AUDIT COMMITTEE MEETING
AGENDA

October 25, 2017

9:00 A.M.

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

CALL TO ORDER

- Adoption of Minutes September 13, 2017 — Ms. Emily A. Youssouf

INFORMATION ITEMS

- Fiscal Year 2017 Draft Financial Statements and Related Notes — Mr. PV Anatharam/ Mr. Jay Weinman
- Fiscal Year 2017 Report to the Audit Committee — Ms. Maria Tiso, Partner KPMG

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: September 13, 2017
TIME: 1:00 PM

COMMITTEE MEMBERS

Stanley Brezenoff
Mark Page
Gordon Campbell

STAFF ATTENDEES

Salvatore J. Russo, General Counsel, Legal Affairs
Colicia Hercules, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
PV Anantharam, Senior Vice President/Corporate Chief Financial Officer
Susan Sales, Chief Executive Officer, NYC H + H/Gouverneur
Paul Albertson, Vice President, Supply Chain
Jay Weinman, Corporate Comptroller
Paulene Lok, Senior Director, Finance
Donna Hua, Director, Finance
Wayne McNulty, Corporate Compliance Officer/Senior Assistant Vice President
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President
Robert de Luna, Senior Director, Press Secretary
Zoya Shapiro, Controller
Timi Diyaolu, Controller
Devon Wilson, Senior Director, Office of Internal Audits
Chalice Piña, Director, Office of Internal Audits
Delores, Rahman, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Frank Zanghi, Audit Manager, Office of Internal Audits
Sonja Aborisade, Audit Manager, Office of Internal Audits
Melissa Addonisio, Audit Manager, Office of Internal Audits
Armel Sejour, Senior Auditor, Office of Internal Audits
Roshney Kaur, Staff Auditor, Office of Internal Audits
Erica Nairne-Hamilton, Staff Auditor, Office of Internal Audits
Jessica Fortes, Staff Auditor, Office of Internal Audits
Peter Papadopoulos, Staff Auditor, Office of Internal Audits
Robert Hogan, Staