – DSHRIP Compliance Activities –

As reported to the Audit Committee in April 2018, NYC Health + Hospitals/OneCity Health ("OneCity Health"), as a Performing Provider System ("PPS") Lead in the DSRIP Program, is responsible for taking "reasonable steps to ensure that Medicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse.

OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations.

OneCity Health Partners were asked to confirm they have completed the compliance training requirements and specify the method by which the training was conducted.

The Attestation requires Partners who confirmed that they completed the SSL certification to include proof of such completion (e.g., a copy of the electronic confirmation receipt that OMIG provides to each Partner upon their SSL § 363-d certification submission) along with their completed Attestation.

The Attestation requires Partners who confirmed that they completed the DRA certification to include proof of the same (e.g., a copy of the electronic confirmation receipt that OMIG provides to each Partner upon their DRA certification submission) along with their completed Attestation.

To date, of the one hundred sixty-eight that were sent out, we received 77.

Audit of OneCity Health DSRIP Program by Outside Auditor - The committee voted in favor of the vendor Bonadio, which has extensive experience in this area. Bonadio has begun its audit of OneCity Health, and has provided a list of documents for OneCity Health to submit for the audit. Last Friday, June 8, 2018, Bonadio conducted a full-day walkthrough of OneCity Health, which covered OneCity Health's internal processes, including Partner selection and

contracting, quarterly reporting, funds flow, and the Partner portal. The audit is expected to be completed in October 2018.

With regard to ACO, there is no update.

HHC ACO Application for New York State ACO Certification of Authority – That application is still pending.

Aetna Desk Review Update - On April 16, 2018, the OCC received a draft of Aetna's review of the OCC's document submissions and its conclusions based thereon. According to the draft review, Aetna concluded that NYC Health + Hospitals passed three of the compliance requirements, and failed nine of the requirements. During a conference call with Aetna auditors, however, the OCC presented verification for five of the requirements that Aetna had concluded were failed, prompting Aetna to conclude that NYC Health + Hospitals passed those requirements.

On April 30, 2018, the OCC received Aetna's Notice of Compliance Program Audit (the "Audit Report"), which included Aetna's final conclusions regarding NYC Health + Hospitals' compliance with its audit. According to the Audit Report, NYC Health + Hospitals satisfied eight of the compliance requirements, but failed to satisfy four compliance requirements. The Audit Report also required NYC Health + Hospitals to submit to Aetna corrective action plans for the failed compliance requirements, which the OCC did on May 25, 2018. NYC Health + Hospitals has ninety (90) days to implement these corrective actions plans, most of which involve changes to Operating Procedures.

We are in the process of developing the FY 2018 Risk Assessment. On June 8th, we met with the Executive Compliance Work Group which reviewed the draft compliance assessment, this work is ongoing. As a follow-up we will be meeting with the facilities' compliance committees to address their concerns. The final product will be a final risk assessment that will be used to develop next fiscal year's work plan to address the risk that are identified. Ultimately the risks that are identified will be presented to the Audit Committee for risk tolerance and determination of the final fiscal year work plan.

Ms. Bolus asked if we are going to have the same problem with other insurance companies we bring in.

Ms. Patsos replied that this is the first time we had this review and nothing else has come through.

Mr. Campbell call for a motion to conduct an executive session to discuss matters of quality assurance, patient privacy; and potential litigation.

There being no other business, the meeting was adjourned at 11:34 AM.

Grant Thornton

2018 Audit Results
New York City Health and Hospitals Corporation

Meeting with the Audit Committee of the Board of Directors; Those Charged with Governance

October 15, 2018

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October 15, 2018

The Audit Committee of the Board of Directors
New York City Health and Hospitals Corporation

We are pleased to meet with you to discuss our audit results and status for the audit of New York City Health and Hospitals Corporation ("NYC Health + Hospitals") for the year ended June 30, 2018.

This report to the Board summarizes our audits, the scope of our engagement, the reports issued, any matters that came to our attention during the audits, communications required by our professional standards and current accounting issues that could or will impact NYC Health + Hospitals.

The audit approach was developed to express an opinion on the financial statements of the business type activities and the discretely presented component unit of NYC Health + Hospitals, a component unit of The City of New York, as of and for the year ended June 30, 2018, in accordance with professional standards.

NYC Health + Hospitals and Grant Thornton share a commitment to quality. Our firm's global vision, CLEARR, (**C**ollaboration, **L**eadership, **E**xcellence, **A**gility, **R**espect and **R**esponsibility) serves as the foundation for each step we take toward executing our firm strategy and achieving our vision. CLEARR is the way in which we provide the Grant Thornton Experience to our people and our clients. The most important element of the Grant Thornton Experience for our clients is our service. We recognize that our success depends entirely on how well we know and serve our clients. Nothing takes precedence over our commitment to meet each client's continuing need for effective, insightful and responsive professional service. This commitment means that you will receive the attention and service you deserve.

We look forward to meeting with you to present this report, address your questions and discuss any other matters of interest of the Board. This report is intended solely for the information and use of the Board, and management, and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

Grant Thornton LLP

Our Values are CLEARR

To achieve our global vision, we capitalize on our strengths by embracing the following values:

- Unite through global **Collaboration**
- Demonstrate **Leadership** in all we do
- Promote a consistent culture of **Excellence**
- Act with **Agility**
- Ensure deep **Respect** for people
- Take **Responsibility** for our actions

Our values serve as the foundation of each step we take toward achieving our vision. They guide our decision-making and ensure that our people make correct and appropriate choices.

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Responsibilities

An audit process has various stakeholders including: Grant Thornton, Management and Those Charged with Governance

Our Responsibilities

We are responsible for:

- Performing an audit under US GAAS and *Government Auditing Standards* of the financial statements prepared by management, with your oversight
- Forming and expressing an opinion about whether the financial statements are presented fairly, in all material respects in conformity with US GAAP
- Forming and expressing an opinion about whether certain supplementary information is fairly stated in relation to the financial statements as a whole
- Communicating specific matters to you on a timely basis; we do not design our audit for this purpose

An audit provides reasonable, not absolute, assurance that the financial statements do not contain material misstatements due to fraud or error. It does not relieve you or management of your responsibilities. Our respective responsibilities are described further in our engagement letter.

Management

Management is responsible for:

- Preparing and fairly presenting the financial statements in conformity with US GAAP
- Designing, implementing, evaluating, and maintaining effective internal control over financial reporting
- Communicating significant accounting and internal control matters to those charged with governance
- Providing us with unrestricted access to all persons and all information relevant to our audit
- Informing us about fraud, illegal acts, significant deficiencies, and material weaknesses
- Adjusting the financial statements, including disclosures, to correct material misstatements
- Informing us of subsequent events
- Providing us with certain written representations

Those Charged with Governance

Those charged with governance are responsible for:

- Overseeing the financial reporting process
- Setting a positive tone at the top and challenging the company's activities in the financial arena
- Discussing significant accounting and internal control matters with management
- Informing us about fraud or suspected fraud, including its views about fraud risks
- Informing us about other matters that are relevant to our audit, such as:
    - Objectives and strategies and related business risks that may result in material misstatement
    - Matters warranting particular audit attention
    - Significant communications with regulators
    - Matters related to the effectiveness of internal control and your related oversight responsibilities
    - Your views regarding our current communications and your actions regarding previous communications

Deliverables

The audit process is a mutual undertaking and executed in cooperation with management. It is a combined effort that gives full recognition to the existing internal controls as well as the assessment of inherent and control risks. There were no significant changes to the scope of planned deliverables.

Our 2018 audit scope is as follows:
Perform the following audits of financial statements as prepared by management, with your oversight, conducted under US Generally Accepted Auditing Standards (GAAS) and, where applicable, under *Government Auditing Standards*: • New York City Health and Hospitals Corporation ("NYC Health + Hospitals") for the fiscal year ended June 30, 2018 • NYC Health + Hospitals Accountable Care Organization Inc. annual financial statements for the fiscal year ended June 30, 2018 • Metro Plus Health Plan's annual financial statements under GAAP for the fiscal year ended June 30, 2018 • Metro Plus Health Plan's annual statutory financial statements for the fiscal year ending December 31, 2018 • NYC Health + Hospitals Insurance Company's annual statutory financial statements for the fiscal year ending December 31, 2018
Perform the following audits, as applicable, of cost reports for the year ended June 30, 2018 and issuance of certifications and attestation reports: • Annual Report of Ambulatory Health Care Facility (AHCF-1) • Annual Report of residential Health Care Facility (RHCF-4)
Internal control communications: • Issue management letter describing significant deficiencies and material weaknesses identified during the audit, if any
Required communications to Those Charged with Governance

Summary of Audit Process

	A five-step process
Planning	Reviewing our understanding of your operations, internal controls, accounting procedures and information systems.
Risk assessment	Using our understanding of your internal controls and operations to identify the inherent risks and strengths of your business and information systems. After assessing risks, our approach will be customized to focus on your key cycles.
Testing and evaluation of controls	Evaluate the operations and controls of each significant internal control system. Based on the results of this evaluation, the extent of substantive testing will be determined.
Substantive testing	Perform year-end procedures, when appropriate audit software will be used to perform substantive testing. This software will enable us to retrieve information from your data files without affecting the integrity of the data.
Concluding and reporting	Concluding your audit promptly. The drafts of the financial statements and management advisory comments were reviewed with those charged with governance and management prior to final issuance.

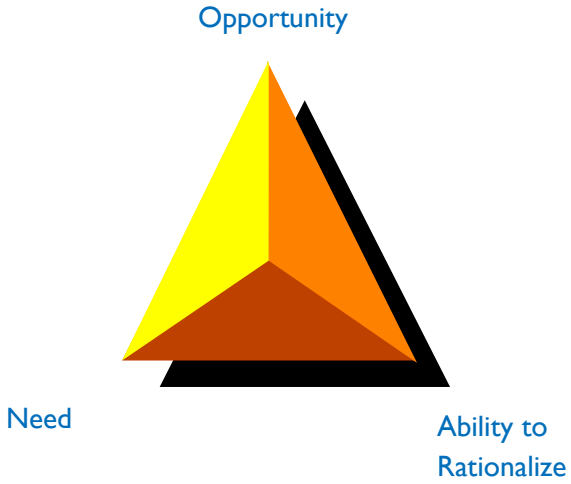
Fraud Considerations and the Risk of Management Override

We are responsible for planning and performing the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether caused by error or by fraud (SAS No. 99, *Consideration of Fraud in a Financial Statement Audit*).

Our audit procedures consider the requirements of SAS No. 99: brainstorming; gathering information to facilitate the identification of and response to fraud risks; and performing mandatory procedures to address the risk of management override (including examining journal entries, reviewing accounting estimates, and evaluating business rationale of significant unusual transactions).

We consider, among other things:

- Code of conduct policy/ethics
- Effective and independent oversight by Those Charged with Governance
- Process for dealing with whistle-blower allegations
- Internal audit/corporate compliance activities
- Entity's risk assessment processes



Role and oversight responsibilities of Those Charged with Governance:

- Management's assessment of the risks of fraud
- Programs and controls to mitigate the risk of fraud
- Process for monitoring multiple locations for fraud
- Management communication to employees on its views on business practices and ethical behavior

Internal Control Matters

Our Responsibilities

- Obtain reasonable assurance about whether the financial statements are free of material misstatement
- Our audit included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of NYC Health + Hospitals' internal control
- We express no opinion on the effectiveness of internal control
- Control deficiencies that are of a lesser magnitude than a significant deficiency were communicated to management

Definitions

- A deficiency in internal control ("***control deficiency***") exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect, misstatements on a timely basis.
- A ***material weakness*** is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the company's annual or interim financial statements will not be prevented or detected on a timely basis.
- A ***significant deficiency*** is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those responsible for oversight of the company's financial reporting.

Areas of Emphasis

GT has concluded that the balances and disclosures related to the areas of emphasis are reasonable and there were no issues identified requiring direct communication to those charged with governance.

Accounts receivable from patients, net patient service revenue, and related contractual allowances and bad debt reserves Risk – significant asset, management establishes reserves for allowances based on specific identification and historical data and reviews the reserve as part of their monthly closing process	• Reviewed account reconciliations. • Performed analytical procedures over key indicators such as days in accounts receivable, account write-offs and aging of balances. • Performed detailed account balance testing. • Performed cut-off testing. • Reviewed management's methodology for estimating allowances. • Performed medical records testing (in lieu of confirmations) for existence. • Performed cash to revenue proof. • To ensure reasonableness of accounts receivable allowances, we reviewed and tested subsequent cash receipts on June 30, 2017 net accounts receivable collected in FY2018, as well as June 30, 2018 collected through the first two months of FY2019.
Estimated settlements with third-party payors Risk - Estimated settlements with third-party payors are not complete and accurate.	• Reviewed account reconciliations and roll-forward and agreed significant reconciling items to supporting schedules and documentation. • Performed detailed account balance testing. • Reviewed management's methodology for estimating amounts. • Reviewed the financial statement presentation and disclosures.
Cash and cash equivalents, investments, assets restricted as to use and investment income Risk – Cash and investment balances do not exist or are not complete and accurately stated.	• Confirmed all material account balances directly with outside financial institutions. • Reviewed account reconciliations and supporting documentation. • Performed interbank transfer testing. • Reviewed management's disclosure over fair value in accordance with the adoption of GASB 72, *Fair Value Measurement and Application*
Capital assets Risk –Completeness, existence and accuracy of current year additions, CIP, capitalized interest and accumulated depreciation	• Obtained a roll-forward of the property and equipment balances. • Tested current year additions, including the calculation of capitalized interest. Additions testing address the large additions to CIP due to the construction of the ambulatory wing. • Performed analytical procedures over depreciation expense. • Reviewed leases. • Reviewed the financial statement presentation and disclosures.

Areas of Emphasis - Continued

Long-term debt, compliance with debt covenants and debt transaction Risk – completeness and current vs. long-term classification.	• Confirmed all material long-term debt balances. • Performed accrued interest and interest expense reasonableness testing. • Reviewed debt compliance calculations prepared by management. • Reviewed the financial statement presentation and disclosures.
Accrued liabilities, including payables due to vendors, affiliation payables and accruals, and employee compensation accruals Risk – exposure and risks associated with reporting accruals and related expenses in the appropriate period	• Performed detail testing of management's calculations, including underlying inputs and data. • Assessed for reasonableness the assumptions used in developing estimates. • Performed search for unrecorded liabilities.
Other postemployment benefit (OPEB) liabilities Risk – the net OPEB liability is not valued accurately and the required disclosures are not complete as required by GASB Statement 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*	• Performed detail testing of underlying data provided to actuary for OPEB liability. • Documented our reliance on the actuary in accordance with SAS 73. • Reviewed management's documentation for assumptions selected (i.e. discount rate, health care cost trend rates). • Reviewed the footnote disclosures to ensure that they are complete and accurate as required by GASB 75. • Actuarial assumptions used in the actuarial reports were reviewed by subject matter professional for reasonableness.
Net Pension Liability Risk – the net pension liability is not recorded accurately and required disclosures are not complete as required by GASB Statement 68, *Accounting and Financial Reporting for Pensions – an amendment of GASB Statement No. 27*.	• Obtained the actuarial valuation report • Performed procedures to ensure that the amounts in the actuarial valuation report of pension amounts agree to amounts reported in the NYC Health + Hospitals' financial statements • Reviewed the footnote disclosures to ensure that they are complete and accurate as required by GASB 68.

Areas of Emphasis - Continued

Claims Payable Reserves (IBNR) Significant Risk – High estimation uncertainty	• Considered the experience, objectivity and capability/competence of the external actuarial specialist, Conduent. • Tested completeness and accuracy of claims data that was provided to the client's external actuary, Conduent. • Selected a sample of 30 Medicaid, Medicare and Marketplace claims covering the current fiscal year and prior fiscal year and performed substantive test of details over the selection. • Tested, with the assistance of GT internal actuary, the methodologies and assumptions used by Conduent in the calculation of IBNR for reasonableness. • Performed a look back analysis to compare the prior year IBNR estimate to current year results. • Performed journal entry testing covering transactions included transactions related to IBNR.
Risk Transfer Adjustment Significant Risk – High estimation uncertainty	• Considered the experience, objectivity and capability/competence of the external actuarial specialist, Wakely. • GT tested the inputs related to the Risk Transfer calculations along with getting support from third party actuaries and industry data. • Tested, with the assistance of GT internal actuary, the methodologies and assumptions used by Wakely in the calculation for reasonableness. • Completed a look back analysis to compare the prior year estimates to what was settled in 2018 related to the prior year reserves.
Premium Revenue Recognition Significant Risk – Presumed risk of fraud with respect to revenue	• Selected one month per quarter and tested the Medicaid/Medicare and Marketplace revenues received by MetroPlus. • Selected a sample of 25 individual Medicaid participants and agreed the rate they receive from the state to the premium rate per the Medicaid contract for reasonableness. • Select a sample of 25 individual Marketplace participants and agreed the rate they receive from CMS to the MetroPlus marketplace rate. • Performed journal entry testing covering transactions included in the revenue cycle.

Areas of Emphasis - Continued

Subsequent Events Risk – that significant events occurring subsequent to June 30, 2018 that impact NYC Health + Hospitals are not disclosed	• Held discussions with management and reviewed subsequent to year end documents to determine if management had disclosed all significant subsequent events. • Reviewed available financial information subsequent to June 30, 2018 to identify any significant subsequent events. • Included representation from management regarding the completeness of the subsequent event information provided in the annual representation letter.
Financial reporting and Financial Statement Presentation Risk – combined amounts and disclosures are not in accordance with GAAP	• Reviewed GAAP/GASB disclosure checklists and tested footnote data. • Reviewed consolidating and eliminating entries and ensured they were accurate and properly reviewed by management. • Reviewed the applicability of new accounting pronouncements and their potential impact to NYC Health + Hospitals.
Fraud procedures Risk – revenue recognition, journal entries and other top sided adjustments, accounting estimates, significant unusual transactions, and related party transactions are improperly recorded.	• Performed key analysis on the overall financial statements • Examined journal entries and other adjustment for evidence of possible material misstatement due to fraud. • Reviewed estimates made by management for reasonableness and consistency. • Fraud inquires with the audit committee chair, key members of the executive management team and key members of the finance management team • Reviewed intercompany and related party balances.

Required Communications

Matters to be communicated	Auditor's comments
Auditor's responsibility under Generally Accepted Auditing Standards (GAAS) The auditor is responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management with the oversight of those charged with governance are presented fairly, in all material respects, in conformity with generally accepted accounting principles. The auditor is responsible for conducting an audit in accordance with GAAS. Those standards require that the auditor obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement. Accordingly, a material misstatement may remain undetected. An audit includes obtaining an understanding of internal controls sufficient to plan the audit and to determine the nature, timing, and extent of audit procedures to be performed. An audit is not designed to provide assurance on internal controls or to identify material weaknesses.	These items have been communicated to you in our engagement letter. We are prepared to issue an unmodified opinion on the financial statements of NYC Health + Hospitals. Our opinion will include mention that the 2017 financial statements were audited by other auditors who expressed an unmodified opinion on those statements.
Significant accounting policies, alternative treatments within generally accepted accounting principles (GAAP), and the auditor's judgment about the quality of accounting policies including modifications to the auditor's report We are responsible for providing our views about qualitative aspects of the significant accounting practices, including accounting policies, accounting estimates and financial statement disclosures. GAAP requires management to make accounting estimates and judgments about accounting policies and financial statement disclosures. Certain estimates are particularly sensitive due to their significance to the financial statements and the possibility that future events may differ significantly from management's current judgments. We will inform you about the appropriateness of the accounting policies to the particular circumstance of the entity. When acceptable alternative accounting policies exist, we will identify the financial statement items that are affected by the choice of significant policies as well as information on accounting policies used by similar entities. We will inform you of changes in significant accounting policies and application of new accounting pronouncements. Additionally we will communicate any accounting policies in controversial or emerging areas or those unique to an industry, particularly when there is a lack of authoritative guidance or consensus.	We are not aware of any significant alternative accounting treatments, policies, and unusual transactions, controversial or emerging areas for which there is a lack of authoritative guidance that NYC Health + Hospitals has recorded or used. We have discussed with you our views of estimates and areas of emphasis in an earlier section of this report. During FY 2018 NYC Health + Hospitals adopted the following accounting pronouncements: • GASB Statement No. 83, Certain Asset Retirement Obligations (GASB 83) • GASB Statements No. 85, Omnibus 2017 (GASB 85) • GASB Statement No. 86, Certain Debt Extinguishment Issues (GASB 86) See financials statements Note 1 for Recent Accounting Pronouncements noting that the newly adopted accounting pronouncements did not materially impact the 2018 financial statements.

Required Communications - Continued

Matters to be communicated	Auditor's comments
Materiality Essentially, materiality is the magnitude of an omission or misstatement that likely influences a reasonable person's judgment. It is based on a relevant financial statement benchmark selected by the audit team.	We believe that total revenues for NYC Health + Hospitals and surplus for Metro Plus component unit are the relevant benchmark for the company. Financial statement items greater than materiality are within our audit scope. Other accounts or classes of transactions less than materiality may be in our scope if qualitative risk factors are present (for example, related party relationships or significant unusual transactions).
Audit differences or omitted financial statement disclosures including other findings or issues	GT identified an unrecorded difference between the general ledger and the supporting detail for vendor accounts payable which resulted in a potential overstatement of accounts payable of $50 million. This did not have a material effect on financial position, net position or changes in net position. There were no omitted financial statement disclosures identified during the course of our audit.
Use of the Work of Others We are required to discuss the procedures performed by other professionals as part of our audit procedures.	Grant Thornton Valuation Services Group (VSG) • Utilized to review the assumptions used in the valuation of NYC Health + Hospitals' Health and Benefit Postretirement Plans
Potential effect on the financial statements of any significant risk and exposures	The financial statements disclose significant risks and uncertainties, including, but not limited to significant estimates, regulatory compliance, and commitment and contingencies.
Fraud and illegal acts	No irregularities, frauds or illegal acts involving senior management or that would cause a material misstatement to the financial statements, came to our attention as a result of our audit procedures.
Material uncertainties related to events and conditions that may cast doubt on the ability to continue as a going concern	We are not aware of any material uncertainties that cast doubt on NYC Health + Hospitals' ability to continue as a going concern.
Significant deficiencies and material weaknesses in internal control over financial reporting	GT noted a significant deficiency in the area of Vendors Accounts Payable (described above). As a result the *Report of Independent Certified Public Accountants on Internal Control Over Financial Reporting and on Compliance and Other Matters* will reflect the significant deficiency noted.

Required Communications - Continued

Matters to be communicated	Auditor's comments
Other information in documents containing audited /reviewed financial information Our responsibility with respect to other information in documents containing audit financial statement is to consider whether its content or manner of presentation is materially inconsistent with the financial information covered by our report or whether it contains a material misstatement.	We are not aware of and therefore have not reviewed any documents containing audited financial information.
Disagreements with management Our responsibility is to describe disagreements, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to NYC Health + Hospitals' financial statements or the auditor's report.	We have had no disagreements with management.
Management's consultation with other accountants We will inform you when management has consulted with other accountants about significant accounting or auditing matters.	None of which we are aware.
Significant issues discussed with management and difficulties encountered during the audit	No such issues were discussed with management or instances of difficulties were encountered.
Other material written communications	Items include: • Engagement letter • Representation letter

GASB Technical Update

Selected pronouncements effective for the year ending June 30, 2018 or subsequent periods – GASB

Title	Effective fiscal year ending
GASB 83- *Certain Asset Retirement Obligations*	June 30, 2019 *
GASB 84- *Fiduciary Activities*	June 30, 2020
GASB 85- *Omnibus 2017*	June 30, 2018 +
GASB 86- *Certain Debt Extinguishment Issues*	June 30, 2018 +
GASB 87- *Leases*	June 30, 2021
GASB 88- *Certain Disclosures Related to Debt, including Direct Borrowing and Direct Placements*	June 30, 2019
GASB 89- *Accounting for Interest Cost Incurred before the end of a Construction Period*	June 30, 2021

*** NYC Comptroller's office is requesting early adoption for June 30, 2018**

+ Adopted for the year ended June 30, 2018

GASB Technical Update - Continued

GASB 83- Certain Asset Retirement Obligations	Potential impact
• Objective is to develop requirements on recognition and measurement for asset retirement obligations (ARO), other than landfills (GASB 18) or pollution remediation obligations (GASB 49), such as nuclear power plants and sewage treatment facilities • The pronouncement addresses the following: - Establishes criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources when a governmental entity has a legal obligation to perform future asset retirement activities related to its tangible capital assets - Proposes capitalization of the ARO as a deferred outflow of resources, to be amortized in a systematic and rational manner (such as the straight-line method), generally over the life of the related asset giving rise to the obligation - Requires disclosures regarding governmental entity legal requirements to provide funding or other financial assurance for their performance of asset retirement obligations (e.g., how are those requirements being met) as well as nature and timing of AROs, method used to determine the estimated liability and useful life of the associated tangible asset. • Effective for periods beginning after June 15, 2018. Earlier application is encouraged.	Similar to the efforts organizations underwent when adopting GASB 49, management should inventory any activity whereby there is a related obligation to dispose of certain assets subject to regulatory and legal requirements. With that list, management must calculate the expense of that effort and track it annually. The effort to inventory these assets/costs may requirement input from facilities and potentially other areas of the Organization and the process to estimate costs of future events may also require assistance from facilities and other departments.

GASB 84- Fiduciary Activities	Potential impact
• Guidance addresses the following: - The categorization of fiduciary activities for financial reporting - How fiduciary activities are to be reported - When liabilities to beneficiaries must be disclosed • Types of fiduciary funds that must be reported include the following: - Pension (and other employee benefit) trust funds - Investment trust funds - Private-purpose trust funds - Custodial funds • A government controls the assets of an activity if it holds the assets or "has the ability to direct the use, exchange or employment of the assets in a manner that provides benefits to the specified or intended recipients" • Fiduciary activities must be disclosed in the basic financial statements of the government entity and a statement of fiduciary net position and changes in fiduciary net position should be presented (unless the period of custody is less than three months). • Effective for periods beginning after December 31, 2018, with early adoption encouraged.	Organizations often will agree to act as a fiduciary for certain third party entities that might be somehow affiliated to the organization. Under this new requirement, the Organization must report the fiduciary activity on its financial statements, where it may not have done so in the past. Management should identify which fiduciary activities it is engaged in to inventory the relationships, which may need to be reported. Management may want to consider changing the terms of the relationships such that they are not subject to reporting on the financial statements of the Organization when the requirement becomes effective.

GASB Technical Update - Continued

GASB 86- Certain Debt Extinguishment Issues	Potential impact
• The purpose of this guidance is to achieve consistency regarding accounting for the defeasance of debt irrespective of the source of funds set aside in an irrevocable trust for the purpose of funding the remaining debt (source of funds could be proceeds from a refunding arrangement or existing sources within the governmental entity). • New guidance clarifies the accounting for debt extinguishment when the source of the assets to be set aside in an irrevocable trust is existing resources rather than refund proceeds. When all of the other criteria for in-substance defeasance are in place, the debt is removed from the statement of net position and is disclosed in the footnotes in either scenario. • GASB 86 also requires that any remaining prepaid insurance related to the debt being extinguished must be included in the net carrying amount of that debt (to determine gain or loss on refunding). • Disclosures include a description of the transaction in the related period and remaining amounts outstanding in each subsequent period that the debt remains outstanding. • Effective for periods beginning after June 15, 2017, with early adoption encouraged. Changes to adopt this standard should be applied retroactively.	Depending on how organizations fund the irrevocable trust related to debt extinguishments, the new standard may create additional situations where debt will be "removed" from the statement of net position, and disclosed in the footnotes to the financial statements. For organizations considering future refundings, there is no longer a distinction in the accounting if the source of funds to be placed in an irrevocable trust are from existing resources or refunding arrangements.

GASB 87- Leases

- The GASB recently issued guidance which resembles the recently issued FASB guidance on leases.
- To determine whether a lease exists, a government should assess whether it has both:
  - The right to obtain the present service capacity from use of the underlying asset as specified in the contract, and
  - The right to determine the nature and manner of use of the underlying asset as specified in the contract
- For Lessees:
  - In general, all leases will be reported on the statement of net position (the distinction between operating and capital leases is no longer relevant) as a "right of use" asset and a corresponding lease liability within long term debt
  - On the statement of changes, rent expense will be replaced by amortization expense of the right-of-use asset as well as interest expense on the lease liability (thus accelerating expenses in the beginning years of the lease term)
  - There is an exemption for short term leases (those with a term of 12 months or less, including extension options) as well as leases that transfer ownership at the end of the term
  - Disclosures regarding matters such as total leased assets by major class of underlying assets and related accumulated amortization (in total), principal and interest payments for each of the five subsequent fiscal years and in five year increments thereafter and commitments under leases before a lease commencement period, among other items
- Effective for periods beginning after December 15, 2019, with early adoption encouraged. Existing leases will be adjusted based on the remaining lease payments as of the beginning of the period of adoption or beginning of any earlier periods restated (for example, for June 30 year ends, adoption is June 30, 2021 so the beginning period is July 1, 2020).

GASB Technical Update - Continued

GASB 87- Leases – Potential Impact
For those organizations which use operating leases to finance certain capital activities, this standard could have a significant impact on the financial statements of the organization upon adoption. Management should consider the impact on financial covenants, as well as ensuring a complete inventory of existing leases that will be subject to the new accounting and disclosures.

GASB 88- Certain Disclosures Related to Debt, including Direct Borrowing and Direct Placements	Potential impact
• Improves consistency of information presented in the footnotes with respect to long-term debt, and to distinguish it from other long-term liabilities in applying disclosure requirements. • New guidance defines debt as "a liability that arises from a contractual obligation to pay cash (or other assets that may be used in lieu of payment of cash) in one or more payments to settle an amount that is fixed at the date the contractual obligation is established". • In addition to the existing debt disclosures, organizations should disclose the following about all types of debt: - Amount of unused lines of credit - Assets pledged as collateral for debt - Terms specified in debt agreements related to significant events of default or termination events with finance-related consequences, as well as any subjective acceleration clauses - Direct borrowings and direct placements of debt should be distinguishable from other types of debt for all disclosures. • Effective for periods beginning after June 15, 2018. Changes to adopt this standard should be applied to all periods presented within the footnotes.	Depending on the amount of information currently disclosed as it relates to debt, organizations may find themselves having to augment existing footnotes to comply with the standard, specifically as it relates to direct borrowings, lines of credit, and other debt instruments.

GASB 89- Accounting for Interest Cost Incurred before the end of a Construction Period	Potential impact
• This Statement improves financial reporting by providing users with more relevant information about capital assets and the cost of borrowing, and enhancing comparability of information for both governmental activities and business-type activities. • Financial statements prepared using the economic resources measurement focus: - Interest cost should be recognized as an expense in the period incurred. • Financial statements prepared using the current financial resources measurement focus: - Interest cost should be recognized as an expenditure consistent with governmental fund accounting principles. • Effective for periods beginning after December 15, 2019, with early adoption encouraged. Changes to adopt this standard should be applied prospectively at adoption.	Organizations may have varying amounts of interest incurred during periods of significant construction. With the implementation of this new guidance, complex calculations of interest to be capitalized will no longer be required, thus simplifying accounting requirements. The new accounting accelerates the expense impact for the construction period, which should be considered when preparing budgets for future periods.

Board of Trustee and Management Resources

Bringing meaningful information to our clients

As a health care provider, you must always stay up to date on the latest developments, current challenges and practical solutions, as well as emerging industry knowledge and research. You also need to convey vital information to those you serve in a helpful yet authoritative manner, supplying both industry information and expert opinion on the most effective approach to a wide range of issues. At Grant Thornton, our clients expect the very same from us. That is why we provide timely alerts, surveys and newsletters to keep you informed on issues that may affect your organization.

Your challenges are our focus. Through events (in person and via webcast), publications and sponsorships, our goal is to guide and assist you with meaningful thought leadership.

Electronic Tools

To meet your audit needs, Grant Thornton's electronic audit tool, Voyager, utilizes the same software system across all offices and delivers a consistent standard of audit service for your organization. This means you and your team will not need to reconcile documentation from a patchwork of different tools, and **you will not get repeated requests for the same information.**

Events and sponsorships

- We offer customized, continued professional education sessions delivered by firm professionals to your boardroom, management teams and audit committees.
- We hold regular education seminars in collaboration with national, regional and local chapters of the Healthcare Financial Management Association (HFMA).
- We are national sponsors, participants and speakers with the HFMA, Association of Healthcare Internal Auditors (AHIA), the Health Care Compliance Association (HCCA) and AICPA, among many other industry organizations.

Surveys, newsletters and alerts

- ***Governance in Nonprofit Community Health Systems: An initial report on CEO perspectives*** is a survey of nonprofit community health systems' chief executive officers to examine the structures, practices and cultures of community health systems' governing boards and compare them to selected benchmarks of good governance.

- ***Governance in High-Performing Community Health Systems: A report on Trustee and CEO views*** compares community health systems performance on selected measures. Site visits and interviews with leaders of high-performing systems result in findings and recommendations that will assist board leaders and chief executive officers in assessing and enhancing board effectiveness. Both surveys were produced in collaboration with the **American Hospital Association** and the **University of Iowa**.

- ***National Board Governance Survey for Not-for-Profit Health Care Organizations*** is an exclusive annual survey that provides board governance trends in view of increased scrutiny of tax-exempt health care organizations. A complimentary webcast is held each year to present the findings.

Board of Trustee and Management Resources

- ***Health CareRx*** is a quarterly business intelligence newsletter for health care financial executives that covers best practices, regulatory and tax updates and industry information affecting health care organizations.

- ***ForwardThinking*** is a timely newsletter that highlights best practices for governance of tax-exempt organizations and provides board and committee members with timely information on current governance issues.

- ***Health Care Alerts*** are timely electronic alerts on tax, regulatory and legislative actions that may have an effect on various segments of the health care industry.

- ***Serving on the Board of a Not-for-Profit Organization*** is a booklet offering guidance and best practices for board members of not-for-profit organizations.

- ***Serving on the Audit Committee of a Not-for-Profit Organization*** is a booklet offering guidance and best practices for audit committee members of not-for-profit organizations.

- ***Tax Hot Topics*** is a biweekly newsletter written by the tax professionals in our National Tax Office. To make the right choices for your business, you need the latest information on a wide range of tax issues, e.g., IRS rulings, litigation, and state, local and international tax developments.

- ***NFP Tax Alerts*** are issued by Grant Thornton's Board Governance Institute. Not-for-Profit Tax Alerts provide you with timely notification of tax issues affecting not-for-profit organizations.

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Financial Statements and Supplemental Schedules and
Report of Independent Certified Public Accountants

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of The City of New York)

June 30, 2018 and 2017

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

The Board of Directors
New York City Health and Hospitals Corporation

Report on the financial statements

We have audited the accompanying financial statements of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation (NYC Health + Hospitals), a component unit of The City of New York, as of and for the year ended June 30, 2018, and the related notes to the financial statements, which collectively comprises the NYC Health + Hospitals' basic financial statements as listed in the table of contents.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement. The financial statements as of and for the year ended June 30, 2018 of MetroPlus Health Plan, Inc., a discretely presented component unit, and HHC Insurance Company, Inc., a blended component unit, were not audited in accordance with *Government Auditing Standards*.

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

An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component unit of NYC Health + Hospitals as of June 30, 2018, and the respective changes in financial position, and cash flows thereof for the year then ended, in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the management's discussion and analysis on pages 3 through 13 and the schedule of NYC Health + Hospitals' contributions and the schedule of NYC Health + Hospitals' proportionate share of the net pension liability and the schedule of NYC Health + Hospitals' Changes in Total OPEB Liability and Related Ratios on pages 68, 69 and 70, respectively, be presented to supplement the basic financial statements. Such information, although not a required part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. This required supplementary information is the responsibility of management. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America. These limited procedures consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Matter

The business-type activities and the discretely presented component unit of the financial statements of NYC Health + Hospitals as of and for the year ended June 30, 2017 were audited by other auditors. Those auditors expressed an unmodified opinion on those 2017 financial statements in their report dated October 25, 2017.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October XX, 2018, on our consideration of NYC Health + Hospitals' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of NYC Health + Hospitals' internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering NYC Health + Hospitals' internal control over financial reporting and compliance.

New York, New York
October XX, 2018

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Management's Discussion and Analysis (Unaudited)
Statements of Net Position
As of June 30, 2018, 2017, and 2016
(In thousands)

Financial Analysis

Summary of Statement of Net Position

June 30, 2018, 2017, and 2016

(In thousands)

	2018 Business-type Activities – HHC	2017 Business-type Activities – HHC	2016 Business-type Activities – HHC (As Adjusted)
Assets:			
Current assets	$ 2,421,534	2,233,423	2,506,602
Capital assets, net	3,490,264	3,395,964	3,401,861
Other assets	134,442	151,480	162,777
Total assets	6,046,240	5,780,867	6,071,240
Deferred outflows:			
Net differences between projected and actual earnings on pension plan investments and other changes, net	—	13,794	480,191
Unamortized refunding cost	8,567	10,537	12,785
Liabilities:			
Current liabilities	2,380,215	2,444,027	2,637,985
Long-term debt, net of current installments	792,702	776,783	868,626
Other noncurrent liabilities	582,833	340,600	296,811
Pension, net of current portion	2,090,713	2,514,409	3,031,476
Postemployment benefits obligation, other than pension, net of current portion	5,026,936	4,622,435	5,037,778
Total liabilities	10,873,399	10,698,254	11,872,676
Deferred inflows:			
Net differences between projected and actual earnings on pension plan investments	310,683	—	—
Net differences between expected and actual experience and changes in actuarial assumptions in postemployment benefits obligation, other than pension	408,912	684,300	35,951
Net position:			
Net investment in capital assets	2,545,082	2,553,374	2,514,112
Restricted	146,104	153,319	154,926
Unrestricted	(8,229,373)	(8,284,049)	(8,013,449)
Total net deficit position	$ (5,538,187)	(5,577,356)	(5,344,411)

See accompanying notes to management's discussion and analysis.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Management's Discussion and Analysis (Unaudited)
Statements of Net Position
As of June 30, 2018, 2017, and 2016
(In thousands)

Financial Analysis

Summary of Statements of Revenue, Expenses, and Changes in Net Position

Years ended June 30, 2018, 2017, and 2016

(In thousands)

	2018 Business-type Activities – HHC	2017 Business-type Activities – HHC	2016 Business-type Activities – HHC (As Adjusted)
Operating revenue:			
Net patient service revenue	$ 6,216,713	5,611,114	5,812,049
Appropriations from City of New York, net	787,331	723,425	1,405,091
Grants revenue	651,966	863,808	362,339
Other revenue	104,981	95,287	103,080
Total operating revenue	7,760,991	7,293,634	7,682,559
Operating expenses:			
Personal services, fringes benefits, and employer payroll taxes	3,911,188	3,628,339	3,607,126
Other than personal services	1,789,369	1,842,665	1,753,336
Pension	394,420	426,325	502,374
Postemployment benefits, other than pension	337,745	289,166	447,783
Affiliation contracted services	1,076,202	1,069,545	1,050,535
Depreciation	309,574	310,325	302,530
Total operating expenses	7,818,498	7,566,365	7,663,684
Operating (loss) income	(57,507)	(272,731)	18,875
Nonoperating expenses, net	(113,347)	(115,994)	(112,910)
Loss before other changes in net deficit	(170,854)	(388,725)	(94,035)
Other changes in net deficit:			
Capital contributions	210,023	155,780	151,403
(Decrease) increase in net deficit	39,169	(232,945)	57,368
Net deficit position at beginning of year	(5,577,356)	(5,344,411)	(5,401,779)
Net deficit position at end of year	$ (5,538,187)	(5,577,356)	(5,344,411)

See accompanying notes to management's discussion and analysis.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)
Management's Discussion and Analysis (Unaudited)
Statements of Net Position
As of June 30, 2018, 2017, and 2016
(In thousands)

See accompanying notes to management's discussion and analysis.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Management's Discussion and Analysis (Unaudited)
Summary of Statements of Revenue, Expenses, and Changes in Net Position
For the years ended June 30, 2018, 2017, and 2016
(In thousands)

See accompanying notes to management's discussion and analysis.

This section of thr New York City Health and Hospitals Corporation's (NYC Health + Hospitals) annual financial report presents management's discussion and analysis (MD&A) of the financial performance during the years ended June 30, 2018 and 2017. The purpose is to provide an objective analysis of the financial activities of NYC Health + Hospitals based on currently known facts, decisions, and conditions. Please read it in conjunction with the financial statements, which follow this section.

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

Overview of the Financial Statements

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

The basic financial statements include *Statement of Net Position, Statement of Revenues, Expenses, and Changes in Net Position*, *Statement of Cash Flows*, and notes to financial statements. These statements present, on a comparative basis, the financial position of NYC Health + Hospitals at June 30, 2018 and 2017, and the changes in net position and its financial activities for each of the years then ended. The S*tatement of Net Position* includes all of NYC Health + Hospitals' assets and liabilities in accordance with U.S. generally accepted accounting principles. The S*tatement of Revenue, Expenses, and Changes in Net Position* presents each year's activities on the accrual basis of accounting, that is, when services are provided or obligations are incurred, not when cash is received or bills are paid. The financial statements also report the net position of NYC Health + Hospitals and how it has changed. Net position, or the difference between assets and liabilities and deferred inflows and deferred outflows, is a way to measure the financial health of NYC Health + Hospitals. The *Statement of Cash Flows* provides relevant information about each year's cash receipts and cash payments and classifies them as to operating, noncapital financing, capital and related financing, and investing activities. The notes to financial statements explain information in the statements and provide more detailed data.

Overall Financial Position and Operations

NYC Health + Hospitals' total net deficit position improved by $36.2 million from June 30, 2017 to June 30, 2018, and increased $232.9 million from June 30, 2016 to June 30, 2017, as adjusted. Net investment in capital assets decreased by $8.3 million and increased by $39.3 million in fiscal years 2018 and 2017, respectively, as some of the major modernization projects that increased fiscal year 2017's balance, were completed in fiscal year 2018. NYC Health + Hospitals' unrestricted net deficit position remained consistent between June 30, 2018 and June 30, 2017. NYC Health + Hospitals ended fiscal year 2018 with an operating loss of $57.5 million compared with an operating loss of $272.7 million for the year ended June 30, 2017. NYC Health + Hospitals' net deficit position benefited from $126.1 million and $135.4 million in capital contributions from The City of New York (The City) in fiscal years 2018 and 2017, respectively.

Significant financial ratios are as follows:

	2018	2017	2016
Current ratio	1.02	0.91	0.95
Quick ratio	0.60	0.48	0.46
Days of cash on hand	36.33	30.18	26.61
Net number of days of revenue in patient receivables	65.16	58.31	66.87

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

Variances in Financial Statements

In this section, NYC Health + Hospitals explains the reasons for certain financial statement items with variances relating to fiscal year 2018 amounts when compared to fiscal year 2017 amounts and, where appropriate, fiscal year 2017 amounts when compared to fiscal year 2016 amounts. Fiscal years 2017 and 2016 amounts have been adjusted for the retrospective application of GASB 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* (GASB 75).

Statement of Net Position

Cash and cash equivalents - Increased by $137.7 million from June 30, 2017 to June 30, 2018 mainly due to the receipt of outpatient Upper Payment Limit (UPL) and Care Restructuring Enhancement Pilot (CREP) reimbursement during the last quarter of the fiscal year. Cash and cash equivalents increased by $66.0 million from June 30, 2016 to June 30, 2017 mainly due to yearly operations.

Patient accounts receivable, net - Increased by $118.2 million from fiscal year 2017 to 2018 mainly due to an increase in the patient Case Mix Index (CMI) in 2018 and increases in risk incentive pools receivables in 2018. Patient accounts receivable, net decreased by $99.4 million from fiscal year 2016 to 2017 due to additional reserves for long-term in-house patients, decreases in risk incentive pools receivables, and decreases in patient care services.

Estimated third-party payor settlements, receivable - Decreased $130.7 million from June 30, 2017 to June 30, 2018 due to a decrease in UPL receivable balances. Estimated third-party payor settlements, receivable decreased $318.3 million from June 30, 2016 to June 30, 2017 mainly due to Upper Payment Limit (UPL) cash receipts of $314.0 million in the 2017 fiscal year.

Grants receivable - Grants receivable remained consistent from June 30, 2017 to June 30, 2018. Grants receivable increased $68.0 million from June 30, 2016 to June 30, 2017 mainly due to the recognition of $58 million related to New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) program funds.

Assets restricted as to use - Decreased by $16.9 million due to the use of equipment financing to buy equipment during fiscal year 2018 as well as the use of donations for operations and capital purchases. It decreased $14.7 million from June 30, 2016 to June 30, 2017 due to the use of equipment financing to purchase equiment.

Capital Assets, net - Increased by $94.3 million from June 30, 2017 to June 30, 2018 due to increases in CIP for the Electronic Medical Records (EMR) and Federal Emergency Management Agency (FEMA) projects. It remained consistent between fiscal years 2016 and 2017.

Other current assets - Increased $14.1 million from June 30, 2017 to June 30, 2018 primarily due to estimated affiliate settlements for performance indicators and contract reconciliations. It increased $14.0 million from June 30, 2016 to June 30, 2017 primarily due to affiliate payments for performance indicators based on prior year's experience which was offset by a $2.3 million decrease in inventory.

Deferred outflows of resources - Decreased $15.8 million from June 30, 2017 to June 30, 2018 mainly due to changes in projected and actual earnings and experience in pensions which shifted the reporting of an outflow to an inflow for fiscal year 2018. It decreased $466.4 million from June 30, 2016 to June 30, 2017 mainly due to a positive difference between projected and actual earnings on pension plan investments. Deferred outflows of resources are largely determined by the New York City Office of the Actuary.

Estimated pools, net - As of June 30, 2018, NYC Health + Hospitals reported a receivable of $54.7 million versus having reported a payable of $43.2 million as of June 30, 2017. This change was attributable to an increase of $136.4 million in change in estimate of the Disproportionate Share Hospital Maximum (DSH Max). Estimated pools payable, net, decreased $265.6 million from June 30, 2016 to June 30, 2017 primarily due to the recording of the New York State fiscal year 2017 DSH Max program receivable which had not been paid as of June 30, 2017.

Deferred inflows of resources - Increased $35.3 million from June 30, 2017 to June 30, 2018 due to changes in projected and actual investment earnings and experience for pensions which was offset by changes in expected and actual experience and changes in assumptions for OPEB during fiscal year 2018. It increased $648.3 million from June 30, 2016 to June 30, 2017 mainly due to an amortized decrease in OPEB expense arising from the recognition of changes in actuarial assumptions of $661.1 million. Deferred inflows of resources are determined by the New York City Office of the Actuary.

Accrued salaries, fringe benefits, payroll taxes, and accrued compensated absences (current and long-term - Increased $283.5 million from fiscal year 2017 to 2018 due to recognition of collective bargaining settlements. It decreased $33.8 million from June 30, 2017 to June 30, 2016 due to staff restructuring and attrition in fiscal year 2017.

Accounts payable and accrued expenses - Increased $10.9 million from June 30, 2017 to June 30, 2018 and by increased $74.7 million from June 30, 2016 to June 30, 2017 primarily due to increases in vendor payable balances.

Estimated third-party payor settlements, payable - Increased by $20.7 million from June 30, 2017 to June 30, 2018 due to receipt of more cash for UPLs in fiscal year 2018. There was a decrease of $48.6 million from June 30, 2016 to June 30, 2017 due to a re-estimation of third party settlements for Medicaid and Medicare rate changes.

Due to The City of New York, net (current and long term) - Decreased $136.8 million due to timely payments of fiscal years 2017 and 2018 Medicare Part B, stabilization fund, and medical malpractice insurance expenses to The City which was offset by a malpractice prepayment in fiscal year 2018 of $9.1 million. It increased $112.3 million from June 30, 2016 to June 30, 2017 mainly due to a long term medical malpractice liability in the amount of $112.9 million that had not been paid by June 30, 2017.

Long-term debt (includes current installments) - Increased $32.1 million from June 30,2017 to June 30, 2018 primarily due to the recognition of $44.3 million in New York Power Authrotiy (NYPA) loans which fund a number of NYC Health + Hospitals' energy efficiency projects which was offset by decreases in other long term debt during the year. It decreased $88.1 million from June 30, 2016 to June 30, 2017 due to a continuation of scheduled principal

payments during fiscal year 2017 and a revaulation of the Henry J. Carter capital lease obligation of $19.2 million. (Note 8)

Pension (current and long-term) - Decreased $411.0 from June 30, 2017 to June 30, 2018 and decreased $520.4 million from June 30, 2016 to June 30, 2017 as NYC Health + Hospitals recognized its annual pension costs and payments toward its liability, as determined by the New York City Office of the Actuary (Note 10).

Postemployment benefits obligation, other than pension (current and long-term) - Increased $415.0 million from June 30, 2017 to June 30, 2018 and decreased $404.8 million from June 30, 2016 to June 30, 2017 as NYC Health + Hospitals recognized its annual other post employment benefits (OPEB) costs, as determined by the New York City Office of the Actuary (Note 11).

Changes in Components of Net Position

Net investment in capital assets - Decreased by $8.3 million and increased by $39.3 million in fiscal years 2018 and 2017, respectively, as some of the major modernization projects that increased fiscal year 2017's balance, were completed in fiscal year 2018.

Restricted - Restricted net assets decreased $7.2 million from June 30, 2017 to June 30, 2018 mainly due to a decrease in restricted funds expendable for specific operating activities. Restricted net assets decreased $1.6 million from June 30, 2016 to June 30, 2017 mainly due to a decrease in restricted funds for debt service.

Unrestricted - Net position activities, other than those mentioned above, resulted in an increase of $54.7 million and $270.6 million in the unrestricted net deficit when comparing fiscal years 2017 and 2018 balances, respectively. Please see the *Statement of Revenue, Expenses, and Changes in Net Position*.

Capital Assets, Net and Long-Term Debt Activity

Capital Assets, Net

At June 30, 2018, NYC Health + Hospitals had capital assets, net of accumulated depreciation, of $3.5 billion compared to $3.4 billion at June 30, 2017 and $3.4 billion at June 30, 2016, as shown in the table below (in thousands):

	2018	2017	2016
Land and land improvements	$ 27,171	$ 27,969	$ 29,111
Buildings and leasehold improvements	2,024,215	2,075,173	2,157,515
Equipment	828,136	827,178	844,084
Construction in progress	610,742	465,644	371,151
Total	$ 3,490,264	$ 3,395,964	$ 3,401,861

2018's major capital asset additions include the following:

- NYC Health + Hospitals capitalized net interest costs on TFA debt and City General Obligation Bonds in both fiscal years 2018 and 2017, as well as NYC Health + Hospitals' own bonds. Such debt was issued to finance construction of various NYC Health + Hospitals facilities, with such debt to be paid by The City on behalf of NYC Health + Hospitals. Such amounts capitalized in fiscal years 2018 and 2017 approximated $20.3 million and $17.8 million, respectively. In addition, NYC Health + Hospitals capitalized net interest costs of $0.1 million in fiscal year 2018 and $0.3 million in fiscal year 2017 related to its 2008 and 2010 Series bonds.

- NYC Health + Hospitals continues developing an Electronic Medical Records (EMR) system which has two components: a Clinical budget of approximately $764.0 million and a Revenue Cycle budget of approximately $289.1 million. It is projected to be implemented within an eight year period. Fiscal year 2018 added $43.1 million to construction in progress (CIP) related to this project; which is inclusive of capitalizable expenditures of $37.2 million for the Clinical portion and $5.9 million for the Revenue Cycle portion. Capitalized payroll additions for fiscal year 2018 were $10.3 million. As of June 30, 2018, total capital CIP reported was $187.1 million.

- NYC Health + Hospitals continued the development of an Enterprise Resource Planning (ERP) system with a capital addition to CIP of $2.7 million in fiscal year 2018 and total CIP as of June 30, 2018 of $17.6 million. The ERP project budget assigned through fiscal year 2025, which includes post implementation expenses, was approximately $114.9 million. This amount excludes the costs of capitalized in-house payroll assigned to the project.

- Energy efficiency upgrade projects at multiple facilities represent an increase in CIP of $20.2 million for fiscal year 2018, with a total budget of $54 million for completion. The Comprehensive Energy Efficiency project at Metropolitan Hospital, which was managed by NYPA, was completed and placed in service in fiscal year 2018 for $34.1 million. Parts of the Comprehensive Energy Efficiency project at Elmhurst Hospital, which was also managed by NYPA, were completed and placed in service in both fiscal year 2017 for $5.9 million and fiscal year 2018 for $1.9 million.

- NYC Health + Hospitals- Gouverneur's major modernization construction project was almost completed and was in the close-out process as of fiscal year end 2018. Approximately $6.7 million was expended as of June 30, 2018 and portions of this project in amount approximating $29.6 million were transferred out of CIP and placed into service during fiscal year 2018.

- Construction was completed on the new NYC Health + Hospitals Gotham diagnostic and treatment center on Staten Island with $19.9 million of the project placed in service during fiscal year 2018. There were also projects at multiple facilities for priority mitigation and major work components which represented $42.5 million of CIP in fiscal year 2018, with an estimated cost to complete of $1.4 billion.

2017's major capital asset additions included the following:

- Development of the electronic medical record (EMR) system continued with increases of approximately $67.0 million in fiscal year 2017, which included in-house payroll amounts of $11.3 million associated with direct implementation. During fiscal year 2017, portions of the project totaling $20.0 million were placed in use.

- Development of the Enterprise Resource Planning (ERP) system continued with an increase of capitalized costs of $15.3 million in fiscal year 2017. Included in that amount was in-house payroll amounts of $2.1 million associated with direct implementation.

- Construction was mostly completed on the major modernization of Gouverneur Healthcare Services, with additional amounts capitalized of $3.6 million in fiscal year 2017. During fiscal year 2017, portions of the project totaling $15.0 million were placed in use.

- Energy Efficiency Measures upgrade projects managed by NYPA continued at multiple facilities with $14.0 million capitalized in fiscal year 2017.

- Construction continued on a new Diagnostic and Treatment Center facility in Staten Island, with the addition of $2.5 million in fiscal year 2017.

- FEMA funded projects at multiple facilities were in-design and under construction during the year. These projects are being managed jointly by the New York City Economic Development Corporation and NYC Health + Hospitals with $15.0 million of total costs capitalized in fiscal year 2017.

2016's major capital asset additions included the following:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional amounts capitalized of approximately $3.7 million in fiscal year 2016. During fiscal year 2016, portions of the project totaling $20.0 million were placed in use.

- Construction was mostly completed on the major modernization of Harlem Hospital Center, with additional amounts capitalized of approximately $0.4 million in fiscal year 2016.

- Construction was mostly completed on the major modernization of Henry J. Carter Center, with additional amounts capitalized of approximately $1.6 million in fiscal year 2016.

- Construction of the new Ida G. Israel Community Health Center continued with amounts capitalized of $0.7 million in fiscal year 2016.

- Developing the EMR system continued with spending of $37.7 million in fiscal year 2016.

- Boiler replacements and repairs occurred at multiple facilities with $30.0 million of spending in fiscal year 2016.

- Construction costs related to the major modernization project at Coney Island Hospital of approximately $17.5 million capitalized in fiscal year 2016.

- Construction projects of $2.2 million occurred at Metropolitan Hospital in fiscal year 2016.

NYC Health + Hospitals fiscal year 2019 capital budget projects spending is $421.9 million, which includes acquisition of medical equipment, information techonology upgrades, continued additions to the EMR system, and construction work on rehab-infrastructure projects. The 2019 capital budget is expected to be primarily financed by New York City General Obligation Bonds, Transitional Finance Authority Bonds, and a NYS Grant called the Capital Restructuring Financing Program (CRFP).

Long-Term Debt

At June 30, 2018, NYC Health + Hospitals had approximately $876.1 million in current and long-term debt financing relating to its capital assets, as shown with comparative amounts at June 30, 2017 and 2016 (in thousands):

	2018	2017	2016
Bonds payable	$ 698,027	$ 756,939	$ 814,342
New York Power Authority (NYPA) financing	44,328	-	-
Clinical bed financing	-	-	80
Henry J. Carter capital lease obligation	25,095	27,217	48,254
New Market Tax Credit	14,700	14,700	14,700
Key Bank CISCO leases	14,240	21,260	28,216
Oracle ERP financing	1,308	3,923	6,540
JP Morgan Equipment financing	48,411	10,000	10,000
Revolving loan (Citibank)	30,000	10,000	10,000
Total	$ 876,109	$ 844,039	$ 932,132

At June 30, 2018, NYC Health + Hospitals' outstanding bonds at par were approximately $679.7 million, with 78.7% uninsured fixed and 21.3% variable secured by letters of credit. NYC Health + Hospitals is rated Aa3, A+, and AA- by Moody's, S&P's, and Fitch, respectively. The variable rate bonds are secured by TD Bank's and JPMorgan Chase Bank's letters of credit. As of July 13, 2018, the Moody's, S&P's, and Fitch long-term/short-term ratings for TD Bank and JPMorgan Chase Bank are Aa2/P-1, AA-/A-1+, and AA-/F1+ and Aa2/P-1, A+/A-1, and AA/F1+, respectively. There are no statutory debt limitations that may affect NYC Health + Hospitals' financing of planned facilities or services.

More detailed information about NYC Health + Hospitals long-term debt is presented in Note 8 to the financial statements.

Statements of Revenue, Expenses, and Changes in Net Position

Net patient service revenue - Increased $605.6 million from June 30, 2017 to June 30, 2018 as a result of additional Disproportionate Share Hospital (DSH) revenue of approximately $404.0 million, increased CMI and managed care risk pool distributions. It decreased $200.9 million from June 30, 2016 to June 30, 2017 as a result of a 3% decrease in DSH revenue of approximately $214.7 million.

Appropriations from City of New York, net - Increased $63.9 million from June 30, 2017 to June 30, 2018 due to an increase in cash received from The City over the prior year. It decreased $681.7 million from June 30, 2016 to June 30, 2017 as The City increased its local share of funding through DSRIP, Value Based Quality Improvement Program (VBP-QIP), and CREP reported in grants revenue.

Grants revenue - Decreased $211.8 million from June 30, 2017 to June 30, 2018 due to fiscal year 2018 ending without a signed agreement for VBP QIP grant revenue reimbursement which kept NYC Health + Hospitals from recognizing revenue. Additionally, fiscal year 2017 reported the collection of two years' of VBP QIP: that was owed in fiscal year 2017 as well as an amount that was uncollected from a previous fiscal year. It increased

$501.5 million from June 30, 2016 to June 30, 2017 due to an increase in DSRIP of $140.0 million, along with new grants for VBP-QIP of $240.0 million and CREPs of $163.0 million.

Other revenue - Remained consistent with the prior year with an increase of $9.7 million in miscellanous revenue from fiscal year 2017 to 2018 due to an increase in 340B pharmacy revenue of $30 million offset by a reduction of $10 million in the component unit, HHC ACO, rent, and parking and a re-classification of $9 million to patient pharmacy revenue from miscellaneous revenue in prior fiscal years. In 2017, it increased $41.8 million primarily due to an increase of $18.0 million in miscellaneous revenues and a $12.2 million increase in 340B pharmaceutical program revenue from June 30, 2015 to June 30, 2016.

Personal services - Increased $317.1 million due to recognition of collective bargaining increases offset by continued controls over headcount which began in fiscal year 2017. It remained consistent from June 30, 2016 to June 30, 2017 mainly due to efforts to control the headcount of full-time equivalent employees.

Other-than-personal services - It decreased $53.3 million in fiscal year 2018 due to a decrease in accrued expenses. . It increased $89.3 million from June 30, 2016 to June 30, 2017 primarily due to an increase in utility costs and general increases to medical and surgical supplies.

Fringe benefits and employer payroll taxes - Decreased $34.2 million from June 30, 2017 to June 30, 2018 due to a reduction in accrued health benefits. It increased $22.4 million from June 30, 2016 to June 30, 2017 mainly due to health benefit increases.

Pension - Decreased $31.9 million from June 30, 2017 to June 30, 2018 mainly due to differences between projected and actual earnings on plan investments, as computed by the New York City Office of the Actuary. It decreased $76.0 million from June 30, 2016 to June 30, 2017 mainly due to differences between projected and actual earnings on plan investments, as computed by the New York City Office of the Actuary. Pension plan expense as of June 30, 2018 and 2017, is determined by the New York City Office of the Actuary. (Note10.)

Postemployment benefits, other than pension - Increased $48.6 million from June 30, 2017 to June 30, 2018 due to changes in assumptions by the New York City Office of the Actuary such as a decrease in the discount rate netted against an increase in recognition of benefit payments. It decreased $158.6 million from June 30, 2016 to June 30, 2017 mainly due to an increase in the discount rate as calculated by the New York City Office of the Actuary as GASB 75 was implemented. Postemployment benefits, other than pension as of June 30, 2018 and 2017 are determined by the New York City Office of the Actuary. (Note 11).

Affiliation contracted services - This remained consistent from June 30, 2017 to June 30, 2018. Affiliation contracted services increased $19.0 million from June 30, 2016 to June 30, 2017 which was mainly attributable to service enhancements added to the clinical programs since prior year and market adjustments for clinical staff.

Capital contributions funded by The City of New York - Remained consistent from June 30, 2017 to June 30, 2018 and from June 30, 2016 to June 30, 2017.

Corporation Issues and Challenges

NYC Health + Hospitals, with The City's assistance, continues to address and adapt to the increasing fiscal challenges placed on healthcare institutions in the New York City area. Specifically, these include:

- Insufficient Medicaid and Medicare reimbursements to meet the costs of caring for low-income New Yorkers
- Ability of The City of New York to increase capital reimbursement
- Shifting from a fee-for-service payment system to a managed care system which includes a value-based payment structure

NYC Health + Hospitals has responded to these challenges by continuing its ambitious transformation effort to comprehensively redesign the public health system and to build a competitive, sustainable organization which began in fiscal year 2017. The appointment of the new President and CEO, Mitchell Katz, MD, has also resulted in new intiatives being enacted to create a balanced financial plan through fiscal year 2022 and to further stabilize the health system for the population it serves.

Federally Qualified Health Center

NYC Health + Hospitals entered into a co-applicant agreement with Gotham Health FQHC, Inc. (Gotham), for the purposes of operating certain community health centers (Health Centers) together as a public entity model in order to obtain designations as Federally Qualified Health Center(s) (FQHC). This type of federal designation provides for enhanced reimbursement rates for the care of patients. Gotham is a New York not-for-profit corporation organized to participate with NYC Health + Hospitals in the governance of these Health Centers which were previously operated solely by NYC Health + Hospitals. The purpose of the co-applicant process is to permit these Health Centers to operate under FQHC status. Gotham is not considered a related organization to NYC Health + Hospitals, nor is there any overlap in any members of their respective boards.

Contacting NYC Health + Hospitals Financial Management

This financial report provides the citizens of The City, NYC Health + Hospitals' patients, bondholders, and creditors with a general overview of NYC Health + Hospitals' finances and operations. If you have questions about this report or need additional financial information, please contact Mr. John Ulberg, Senior Vice President/Chief Financial Officer, NYC Health + Hospitals, 160 Water Street, Room 1014, New York, New York 10038.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Statement of Net Position
As of June 30, 2018 and 2017
(In thousands)

	2018				2017			
Assets	**Business-type Activities – HHC**	**Discretely Presented Component Unit-MetroPlus**	**Eliminations**	**Total**	**Business-type Activities – HHC**	**Discretely Presented Component Unit-MetroPlus**	**Eliminations**	**Total**
Current assets:								
Cash and cash equivalents	$ 747,399	551,100	—	1,298,499	609,647	574,396	—	1,184,043
U.S. government securities	—	147,379	—	147,379	—	89,832	—	89,832
Patient accounts receivable, net	689,973	—	(299,204)	390,769	571,810	—	(217,437)	354,373
Premiums receivable	—	485,501	(2,746)	482,755	—	214,993	(2,376)	212,617
Estimated third-party payor settlements, receivable	473,200	—	(364,195)	109,005	603,900	—	(146,255)	457,645
Estimated pools receivable, net	54,700	—	—	54,700	—	—	—	—
Grants receivable	323,316	183	—	323,499	329,408	201	—	329,609
Assets restricted as to use and required for current liabilities	31,162	—	—	31,162	31,020	—	—	31,020
Other current assets	101,784	59,802	—	161,586	87,638	42,103	—	129,741
Total current assets	2,421,534	1,243,965	(666,145)	2,999,354	2,233,423	921,525	(366,068)	2,788,880
Assets restricted as to use, net of current portion	123,781	149,590	—	273,371	140,819	143,342	—	284,161
U.S. government securities	—	315,325	—	315,325	—	333,758	—	333,758
Other receivable	10,661	—	—	10,661	10,661	14,749	—	25,410
Capital assets, net	3,490,264	5,901	—	3,496,165	3,395,964	6,288	—	3,402,252
Total assets	6,046,240	1,714,781	(666,145)	7,094,876	5,780,867	1,419,662	(366,068)	6,834,461
Deferred Outflows of Resources								
Net differences between projected and actual earnings on pension plan investments and other changes, net	—	—	—	—	13,794	339	—	14,133
Unamortized refunding cost	8,567	—	—	8,567	10,537	—	—	10,537
	$ 6,054,807	1,714,781	(666,145)	7,103,443	5,805,198	1,420,001	(366,068)	6,859,131
Liabilities								
Current liabilities:								
Current installments of long-term debt	$ 83,407	—	—	83,407	67,256	—	—	67,256
Accrued salaries, fringe benefits, and payroll taxes	501,685	12,212	(2,746)	511,151	518,167	6,214	(2,376)	522,005
Accounts payable and accrued expenses	603,150	1,032,661	(663,399)	972,412	592,221	711,198	(363,692)	939,727
Estimated third-party payor settlements, net payable	79,845	—	—	79,845	59,175	—	—	59,175
Estimated pools payable, net	—	—	—	—	43,200	—	—	43,200
Current portion of due to The City of New York, net	480,389	—	—	480,389	555,464	—	—	555,464
Current portion of pension	495,496	12,181	—	507,677	482,816	11,873	—	494,689
Current portion of postemployment benefits obligation, other than pension	136,243	3,379	—	139,622	125,728	1,232	—	126,960
Total current liabilities	2,380,215	1,060,433	(666,145)	2,774,503	2,444,027	730,517	(366,068)	2,808,476
Long-term debt, net of current installments	792,702	—	—	792,702	776,783	—	—	776,783
Accrued compensated absences, net of current portion	282,833	5,914	—	288,747	278,910	5,402	—	284,312
Accrued salaries, fringe benefits, and payroll taxes, net of current portion	300,000	—	—	300,000	—	—	—	—
Due to City of New York, net of current portion	—	—	—	—	61,690	—	—	61,690
Long-term pension, net of current portion	2,090,713	51,328	—	2,142,041	2,514,409	61,830	—	2,576,239
Postemployment benefits obligation, other than pension, net of current portion	5,026,936	42,358	—	5,069,294	4,622,435	41,249	—	4,663,684
Total liabilities	10,873,399	1,160,033	(666,145)	11,367,287	10,698,254	838,998	(366,068)	11,171,184
Deferred Inflows of Resources								
Net differences between projected and actual earnings on pension plan investments and other changes, net	310,683	7,706	—	318,389	—	—	—	—
Net differences between expected and actual experience and changes in actuarial assumptions in postemployment benefits obligation, other than pension	408,912	2,839	—	411,751	684,300	10,159	—	694,459
	11,592,994	1,170,578	(666,145)	12,097,427	11,382,554	849,157	(366,068)	11,865,643
Net position								
Net investment in capital assets	2,545,082	5,909	—	2,550,991	2,553,374	6,315	—	2,559,689
Restricted:								
For debt service	136,059	—	—	136,059	138,854	—	—	138,854
Expendable for specific operating activities	9,117	—	—	9,117	13,537	—	—	13,537
Nonexpendable permanent endowments	928	—	—	928	928	—	—	928
For statutory reserve requirements	—	372,135	—	372,135	—	347,342	—	347,342
Unrestricted	(8,229,373)	166,159	—	(8,063,214)	(8,284,049)	217,187	—	(8,066,862)
Total net deficit position	(5,538,187)	544,203	—	(4,993,984)	(5,577,356)	570,844	—	(5,006,512)
	$ 6,054,807	1,714,781	(666,145)	7,103,443	5,805,198	1,420,001	(366,068)	6,859,131

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Statement of Revenue, Expenses, and Changes in Net Position
For the years June 30, 2018 and 2017
(In thousands)

	2018				2017			
	Business-type Activities – HHC	Discretely Presented Component Unit – MetroPlus	Eliminations	Total	Business-type Activities – HHC	Discretely Presented Component Unit – MetroPlus	Eliminations	Total
Operating revenue:								
Net patient service revenue	$ 6,216,713	—	(1,037,499)	5,179,214	5,611,114	—	(741,688)	4,869,426
Appropriations from City of New York, net	787,331	—	—	787,331	723,425	—	—	723,425
Premium revenue	—	3,332,526	(32,981)	3,299,545	—	3,018,676	(28,864)	2,989,812
Grants revenue	651,966	928	—	652,894	863,808	960	—	864,768
Other revenue	104,981	5,198	—	110,179	95,287	8,223	—	103,510
Total operating revenue	7,760,991	3,338,652	(1,070,480)	10,029,163	7,293,634	3,027,859	(770,552)	9,550,941
Operating expenses:	—							
Personal services	3,070,082	83,289	—	3,153,371	2,753,026	78,712	—	2,831,738
Other than personal services	1,789,369	3,239,540	(1,037,499)	3,991,410	1,842,665	2,868,589	(741,688)	3,969,566
Fringe benefits and employer payroll taxes	841,106	24,851	(32,981)	832,976	875,313	19,945	(28,864)	866,394
Pension	394,420	9,781	—	404,201	426,325	10,445	—	436,770
Postemployment benefits, other than pension	337,745	8,375	—	346,120	289,166	7,384	—	296,550
Affiliation contracted services	1,076,202		—	1,076,202	1,069,545	—	—	1,069,545
Depreciation	309,574	2,530	—	312,104	310,325	2,446	—	312,771
Total operating expenses	7,818,498	3,368,366	(1,070,480)	10,116,384	7,566,365	2,987,521	(770,552)	9,783,334
Operating (loss) income	(57,507)	(29,714)	—	(87,221)	(272,731)	40,338	—	(232,393)
Nonoperating revenue (expenses):								
Investment (loss) income	2,673	3,075	—	5,748	(143)	(962)	—	(1,105)
Interest expense	(120,759)	(2)	—	(120,761)	(116,653)	—	—	(116,653)
Contributions restricted for specific operating activities	4,739	—	—	4,739	802	—	—	802
Total nonoperating (expenses) revenue, net	(113,347)	3,073	—	(110,274)	(115,994)	(962)	—	(116,956)
(Loss) income before other changes in net position	(170,854)	(26,641)	—	(197,495)	(388,725)	39,376	—	(349,349)
Other changes in net position:	—							
Capital contributions funded by City of New York, net	126,126	—	—	126,126	135,395	—	—	135,395
Capital contributions funded by grantors and donors	83,897	—	—	83,897	20,385	—	—	20,385
Total other changes in net position	210,023	—	—	210,023	155,780	—	—	155,780
(Decrease) increase in net position	39,169	(26,641)	—	12,528	(232,945)	39,376	—	(193,569)
Net deficit position at beginning of period	(5,577,356)	570,844	—	(5,006,512)	(5,344,411)	531,468	—	(4,812,943)
Net deficit position at end of period	$ (5,538,187)	544,203	—	(4,993,984)	(5,577,356)	570,844	—	(5,006,512)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Statement of Cash Flows
For the years June 30, 2018 and 2017
(In thousands)

Statement of Cash Flows to be inserted here

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Statement of Cash Flows
For the years June 30, 2018 and 2017
(In thousands)

Statement of Cash Flows to be inserted here (cont.)

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

On July 1, 1970, the New York City Health and Hospitals Corporation ("NYC Health + Hospitals"), a New York State (the "State") public benefit corporation created by Chapter 1016 of the Laws of 1969, assumed responsibility for the operation of the municipal hospital system of The City of New York (The City) pursuant to an agreement with The City dated June 16, 1970 (the Agreement). As a main element of its core mission, NYC Health + Hospitals provides to all equally, on behalf of The City, comprehensive medical and mental health services of the highest quality in an atmosphere of humane care, dignity, and respect, regardless of a patient's ability to pay. NYC Health + Hospitals operates eleven acute care hospitals, five long-term care facilities, six diagnostic and treatment centers (five of those freestanding facilities), many hospital-based and neighborhood clinics, a certified home health agency, and MetroPlus Health Plan, Inc. ("MetroPlus"), a prepaid health services provider. During 2017, NYC Health + Hospitals realigned the delivery of care to three defined areas as follows: acute care (hospitals), post-acute care (long-term care facilities), and ambulatory care services. Prior to the re-alignment, all facilities were organized into six integrated networks based on proximity to one another.

This change for NYC Health + Hospitals permits for the alignment of the three areas of vertically integrated facilities providing the full continuum of care for primary and specialty care, inpatient episodic acute care, outpatient services, and long-term care. The re-alignment of the delivery of services was intended to enhance and improve the efficiencies achieved under the former network model through better alignment of services.

NYC Health + Hospitals is a discretely presented component unit of The City, and accordingly, its financial statements are included in The City's Comprehensive Annual Financial Report.

NYC Health + Hospitals has a number of blended component units, which means that they are reported as if they were part of NYC Health + Hospitals. These entities meet the requirements for blending when they provide services exclusively to NYC Health + Hospitals and/or NYC Health + Hospitals is the sole corporate member and appoints a voting majority of the governing board of each of the blended component units. The accompanying financial statements include the operations of the following component units, which are blended with the accounts of Business-type Activities- HHC in the preceding Statement of Net Position and Statement of Revenues, Expenses, and Changes in Net Position:

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

- HHC Insurance Company, Inc. ("HHC Insurance") was created in 2003 by NYC Health + Hospitals as a public benefit corporation, of which NYC Health + Hospitals is the sole member. It is a not-for-profit captive insurance company licensed by the New York State Insurance Department. Its license is renewed annually and was renewed on July 1, 2017. HHC Insurance underwrites medical

malpractice insurance for NYC Health + Hospitals' attending physicians who specialize in the areas of neurosurgery and obstetrics/gynecology. All insured practitioners can apply for the excess insurance coverage available to them in the New York State Excess Liability Pool, issued by the Medical Malpractice Insurance Pool ("MMIP" or "Pool").

- HHC Insurance issues primary professional liability policies to its insureds on a claims-made basis with policy limits of $1.3 million per incident and $3.9 million in the aggregate. Once the insured practitioner has this primary insurance coverage, the insured is able to apply for excess coverage, in the amount of $1.0 million per incident and $3.0 million in the aggregate, provided by MMIP. HHC Insurance has been a participant in the excess Pool since 2007. MMIP is considered the insurer of last resort for primary medical malpractice coverage in the State (the "Plan"). On the excess level, it operates as a medical malpractice insurance pool created by all the authorized (licensed) insurers writing medical malpractice insurance in New York as an alternative to receiving direct assignments of eligible health care providers. The liability of the members is several but not joint. As an MMIP member, HHC Insurance recognizes its allocable share of the premium, loss expense, underwriting expense, administrative expense activities of MMIP, and shortfall coverage, as needed. HHC Insurance is the only captive insurance company in the Pool.

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

- HHC ACO Inc. ("HHC ACO"), a New York not-for-profit corporation, was formed in June 2012 by NYC Health + Hospitals was formed as an Accountable Care Organization ("ACO") for purposes of applying to the federal Centers for Medicare and Medicaid Services ("CMS") to participate in the Medicare Shared Savings Program (MSSP). HHC ACO was approved to participate in the MSSP as of January 1, 2013 through December 31, 2015, and began operations in fiscal year 2014. CMS subsequently approved HHC ACO for a renewal term from January 1, 2016 to December 31, 2018. ACO is in the process of seeking another renewal. NYC Health + Hospitals is its sole member.

- HHC Assistance Corporation ("HHCAC"), a membership not-for-profit corporation, was formed in October 2012 by NYC Health + Hospitals and is the sole corporate member. All members of HHCAC's board of directors are officers of NYC Health + Hospitals. The HHCAC's purpose is to perform activities that are helpful to NYC Health + Hospitals in the fulfillment of its statutory purposes. During 2012, the HHCAC facilitated NYC Health + Hospitals' participation in a New Market Tax Credit supplementary financing transaction to be used for the construction of certain new facilities at the Harlem Hospital Center (Note 8). In 2015, HHCAC took on the function of the "Central Service Organization" in the NYC Health + Hospitals-led Participating Provider System under the New York State Department of Health's Delivery System Reform Incentive Payment ("DSRIP") program. In that capacity, HHCAC operates under the d/b/a "One City Health" and

performs various functions on NYC Health + Hospitals' behalf to advance its participation in the DSRIP program (Note 12).

The financial statements also include MetroPlus, which is a discretely presented component unit and is a public benefit corporation created by NYC Health + Hospitals. As the sole member, NYC Health + Hospitals appoints a voting majority of the governing board of MetroPlus. MetroPlus contracts with NYC Health + Hospitals facilities and other providers to provide managed healthcare services on a prepaid basis and operating as a health maintenance organization.

MetroPlus' major lines of business include Medicaid, Essential Plan(EP), HIV Special Needs Plan (HIV-SNP), Child Health Plus ("CHP"), Medicare Advantage, partially capitated Managed Long-Term Care ("MLTC"), and Health and Recovery Plan (HARP). In addition, MetroPlus offers an Individual Qualified Health Plan ("QHP") and a Small Business Health Options Program ("SHOP"), with coverage effective January 1, 2014, through the New York State of Health Plan Marketplace. Such plans are the result of the Patient Protection and Affordable Care Act ("ACA") signed into law in March 2010.

MetroPlus has contractual agreements with the New York State Department of Health (NYSDOH) to provide comprehensive medical service to members of the Medicaid, EP, MLTC, HARP and CHP lines of business. The Plan also has contracts with the Center for Medicare and Medicaid Services ("CMS") and NYSDOH, to offer Medicare coverage to individuals, including those dually eligible for benefits under Medicare and Medicaid. Beneficiaries have the option of selecting MetroPlus or the State of New York as their Medicaid coverage provider. MetroPlus has an agreement with the New York State Department of Financial Services ("NYSDFS") to offer the QHP and SHOP programs.

Additionally, NYC Health + Hospitals employees as well as all City employees, can elect MetroPlus Gold as part of their employee benefits. Effective December 1, 2016, MetroPlus offered GoldCare I and GoldCare II, low cost, high quality plans, to all day care workers of New York City agencies.

Primary care medical services, provided by physicians associated with NYC Health + Hospitals and other physicians and provider groups, are capitated, which refers to reimbursement at a per member per month value based on the provider's assigned membership.

Supplementary disclosures for MetroPlus are presented beginning with Note 17 of the financial statements. MetroPlus and HHC Insurance issue separate statutory annual financial statements as of December 31st, which are available through the Office of the Corporate Comptroller, 160 Water Street, Room 642, New York, New York 10038. Additionally, while not a statutory requirement, HHC ACO issues fiscal yearend financial statements as of June 30th, which are also available through the Office of the Corporate Comptroller.

The NYC Health + Hospitals' significant accounting policies are as follows:

(a) Basis of Presentation

The accompanying basic financial statements of NYC Health + Hospitals are presented in conformity with generally accepted accounting principles "(U.S. GAAP" or "GAAP") for state and local governments in the United States of America as prescribed by the Governmental Accounting Standards Board ("GASB"). The

financial statements of NYC Heath + Hospitals have been prepared on the accrual basis of accounting using the economic resources measurement focus.

All significant intercompany balances and transactions between NYC Health + Hospitals and the blended component units have been eliminated within the business-type activities column. All significant intercompany balances and transactions between NYC Health + Hospitals and MetroPlus have been eliminated in the eliminations column.

(b) Assets Restricted As to Use and Contributions

Assets restricted as to use primarily include assets held by a trustee under bond resolutions and statutory reserve investments. Amounts required to meet current liabilities of NYC Health + Hospitals have been classified as current assets in the Statement of Net Position at June 30, 2018 and 2017. Assets restricted as to use are stated at fair value, with unrealized and realized gains and losses included in investment income.

Donor-restricted net positions are used to differentiate resources, the use of which is restricted by donors, from resources of unrestricted assets on which donors place no restriction or that arise as a result of the operations of NYC Health + Hospitals for its stated purposes. Donor-restricted net positions represent contributions to provide healthcare services, of which $0.9 million are held in perpetuity, as nonexpendable permanent endowments, at June 30, 2018 and 2017. Resources restricted by donors for plant replacement and expansion are recognized as capital contributions and are added to the net investment in capital assets, net position balance. Resources restricted by donors for specific operating activities are reported as nonoperating revenue. NYC Health + Hospitals utilizes available donor-restricted assets before utilizing unrestricted resources for expenses incurred.

(c) Charity Care

NYC Health + Hospitals provides care to patients who meet certain criteria under its charity care policy at amounts less than its charges or established rates. NYC Health + Hospitals does not pursue collection of amounts determined to qualify as charity care, and they are not reported as revenue (Note 3).

(d) Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results may differ from those estimates.

Included in net patient service revenue are adjustments to prior year estimated third-party payor settlements, estimated pools receivables and payables that were originally recorded in the period the related services were rendered. The adjustments to prior year estimates and other third-party reimbursement receipts or recoveries that relate to prior years resulted in an increase to net patient service revenue of $260.3 million and $160.2 million for the years ended June 30, 2018 and 2017, respectively.

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

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

(f) Patient Accounts Receivable, Net and Net Patient Service Revenue

NYC Health + Hospitals has agreements with certain third-party payors that provide for payments at amounts different from its charges or established rates. Payment arrangements include prospectively determined rates, discounted charges, per diem payments, and value-based payment arrangements; a payment relationship in which there is a shift from a pure volume-based payment (i.e., fee for service) to an outcome-based payment where health providers are paid based on improvement of health of the patient rather than volume of services provided to the patient. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated third-party payor settlements resulting from audits, reviews, and investigations. These estimated third-party payor settlements are accrued in the period the related services are rendered and adjusted in future periods as revised information becomes known or as years are no longer subject to such audits, reviews, and investigations. Net patient service revenue is reported net of the provision for bad debts of $306.1 million in 2018 and $579.3 million in 2017 which reflects a reduction in the prior year amount of $191.5 million for an adjustment of self-pay collections.

The allowance for doubtful accounts is the NYC Health + Hospitals estimate of the amount of probable credit losses in its patient accounts receivable. NYC Health + Hospitals determines the allowance based on collection studies and historical write-off experience. Past-due balances are reviewed individually for collectability. Account balances are charged off against the allowance after all means of collection have been exhausted and the potential for recovery is considered remote. The allowance for doubtful accounts at June 30, 2018 and 2017 was approximately $464.0 million and $663.9 million, respectively, including a reduction to allowances in 2018 for the prior year in the amount of $191.5 million for an adjustment of self-pay collections.

(g) Appropriations from The City of New York, net

NYC Health + Hospitals considers appropriations from The City to be ongoing and central to the provision of healthcare services and, accordingly, classifies them as operating revenue. Funds appropriated from The City are direct or indirect payments made by The City on behalf of NYC Health + Hospitals for the following:

- Settlements of claims for medical malpractice, negligence, other torts, and alleged breach of contracts, and payments by The City (Note 12).

- Patient care rendered to prisoners (Note 16), uniformed City employees, and various discretely funded facility-specific programs.

- Interest on City General Obligation debt that funded NYC Health + Hospitals' capital acquisitions and interest on Dormitory Authority of the State of New York (DASNY) debt and Transitional Finance Authority ("TFA") debt on assets acquired through lease purchase agreements, other than amounts capitalized during construction (Note 5).

- Funding for collective bargaining agreements.

Reimbursement by NYC Health + Hospitals is negotiated annually with The City. NYC Health + Hospitals has agreed to reimburse The City for the following as remittances to The City:

- Medical malpractice settlements, negligence, and other torts up to an agreed-upon amount are negotiated annually and paid by The City on behalf of NYC Health + Hospitals. In 2018 and 2017, the medical malpractice and general liability settlements paid by The City were $108.1 million and $112.9 million, respectively. NYC Health + Hospitals prepaid FY 2019 medical malpractice to The City in the amount of $9.1 million. During 2017, NYC Health + Hospitals owed medical malpractice amounts of $112.9 million plus the remaining amounts owed from 2015 of $123.4 million, of which $61.7 million was not due until after June 30, 2018 and was recorded as long term liability. NYC Health + Hospitals agreed to reimburse The City $112.9 million for 2017, which was recorded as a current liability at June 30, 2017. The reimbursements to The City are recorded by NYC Health + Hospitals as a reduction of appropriations from The City. Such medical malpractice, negligence, and other torts reimbursements by NYC Health + Hospitals do not alter the indemnification by The City of NYC Health + Hospitals' malpractice settlements under the Agreement (Note 12).

- Interest and principal on debt service is negotiated annually, related to debt, which funded NYC Health + Hospitals capital acquisitions and is paid by The City on behalf of the NYC Health + Hospitals. In 2018 and 2017, the debt service paid by The City was $128.8 million and $145.8 million, respectively. During 2018 and 2017, The City assumed Fiscal Year 2018 and 2017 commitments, respectively, thereby alleviating amounts owed to The City of $128.8 million and $145.8 million for 2018 and 2017, respectively. NYC Health + Hospitals agreed to reimburse The City $145.8 million for 2015, which was recorded as a current liability at June 30, 2018 and June 30, 2017. The debt service reimbursements to The City are recorded by NYC Health + Hospitals as a reduction of appropriations from The City.

Refer to Note 9 of the financial statements for balances owed to The City including malpractice and debt service.

(h) Capital Assets and Depreciation

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

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

(In thousands)

NYC Health + Hospitals is the sole beneficiary as to use of the capital assets and is responsible for their control and maintenance. Accordingly, capital assets have been capitalized in the accompanying Statement of Net Position as follows:

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

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

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

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

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

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

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

NYC Health + Hospitals evaluates long-lived assets for impairment when circumstances suggest that the service utility or the usable capacity that upon acquisition was expected to be used to provide service of the capital asset may have significantly or unexpectedly declined. If circumstances suggest that assets may be impaired, an impairment charge is recorded on those assets based upon a method that most appropriately reflects the decline in service utility of the capital asset. No material changes to capital assets were recorded for the fiscal years ended June 30, 2018 and 2017.

(i) Custodial Funds

NYC Health + Hospitals holds funds for safekeeping, primarily cash held for the benefit of its long-term care patients, amounting to approximately $6.9 million and $4.8 million as of June 30, 2018 and 2017, respectively. These amounts are included in other current assets and accounts payable and accrued expenses in the accompanying Statement of Net Position. At June 30, 2018 and 2017, all custodial funds-related bank balances are fully insured.

(j) Affiliation Contracted Services

NYC Health + Hospitals contracts with affiliated medical schools/professional corporations and voluntary hospitals ("Affiliate") to provide patient care services at its facilities and reimburses the Affiliate for

expenses incurred in providing such services. Under the terms of those contracts, each of the Affiliates is required to furnish NYC Health + Hospitals with an independent audit report of receipts, expenditures, and commitments chargeable to the contract, as well as refunds or amounts due to the Affiliate. In addition, the Affiliates submit an annual recalculation document which reconciles allowable contract costs to the expenses incurred by the affiliates. The net effect of these recalculations creates either a payable or receivable by comparing the total advance payments made during the fiscal year to the total contract amount.

The amounts due to/from the affiliates are based upon estimates of expenses, which include adjustments for patient care service modifications, and are included in accounts payable and accrued expenses (Note 13) and other current assets in the accompanying Statements of Net Position. These estimates may differ from the final determination of amounts due to/from the affiliate upon completion of the annual recalculation schedule.

(k) Supplies

Supplies are stated at the lower of cost (first-in, first-out method) or market (net realizable value) and are included within other current assets.

(l) Income Taxes

NYC Health + Hospitals and its component units qualify as governmental entities (or affiliates of a governmental entity), not subject to federal income tax, by reason of the organizations being a state or political subdivision thereof, or an integral part of a state or political subdivision thereof; or, an entity all of whose income is excluded from gross income for federal income tax purposes under Section 115 of the Internal Revenue Code of 1986. NYC Health + Hospitals is a New York State public benefit corporation created by Chapter 1016 of the Laws of 1969 and, as such, is exempt from New York State income tax. MetroPlus is also exempt from federal and New York State income tax under Section 501(a) of the Internal Revenue Code, as an organization described in Section 501(c)(3). Accordingly, no provision for income taxes has been made in the accompanying financial statements.

(m) Grants Receivable

Grants receivable relate to various healthcare provision programs under contract with the State and other grantors, including amounts related to DSRIP, the Value Based Payment Quality Improvement Program ("VBP QIP") and the Care Restructuring Enhancement Pilot ("CREP") (Notes 12). Grants receivable also include grants from The City, which are reimbursement to NYC Health + Hospitals for providing such services as mental health, child health, and HIV-AIDS services.

(n) Net Position

Net position of NYC Health + Hospitals is classified in various components. *Net investment in capital assets* consists of capital assets net of accumulated depreciation and reduced by outstanding borrowings used to finance the purchase or construction of those assets. *Restricted for debt service* consists of assets restricted, by each revenue bond's official statement, for expenditures of principal and interest. *Restricted expendable for specific operating activities* reflects noncapital net assets that must be used for a particular purpose, as specified by creditors, grantors, or donors external to NYC Health + Hospitals, including amounts deposited with trustees as required by revenue bond indentures, discussed in Note 6. *Restricted*

nonexpendable permanent endowments consists of the principal portion of permanent endowments. *Restricted for statutory reserve requirements* represents MetroPlus' statutory reserve as required by the NYSDOH Rules and Regulations. *Unrestricted net position* is the remaining net position that does not meet the definition of *Net investment in capital assets or Restricted*.

(o) Compensated Absences

NYC Health + Hospitals' employees earn vacation and holiday days at varying rates depending on years of service and title. Generally, vacation and holiday time may accumulate up to specified maximums, depending on title. Excess vacation and holiday time are converted to sick leave. Upon resignation or retirement, employees are paid for unused vacation and holiday days, most at the rates in effect during the past 3 years. Most employees earn sick leave at a fixed rate; however, the rate can vary depending on years of service and the contractual terms for their title. There is no accumulation limit on sick leave. Depending on length of service and contractual terms for their title, employees separating from service are paid for sick leave at varying rates. Usage of time is taken on the first-in, first-out method based on NYC Health + Hospitals policy. NYC Health + Hospitals accrues for the employees' earned and accumulated vacation and sick leave, which may be used in subsequent years and earned vacation and sick leave to be paid upon termination or retirement from future resources, and is included as a liability within accrued compensated absences and salaries, fringe benefits and payroll taxes.

(p) Fair Value

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

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

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

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

(q) Reclassifications

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

(r) New Accounting Standards Adopted

In 2018, NYC Health + Hospitals adopted new accounting standards as follows:

GASB Statement No. 83, *Certain Asset Retirement Obligations* ("GASB 83") establishes criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources for asset retirement obligations ("AROs"). An ARO is a legally enforceable liability associated with the retirement of a tangible capital asset.

In analysis of the impact of this Statement on NYC Health + Hospitals, management has determined that the liability is immaterial to the overall reporting of the Corporation's financial statements. As such, the Corporation has met the requirements for disclosure outlined in the Statement, but has determined that restatement of prior years is not necessary (Note 13).

GASB Statements No. 85, *Omnibus* 2017 ("GASB 85") amends parts of Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*; Statement No. 24, *Accounting and Financial Reporting for Certain Grants and Other Financial Assistance*; Statement No. 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments*; Statement No. 38, *Certain Financial Statement Note Disclosures*; Statement No. 61, *The Financial Reporting Entity: Omnibus*; Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*; Statement No. 68, *Accounting and Financial Reporting for Pensions*; Statement No. 72, *Fair Value Measurement and Application*; Statement No. 73, *Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement 68, and Amendments to Certain Provisions of GASB Statements 67 and 68*; Statement No. 74, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*; Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. GASB 85 addresses practice issues that have been identified during implementation and application of certain GASB Statements. The Statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits (pensions and other postemployment benefits [OPEB]). NYC Health + Hospitals has reviewed this Statement and has determined that it is already in compliance with the applicable reporting requirements outlined in this Statement.

GASB Statement No. 86, *Certain Debt Extinguishment Issues* ("GASB 86"), amends parts of Statement No. 7, *Advance Refundings Resulting in Defeasance of Debt*; Statement No. 23, *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*; Statement No. 53, *Accounting and Financial Reporting for Derivative Instruments*; Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*; Statement No. 65, *Items Previously Reported as Assets and Liabilities*. GASB 86 establishes standards of accounting and financial reporting for in-substance defeasance transactions in which cash and other monetary assets acquired with only existing resources - that is, resources other than the proceeds of refunding debt - are placed in an irrevocable trust for the purpose of extinguishing debt. This Statement also amends accounting and financial reporting requirements for prepaid insurance associated with debt that is extinguished, whether through a legal extinguishment or through an insubstance defeasance, regardless of how the cash and other monetary assets were acquired. Finally, this Statement establishes an additional disclosure requirement related to debt that is defeased

in substance, regardless of how the cash and other monetary assets were acquired. The adoption of GASB 86 has no impact on the financial statements or disclosures of NYC Health + Hospitals.

2. CASH AND CASH EQUIVALENTS

Cash and cash equivalents include cash, certificates of deposit ("CDs"), and all highly liquid debt instruments with original maturities of three months or less when purchased. The carrying amount of cash and cash equivalents approximates fair value due to the short-term maturity of the investments. Custodial credit risk is the risk that, in the event of a bank failure, NYC Health + Hospitals' deposits may not be returned to it. NYC Health + Hospitals' policy to mitigate custodial credit risk is to collateralize all balances when permitted (i.e., collected balances). Deposits in the process of collection within the banking system are not collateralized. At June 30, 2018 and 2017, all of NYC Health + Hospitals cash and cash equivalents bank balances were insured and collateralized.

3. CHARITY CARE

NYC Health + Hospitals maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges forgone for services furnished under its charity care policy and the estimated cost of those services calculated using the prior year's cost reports. The following information measures the level of charity care provided during the years ended June 30 (in thousands):

	2018	2017
Charges foregone, based on established rates	$ 953,576	$ 935,743
Estimated expenses incurred to provide charity care	608,275	612,614

4. PATIENT ACCOUNTS RECEIVABLE, NET AND NET PATIENT SERVICE REVENUE

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

Disproportionate Share Hospital ("DSH") and Upper Payment Limit ("UPL") are supplemental payments to hospitals for their care to the indigent and are included in net patient service revenue. Hospital participants of DSH serve a significantly disproportionate number of low-income patients and receive payments from CMS to cover the costs of providing care to uninsured patients. The UPL is a federal limit placed on a fee-for-service reimbursement of Medicaid providers. The UPL is the maximum a given state Medicaid program may pay a type of provider in the aggregate, statewide, in Medicaid fee-for-service. State Medicaid programs cannot claim federal matching dollars for provider payments in excess of the applicable UPL; however, UPL Federal regulations allow states to pay Medicaid providers up to Medicare levels or the costs of care.

Net patient service revenue by primary payor for the years ended June 30, 2018 and 2017 is as follows (in thousands):

	2018		2017	
Medicaid	$ 1,248,612	20.1 %	$ 1,479,382	26.4 %
Medicare	646,228	10.4	565,659	10.1
Bad debt/charity care pools	687,067	11.0	393,647	7.0
Disproportionate share supplemental pool (DSH)	1,109,168	17.8	949,800	16.9
Other third-party payors that include Medicaid and Medicare managed care	1,464,787	23.6	1,440,893	25.7
MetroPlus	1,037,499	16.7	741,688	13.2
Self-pay	23,352	0.4	40,045	0.7
	$ 6,216,713	100.0 %	$ 5,611,114	100.0 %

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

	2018		2017	
Medicaid	$ 69,006	10.0 %	$ 70,544	12.3 %
Medicare	56,483	8.2	45,588	8.0
Other third-party payors, that include Medicaid and Medicare managed care	244,780	35.4	201,131	35.2
MetroPlus	299,204	43.3	217,437	38.0
Self-pay	20,500	3.1	37,110	6.5
	$ 689,973	100.0 %	$ 571,810	100.0 %

5. CAPITAL ASSETS

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

	2018	2017
Land and land improvements	$ 57,726	$ 56,971
Buildings and leasehold improvements	4,450,202	4,366,964
Equipment	3,694,217	3,526,013
	8,202,145	7,949,948
Less: accumulated depreciation	5,322,623	5,019,628
	2,879,522	2,930,320
Construction in progress	610,742	465,644
Capital assets, net	$ 3,490,264	$ 3,395,964

Capital assets activity for the years ended June 30, 2018 and 2017 was as follows (in thousands):

	Land and Land Improvements	Buildings and Leasehold Improvements	Equipment	Construction in Progress	Total
June 30, 2016 balance	$ 56,657	$ 4,313,853	$ 3,623,133	$ 371,151	$ 8,364,794
Acquisitions, net of transfers	499	54,725	154,711	94,493	304,428
Sales, retirements, and adjustments	(185)	(1,614)	(251,831)	-	(253,630)
June 30, 2017 balance	56,971	4,366,964	3,526,013	465,644	8,415,592
Acquisitions, net of transfers	758	84,284	228,321	145,098	458,461
Sales, retirements, and adjustments	(3)	(1,046)	(60,117)	-	(61,166)
June 30, 2018 balance	$ 57,726	$ 4,450,202	$ 3,694,217	$ 610,742	$ 8,812,887

Related information on accumulated depreciation for the years ended June 30, 2018 and 2017 was as follows (in thousands):

	Land and Land Improvements	Buildings and Leasehold Improvements	Equipment	Total
June 30, 2016 balance	$ 27,546	$ 2,156,338	$ 2,779,049	$ 4,962,933
Depreciation expense	1,641	137,067	171,617	310,325
Sales, retirements, and adjustments	(185)	(1,614)	(251,831)	(253,630)
June 30, 2017 balance	29,002	2,291,791	2,698,835	5,019,628
Depreciation expense	1,554	134,795	173,225	309,574
Sales, retirements, and adjustments	(1)	(599)	(5,979)	(6,579)
June 30, 2018 balance	$ 30,555	$ 2,425,987	$ 2,866,081	$ 5,322,623

NYC Health + Hospitals capitalizes interest costs incurred in connection with construction projects. Interest activity relating to construction projects and net capitalized interest for the years ended June 30, 2018 and 2017 was as follows (in thousands):

	2018	2017
Interest costs subject to capitalization	$ 20,593	$ 17,884
Interest income	(148)	(290)
Capitalized interest costs, net	$ 20,445	$ 17,594

NYC Health + Hospitals capitalized net interest costs on TFA debt and City General Obligation Bonds in both 2018 and 2017, as well as NYC Health + Hospitals' own bonds. Such debt was issued to finance construction of various NYC Health + Hospitals facilities, with such debt to be paid by The City on behalf of NYC Health + Hospitals. Amounts capitalized in 2018 and 2017 approximated $20.6 million and $17.8 million, respectively. In addition, NYC Health + Hospitals capitalized net interest costs of $0.1 million in 2018 and $0.3 million in 2017 related to its 2008 and 2010 Series bonds.

NYC Health + Hospitals- Gouverneur's major modernization construction project was almost completed and was in the close-out process as of fiscal year end 2018. Approximately $6.7 million was expended as of June 30, 2018 and portions of this project in amount approximating $29.6 million were transferred out of CIP and placed into service during fiscal year 2018.

NYC Health + Hospitals continues developing an Electronic Medical Records ("EMR") system that has a six-year implementation period with a budget of $764.0 million. The fiscal year ended 2018 addition to CIP related to this project is $43.1 million; which is inclusive of capitalizable expenditures of $37.2 million

and capitalized payroll amounts of $10.3 million. Total CIP is reported as $187.1 million and $160.1 million as of June 30, 2018 and 2017, respectively.

NYC Health + Hospitals continues the development of an Enterprise Resource Planning ("ERP") system with a capital addition to CIP of $2.7 million in fiscal year 2018. The ERP project budget assigned through fiscal year 2025, including post implementation expenses, is approximately $114.9 million. This amount excludes the costs of capitalized in-house payroll assigned to the project.

Also, there are energy efficiency upgrade projects at multiple facilities representing an increase in CIP of $20.2 million for fiscal year 2018, with a total budget of $54.0 million for completion. The Comprehensive Energy Efficiency project at Metropolitan Hospital, which is managed by the New York Power Authority (NYPA), was completed and placed in service in 2018 for $34.1 million and the NYPA-managed Comprehensive Energy Efficiency project at Elmhurst Hospital was completed and placed in service in both fiscal years 2018 and 2017 at a cost of $1.9 million and $5.9 million, respectively.

Additionally, construction was completed on the new NYC Health + Hospitals Gotham diagnostic and treatment center on Staten Island with $19.9 million of the project placed in service during fiscal year 2018. There were also projects at multiple facilities for priority mitigation and major work components which represent $42.5 million of the total to CIP in fiscal year 2018, with an estimated cost to complete of $1.4 billion.

6. ASSETS RESTRICTED AS TO USE

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

	2018	2017
Under bond resolutions [a]		
Construction funds	$ 1,174	$ 2,990
Capital reserve funds	87,487	87,775
Revenue funds	44,204	46,630
	132,865	137,395
New Market Tax Credit [b]	119	198
By donors for specific operating activities and permanent endowments [c]	10,362	14,465
Equipment financing [d]	11,597	19,781
Total assets restricted as to use	154,943	171,839
Less: current portion of assets restricted as to use	31,162	31,020
Assets restricted as to use, net of current portion	$ 123,781	$ 140,819

a. Assets restricted as to use under the terms of the bond resolutions (Note 6) are to provide for debt service requirements and the acquisition of capital assets. Terms of the bond resolutions provide that assets be maintained in separate funds held by the trustee. The construction funds are invested in an interest-bearing negotiable order of withdrawal ("NOW") account, which is fully collateralized. The capital reserve funds are invested primarily in a ten-year U.S. Treasury note and a two-year U.S. Treasury note. Security maturity date decisions are based on the final maturity of the specific Bond series, potential need for liquidity due to refunding, and/or an assessment of the current market interest rate conditions. The majority of the revenue funds are invested in U.S. Treasury bills for the time period between a month and a maximum of twelve months. Investments are timed so that funds are available for required semiannual debt service payments. Possible exposure to fair value losses arising from interest rate volatility is limited by investments in securities having maturities of less than one year and at most ten years and by intending to hold the security to maturity.

b. The New Market Tax Credit ("NMTC") transaction required the execution of a loan agreement between NYC Health + Hospitals/NCF Sub-CDE, LLC and NYC Health + Hospitals. This agreement required NYC Health + Hospitals to fund a National Community Fund ("NCF") Fee Reserve Account, out of which NYC Health + Hospitals payments of interest and fees associated with the loan are drawn (Note 8).

c. As of June 30, 2018, $7.0 million of donor-restricted funds were invested in CD's and $3.3 million in collateralized checking accounts. The $4.1 million decrease in the donor-restricted funds from FY 2017 to FY 2018 is due to the close out of the Fund of HHC.

d. The equipment financing escrow funds are mostly invested in United States Treasury Money Market Fund accounts (Note 8).

The current portion is related to the 2013 Series A bonds, 2010 Series A bonds, and the 2008 Series A, B, C, D, and E bonds debt service payable in fiscal year 2018.

The following presents NYC Health + Hospitals fair value measurements for assets restricted as to use measured at fair value on a recurring basis as of June 30, 2018 and 2017 (in thousands):

	June 30, 2018		
	Fair Value	**Level 1**	**Level 2**
U.S. government obligations and securities	$ 130,635	$ 8,075	$ 122,560

	June 30, 2017		
	Fair Value	**Level 1**	**Level 2**
U.S. government obligations and securities	$ 132,398	$ 3,575	$ 128,823

Included within assets restricted as to use are CD's of approximately $7.0 million for both 2018 and 2017, and cash and cash equivalents of $3.3 million and $7.5 million for 2018 and 2017, respectively. NYC Health + Hospitals does not have any assets or liabilities based upon Level 3 inputs.

7. U.S GOVERNEMENT SECURITIES

U.S. government securities consist of U.S. Treasury bills, U.S. Treasury notes, and U.S. Treasury zero-coupon strips. Such securities are stated at fair value based upon Level 2 inputs, with unrealized and realized gains and losses included in investment income. Securities maturing within a year are presented as current assets. Securities presented as noncurrent assets mature after a year.

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

As of June 30, NYC Health +Hospitals had the following U.S. government securities (in thousands):

			Investment Maturing in (Years)	
Year	**Investment Type**	**Fair Value**	**Less than 1**	**1 to 3**
2018	U.S. Treasury bills, notes, bonds and strips	$ 494,524	$ 494,524	$ -
2017	U.S. Treasury bills, notes, bonds, and strips	-	-	-

8. LONG-TERM DEBT

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

	2018	2017
Bonds payable:		
2013 Series A Fixed Rate Health System Bonds – weighted average interest of 2.44%, payable in installments to 2023:		
Uninsured Bonds (a)	$ 118,785	$ 121,847
2010 Series A Fixed Rate Health System Bonds – weighted average interest of 3.89%, payable in installments to 2030:		
Uninsured Bonds (b)	350,069	392,440
2008 Series A Fixed Rate Health System Bonds – weighted average interest of 4.51%, payable in installments to 2026:		
Uninsured Bonds (c)	83,930	92,842
2008 Series B, C, D, and E Variable Rate Health System Bonds – subject to short-term liquidity arrangements, weighted average interest of 1.35% in 2017 and 0.80% in 2016, payable in installments to 2031:		
Uninsured Bonds (d)	145,243	149,810
Total bonds payable	698,027	756,939
New York Power Authority (NYPA) financing	44,328	-
Henry J. Carter capital lease obligation (e)	25,095	27,217
New Market Tax Credit (f)	14,700	14,700
JP Morgan Equipment Financing (g)	48,411	10,000
Term Loan and Revolving Loan (Citibank) (h)	30,000	10,000
Key Bank CISCO Leases (i)	14,240	21,260
Oracle ERP Financing (j)	1,308	3,923
Total long-term debt	876,109	844,039
Less: current installments	83,407	67,256
Total long-term debt, net of current installments	$ 792,702	$ 776,783

Long-term debt activity for the years ended June 30, 2018 and 2017 was as follows (in thousands):

	June 30, 2017 Balance	Additions	Reductions	June 30, 2018 Balance	Amount Due Within 1 Year
Long-term debt					
Bonds payable	$ 756,939	$ -	$ (58,912)	$ 698,027	$ 56,020
NYPA financing	-	44,328	-	44,328	1,767
Equipment and renovation financing	45,183	80,326	(31,551)	93,958	22,907
Clinical bed financing	-	-	-	-	-
Henry J. Carter capital lease obligation	27,217	-	(2,121)	25,096	2,713
New Market Tax Credit	14,700	-	-	14,700	-
	$ 844,039	$ 124,654	$ (92,584)	$ 876,109	$ 83,407

	June 30, 2016 Balance	Additions	Reductions	June 30, 2017 Balance	Amount Due Within 1 Year
Long-term debt					
Bonds payable	$ 814,342	$ -	$ (57,403)	$ 756,939	$ 53,545
Equipment and renovation financing	54,756	-	(9,573)	45,183	9,636
Clinical bed financing	80	-	(80)	-	-
Henry J. Carter capital lease obligation	48,254	-	(21,037)	27,217	4,075
New Market Tax Credit	14,700	-	-	14,700	-
	$ 932,132	$ -	$ (88,093)	$ 844,039	$ 67,256

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

(a) 2013 Series A Bonds

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

Proceeds of the 2013 Bonds and $13,229,202 in residual funds from the 2008 Series A bonds were used (i) to refund and redeem all of NYC Health + Hospitals' 2003 Series A bonds totaling $111,810,000; (ii) to refund and defease a portion of NYC Health + Hospitals' 2008 Series A bonds totaling $30,675,000 ($2,405,000 matured in 2014 bearing interest at 4.0%, $16,450,000 matured in 2015 bearing interest at 5.0%, and $11,820,000 matured in 2015 bearing interest at 5% were refunded); and (iii) to pay cost of issuance of $1,131,283. Proceeds used to refund and redeem the 2003 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2003 Series A bonds to and including their final redemption date of April 22, 2013. Also, proceeds used to refund and defease 2008 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2008 Series A bonds to and including their final redemption date of February 15, 2015.

NYC Health + Hospitals completed the current refunding of the 2003 Series A bonds and the advance refunding of the 2008 Series A bonds to reduce its total debt service payments over the next 10 years by $23,026,587 and to obtain an economic gain (difference between the present values of the old and new debt service payments) of $21,904,183, which is being amortized over the life of the 2013 Bonds.

The following table summarizes debt service requirements as of June 30, 2018 (in thousands):

	Principal	Interest	Total
Years			
2019	$ 735	$ 5,216	$ 5,951
2020	745	5,186	5,931
2021	34,515	4,558	39,073
2022	36,195	2,901	39,096
2023	37,850	1,145	38,995
Total	110,040	19,006	129,046
Unamortized premium on 2013 Bonds	8,745	-	8,745
	$ 118,785	$ 19,006	$ 137,791

(b) 2010 Series A Bonds

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

Proceeds of the 2010 Bonds were used (i) to finance and reimburse NYC Health + Hospitals for the costs of its capital improvement program of $199,758,168; (ii) to refund and redeem all of NYC Health + Hospitals' 1999 Series A bonds totaling $199,715,000; (iii) to refund and defease substantially all of NYC Health + Hospitals' 2002 Series A bonds totaling $142,315,000 ($11,905,000 of the 2002 Series A bonds were not refunded); (iv) to fund the Capital Reserve Fund of $1,751,329; and (v) to pay cost of issuance of $3,281,608. Proceeds used to refund and redeem the 1999 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 1999 Series A bonds to and including their final redemption date of November 26, 2010. Also, proceeds used to refund and defease 2002 Series A bonds were deposited with the bond trustee sufficient to pay the interest and principal of the refunded 2002 Series A bonds to and including their final redemption date of February 15, 2012.

The following table summarizes debt service requirements as of June 30, 2018 (in thousands):

	Principal	Interest	Total
Years			
2019	$ 41,565	$ 16,067	$ 57,632
2020	43,560	14,020	57,580
2021	11,970	12,452	24,422
2022	12,485	11,875	24,360
2023	13,145	11,238	24,383
2024 - 2028	138,220	38,916	177,136
2029 - 2030	79,920	4,406	84,326
Total	340,865	108,974	449,839
Unamortized premium on 2010 Bonds	9,204	-	9,204
	$ 350,069	$ 108,974	$ 459,043

(c) 2008 Series A Bonds

During fiscal 2009, NYC Health + Hospitals restructured its 2002 Series B, C, D, E, F, G, and H auction rate bonds of $346,025,000. The related bond insurance was canceled. The auction rate bonds were refunded into uninsured fixed rate bonds (2008 Series A - $268,915,000, of which $152,890,000 was used for refunding and the remaining $116,025,000 used for capital projects) and into variable rate bonds supported by letters of credit (2008 Series B, C, D, and E - $189,000,000).

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

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

On March 28, 2013, NYC Health + Hospitals refunded and defeased a portion of the 2008 Series A bonds maturing in 2014 and 2015 (Note 8).

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

On September 4, 2008, NYC Health + Hospitals issued $189,000,000 of tax-exempt variable rate Health System Bonds, 2008 Series B, C, D, and E bonds (the 2008 Variable Rate Bonds). This issuance included four subseries, consisting of $50,470,000 of 2008 Series B bonds, $50,470,000 of 2008 Series C bonds, $44,030,000 of 2008 Series D bonds, and $44,030,000 of 2008 Series E bonds. The 2008 Series B and C bonds are due February 15, 2025 through February 15, 2031 and the 2008 Series D and E bonds are due February 15, 2009 through February 15, 2026. The 2008 Variable Rate Bonds are supported by irrevocable direct-pay letters of credit issued from two banks. The 2008 Series B and C letters of credit will expire in September 2019 and the D and E letters of credit will expire in July 2022.

NYC Health + Hospitals maintains the bank letters of credit to ensure the availability of funds to purchase any bonds tendered by bondholders that the remarketing agents are unable to remarket to new bondholders. Draws related to such tenders under the letters of credit will become Bank Bonds. As Bank Bonds, they can still be remarketed by the remarketing agents. If not remarketed successfully as Bank Bonds, NYC Health + Hospitals will have the opportunity to refinance them during a period of up to 365 days from initial draw date. If the Bank Bonds are not refunded and remain outstanding exceeding 365 days from initial draw date, NYC Health + Hospitals will be required to make quarterly payments over four years commencing one year after the initial draw date. There were no draws under the letters of credit as of June 30, 2018.

The initial interest rates for the 2008 Variable Rate Bonds were set at 1.45%–1.50%, bearing interest at a weekly interest rate mode. However, the 2008 Variable Rate Bonds of any series may be converted by NYC Health + Hospitals to bear interest at either a daily interest rate, a bond interest term rate, a NRS (nonputable remarketed securities) rate, an auction rate, an index rate, or a fixed rate. The overall weighted average interest was 1.79% for 2018 and 1.35% for 2017.

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

The following table summarizes debt service requirements for all of the 2008 Series Bonds as of June 30, 2018 (in thousands). The interest payments are based on the interest rate in effect at June 30, 2018:

	Principal	Interest	Total
Years			
2019	$ 13,720	6,315	$ 20,035
2020	14,300	5,756	20,056
2021	14,950	5,168	20,118
2022	15,575	4,550	20,125
2023	16,275	3,900	20,175
2024 - 2028	102,920	9,555	112,475
2029 - 2031	51,035	1,201	52,236
Total	228,775	36,444	265,219
Unamortized premium on 2008 Bonds	398	-	398
	$ 229,173	$ 36,444	$ 265,617

(e) Henry J. Carter Capital Lease Obligation

In September 2010, NYC Health + Hospitals and The City of New York entered into a Memorandum of Understanding ("MOU") with the NYSDOH, DASNY, and North General Hospital, to relocate the Goldwater operations of the Coler-Goldwater Specialty Hospital and Nursing Facility to the North General Hospital campus in northern Manhattan. This relocation allowed NYC Health + Hospitals to relinquish an aging and outdated campus, while facilitating the reorganization and downsizing of NYC Health + Hospitals' long-term care services consistent with NYC Health + Hospitals' restructuring plan.

The MOU provides for a capital lease of the existing North General Hospital building that was renovated to house long-term acute care hospital services. NYC Health + Hospitals has also acquired a parking lot on the North General campus, where a new tower building has been constructed to house skilled nursing services. NYC Health + Hospitals renamed the site of the former North General Hospital to the Henry J. Carter site. The City financed acquisition, renovation, and construction of the Henry J. Carter campus, with supplemental funding from State grants.

A lease agreement was executed in June 2011. The lease expires at the later of the date of full repayment of the North General Hospital DASNY bonds issued in relation to the leased property or the date of NYC Health + Hospitals' rent payment based on the final Medicaid capital reimbursement receipt attributable to depreciation expense for the leased assets. Assets acquired under this lease agreement have been capitalized and the related obligation is reflected in the accompanying financial statements. Upon expiration of the lease, all leased property will be conveyed to NYC Health + Hospitals, upon payment of a nominal sum. The interest rate for this obligation is 3.28%.

The following table summarizes debt service requirements as of June 30, 2018 (in thousands):

	Principal	Interest	Total
Years			
2019	$ 2,713	$ 1,091	$ 3,804
2020	4,289	1,948	6,237
2021	1,877	565	2,442
2022	1,939	503	2,442
2023	2,004	438	2,442
2024 - 2028	11,064	1,145	12,209
2029 - 2030	1,209	12	1,221
Total	$ 25,095	$ 5,702	$ 30,797

(f) New Market Tax Credit (NMTC)

In 2012, NYC Health + Hospitals entered into a New Market Tax Credit ("NMTC") to fund construction of a new maternal postpartum unit at the Harlem Hospital Center. The transaction, structured under Section 45D of the Internal Revenue Code ("IRC"), involved a complex structure designed to meet IRC requirements.

NYC Health + Hospitals formed HHCAC to assist NYC Health + Hospitals with various financial and other matters and initially to help finance the NMTC transaction. NYC Health + Hospitals capitalized HHCAC with $10.7 million, which was loaned to HHC/NCF Sub-CDE, LLC (the Sub-CDE), a Missouri limited liability company controlled by U.S. Bancorp Community Development Corporation (U.S. Bank). Along with outside investors' capital, the Sub-CDE made two loans to NYC Health + Hospitals in the amounts of approximately $10.7 million and $4.0 million. Both loans are at interest rates of 1.217%. The principal on the two loans is not payable, and cannot be paid, until the end of the seventh year, at which time the principal on both loans are due ratably over the remaining 23 years of their term. U.S. Bank may, however, exercise a put option to require NYC Health + Hospitals to purchase the entire equity in the Sub-CDE for $1,000 at the end of the seventh year. The larger of the two loans, through several intermediaries, is ultimately due to HHCAC. The smaller of the two loans would also become due to NYC Health + Hospitals or a controlled entity if the put option is exercised. If the put option is not exercised, then HHCAC could elect to purchase the equity in the Sub-CDE for its fair market value or it could elect to repay the smaller loan over the remaining 23 years at its stated interest rate.

The following table summarizes debt service requirements as of June 30, 2018 (in thousands):

	Principal	Interest	Total
Years			
2019	$ -	$ 179	$ 179
2020	324	181	505
2021	561	172	733
2022	568	165	733
2023	575	158	733
2024 - 2028	2,983	683	3,666
2029 - 2033	3,170	496	3,666
2034 - 2038	3,368	297	3,665
2039 - 2043	3,151	87	3,238
Total	$ 14,700	$ 2,418	$ 17,118

(g) Equipment Financing Agreement (JP Morgan)

On July 9, 2015, NYC Health + Hospitals entered into a $60.0 million Equipment Financing Agreement (JP Morgan Agreement) with JP Morgan Chase Bank for the purpose of financing medical, information technology, and other equipment with useful lives ranging from 5 to 10 years. The JP Morgan Agreement is a drawdown loan, which allows NYC Health + Hospitals to make multiple draws (i.e., borrowings) up to August 1, 2017 for an aggregated not-to-exceed amount of $60.0 million. During the drawdown period, all borrowings will incur monthly interest expense based on an agreed-upon variable rate formula. On July 9, 2015, NYC Health + Hospitals drew down $10.0 million at the initial interest rate of 0.9318%. On July 31, 2017, NYC Health + Hospitals drew down the remaining $50.0 million and thereafter converted the $60.0 million outstanding loan to a fixed rate loan at the interest rate of 2.088%, which was based on an agreed-upon fixed rate formula with a final maturity of July 1, 2022. The debt is secured by the equipment financed.

(h) Term Loan and Revolving Loan (Citibank)

On October 14, 2015, NYC Health + Hospitals entered into a $60.0 million revolving loan with Citibank for the purpose of financing Community Reinvestment Act-eligible capital projects. The revolving loan allows NYC Health + Hospitals to borrow up to $60.0 million at any time in advance of the maturity date and repay in full no later than the maturity date, which is October 12, 2018.

On October 14, 2015, NYC Health + Hospitals initiated a draw-down of $10.0 million at the initial interest rate of 0.77% (Prior Loan).

On November 1, 2017, NYC Health + Hospitals entered in a $30.0 million Term Loan and $30.0 million Revolving Loan with Citibank to refinance the Prior Loan and to finance additional Community Reinvestment Act-eligible capital projects. On November 1, 2017, NYC Health + Hospitals borrowed

$30.0 million on the Term Loan at a fixed interest rate of 2.17% and refinanced the then outstanding $10.0 million Prior Loan. The Term Loan maturity date is November 1, 2022.

The $30.0 million Citibank Revolving Loan allows NYC Health + Hospitals to make multiple draws (i.e. borrowings) up to October 31, 2018 for an aggregated not-to-exceed amount of $30.0 million. During this 1 year drawdown period, all borrowings will incur monthly interest expense based on an agreed-upon variable rate formula and a 5 year loan term from drawdown date. As of June 30, 2018, there is no borrowing under the Revolving Loan.

Both the Term Loan and the Revolving Loan will be secured by a second lien on Health Care Reimbursement Revenues.

(i) Key Bank CISCO Leasing

On October 30, 2015, NYC Health + Hospitals entered into a $5.7 million taxable lease purchase agreement (Taxable 1) and a $5.8 million tax-exempt lease purchase agreement ("TELP 1") with Key Government Finance, Inc. to purchase a Cisco Enterprise License Agreement that provides the operating software for all of NYC Health + Hospitals' voice over internet protocol phones and devices. Both have maturity dates of January 30, 2020.

On November 25, 2015, NYC Health + Hospitals entered into a $10.2 million tax-exempt lease purchase agreement ("TELP 2") with Key Government Finance, Inc. to fund the cost of renovations at two hospitals and health centers. On the same day, NYC Health + Hospitals entered into a $13.7 million tax-exempt lease purchase agreement ("TELP 3") with Key Government Finance, Inc. to fund the cost of Cisco and Cisco-partner equipment for the same facilities above; both of which have a maturity date of February 25, 2020.

NYC Health + Hospitals does not pay interest on the Taxable 1, TELP 1 and TELP 3 financing agreements as they are non-interest bearing. The interest rate for the TELP 2 financing agreement is 3.525%. The debt for each of the agreements is secured by the equipment financed.

(j) Oracle ERP Financing

On February 26, 2016, NYC Health + Hospitals entered into a $7.8 million Municipal Payment Plan Agreement ("MPP Agreement") with Oracle Credit Corporation for the purpose of financing one-time licensing fees for an integrated ERP software solution for finance, supply chain, nurse/physician scheduling and human resources. The payment schedule under the MPP Agreement is based upon 0% interest with the first payment made one month from closing, on May 2, 2016, then quarterly payments starting on June 1, 2016, and a final payment on December 1, 2018. The debt is secured by the software purchased through the financing agreement.

The following table summarizes debt service requirements combined for the JP Morgan Agreement, Revolving Loan (Citibank), all four financing agreements for Key Bank Cisco, and Oracle ERP as of June 30, 2018 (in thousands):

	Principal	Interest	Total
Years			
2019	$ 22,907	$ 1,707	$ 24,614
2020	24,936	1,268	26,204
2021	18,158	818	18,976
2022	18,548	430	18,978
2023	9,410	84	9,494
Total	$ 93,959	$ 4,307	$ 98,266

(k) New York Power Authority (NYPA) Financing

NYC Health + Hospitals has had two energy efficiency upgrade projects at both Metropolitan and Elmhurst hospitals in the last few years. The projects fall under NYPA's energy efficiency program which allows for NYPA to provide contruction management, interim financing, and long-term financing upon project completion for qualifying projects. During fiscal year 2018, both projects were largely completed and placed into service, thereby moving costs from CIP to assets with long-term debt associated with their costs. The long-term debt agreement was finalized in August 2018 and debt service payments began at that time.

On August 1, 2018, the Corporation began debt service payments related to the two boiler projects constructed and financed by ("NYPA") at Elmhurst and Metropolitan Hospitals. The tax-exempt variable rate loan amounts are based on construction spending plus capitalized interest minus certain grant funding received from The City of New York from May 1, 2011 to May 31, 2018, which represents greater than 95% of the projects' completion. Upon the completion of the projects, the remaining construction costs will be added to the balance of the respective loans and will be repaid in the remaining loan term.

On August 1, 2018, the Elmhurst Hospital loan amount was $21.5 million and the Metropolitan Hospital loan amount was $22.8 million, and both loans were set at the initial variable interest rate of 1.43% with a 20 year maturity date of August 1, 2038. Monthly debt service for Elmhurst and Metropolitan Hospitals are $0.103 million and $0.110 million, respectively, and will commence on September 4, 2018. The interest rate of the variable rate loans are to be reset annually in January or February each year by NYPA based on NYPA's prior 12 months' funding cost.

The following table summarizes debt service requirements as of June 30, 2018 (in thousands):

	Principal	Interest	Total
Years			
2019	$ 1,767	$ 571	$ 2,338
2020	1,954	596	2,550
2021	1,982	568	2,550
2022	2,011	539	2,550
2023	2,039	510	2,549
2024 - 2028	10,646	2,102	12,748
2029 - 2033	11,435	1,314	12,749
2034 - 2038	12,282	467	12,749
2039	212	-	212
Total	$ 44,328	$ 6,667	$ 50,995

9. DUE TO THE CITY OF NEW YORK, NET

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

	2018	2017
FDNY EMS operations [a]	$ 192,692	$ 183,691
Medical malpractice payable [b]	123,380	236,320
Other accrued expenses [c]	27,651	51,363
Debt service [d]	145,781	145,780
Medical malpractice prepayment [e]	(9,115)	-
	$ 480,389	$ 617,154

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

b. Payable represents final malpractice balances due to The City (Note 1(g)) and in both fiscal years 2018 and 2017, $61.7 million of the reported amount was classified as a long term liability because it was not due to The City until after June 30, 2018.

c. Payable mainly represents final and reconciled fringe benefit costs.

d. Payable represents final and reconciled debt service costs. These debt service costs relate to debt incurred by The City, which funded NYC Health + Hospitals capital acquisitions (Note 1(g)).

e. Receivable represents NYC Health + Hospitals' prepaid portion of its fiscal year 2019 medical malpractice liability in fiscal year 2018.

10. PENSION PLAN

NYC Health + Hospitals participates in the New York City Employees Retirement System (NYCERS) Qualified Pension Plan ("QPP"), which is a cost-sharing, multiple-employer public employees' retirement system. NYCERS provides defined-pension benefits to 185,481 active municipal employees, 147,514 pensioners, 8,895 deferred vested, and 17,989 members who are no longer on payroll through $77.2 billion in assets. Employees who receive permanent appointment to a competitive position and have completed six months of service are required to participate in NYCERS, and all other employees are eligible to participate in NYCERS. NYCERS provides pay-related retirement benefits, as well as death and disability benefits. Total amounts of NYC Health + Hospitals' covered payroll for the years ended June 30, 2018 and 2017 are approximately $2.1 billion and $2.2 billion, respectively. NYCERS issues a financial report that includes financial statements and required supplementary information, which may be obtained by writing to NYCERS, 335 Adams Street, Brooklyn, New York 11201 or from the following website: https://www1.nyc.gov/site/actuary/reports/reports.page.

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of NYCERS and additions to/deductions from NYCERS' fiduciary net position have been determined on the same basis as they are reported by NYCERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

NYCERS QPP provides three main types of retirement benefits: service retirements, ordinary disability retirements (non-job-related disabilities), and accident disability retirements (job-related disabilities) to members who are in different "Tiers." The members' Tiers are determined by the date of membership in the QPP. Subject to certain conditions, members generally become fully vested as to benefits upon the completion of 5 or 10 years of service. Employees may be required to contribute a percentage of their salary to the pension plan based on their Tier, determined by their date of membership in the plan. Annual pension benefits can be calculated as a percentage of final average salary multiplied by the number of years of service and changes with the number of years of membership within the plan.

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

NYC Health + Hospitals' net pension liability, deferred inflows of resources, deferred outflows of resources and pension expense is calculated by the Office of the Actuary, City of New York (the Actuary), and includes the information for MetroPlus. At June 30, 2018 and 2017, NYC Health + Hospitals reported a liability of $2.6 billion and $3.1 billion, respectively, for its proportionate share of the NYCERS net pension liability. The total pension liability used to calculate the net pension liability was determined by actuarial valuations as of June 30, 2016 and June 30, 2015, and rolled forward to each respective fiscal year.

(In thousands)

NYC Health + Hospitals' proportion for the net pension liability for each fiscal year was based on NYC Health + Hospitals' actual contributions to NYCERS relative to the total contributions of all participating employers for 2018 and 2017, which was 15.0% and 14.8%, respectively. NYC Health + Hospitals made contributions of $507.3 million and $492.2 million for 2018 and 2017, respectively.

(a) Actuarial Assumptions

The total pension liability in the June 30, 2016 actuarial valuation was determined using the following actuarial assumptions:

Inflation	2.5%
Salary increases	In general, merit and promotion increases plus assumed general wage increase of 3% per annum.
Investment rate of return	7.0%, net of pension plan investment expense.
Cost of living adjustment	1.5% and 2.5% for various Tiers.

Mortality rates and methods used in determination of the total pension liability were adopted by the NYCRS Boards of Trustees during fiscal year 2012 and updated for fiscal year 2016 based primarily on the experience of the Plan and the application of Mortality Improved Scale MP-2015 published by the Society of the Actuaries in October 2015. Scale MP-2015 applied on a generational basis, replaced Mortality Improvement Scale AA, which was applied on a static projection basis. Pursuant to Section 96 of the New York City Charter, studies of the actuarial assumptions used to value liabilities of the five actuarially funded NYCRS are conducted every two years.

Mortality tables for service and disability pensioners were developed from an experience study of the Plan. The mortality tables for beneficiaries were developed from an experience review. For more details, see the reports entitled "Proposed Changes in Actuarial Assumptions and Methods for Determining Employer Contributions for Fiscal Years Beginning on and After July 1, 2011", also known as "Silver Books". Electronic versions of the Silver Books are available on the Office of the Actuary website (https://www1.nyc.gov/site/actuary/index.page) on the Reports page.

(b) Expected Rate of Return on Investments

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

asset allocation and best estimates of Arithmetic RROR for each major asset class are summarized in the following table:

Asset class	Target Asset Allocation	Arithmetic RROR by Asset Class	Portfolio Component Arithmetic RROR
U.S. public market equities	29.00 %	6.30 %	1.83 %
International public market equities	13.00	7.00	0.91
Emerging public market equities	7.00	9.50	0.67
Private market equities	7.00	10.40	0.73
Fixed invoice (Core, TIPS, High Yield, Opportunistic, convertibles)	33.00	2.20	0.73
Alternatives (real assets, hedge funds)	11.00	5.50	0.61
Portfolio long-term average arithmetic RROR	100.00 %		5.46 %

(c) Discount Rate

The discount rate used to measure the total pension liability as of June 30, 2018 and 2017, respectively, was 7.00%. The projection of cash flow used to determine the discount rate assumed that employee contributions will be made at the rates applicable to the current Tier for each member and that employer contributions will be made based on rates determined by the Actuary. Based on those assumptions, the NYCERS fiduciary net position was projected to be available to make all projected future benefit payments of current active and nonactive NYCERS members. Therefore, the long-term expected rate of return on NYCERS investments was applied to all periods of projected benefit payments to determine the total pension liability.

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

	1% Decrease (6.00%)	Discount rate (7.00%)	1% Increase (8.00%)
NYC Health + Hospitals' proportionate share of the net pension liability	$ 4,062	$ 2,650	$ 1,476

(d) Deferred Inflows and Outflows of Resources

The following are components of deferred inflows and (outflows) at June 30, 2018 and 2017 (in thousands):

	2018	2017
Differences between projected and actual earnings on pension plan investments	$ 147,939	$ 123,196
Differences between expected and actual experience	255,369	81,939
Changes in Assumptions	(69,160)	(151,384)
Differences between employer contributions and proportionate share of contributions	(15,759)	(67,884)
	$ 318,389	$ (14,133)

The deferred inflows and (outflows) of resources at June 30, 2018 will be recognized in expense as follows (in thousands):

	Amount
Year ended June 30,	
2019	$ (35,456)
2020	84,403
2021	163,048
2022	68,118
2023	37,903
2024	373
	$ 318,389

(e) Annual Pension Expense

NYC Health + Hospitals' annual pension expense for fiscal years ending 2018 and 2017, which includes contributions toward the actuarially determined accrued liability, including the information for MetroPlus, were approximately $404.2 million and $436.8 million, respectively.

(In thousands)

11. POSTEMPLOYMENT BENEFITS, OTHER THAN PENSION (OPEB)

The OPEB provided to NYC Health + Hospitals is managed by The New York City Other Postemployment Benefits Plan, a fiduciary component unit of The City of New York, and is classified as a single employer plan under GASB 75.

In accordance with collective bargaining agreements, NYC Health + Hospitals provides OPEB that include basic healthcare benefits to eligible retirees and dependents at no cost to many of the participants. Basic healthcare premium costs that are partially paid by NYC Health + Hospitals for the remaining participants vary according to the terms of their elected plans. To qualify, retirees must (i) have at least 10 years of credited service (five years of credited service if employed on or before December 27, 2001) as a member of a pension system approved by The City (requirement does not apply if retirement is as a result of accidental disability); (ii) have been employed by NYC Health + Hospitals prior to retirement; (iii) have worked regularly for at least 20 hours a week prior to retirement; and (iv) be receiving a pension check from a retirement system maintained by The City or another system approved by The City.

At June 30, 2017, the following employees were covered by the benefit terms:

Employees covered by benefit terms	
Active	30,944
Inactive	4,350
Term vested/deferred	1,536
Retirees	21,707
Total	58,537

NYC Health + Hospitals' total OPEB liability, deferred inflow of resources, and OPEB expense is calculated by the Actuary, and includes the information for Metroplus.

Contributions: NYC Health + Hospitals funds the postretirement benefits program on a pay-as-you go basis. In 2018 and 2017, NYC Health + Hospitals' contributions were $235.4 million and $56.1 million, respectively. For the years ended June 30, 2018 and 2017, the NYC Health + Hospital's average contribution rate was 10.6 percent and 2.46 percent, respectively, of covered-employee payroll. Employees are not required to contribute to the plan.

Total OPEB Liability: NYC Health + Hospitals total OPEB liability measured at June 30, 2018 and 2017 of $5.209 billion and $4.791 billion, respectively, were determined by actuarial valuations as of June 30, 2017 and June 30, 2016, respectively.

(In thousands)

(a) Actuarial Assumptions

The total OPEB liability in the June 30, 2017 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.5 percent
Salary increases	3.0 percent per annum.
Investment rate of return	4.0 percent, net of investment expenses includes an inflation rate of 2.5 percent
Healthcare cost trend rates	1.5 percent and 2.5 percent for various Tiers.
Pre-Medicare Plans	7.61 percent for 2018, decreasing .61% in 2019 and 0.5 percent per year thereafter to an ultimate rate of 5.0 percent for 2023 and later years
Medicare Plans	2.42 percent for 2018, increasing to 5.0 percent each year thereafter
Welfare Fund Contributions	0.0 percent for 2018, increasing to 3.5 percent in 2019 and staying constant until 2023 and later years

Mortality rates and methods used in determination of the total OPEB liability were proposed by the Actuary and adopted by the NYCRS Boards of Trustees during fiscal year 2016. These tables were based primarily on the experience of each system and the application of Mortality Improvement Scale, MP-2015, published by the Society of Actuaries in October 2015. Scale MP-2015 applied on a generational basis, replaced Mortality Improvement Scale AA, which was applied on a static projection basis. Pursuant to Section 96 of the New York City Charter, studies of the actuarial assumptions used to value liabilities of the five actuarially funded NYCRS are conducted every two years. For more details, see the five "Silver Books" available on the Reports page of the Office of the Actuary's website (https://www1.nyc.gov/site/actuary/index.page).

(b) Changes in the Total OPEB Liability

	2018 Activity Total OPEB Liability	2017 Activity Total OPEB Liability
Balances at end of prior fiscal year	$ 4,790,644	$ 5,207,805
Changes for the year		
Service Cost	279,874	274,749
Interest	158,153	147,667
Difference between expected and actual experience	104,933	(122,396)
Change in assumptions	110,707	(661,094)
Actual benefit payments	(235,395)	(56,087)
Net changes	418,272	(417,161)
Balances at June 30, 2018 and 2017, respectively	$ 5,208,916	$ 4,790,644

(c) Discount Rate

The discount rate used to measure the total OPEB liability as of June 30, 2018 and 2017 was 2.98% and 3.13%, respectively, based on the Municipal Bond 20-year index rate.

Sensitivity of the total OPEB liability to changes in the discount rate. The following presents NYC Health + Hospitals' total OPEB liability calculated using the discount rate of 2.98%, as well as what NYC Health + Hospitals' total OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (1.98%) or 1-percentage-point higher (3.98%) than the current rate (in billions):

	1% Decrease (1.98%)	Discount rate (2.98%)	1% Increase (3.98%)
NYC Health + Hospitals' total OPEB liability	$ 6,107	$ 5,209	$ 4,503

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rates. The following presents NYC Health + Hospitals' total OPEB liability calculated using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates (in billions):

	1% Decrease (6.61% Decreasing to 4.0%)	Healthcare Cost Trend Rates (7.61% Decreasing to 5.0%)	1% Increase (8.61% Decreasing to 6.0%)
NYC Health + Hospitals' total OPEB liability	$ 4,322	$ 5,209	$ 6,461

(d) Deferred Outflows and Inflows of Resources

The following are components of deferred outflows and inflows at June 30, 2018 and 2017 (in thousands):

	2018		2017	
	Deferred Outflows	Deferred Inflows	Deferred Outflows	Deferred Inflows
Differences between expected and actual experience	$ 88,408	$ 108,746	$ -	$ 133,988
Changes in sssumptions	93,273	484,686	-	560,471
Net	$ 181,681	$ 593,432	$ -	$ 694,459
	411,751		694,459	

The net deferred outflows and inflows of resources at June 30, 2018 will be recognized as follows (in thousands):

	Amount
Year ended June 30,	
2019	$ 96,531
2020	96,531
2021	96,531
2022	93,688
2023	38,640
Thereafter	(10,170)
	$ 411,751

(e) Annual OPEB Expense

NYC Health + Hospitals' annual OPEB expense for fiscal years ended 2018 and 2017, including the information for MetroPlus, were $346.1 million and $296.6 million, respectively. Implicit rate subsidy credits of $23.0 million and $22.0 million contributed to the reduction of OPEB expenses for 2018 and 2017, respectively.

12. COMMITMENTS AND CONTINGENCIES

(a) Reimbursement

NYC Health + Hospitals derives significant third-party revenue from the Medicare and Medicaid programs. Medicare reimburses most inpatient acute services on a prospectively determined rate per discharge, based on diagnosis-related groups ("DRGs") of illnesses, i.e., the Prospective Payment System ("PPS"). Long-term acute care is also reimbursed under PPS. For outpatient services, Medicare payments are based on service groups called ambulatory payment classifications (APCs).

Medicare provides PPS reimbursement for psychiatric units on a per diem basis, recognizing the intensity of care provided to the patients. NYC Health + Hospitals also receives Medicare payments for rehabilitation services using a PPS methodology, which requires facilities to complete patient health assessments. Using these assessments, Medicare defines a case-based payment, accounting for acuity, and comorbidities.

Medicare adjusts the reimbursement rates for capital, medical education, and the costs related to treating a disproportionate share of indigent patients. Additionally, some physician services are reimbursed on a cost basis. Due to these adjustments and other factors, final determination of the reimbursement settlement for a given year is not known until Medicare performs its annual audit. The earliest fiscal year for open Medicare cost report audits and final settlement for NYC Health + Hospitals facilities ranges from 2011 to 2017.

Effective January 1, 1997, the State enacted the Healthcare Reform Act ("HCRA"), which covers Medicaid, Workers' Compensation and No-Fault. In January 2000, the State passed HCRA 2000 extending the

HCRA methodology until June 30, 2003, which has subsequently been extended several times and is now scheduled to expire December 31, 2020.

HCRA continues funding sources for public goods pools to finance healthcare for the uninsured; support graduate medical education; and fund initiatives in primary care. Under HCRA, the State continues to pay outpatient reimbursements under Ambulatory Patient Groups ("APGs") for ambulatory surgery services, emergency room services, diagnostic and treatment center medical services, and most chemical dependency and mental health clinic services, and provides for service intensity adjusted prospective payments based on patient diagnoses and procedures groupings. Outpatient services for all non-governmental payors are based on charges or negotiated rates.

Medicaid pays for inpatient acute care services on a prospective basis using a combination of statewide and hospital-specific 2010 costs per discharge adjusted to meet state budget targets and for severity of illness based on DRGs. Certain hospital specific non-comparable costs are paid as flat-rate per discharge add-ons to the DRG rate. Certain psychiatric, rehabilitation, long-term acute care, and other services are excluded from this methodology and are reimbursed on the basis of per diem rates. Per diem reimbursement for inpatient psychiatric services is determined by a PPS methodology taking into account comorbidities and length of stay.

Commercial insurers, including Health Maintenance Organization's ("HMO's"), pay negotiated reimbursement rates or usual and customary charges, with the exception of inpatient Medicaid HMO cases that may be paid at the State-determined Payment Rate, which is related to the Medicaid rate. In addition, the State pays hospitals directly for graduate medical education costs associated with Medicaid HMO patients. NYC Health + Hospitals' current negotiated rates include per case, per diem, per service, per visit, partial capitation and value based payment arrangements.

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

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

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

Laws and regulations governing Medicaid and Medicare are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. NYC Health + Hospitals believes that it is in compliance with all applicable regulations and

that any pending or possible investigations involving allegations of potential wrongdoing will not materially impact the accompanying financial statements. While certain regulatory inquiries have been made, compliance with the regulations can be subject to future government review and interpretation as well as significant regulatory action, e.g., fines, penalties, and possible exclusion from Medicaid and Medicare, in the event of noncompliance. NYC Health + Hospitals has a Corporate Compliance Committee and a Corporate Compliance Officer to monitor adherence to laws and regulations.

(b) Audits

Federal and State governmental entities have a variety of audit programs to review and recover potential improper payments to providers from the Medicare and Medicaid programs. Stated below are various recovery audits of which NYC Health + Hospitals continues to be subject to:

i. Medicare Recovery Audit Contractor Program (RAC)

The RAC program, which primarily reviews medical necessity of inpatient admissions and hospital coding practices was enacted by CMS on a demonstration basis for 2002, and as a full program for 2009 although implementation was delayed until 2012. Subsequently, in 2013 CMS implemented a policy, known as the "Two-Midnight" rule, which establishes that hospital stays expected to span two or more midnights after the beneficiary is properly and formally admitted as an inpatient, are reasonable and necessary proper admissions for reimbursement. CMS implemented a "Probe and Educate" training period beginning May 4, 2016, during which RAC audits for medical necessity were temporarily suspended until September 2016. Since the suspension has been lifted RAC audit activities for NYC Health and Hospitals have continued to be minimal. NYC Health + Hospitals maintains distinct estimates of liabilities for RAC audits related to the demonstration period, and for fiscal years during the period FY 2009 through FY 2014 for which we have received final settlement notices indicating a reopening to account for adjustments due to an issue where the claim payments on the Provider Statistical and Reimbursement report ("PS&R") were not accounting for the RAC adjustments applicable to claims paid on a Periodic Interim Payment basis (PIP). For fiscal years after FY 2014, RAC liabilities are reflected in the PS&R data used to estimate Medicare cost report final settlements, therefore no separate RAC liability estimate is developed.

ii. Disproportionate Share Hospital (DSH) Payment Audits

Pursuant to federal regulations, all New York State hospital recipients of DSH participate in Medicaid DSH Audits to determine the final calculation of limits on hospital specific DSH payments. Since 2014, these audits have been conducted for each Medicaid State Plan Rate Year (SPRY) on an approximate three year lag. DSH Audits have been completed through SPRY 2014; the SPRY 2014 audit is currently in progress.

(c) Budget Control Act

The Budget Control Act of 2011 (the Budget Control Act) mandated significant reductions and spending caps on the federal budget for fiscal years 2012 through 2021. The Budget Control Act also created a requirement for Congress to enact recommendations of a bipartisan "super committee" achieving at least $1.2 trillion in deficit savings over a 10-year period by January 1, 2013, otherwise $1.2 trillion of across the board reductions known as the "sequester" would be triggered. The super committee failed to produce recommendations and after passing the American Taxpayer Relief Act to provide a two-month delay,

Congress was unable to reach an agreement to avoid imposition of the sequester. As a result, Medicare reimbursement was reduced by 2% effective April 1, 2013, known as Sequestration. The Sequestration period was extended by legislation until 2027.

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

In April 2014, the federal government approved a New York State Medicaid waiver request to reinvest $8 billion in federal savings to support implementation of transformative reforms to the State's healthcare system. Delivery system reforms will primarily be implemented through $7.4 billion of DSRIP Incentive payments for community-level collaborations to achieve programmatic objectives with a goal of reducing avoidable hospital use by 25% over five years.

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

OneCity Health DSRIP PPS governance structures include an Executive Committee, three subcommittees to the Executive Committee, and four Hub Steering Committees, for each of four OneCity Health hubs corresponding to each of the boroughs Bronx, Brooklyn, Queens, and Manhattan. All governance approvals are made by the Executive Committee, and NYC Health + Hospitals has the final approval authority in its role as fiduciary of the DSRIP PPS. The OneCity Health CSO is charged with supporting NYC Health + Hospitals and all DSRIP PPS partners in implementing all aspects of the DSRIP program. The CSO Board comprises NYC Health + Hospitals leadership plus a minority (<25%) of outside members. Since the establishment of the CSO, the CSO team of NYC Health + Hospitals employees has advanced the planning and implementation work of the DSRIP PPS by completing a complex partner readiness assessment of over 220 partner organizations, over 1,200 sites of care and over 12,000 individual practitioners; performing initial project planning for the eleven selected DSRIP projects; and committing to a high-level DSRIP budget and flow of funds, which was approved by the DSRIP PPS Executive Committee and included in the NYSDOH-required State Implementation Plan submitted in August, 2015.

In June 2015, the NYSDOH announced DSRIP valuation awards, which represent the total potential amount that each DSRIP PPS is eligible to earn in performance payments over the five years of the DSRIP program. OneCity Health, the HHC-led DSRIP PPS received a valuation award of $1.2 billion (Note 1).

During 2017, NYC Health + Hospitals received DSRIP payments from NYSDOH in the amount of $246.0 million and remitted required IGT payments to fund the nonfederal share of the DSRIP program totaling $152.5 million, after meeting the applicable eligibility requirements for DSRIP. In addition, NYC Health + Hospitals made a payment to the State University of New York ("SUNY") in the amount of $11.6 million in recognition of DSRIP IGT payments remitted by SUNY to NYSDOH. A DSRIP receivable at June 30,

2017 in the amount of $132.1 million is recorded within grants receivable; and the net amount of these transactions, $214.0 million, was recorded as grant revenue for the fiscal year ended June 30, 2017, based on meeting the applicable eligibility requirements.

During 2018, NYC Health + Hospitals received DSRIP payments from NYSDOH in the amount of $307.4 million and remitted required IGT payments to fund the nonfederal share of the DSRIP program totaling $190.5 million, after meeting the applicable eligibility requirements for DSRIP. In addition, NYC Health + Hospitals made a payment to SUNY in the amount of $14.4 million in recognition of DSRIP IGT payments remitted by SUNY to NYSDOH. A DSRIP receivable at June 30, 2018 in the amount of $138.0 million is recorded within grants receivable; and the net amount of these transactions, $240.5 million, was recorded as grant revenue for the fiscal year ended June 30, 2018, based on meeting the applicable eligibility requirements.

(e) Value Based Quality Improvement Program ("VBP QIP")

VBP QIP is a New York State Medicaid Managed Care initiative that partners hospital providers, DSRIP PPS's and managed care plans to improve quality and support transformation to value based purchasing arrangements. The purpose of VBP QIP is to transition financially distressed facilities to a value-based payment ("VBP"), improve the quality of care, and as a result, achieve financial sustainability over the five years of the program, which commenced in April 2015 and is scheduled to end with the state fiscal year commencing in April 2020. This program is meant to ensure long-term financial sustainability through active changes in the delivery and contracting of healthcare services, not to solely sustain operations.

NYC Health + Hospitals was allocated $120.0 million per year for the five year program which started as of the state fiscal year April 1, 2015 to March 31, 2016 (Year 1). For year 1, NYC Health + Hospitals, through OneCity Health, partnered with EmblemHealth, HealthFirst and MetroPlus. In April 2016 (Year 2), HealthFirst was reassigned to a different VBP QIP Partnership. In years one and two, there were planning and reporting milestones. Year 2 started to incorporate DSRIP VBP baseline metrics, and Year 3 (April 1, 2017 to March 31, 2018), providers are required to maintain or improve performance on selected quality metrics. Additionally, years four and five funding requires providers to demonstrate by April 1, 2018 that 80% of Medicaid Managed Care revenue is paid through value-based payment arrangements.

During the fiscal year ended June 30, 2018, NYC Health + Hospitals received $240.0 million related to meeting the eligibility requirements in accordance with the reporting and performance metrics by NYSDOH for Years 1 and 2, which had been recorded as grants revenue for the year ended June 30, 2017. Agreements between NYC Health + Hospitals and NYSDOH and The City and NYSDOH related to IGT funding for Year 3 had not been executed as of June 30, 3018. Therefore, no revenue was recorded for FY 2018. It is anticipated that Year 3 agreements will be executed during FY 2019.

(f) Care Restructuring Enhancement Pilot ("CREP")

CREPs is a New York State initiative funded through the State's 1115 Medicaid Waiver. CREPs is designed to meet programmatic goals and support the expansion of Medicaid Managed Care in two specific special need areas - Home and Community Based Behavioral Health ("HCBS") services and Managed Long Term Care ("MLTC"). Under CREPs, selected public hospitals assess HCBS needs and gaps for the HARP population, and develop workforce training initiatives for both HCBS and MLTC. NYC Health + Hospitals was awarded $432 million over four years beginning in April 2016.

CREPs program funds are paid to participating facilities for completion of program related deliverables defined by the NYS Department of Health and evaluated by Fidelis Care, NYS' administrator for the program. Similar to the DSRIP funds, CREPs require provision of matching funds through Intergovernmental Transfers (IGTs) from NYC Health + Hospitals to the State.

During the year ended June 30, 2018, NYC Health + Hospitals earned $31.0 million in grants revenue related to CREPs Year 1 and $134.6 million related to CREPs Year 2. Total CREPs payments net of related IGTs were $197.9 million, leaving a year end liability of $32.3 million, due to the scheduled timing of a related IGT in that amount after June 30, 2018.

(g) Legal Matters

There are a significant number of outstanding legal claims against NYC Health + Hospitals for alleged negligence, medical malpractice, and other torts, and for alleged breach of contract. Pursuant to the Agreement, NYC Health + Hospitals is indemnified by The City for such costs, which were $108.1 million for 2018 and $112.9 million for 2017. In FY 2018 and FY 2017, NYC Health + Hospitals agreed to reimburse The City $108.1 million and 112.9 million, respectively, which is recorded as a current liability for each respective year within amounts due to The City. NYC Health + Hospitals records these costs when settled by The City as appropriations from The City and as other than personal services expenses in the accompanying financial statements (Note 9). Accordingly, no provision has been made in the accompanying financial statements for unsettled claims, whether asserted or unasserted.

(h) Operating Leases

NYC Health + Hospitals leases equipment, off-site clinic space, and office space under various operating leases. Total rental expense for operating leases was approximately $30.0 million in 2018 and $40.7 million in 2017 and included in other than personal services in the accompanying financial statements.

The following is a schedule by years of future minimum rental payments required under operating leases that have initial or remaining noncancelable lease terms in excess of one year as of June 30, 2018 (in thousands):

	Amount
Years	
2019	$ 24,532
2020	20,251
2021	18,742
2022	16,754
2023	58,409
2024 - 2027	61,755
Total minimum payments required	$ 200,443

13. ACCOUNTS PAYABLE AND ACCRUED EXPENSES

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

	2018	2017
Vendors payable	$ 445,360	$ 437,219
Per diem nurses payable	42,410	47,866
Accrued interest	13,151	11,156
Affiliations payable	45,483	46,377
Affiliations vacation accrual	29,945	33,282
Pollution remediation liability	13,765	11,530
Asset Retirement Obligations	5,000	0
Other	8,036	4,791
	$ 603,150	$ 592,221

GASB Statement No. 83, *Certain Asset Retirement Obligations* (GASB 83) establishes criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources for asset retirement obligations (AROs). An ARO is a legally enforceable liability associated with the retirement of a tangible capital asset. In accordance with GASB 83, the Corporation completed analysis of assets meeting the criteria of an ARO such as specific types of medical equipment such as medical imaging equipment (e.g. MRIs, CT scanners, and PET scanners), X-Rays, and ultrasounds as well as computers containing information protected by HIPPA laws, and certain types of laboratory equipment. NYC Health + Hospitals determined, based on industry standards for disposition of similar equipment and

other known costs, that the future cost for disposition of these assets, in the aggregate, totals less than $5.0 million. Given the minimial future liability when compared to the financial statements as a whole, NYC Health + Hospitals will continue to refine the estimation in future reporting periods.

14. SUPER STORM SANDY

NYC Health + Hospitals has applied for public assistance through the Federal Emergency Management Agency ("FEMA") to cover the costs of: (1) Debris Removal and Emergency Protective Measures for life safety and safeguarding assets (2) Repairs and replacements of facilities to pre-storm conditions (3) Meet codes and standards, and (4) To make hazard mitigation improvements to harden H+H facilities for future disasters. As of June 30, 2018, the Corporation's FEMA claims for the aforementioned reconstruction categories are in excess of $1.9 billion. For years ended June 30, 2018 and June 30, 2017, NYC Health + Hospitals received $15.1 million and $17.5 million, respectively, and reported an accrual for $21.2 million and $23.7 million related to FEMA Sandy related expenditures, respectively.

15. INCENTIVE PAYMENTS FOR MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS

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

During the years ended June 30, 2018 and 2017, NYC Health + Hospitals recognized revenue of approximately $19.5 million and $4.5 million, respectively, of HITECH incentives from the Medicare and Medicaid programs that is related to NYC Health + Hospitals meeting the requirements of the Meaningful Use Incentive program. NYC Health + Hospitals elected to recognize the revenue associated with the EHR incentive payment under the grant model and included such amounts in grants revenue in the accompanying statements of revenue, expenses, and changes in net position. EHR amounts received are subject to audit by CMS or its intermediaries and amounts recognized are subject to change.

16. CORRECTIONAL HEALTH SERVICES

On August 9, 2015, NYC Health + Hospitals, via a Memo of Understanding with The City, assumed from the New York City Department of Health and Mental Hygiene ("NYCDOHMH") its contracts for the provision of medical, mental health, and dental services for the inmates of correctional health facilities maintained and owned by The City of New York (Correctional Health Services (CHS)), from other providers of care for the duration of their terms. Included is the understanding that NYC Health + Hospitals assumed the transfer of staff from NYCDOHMH otherwise engaged in the performance of correctional health functions, together with the transfer of all real and personal property, as used by NYCDOHMH, in its provision of correctional health services. Total expenses funded through appropriations by The City was

$217.7 million and an additional $63.4 million was funded through grants and intra-city agreements for a total funding for the year ended June 30, 2018 of $281.1 million. For the year ended June 30, 2017, $199.3 million was funded through appropriations by The City with an additional $56.0 million funded through grants and intra-city agreements for a total funding of $255.3 million.

17. METROPLUS

(a) Cash and Cash Equivalents

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

(b) U.S. Government Securities

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

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

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

			Investment Maturing in (in Years)	
Year	Investment Type	Fair Value	Less than 1	1 to 5
2018	U.S. Treasury bills, notes, bonds, and strips	$ 462,704	$ 147,379	$ 315,325
2017	U.S. Treasury bills, notes, bonds, and strips	423,590	89,832	333,578

(c) Premiums Receivable and Premium Revenue

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

Medicare premiums are based on rates approved by CMS. Premiums earned include Individual and SHOP QHP revenue. QHP premiums are based on various plan types and coverage levels selected by the enrollee. In addition to premiums from enrolled QHP members, MetroPlus receives premium subsidies from CMS for Individual QHP members, under the Advanced Premium Tax Credit program provided under the ACA.

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

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

Premium revenue, by percentage, from members and third-party payors for the years ended June 30, 2018 and 2017 was as follows:

	2018	2017
Medicaid	61 %	63 %
Essential Plan	12	12
HIV-SNP	7	8
HARP	9	8
Medicare	3	4
MLTC	3	2
Other *	5	3
	100 %	100 %

* - Included in Other are MetroPlus Gold, CHP, FIDA, QHP, SHOP, GoldCare I, and GoldCare II

(d) Assets Restricted As to Use

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

	2018	2017
MetroPlus statutory reserve investments	$ 149,590	$ 143,342

NYSHOH Rules and Regulations Section 98-1.11(f) requires that a plan operating under the authority of Article 44 of the public health law, establish a statutory reserve account for the protection of its enrollees, and that this balance be maintained at 5% of the healthcare services expenditures, as defined, and projected for the following calendar year. The statutory reserve is calculated in accordance with the regulations.

The statutory reserve account of $149.5 million and $143.3 million at June 30, 2018 and 2017, respectively, is invested in U.S. government securities with original maturity dates of one year or more and are measured at fair value based on Level 2 inputs. The account is in the form of an escrow deposit, maintained in a trust account under a custodian arrangement with Citibank approved by the NYSDFS.

In accordance with NYSDOH Rules and Regulations, MetroPlus is also required to maintain a contingent surplus reserve equal to 12.5% of net premiums earned for that year. The contingent surplus reserve as of June 30, 2018 and 2017 was $372.1 million and $347.3 million, respectively.

(e) Change in Claims Payable

Accounts payable and accrued expenses include MetroPlus claims payable of $935.0 million and $594.2 million at June 30, 2018 and 2017, respectively. Activity in the liability for claims payable, which mainly includes health claims, the risk sharing agreement with NYC Health + Hospitals, and claim adjustment expenses related to health claims included in other than personal services, is summarized as follows (in thousands):

	2018	2017
Balance, July 1	$ 594,190	$ 535,471
Less drug rebates receivable	(19,404)	(20,387)
Net balance	574,786	515,084
Incurred related to		
Current year	3,075,247	2,756,755
Prior years	64,063	19,106
Total incurred	3,139,310	2,775,861
Paid related to		
Current year	2,323,518	2,237,585
Prior years	474,906	478,574
Total paid	2,798,424	2,716,159
Net balance at June 30	915,672	574,786
Plus drug rebates receivable	19,329	19,404
Balance, June 30	$ 935,001	$ 594,190

Net reserves for unpaid claims and claim adjustment expenses attributable to insured claims of prior years increased by $64.1 million and $19.1 million in 2018 and 2017, respectively. These changes are generally the result of ongoing analysis of recent loss development trends that include expected healthcare cost and utilization.

(f) Risk Sharing Agreement with NYC Health + Hospitals

MetroPlus entered into a risk sharing agreement with NYC Health + Hospitals in July 2000. The agreement is open to annual negotiation, with the most recent negotiation on March 29, 2018. The agreement shifts all medical risk from MetroPlus to NYC Health + Hospitals, for Medicaid, CHP, HIV-SNP, HARP, EP, MetroPlus Gold, Gold Care I, and Gold Care II. The risk sharing agreement is set at 90.5% for Medicaid,

92% for EP, 93% for CHP, HIV-SNP, HARP, MetroPlus Gold, Gold Care I, and Gold Care II in risk year 2018 of the premium collected for those members.

NYC Health + Hospitals is also entitled to 100% of the one-time maternity and newborn supplemental payments for those members. After the end of the calendar year risk period, both parties settle the net amount remaining after payment of all capitated and fee-for-service medical expenses regardless of whether the provider was part of NYC Health + Hospitals network or not. This risk sharing agreement was expanded beginning October 1, 2011 to shift the prescription drug risk cost component for most Medicaid members from MetroPlus to NYC Health + Hospitals, for 97.5% of the prescription drug premium collected for those members. The risk sharing agreement provides for annual settlement within six months of the end of each risk period or later as mutually agreed upon.

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

Risk sharing payables were $211.3 million and $143.8 million at June 30, 2018 and 2017, respectively, pursuant to the agreement. NYC Health + Hospitals has reported a corresponding receivable at June 30, 2018 and 2017, respectively. Amounts are included in eliminations in the Statement of Net Position.

(g) Risk-Sharing Programs of the Affordable Care Act

MetroPlus is required to participate in the Risk Adjustment program under the Affordable Care Act. The risk adjustment program spreads risk of adverse selection among all QHP plans within the same state. MetroPlus shares risks, associated with uncertainty in pricing during the initial years of the ACA implementation, with HHS. At June 30, 2018 and 2017, MetroPlus estimated a risk adjustment liability of $8.2 million and $40.0 million, respectively, which is included in accounts payable and accrued expenses. Included in the risk adjustment liability of $8.2 million is a $2.6 million liability relating to the 2017 calendar benefit year. The 2016 calendar benefit year estimate was settled in August 2017 for $34.9 million.

(h) Stop-Loss and Reinsurance

MetroPlus uses stop-loss insurance to minimize medical expense losses as a result of a Medicaid member incurring excessive expenses in any one calendar year. Such insurance is provided by the State of New York for Medicaid enrollees with coverage as follows:

- Medical inpatient at 80% of the lower of contractual or Medicaid calculated rate for expenses between $100,000 and $250,000 in any one calendar year. Over $250,000, the coverage is increased to 100% of the cost over $250,000. Effective January 1, 2016, hospital inpatient expenses also include expenses for detoxification services provided in inpatient hospital facilities certified pursuant to 14 NYCRR Part 816 and expenses for services delivered in New York State Office of Alcoholism and Substance Abuse (“OASAS”) certified 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation and Treatment programs for all enrollees.

- Psychiatric, alcohol and substance abuse inpatient stays are covered for members who exceed 45 inpatient days in any one calendar year.

- Residential Health Care Facility inpatient stays are covered for members who exceed 60 inpatient days in any one calendar year.

- Stop-loss insurance is also provided by the State of New York for HIV-SNP members, with coverage for hospital inpatient at 85% of the lower of contractual or Medicaid calculated rate for expenses between $100,000 and $300,000 in any one calendar year. Over $300,000, the coverage is increased to 100% of the cost over $300,000. Effective January 1, 2016, hospital inpatient expenses also include expenses for detoxification services provided in inpatient hospital facilities certified pursuant to 14 NYCRR Part 816 and expenses for services delivered in OASAS certified 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation and Treatment programs for all enrollees.

- Mental Health Stop-Loss for Medicaid Managed Care (MMC) enrollees, MetroPlus will be compensated for medically necessary and clinically appropriate inpatient mental health services provided to MMC enrollees in psychiatric inpatient program licensed by the Office of Mental Health. For episodes of inpatient psychiatric care provided to enrollees beginning before January 1, 2016, the State reimburses 100% of payments for days exceeding of a combined total of 30 days. For episodes of inpatient psychiatric care commencing on or after January 1, 2016, the State reimburses 50% of payments made for the 46th through the 60th day of the episode and 100% of payments made for the days in the episode beyond the 60th day.

MetroPlus contracts with Zurich American Insurance Company ("Zurich") for stop-loss coverage for its CHP, Medicare Advantage, FIDA, MetroPlus Gold, QHP, and SHOP lines of business. The coverage has a per member threshold of the first $500,000 of loss incurred in any one calendar year and covers 80% of eligible medical services, though there are daily limits for certain types of services.

Premiums for the reinsurance provided by the State of New York and any related recoveries on paid losses are netted and reported within other than personal services expenses. Premiums for the reinsurance coverage provided by Zurich are reimbursed to MetroPlus by NYC Health + Hospitals, for lines under the risk sharing agreement, and related recoveries on paid losses are passed through to NYC Health + Hospitals pursuant to the agreement. MetroPlus has two years from the close of the benefit year to file a claim for all stop-loss coverages. Reinsurance recoverable, mainly from the State of New York, was $29.2 million and $24.8 million at fiscal year end June 30, 2018 and 2017, respectively.

(i) Value-based Payment Quality Improvement Program (VBP QIP)

MetroPlus and NYC Health + Hospitals were selected to participate as part of the VBP QIP program administered by the NYSDOH. MetroPlus received $139.3 million through per member per month rate increases, inclusive of an administrative fee and surplus (5% and 1%, respectively) during calendar year 2017. MetroPlus released the award pass-through payments of $129.8 million to NYC Health + Hospital on March 28, 2017. The administrative fee and surplus amounts are reported within other revenue in the amount of $8.2 million for fiscal year ended June 30, 2017. MetroPlus reported $1.3 million due to the State of New York within accounts payable and accrued expenses at June 30, 2018.

(j) Due to State of New York

The State of New York has advised MetroPlus of instances where it will need to return premium payments as a result of State audits and adjustments of its payments made to MetroPlus. Management's estimate of such amounts are included in due to the State of New York and reported within accounts payable and accrued expenses, is $24.2 million and $22.0 million at June 30, 2018 and 2017, respectively. Premiums returned to the State of New York are charged against premiums earned.

(k) Medical Loss Ratio

The ACA Medical Loss Ratio ("MLR") standards require that the MLR for MetroPlus's commercial lines of business individual ("QHP"), small group (SHOP), and large group (MetroPlus Gold, GoldCare I, and GoldCare II) meet specified minimums for the fiscal year ended June 30, 2018 of 82%, 82%, and 85%, respectively. In addition, the Plan is also required to meet the MLR minimum of 85% for Medicare and EP. The MLR represents the percentage of premium dollars spent on healthcare claims and quality improvement activities. MetroPlus is in compliance with these requirements. No MLR liability was required at June 30, 2018 and 2017.

(l) Operating Leases

MetroPlus leases equipment and office space under various operating leases. Total rental expense for operating leases was approximately $10.3 million in 2018 and $11.4 million in 2017 and included in other than personal services in the accompanying financial statements.

The following is a schedule by years of future minimum rental payments required under operating leases that have initial or remaining noncancelable lease terms in excess of one year as of June 30, 2018 (in thousands):

Years	Amount
2019	$ 9,637
2020	9,630
2021	9,656
2022	9,687
2023	9,719
2024 - 2027	1,535
Total minimum payments required	$ 49,864

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Schedule of NYC Health + Hospital's Contributions NYCERS Pension Plan - (Unaudited)
Years ended June 30, 2018, 2017, 2016, 2015 and 2014
(Dollar amounts in thousands)

	2018	2017	2016	2015	2014
Contractually required contribution	$ 507,335	$ 492,161	$ 497,715	$ 443,386	$ 435,678
Contributions in relation to the contractually required contribution	507,335	492,161	497,715	443,386	435,678
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -
HHC covered payroll	$ 2,122,448	$ 2,177,897	$ 2,232,187	$ 2,199,797	$ 2,081,328
Contributions as a percentage of covered payroll	23.90 %	22.60 %	22.30 %	20.46 %	20.93 %

See accompanying notes to the basic financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Schedule of NYC Health + Hospital's Proportionate Share of the Net Pension Liability
NYCERS Pension Plan - (Unaudited)
Years ended June 30, 2018, 2017, 2016, 2015 and 2014
(Dollar amounts in thousands)

	2018	2017	2016	2015	2014
HHC proportion of the net pension liability	15.023 %	14.788 %	14.789 %	14.030 %	13.991 %
HHC proportionate share of the net pension liability	$ 2,649,718	$ 3,070,928	$ 3,593,257	$ 2,832,753	$ 2,521,076
HHC covered payroll	2,122,448	2,177,897	2,232,187	2,166,797	2,081,328
HHC proportionate share of the net pension liability as a percentage of its covered payroll	124.84 %	141.00 %	160.97 %	130.73 %	121.13 %
Plan fiduciary net position as a percentage of the total pension liability	78.80	74.80	69.57	73.12	75.32

See accompanying notes to the basic financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Schedule of NYC Health + Hospital's Changes in Total OPEB Liability and Related Ratios - (Unaudited)
Years ended June 30, 2018, 2017 and 2016
(Dollar amounts in thousands)

	2018	2017	2016
Total OPEB liability			
Service cost	$ 279,874	$ 274,749	$ 326,174
Interest	158,154	147,667	139,260
Differences between expected and actual experience	104,933	(122,396)	(43,448)
Changes of assumptions	110,707	(661,094)	-
Benefit payments	(235,395)	(56,087)	(96,000)
Net Change in total OPEB liability	418,273	(417,161)	325,986
Total OPEB liability - beginning	4,790,644	5,207,805	4,881,819
Total OPEB liability - ending	$ 5,208,916	$ 4,790,644	$ 5,207,805
Covered employee payroll	$ 2,211,014	$ 2,283,056	$ 2,171,336
Total OPEB liability as a percentage of covered employee payroll	235.6 %	209.8 %	239.8 %
Changes of assumptions			
Changes of assumptions reflect the effects of changes in the discount rate.			
The following are the discount rates used in each period:	2.98 %	3.13 %	2.71 %

See accompanying notes to the basic financial statements.

REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS REQUIRED BY *GOVERNMENT AUDITING STANDARDS*

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

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation (NYC Health + Hospitals), a component unit of The City of New York, as of and for the year ended June 30, 2018 , and the related notes to the financial statements, which collectively comprise NYC Health + Hospitals' basic financial statements, and have issued our report thereon dated October __, 2018.

The financial statements of MetroPlus Health Plan, Inc., a discretely presented component unit, and HHC Insurance Company, Inc., a blended component unit, were not audited in accordance with *Government Auditing Standards*.

Internal Control over Financial Reporting

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

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of NYC Health + Hospitals' financial statements will not be prevented, or detected and corrected, on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in NYC Health + Hospitals' internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the NYC Health + Hospitals' financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Intended Purpose

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of NYC Health + Hospitals' internal control

or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering NYC Health + Hospitals' internal control and compliance. Accordingly, this report is not suitable for any other purpose.

New York, New York
October , 2018

NYC HEALTH + HOSPITALS

OFFICE OF INTERNAL AUDITS

AUDIT COMMITTEE BRIEFING
OCTOBER 2018

Index

A. EXTERNAL AUDITS

1. Controls Over Equipment – Office of the State Comptroller

Audit Notification Letter Received – December 5, 2017
Entrance Conference – December 20, 2017
Audit Status – Final Draft Report Received 9/27/18
Exit Conference – August 6, 2018

The Office of the State Comptroller commenced their audit of Controls over Equipment on the day of the entrance conference. The objective of the audit appears to include a physical verification of assets, and the review of the Fixed Asset System and asset disposal procedures.

After meeting with Corporate Finance, the Auditors visited NYC Health + Hospitals/Bellevue to review their processes related to equipment. They also met with EITS and Corporate Operations to discuss their controls in effect over their equipment procurement and maintenance processes.

Their testing began on January 23, 2018. Testing was conducted at 9 facilities:

- NYC Health + Hospitals/Bellevue
- NYC Health + Hospitals/Elmhurst
- NYC Health + Hospitals/Jacobi
- NYC Health + Hospitals/Harlem
- NYC Health + Hospitals/Gotham Health, East New York
- NYC Health + Hospitals/Gotham Health, Belvis
- NYC Health + Hospitals/Gotham Health, Roberto Clemente
- NYC Health + Hospitals/Gotham Health, South Queens
- NYC Health + Hospitals/Sea View

The Comptroller's Office issued preliminary draft reports and met with Corporate Finance, Internal Audits and representatives from the audited facilities to review the findings. The issues discussed included:

1. Items, of minimal value, listed on the Fixed Asset System that could not located.
2. Equipment, of minimal or no value, physically observed at the facilities that were not listed on the Fixed Asset System.
3. Recordkeeping errors within the Fixed Asset System.

The final draft report was received on 9/27/18. The final responses are required to be issued in 30 days.

2. ***Compliance with Federal Tax Requirements – Internal Revenue Service***

Audit Notification Letter Received – August 30, 2018
Entrance Conference – October 30, 2018

The objective of the audit is to ensure compliance with federal tax requirements as an exempt organization. For the entrance conference, the IRS has requested the following documents:

a) Financial Assistance Policy (FAP) for each hospital facility – this document must apply to all emergency and other medically necessary care provided by the hospital facility and include:

- Eligibility criteria for financial assistance and whether such assistance includes free or discounted care.
- The basis for calculating amounts charged to patients.
- The method for applying financial assistance in the case of a hospital that does not have a separate billing and collection policy.
- The actions that may be taken in the event of nonpayment.
- The measures taken to widely publicize the FAP within the community served by the hospital.

b) Minutes from meetings describing the FAP during FY16, the billing and collection policy and actions taken in the event of nonpayment of fees.

c) Community Health Needs Assessment (CHNA) for FY16 - which is required to be conducted by each hospital facility once every three years in order to document the extent to which it understands the unique characteristics and needs of the local communities it serves, and responds to these means by delivering meaningful and effective benefit through clinical services.

B. OTHER AUDIT ACTIVITIES

a) *Reports Issued by the Inspector General*

Given the responsibility of the liaison between the Office of Inspector General (OIG) and the Health + Hospitals functions they review, six OIG reports that were outstanding since 2017 and other current reports were addressed and finalized. Resolving these reports entailed meeting with the appropriate H + H personnel to discuss each report, determining the course of action to address each recommendation and reviewing the response before it is issued to the OIG.

b) Anonymous Letters

Independent investigations was conducted of two anonymous letters received by the Office of the Chair. Internal Audits was asked to issue a report to the Chairman, President and Chief of Staff addressing the allegations within each letter.

c) Auxiliary Audits

These financial statement certifications are conducted by an outside CPA firm (Loeb & Troper). The objective of these audits is to enable the auditors to express an opinion on the financial statements and provide reasonable, not absolute assurance, that the financial statements taken as a whole are free from material misstatement.

Internal Audits responsibilities include:

- Meeting with Loeb & Troper to develop the audit plan, issue notification letters to the Auxiliary representatives, and to assist the Auditors with any problems they may encounter.
- Reviewing the draft report which includes comparing the numbers to the prior year's audit, requesting documentation to support certain financial information and inquiring about questionable numbers.
- Reviewing the final report to ensure it compares favorably to the draft report and issuing to the appropriate individuals at the Auxiliaries and NYC Health + Hospitals.

Thus far, 15 of 22 final reports have been issued.

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

Audit Committee Meeting

Corporate Compliance Report

October 15, 2018

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
October 15, 2018 @ 10:30 AM

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AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
October 15, 2018 @ 10:30 AM

I. Monitoring Excluded Providers

Responsibilities of the System for Sanction List Screening

1) To comply with Federal and state regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General ("OMIG")[1] and the U.S. Department of Health and Human Services Office of Inspector General ("OIG"), each month the Office of Corporate Compliance ("OCC") reviews the exclusion status of the System's workforce members, vendors, and New York State Department of Health ("DOH") Delivery System Reform Incentive Payment ("DSRIP") Program Partners.

Office of Foreign Asset Control ("OFAC") Screening

2) To ensure that the System does not conduct business with individuals or entities that are a threat to the security, economy or foreign policy of the United States, the OCC also screens all NYC Health + Hospitals workforce Members, vendors and DSRIP Partners against the databases of the United States Department of Treasury Office of Foreign Asset Control ("OFAC").[2]

Exclusion and Sanction Screening Report June 1, 2018 through September 30, 2018

3) During the period June 1, 2018 through September 30, 2018, there was one excluded individual, one excluded vendor, two disciplined providers and one disciplined vendor.

4) The excluded individual is a human resources administrator at NYC Health + Hospitals/Kings ("Kings") who was engaged by NYC Health + Hospitals through a staffing agency. The OCC was informed about the excluded individual on July 31, 2018. She worked at Kings from April 2018 through the end of July 2018. The OCC is investigating the possibility of an overpayment for this individual and will be discussing this issue with the agency that coordinates the hiring of agency staff for the hospitals.

[1] *See* DOH Medicaid Update, April 2010, Vol.26, No. 6; OMIG webinar #22, OMIG Exclusion and Reinstatement Process, available at https://omig.ny.gov/resources/webinars/811-omig-webinar-22, (Slide 20 (Sept. 2014)).
[2] *See* Frequently Asked Questions: Who must comply with OFAC regulations? United States Treasury website available at, https://www.treasury.gov/resource-center/faqs/Sanctions/Pages/faq_general.aspx.

5) On June 13, 2018, the OCC was informed about an excluded vendor, Unipro International, which furnished uniforms for NYC Health + Hospitals. The System did not utilize this vendor after the effective date of the exclusion. The OCC worked with the Office of Supply Chain to ensure that NYC Health + Hospitals will not transact any further business with the vendor, or solicit new business from this vendor.

6) The OCC was informed on June 7, 2018 about a disciplined PAGNY physician working at NYC Health + Hospitals/Harlem, who had restrictions placed on his license requiring that his services be supervised by a board certified physician. The OCC confirmed that Dr. Wright, Chief Medical Officer at Harlem, and Dr. Allen were aware of the restrictions on the physician's license, and that he is being adequately supervised.

7) On September 12, 2018, the OCC was informed that a community physician had restrictions placed on his license as well, which require that the physician only practice medicine while being monitored by a licensed physician board certified in an appropriate field. The community physician is also precluded from ordering, prescribing, distributing or administering controlled substances. The OCC confirmed that this physician is not credentialed at any of the facilities to which he has referred patients, and therefore is unable to practice medicine in any such facilities.

8) Finally, on September 11, 2018, the OCC was informed that a disciplined vendor, Mick Radio-Nuclear Instruments, from which the System purchased clinical supplies related to brachytherapy, was a match for a World Bank sanction. NYC Health + Hospitals has terminated its relationship with this vendor.

<u>Death Master File and National Plan and Provider Enumeration System Screening</u>

9) The Centers for Medicaid and Medicare Services' ("CMS") regulations[3] and the contractual provisions found in managed care organization ("MCO") provider

[3] *See* 42 CFR § 455.436; *see also*, CMS' Toolkit to Address Frequent Findings 42 CFR § 455.436 Federal Database Checks, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

agreements[4] both require screening of the System's workforce members, certain business partners, and agents (collectively "Covered Persons") to ensure that none of these Covered Persons are using the social security number ("SSN") or National Provider Identifier ("NPI") number of a deceased person in an effort to hide their true identity. This screening may be accomplished by vetting the SSNs and NPIs of Covered Persons through the Social Security Administration Death Master File ("DMF") and the National Plan and Provider Enumeration System ("NPPES"), respectively.

10) The OCC periodically screens the DMF and NPPES files as part of its sanction screening process. No providers were identified on the DMF or NPPES during the period June 1, 2018 through September 30, 2018.

II. Privacy Incidents and Related Reports

Reported Privacy Incidents for the period of June 1, 2018 through September 30, 2018

11) During the period of June 1, 2018 through September 30, 2018, forty-two (42) privacy complaints were entered into the RADAR Incident Tracking System. Of the forty-two (42) complaints, sixteen (16) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs"); five (5) were determined to be unsubstantiated; nineteen (19) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security OPs; six (6) are still under investigation; and one (1) is on hold due to a law enforcement delay request from the United States Attorney General for the Eastern District of New York. Of the sixteen incidents confirmed as violations, nine (9) were determined to be breaches.

12) Of the nine (9) incidents that were determined to be breaches, three (3) of them were caused by one of our vendors, CIOX, which responds to medical records requests on the System's behalf. In total, CIOX has been responsible for ten (10) HIPAA breaches this year. Consequently, the Chief Corporate Compliance Officer

[4] *See* New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts, Appendix, Revised April 1, 2017, at 4, available at: https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/standard_clauses_revisions.pdf, ("Provider … agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES)").

("CCO") had a conversation with CIOX's Chief Privacy Officer to discuss what CIOX is doing to avoid further breaches. She informed the CCO that CIOX has been and/or will implement the following corrective actions:

- Perform a 100% quality assurance check on records requested from Bellevue and Jacobi, from which the majority of the breaches came, to ensure that the correct documents are being sent to the correct requester;
- Conduct unannounced on-site audits of their workforce at Bellevue and Jacobi to determine whether they are following proper policies and procedures, and HIPAA requirements; and
- Develop an action plan based on the results of the audits to bring their workforce into compliance.

In addition, the Office of Supply Chain has engaged a consulting group to review CIOX's services and determine whether there are opportunities for improvement or change. Currently, the facility Health Information Management ("HIM") Directors oversee CIOX's services; however, we are in the process of centralizing this function. In the meantime, the Office of Supply Chain has identified a temporary point person to act as a liaison between CIOX and the HIM Directors until this function transitions to finance.

Breach Defined

13) A breach is an impermissible use, access, acquisition or disclosure (collectively referred to as "use and/or disclosure") under the HIPAA Privacy Rule that compromises the security and privacy of protected health information ("PHI") maintained by the System or one of its business associates.[5]

14) Pursuant to 45 CFR § 164.402(2), the unauthorized use and/or disclosure of PHI is presumed to be a breach unless the System can demonstrate, through a thorough, good faith risk assessment of key risk factors, that there is a low probability that the PHI has been compromised.[6]

[5] *See* 45 CFR § 164.402.
[6] *See* 45 CFR § 164.402(2); *see also* 78 Fed. Reg. 5565, 5643 & 5695 (Jan. 25, 2013).

Reported Breaches for the Period of June 1, 2018 through September 30, 2018

15) As stated above, there were nine (9) reportable breaches between June 1, 2018 and September 30, 2018, which are summarized below.

- **NYC Health + Hospitals/Bellevue ("Bellevue") – June 2018**

Incident: This incident was brought to the OCC's attention on June 1, 2018, and occurred when a temporary clerk in the outpatient Behavioral Health Clinic at Bellevue inappropriately disclosed the location/type of clinic where the patient was receiving services to the patient's employer while attempting to verify employee financial information. Based on an investigation of the incident, we determined that the PHI disclosed was limited to the type of clinic where the patient receive behavioral health services. Notification of the breach was sent to the affected individual on June 26, 2018.

Mitigation: The individual responsible for the breach was relieved of her duties at Bellevue, and workforce members were retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. In addition, a procedure has been established whereby human resources and the agency from which the employee came are notified of the breach, and human resources flags such individual as not being employable by the System in the future.

- **NYC Health + Hospitals/Bellevue ("Bellevue") – August 2018**

Incident: This incident was brought to the OCC's attention on August 3, 2018, and occurred when a temporary agency nurse from Perfect Choice Staffing discussed a patient's sensitive health information in an area where other individuals were able to overhear her. Based on an investigation of the incident, it was determined that, although the disclosed PHI was limited in nature, it included sensitive health information of the patient. Notification was sent to the affected individual on September 13, 2018.

Mitigation: The individual responsible for the breach was relieved of her duties at Bellevue, and workforce members were retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. In addition, a

procedure has been established whereby human resources and the agency from which the temporary employee came are notified of the breach, and human resources flags such individual as not being employable by the System in the future.

- **NYC Health + Hospitals/Elmhurst ("Elmhurst") – July 2018**

Incident: This incident was brought to the OCC's attention on July 31, 2018, and occurred when the program type where a patient was receiving services was disclosed by a NYC Health + Hospitals social worker to an external home care agency, with which the System does not have an existing relationship or a business associate agreement. Based on an investigation of the incident, it was determined that, although the disclosed PHI was limited in nature, it included enough sensitive health information of the patient to reasonably infer that a behavioral health condition, diagnosis or treatment was involved. Notification was sent to the affected individual on August 16, 2018.

Mitigation: Elmhurst behavioral health administration confirmed that the home health agency was instructed to disregard the information, to not contact the patient, and that the information was disclosed to only one of its staff members. In addition, the workforce member involved was retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information, and were provided counseling by their immediate manager.

- **NYC Health + Hospitals/Coney ("Coney") – August 2018**

Incident: This incident was brought to the OCC's attention on August 3, 2018, and occurred when a business associate of NYC Health + Hospitals mistakenly sent the wrong patient records to an outside law firm. Based on an investigation of the incident, it was determined that the disclosed PHI included the patient's name, date of birth, medical history and treatment, and diagnostic information. Notification was sent to the affected individual on October 2, 2018.

Mitigation: The business associate received written confirmation from the law firm that they had destroyed the records received in error. The business associate also trained its workforce members on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. In addition, as discussed above,

the business associate is engaging in corrective actions to prevent these types of breaches from recurring.

- **NYC Health + Hospitals/Woodhull ("Woodhull") – August 2018**

Incident: This incident was brought to the OCC's attention on August 17, 2018, and occurred when a business associate of NYC Health + Hospitals mistakenly sent the wrong patient records to a records retrieval company. After an investigation into the incident it was determined that the disclosed PHI included the patient's name, birthdate, diagnosis and social security number. Notification was sent to the affected individual on September 25, 2018.

Mitigation: Upon realizing the error, the business associate took immediate steps to delete the information from its systems. The business associate received written confirmation from the record retrieval company that it had destroyed the records received in error. The business associate also trained its workforce members on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. In addition, as discussed above, the business associate is engaging in corrective actions to prevent these types of breaches from recurring.

- **NYC Health + Hospitals/Woodhull ("Woodhull") – August 2018**

Incident: This incident was discovered on August 23, 2018, and occurred when a physician disclosed a patient's diagnosis information in the presence of the patient's mother. The patient reported the incident of unauthorized disclosure himself. Nonetheless, notification was sent to the affected individual on September 12, 2018.

Mitigation: The physician completed one-on-one counseling with the OCC. He was also re-enrolled him in the Compliance/HIPAA training module, which he completed on September 12, 2018.

- **NYC Health + Hospitals/Jacobi ("Jacobi") – August 2018**

Incident: This incident was discovered on August 2, 2018, and occurred when a member of the patient relations department inadvertently sent two letters, each intended for a deceased patient's family, to the address of the other patient. The

disclosed PHI was limited to only the department's review of the concerns expressed by the patients' family members on the patients' hospitalizations. Notifications were sent to the affected individuals' next of kin on October 1, 2018.

Mitigation: In response to this incident, workforce members involved were retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. Workforce members were also reminded to ensure that communications with patients are confirmed for accuracy.

- **NYC Health + Hospitals/Jacobi ("Jacobi") – August 2018**

Incident: This incident was discovered on August 8, 2018, and occurred when a patient removed a sign-in sheet from the registration area at Jacobi. Based on an investigation, it was determined that the PHI on the form was limited to patients' names, appointment times, and whether it was their first visit to the clinic. Notifications were sent to the affected individuals on September 12, 2018.

Mitigation: In response to this incident, steps have been taken to better secure the registration areas at Jacobi.

- **NYC Health + Hospitals/Lincoln ("Lincoln") – August 2018**

Incident: This incident was discovered on August 27, 2018, and occurred when a business associate of NYC Health + Hospitals mistakenly sent a patient's records to another patient's mother. The PHI disclosed included information such as the patient's address, medications, and medical procedures that the patient had undergone at Lincoln. Notification was sent to the affected individual on September 24, 2018.

Mitigation: The patient's medical records were returned to the business associate by the individual who received them in error. In response to this incident, the business associate is taking steps to better secure the accuracy of its processing of documentation requests. In addition, as discussed above, the business associate is engaging in corrective actions to prevent these types of breaches from recurring.

Office for Civil Rights ("OCR") Inquiries Regarding Privacy Incidents

16) There was one follow-up inquiry by the OCR since May 31, 2018. The inquiry pertained to the stolen laptop incident at NYC Health + Hospitals/Harlem, which the OCC previously reported to the Audit Committee. The OCR's follow-up inquiry requests additional information and documents pertaining to the breach including more details about laptops and biomedical devices at Harlem.

Update on Policy for Securing Biomedical Devices

17) As reported at the June 2018 Audit Committee meeting, there was a breach of PHI at Harlem that resulted from the theft of a laptop from the Audiology Department. During the discussion regarding this breach, the OCC reported that it would be working with Enterprise Information Technology Services ("EITS") to develop a policy and procedure for documenting and securing biomedical devices that enter the System and connect to the System's network, as well as devices that do not connect to the System's network. The next step in this process is to identify an enterprise-wide Biomedical Counsel that will be accountable for biomedical devices across the System, and present the issue and need for such a policy and procedure. Thereafter, the OCC and EITS will work with such Counsel to identify the scope of the issue and requirements of such a policy and procedure, upon which a policy and procedure can be based. In addition, EITS is working on revising a 2010 Device and Media Control Plan, which addresses the receipt, movement, and removal of devices and electronic media that contain electronic health information into, within, and out of NYC Health + Hospitals.

III. Compliance Reports

Summary of Reports for the Period of June 1, 2018 through September 30, 2018

18) For the period June 1, 2018 through September 30, 2018, there were one hundred and forty-four (144) compliance reports, three (3) (2.1%) of which were classified as Priority "A";[7] fifty-one (51) (35.4%) were classified as Priority "B"; and ninety

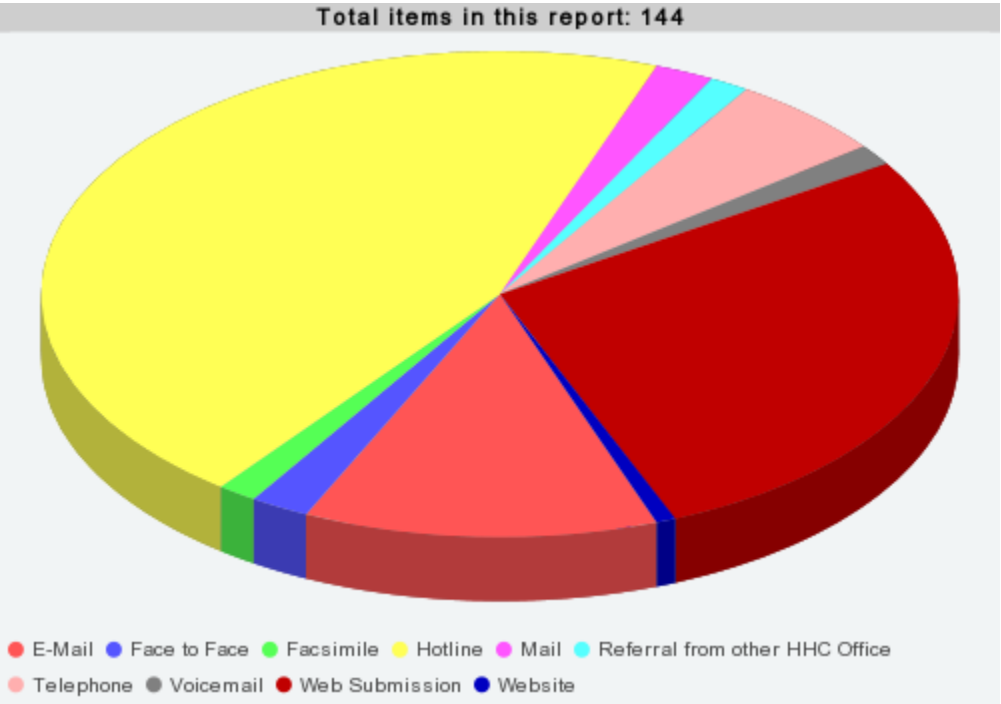
[7] There are three (3) different report categories: (i) Priority "A" reports are matters that require immediate review and/or action due to an allegation of an immediate threat to a person, property or environment; (ii) Priority "B"

(90) (62.5%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. The one hundred forty-four (144) reports were received from the below-listed sources:

a. PRIMARY ALLEGATION SOURCES

SOURCE		
	Total	**Frequency (Percentage)**
E-Mail	18	12.5
Face to Face	3	2.1
Facsimile	2	1.4
Hotline	65	45.1
Mail	3	2.1
Referral from other HHC Office	2	1.4
Telephone	8	5.6
Voicemail	2	1.4
Web Submission	40	27.8
Website	1	0.7
Total	**144**	**100**

reports are matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority "C" reports are matters that do not require immediate action.



b. PRIMARY ALLEGATION CLASS

The class and nature of the reports filed were categorized as follows:

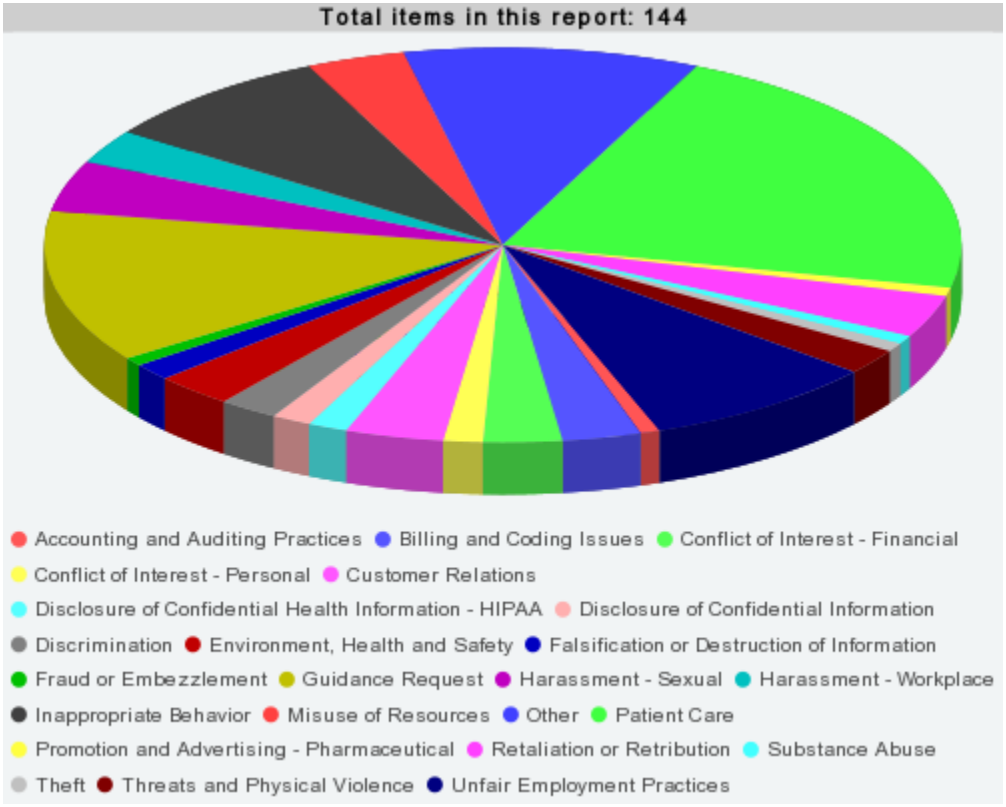
PRIMARY ALLEGATION CLASS

	Total	Frequency (Percentage)
Financial Concerns	5	3.5
Environmental, Health and Safety	8	5.6
Other	33	22.9
Policy and Process Integrity	37	25.7
Diversity, Equal Opportunity and Respect in the Workplace	18	12.5
Misuse or Misappropriation of Assets or Information	17	11.8
Employee Relations	26	18.1
Total	**144**	**100**

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
October 15, 2018 @ 10:30 AM

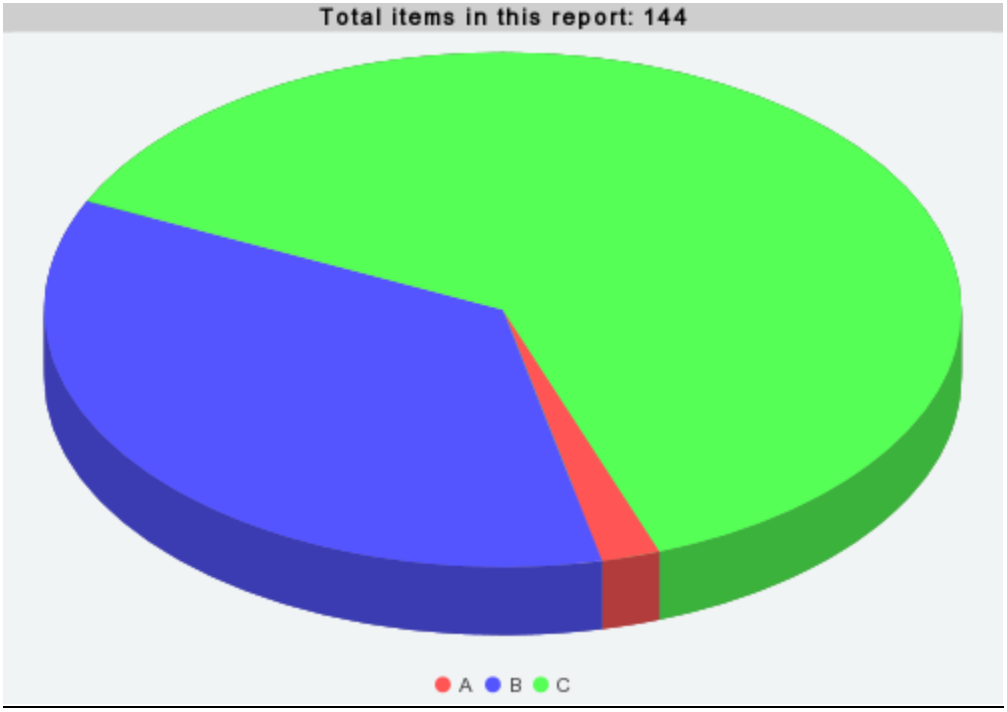
c. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE		
	Total	**Frequency (Percentage)**
Accounting and Auditing Practices	1	0.7
Billing and Coding Issues	4	2.8
Conflict of Interest - Financial	4	2.8
Conflict of Interest - Personal	2	1.4
Customer Relations	5	3.5
Disclosure of Confidential Health Information - HIPAA	2	1.4
Disclosure of Confidential Information	2	1.4
Discrimination	3	2.1
Environment, Health and Safety	4	2.8
Falsification or Destruction of Information	2	1.4
Fraud or Embezzlement	1	0.7
Guidance Request	18	12.5
Harassment - Sexual	6	4.2
Harassment - Workplace	4	2.8
Inappropriate Behavior	12	8.3
Misuse of Resources	5	3.5
Other	15	10.4
Patient Care	31	21.5
Promotion and Advertising - Pharmaceutical	1	0.7
Retaliation or Retribution	5	3.5
Substance Abuse	1	0.7
Theft	1	0.7
Threats and Physical Violence	3	2.1
Unfair Employment Practices	12	8.3
Total	**144**	**100**



d. PRIORITY CLASSIFICATION

PRIORITY		
	Total	**Frequency (Percentage)**
A	3	2.1
B	51	35.4
C	90	62.5
Total	**144**	**100**



Review of Priority "A" Reports

19) As noted above, there were three (3) Priority "A" reports. They are summarized as follows:

- Two of the Priority "A" reports were filed by the same reporter, asserting the same complaint. The reporter was an involuntarily admitted inpatient in the behavioral health service at NYC Health + Hospitals/Coney ("Coney"), who alleged that he was sexually assaulted by Coney staff. The allegations were investigated by Coney's behavioral health leadership and found to be unsubstantiated. Because of the nature of the complaint, however, the behavioral health leadership at Coney reported the allegations to the New York State Justice Center, which investigates allegations of abuse and neglect. The New York State Justice Center acknowledged receipt of the complaint; however, that investigation is still pending.

- The third Priority "A" report will be discussed in Executive Session due to potential litigation.

IV. Status Update – DSRIP Compliance Activities

Background and Legal Requirements Regarding DSRIP Compliance Training

20) Pursuant to State regulations, NYC Health + Hospitals is required to adopt and implement an effective compliance program, which includes the provision of periodic compliance training and education of its workforce members.[8] Per OMIG compliance guidance, these compliance training and education requirements extend to the DSRIP Program.

21) To satisfy its compliance obligations as a Performing Provider System ("PPS") Lead, and to fulfill the requirements of the OMIG DSRIP compliance guidance, NYC Health + Hospitals/OneCity Health ("OneCity Health") developed a compliance Attestation survey, which is designed to assess its performing providers' ("Partners") compliance with such program requirements.

OneCity Health Compliance Attestation

22) OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations. Accordingly, in February 2018, the OCC, on behalf of OneCity Health, distributed a Memorandum to OneCity Health Partners with a *Compliance Attestation of OneCity Health Partners* ("Attestation") survey attached thereto. The Attestation, which provides OneCity Health and the OCC with a critical snapshot of the compliance foundation of its DSRIP Partners, was required to be completed by all OneCity Health Partners and returned to OneCity Health by close of business on June 30, 2018.

23) As part of the Attestation, OneCity Health Partners were asked to confirm that they have completed the compliance training requirements, and to specify the method by which such training was conducted. In addition, they were asked to submit proof of OMIG compliance program-related certifications and certifications of compliance with the Deficit Reduction Act of 2005, if they are required by law and/or OMIG policy to obtain such certifications. Partners were also asked a series

[8] 18 NYCRR §521.3(c)(3); *see* 18 NYCRR § 521.1; Social Services Law § 363-d (2)(c).

of questions to confirm whether or not they have met the requirements outlined in NYC Health + Hospitals' Principles of Professional Conduct ("POPC").

Total Number of Attestations Completed and Returned to OneCity Health

24) Of the one hundred sixty-eight (168) OneCity Health Partners who executed a Schedule B for Phase III, one hundred sixty (160) Partners completed and submitted the Attestation to OneCity Health. Seven (7) Partners did not submit the Attestation, and one withdrew from Phase III. The seven (7) Partners that failed to submit the Attestation have been sent letters terminating their Phase III Schedule B Agreement. The Schedule B Agreement is a contract amendment to the DSRIP Master Services Agreement signed by each OneCity Health Partner that outlines performance requirements to earn DSRIP funding.

Audit of OneCity Health DSRIP Program by Outside Auditor

25) As reported at the June 2018 Audit Committee meeting, OneCity Health engaged a third-party auditor, Bonadio & Co., LLP ("Bonadio"), to audit OneCity Health's internal processes, including Partner selection and contracting, quarterly reporting, funds flow, and the Partner portal. Bonadio has completed its audit of OneCity Health, and submitted its final audit report to the Board of Directors of OneCity Health on October 9, 2018.

V. Status Update - HHC ACO, Inc.

26) As reported at the June 2018 Audit Committee meeting, on October 5, 2017, HHC ACO, Inc. ("HHC ACO") submitted an application to the New York State Department of Health ("DOH") seeking approval for an "all payer" ACO, which includes Medicaid, commercial insurance, and Medicare Advantage patients. That application is still pending.

27) On August 9, 2018, the Centers for Medicare and Medicaid Services ("CMS") issued a proposed rule for CY2019 of the Medicare Shared Savings Program ("MSSP"), which sets forth a number of proposed changes to the MSSP, including changes that encourage ACOs to take on greater risk. The final rule is expected to be released later this year. Based on the provisions of the final rule the HHC ACO will determine whether to adopt a one-sided or two-side risk model in CY2019.

28) The HHC ACO earned shared savings of $2,182,360 in CY2017, and scored better than ninety percent (90%) of all other ACOs on preventative health measures.

VI. Deficit Reduction Act of 2005 ("DRA")

29) The DRA requires providers who receive or make $5 million or more in direct Medicaid payments to annually certify though the OMIG website that they have:[9]

- Established and disseminated to all their workforce members and business partners, including management and contractors or agents, written policies that provide detailed information about:[10]
  - The Federal False Claims Act, remedies for false claims and statements, and state laws pertaining to civil or criminal penalties for false claims and statements;
  - Whistleblower protections under the Federal False Claims Act and state laws;
  - The role of the Federal False Claims Act and state law in preventing and detecting fraud, waste, and abuse in Federal health care programs; and
  - The provider organization's policies and procedures for detecting fraud, waste, and abuse; and
- Included the following information in the provider organization's employee handbook (if one exists):
  - Information about the Federal False Claims Act and comparable New York State laws;
  - A specific discussion of the rights of the provider organization's employees to be protected as whistleblowers; and
  - A specific discussion of the provider organization's policies and procedures for detecting fraud, waste, and abuse.

[9] 42 U.S.C. § 1396a (a)(68).
[10] *See id.*

30) On September 26, 2018, the OCC distributed a notice and attached memorandum to all workforce members and business partners reminding them of the Systems policies and procedures regarding the Federal False Claims Act and similar state laws, and Federal and state fraud, waste, and abuse laws.

VII. Aetna Desk Review

31) As reported at the June 2018 Audit Committee meeting, on January 31, 2018, the OCC received notification from Aetna of a Notice of Compliance Program Audit (the "Notice"), requesting information from NYC Health + Hospitals relating to its compliance with Medicare Parts C and D compliance program elements as required by CMS. The Notice stated that the review would include functions performed by the System (particularly the OCC) which are related to Aetna's Medicare Advantage, Prescription Drug Plans and/or Medicare – Medicaid Plan product lines. Aetna performs such reviews to ensure that the entities it contracts with, such as the System, meet their compliance program obligations. These reviews are conducted under the auspices of their "Delegated Vendor Oversight" responsibilities, as required by CMS.

32) On April 30, 2018, the OCC received Aetna's Compliance Program Elements Audit Report (the "Audit Report"), which included Aetna's final conclusions regarding NYC Health + Hospitals' compliance with its audit. According to the Audit Report, NYC Health + Hospitals satisfied eight of the compliance requirements, but failed to satisfy four compliance requirements. The Audit Report also required NYC Health + Hospitals to submit corrective action plans to Aetna for the failed compliance requirements, which the OCC did on May 25, 2018.

33) On August 27, 2018, the OCC submitted NYC Health + Hospitals' report on the implement of its corrective actions plans, most of which involved changes to Operating Procedures. On September 18, 2018, the OCC received an email from Aetna requesting additional information in response to one of the System's corrective action plans, which the OCC provided on September 20, 2018. The OCC is awaiting Aetna's final response to the corrective action plans.

VIII. Fiscal Year 2018 ("FY2018") Corporate Risk Assessment

Regulatory Requirements

34) The FY2018 Corporate Risk Assessment ("Risk Assessment") was undertaken pursuant to NYS Social Services Law ("SSL") § 363-d(2)(f) and its implementing regulation, 18 NYCRR § 521.3(c)(6), which require the establishment of a system for routine identification of compliance risk areas. The Risk Assessment is also a component of the System's OP 50-1, *Corporate Compliance and Ethics Program*, and it conducted annually.

35) OP 50-1 provides that the CCO shall have primary responsibility for performing System-wide risk identification, assessment, and prioritization activities, and presenting the findings and the resulting Corporate Compliance Work Plan to the President and Audit Committee of the NYC Health + Hospitals Board of Directors for risk appetite determinations. This includes conducting annual risk assessments at the facility, unit, entity, and program levels, and selecting identified items for inclusion and implementation in the Corporate Compliance Work Plan.

The Risk Assessment Process

36) The OCC identified various risks to the System, broken down by service line (*e.g.* acute care, post-acute care, ambulatory, etc.). These risks were presented to the Executive Compliance Workgroup ("ECW") in a draft Risk Assessment on June 8, 2018, for review and potential revision and/or additions/deletions.[11]

37) The risks described in the draft Risk Assessment were derived from the OMIG's Work Plans, and the U.S. Department of Health and Human Services Office of Inspector General's ("OIG") Work Plans and updates thereto, both of which identify risks that these agencies have determined to be areas of concern for overpayment and/or noncompliance. Other risks outlined in the draft Risk Assessment were identified internally.

[11] The Risk Assessment did not include risk assessments of OneCity Health, HHC ACO, Inc., or Correctional Health Services, all of which are being conducted separately.

38) Following the ECW's review, the draft Risk Assessment was presented to the Compliance Committees of the System's facilities, entities, and programs for their input and identification of additional risks pertinent to their facilities, units, entities, or programs. The Compliance Committees were asked to rank each of the relevant risks as high, medium or low.

39) The OCC then finalized the Risk Assessment and identified the impact, vulnerability, and current controls associated with the identified risks, and assigned a severity rating to each risk on a scale of 1 – 5, with 5 being the risks having the greatest impact. The OCC utilized a *Table of Risk Assessment Scoring Parameters,* adopted and derived, in pertinent part, from the Health Care Compliance Association, to score and prioritize the identified risks.

40) Once all the risks were prioritized, the OCC developed a draft FY2019 Work Plan, which included the risks from the Risk Assessment with the highest risk prioritization scores in each service line. On September 10, 2018, the ECW met to review and discuss the draft FY2019 Work Plan. As a result, the ECW identified certain issues in the draft FY2019 Work Plan for which follow-up was necessary. Once the follow-up is completed, the ECW will meet again to finalize the FY2019 Corporate Work Plan for submission to the System President and Chief Executive Officer and the Audit Committee for approval. Through this process, those risks that fall outside the System's established tolerance for risk, and/or require additional remediation measures not currently available, are included in the FY2019 Corporate Work Plan. The final risk tolerance determination will be made by the Audit Committee.

IX. Records Management

Current Situation

41) In May 2018, a Records Task Force was formed to address the issue of more than 621,000 boxes of paper-based files in off-site storage at Iron Mountain, at a monthly storage rate of more than $335,340, and annual storage rate of more than $4,024,080. The Records Task Force was comprised of the System's Corporate Records Management Officer ("RMO"), and representation from the OCC, the Office of Supply-Chain, the Office of Legal Affairs ("OLA") and Enterprise

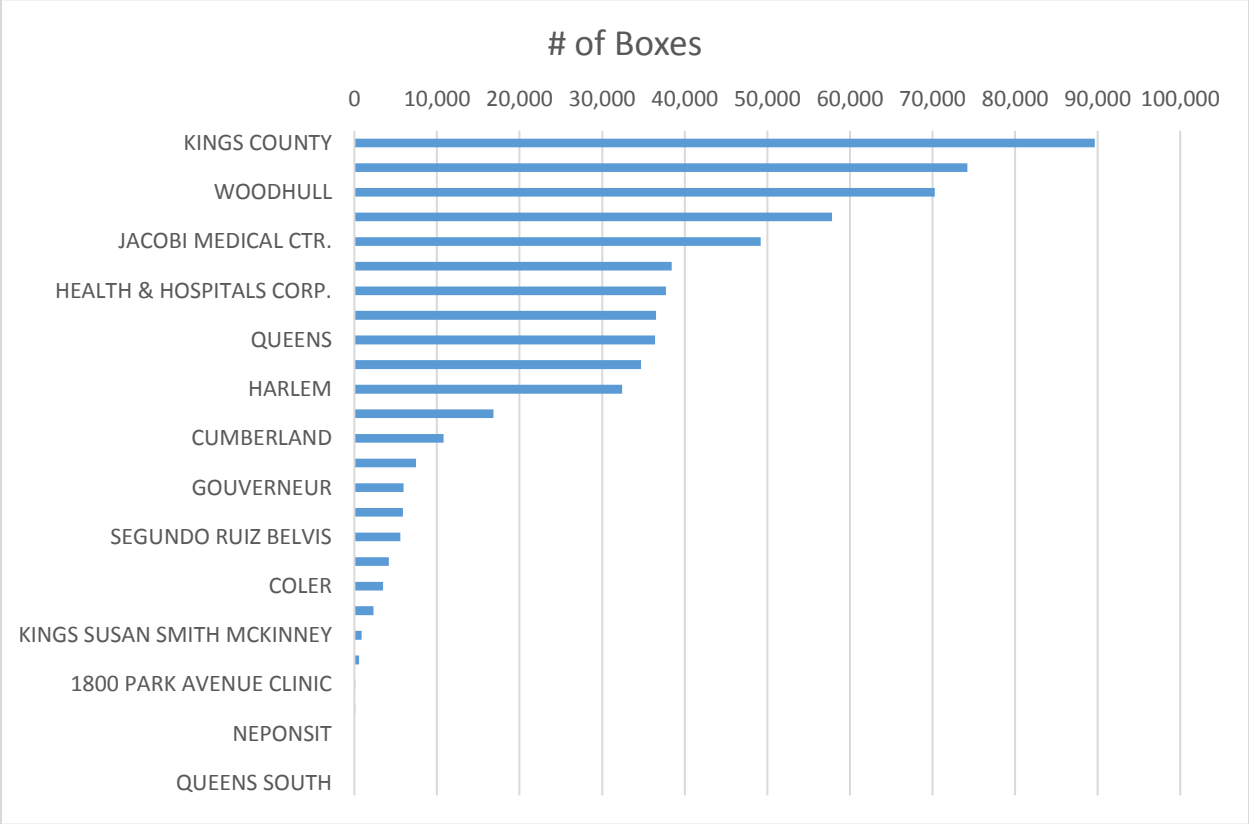
Information Technology Services ("EITS"). The mandate for the Records Task Force was to deal with the immediate problem of the excessive storage at Iron Mountain, and to establish a plan for the future of records management for the System.

42) To date, 61,310 of the 621,000 boxes have been identified for destruction due to the age of boxes based on their in-take dates, and the type of records contained therein (*i.e.* non-clinical records excluding human resource records). The RMO will submit a request for destruction approval for these boxes to the System's senior leadership, explaining the analysis and the methodology used to determine the need for destruction, along with the costs associated with storing such boxes. Once approval is obtained, the RMO will work with Iron Mountain and the Office of Supply Chain to destroy these boxes.

43) In addition, 77,359 of the 621,000 boxes have an identified destruction date that was entered by a System workforce member. Destruction of these records will follow the standard destruction process outlined in OP 120-19, *Corporate Records Management Program and Guidelines for Corporate Record Retention and Disposal.*

44) In total, therefore, there are approximately 138,700 boxes that can be slated for destruction, which would save the System approximately $74,898 monthly, and approximately $898,776 annually.

45) Off-Site Record Storage By Facility:



Next Steps & Future State of Records

46) After a series of meetings with Iron Mountain, the RMO, in conjunction with the Office of Supply Chain, was able to put in place the following immediate steps to curb the mounting storage at Iron Mountain:

- No boxes will be sent to Iron Mountain unless a thorough analysis is completed, including whether records that need to be retained are available in legally acceptable digital format.
- In the event that boxes must be sent to storage, pick up restrictions will be implemented (*i.e.* no pick up without detailed box indexing including department name, unit name, types of records, detailed description, and most importantly destruction date).
- Restrict individual facility records management activities, including sending boxes off-site, to one or two Facility Records Officers per site, who

will work with the RMO. Note that a total of over 600 NYC Health + Hospitals workforce members have been interacting with Iron Mountain regularly, often sending boxes off-site with no labelling and no retention dates.

- With the help of the Facility Records Officers, begin identifying records at Iron Mountain that have no retention requirements and/or are past their retention period.

47) In early September, the RMO along with the Office of Supply Chain met with EITS to plan for digitization of records. In subsequent meetings, EITS presented the software solution OnBase to the Records Task Force, which can be used as an enterprise content management system ("ECM"). Among other things, an ECM provides functionality such as indexing and labelling of digitized records, recording meta-data pertaining to the records, and manual or auto-purging of records past their retention period.

48) It is expected that with the help of EITS and some key early adopters, the System can begin implementing an ECM system with the ultimate goal of digitizing all records as the future state of records management. While infrastructure such as scanners, scanning software, and availability for digital files and applications for indexing and retrieval of digital files remains to be examined and finalized, the long-term benefits of digitization will ensure that the System will not be in the position of excessive and redundant paper storage going forward.

X. Workforce Member Compliance and HIPAA Training

Overview of NYC Health + Hospitals' Compliance and HIPAA Training

49) Compliance and HIPAA training is provided to all workforce members at NYC Health + Hospitals, as required by state regulations and OP 50-1. Generally, such training is provided electronically through the System's PeopleSoft Enterprise Learning Management System ("ELM"). Such training has also included in-person, live training by Compliance Officers for new workforce members on their orientation day(s), on a monthly basis at all hospitals and skilled nursing facilities, and at central office. Targeted and specific Compliance and HIPAA training is also provided throughout the year as needed.

Updates to NYC Health + Hospitals' Compliance and HIPAA Training

50) Over the last year, the OCC has made significant revisions and updates to how the System provides Compliance and HIPAA training and education to its workforce members and business partners. The revisions and updates were designed to enhance and ease the training and education process, while simultaneously meeting regulatory requirements in a more efficient and expeditious manner. The following is a brief summary of the OCC's efforts to enhance the training and education process:

- Combined previously separate annual courses (*i.e.* Compliance and HIPAA) into one (1) course entitled "*Workforce Member General Compliance/HIPAA Training and Education*" – making it easier for workforce members to meet regulatory requirements in one step;
- Developed a similar yet separate course for new workforce members, thus allowing a clear distinction of completed required orientation training, which is now maintained in their records;
- Developed "tracks" in both online courses which are more specific to the workforce member's role at NYC Health + Hospitals (*e.g.* physician track, non-clinical workforce member track, and volunteer/student track);
- Replaced previous in-person/live training with ELM training, which has allowed Compliance Officers to dedicate more time to other critical compliance activities;
- Worked with Human Resources Shared Services ("HRSS"), Workforce Development, and Affiliate Administration across the System to ensure that the training and education is available to a broader population of the workforce than in the past;
- Worked with EITS leadership to revise the process for new workforce member training, which ensures that the System meets its regulatory requirements, as well preventing inappropriate access to clinical systems that contain sensitive patient information prior to receiving HIPAA training; and

- Worked with HRSS to offer, for the first time, in June and July 2018, a method of online training for the incoming class of resident physicians across the System. More than 1,800 residents were able to complete their training and education obligations prior to their start date, which lead to a faster and more seamless assignment of their clinical duties. This lead to a completion rate within the first week of on-boarding of close to 97%.

Board of Directors Compliance Training

51) In accordance with New York State Social Services Law and regulation, and consistent with NYC Health + Hospitals' OP 50-1, *Corporate Compliance and Ethics Program*, as part of the Systems' compliance program, governing body members are required to receive compliance training. Accordingly, the OCC will be scheduling such training for the System's Board of Directors for early next month.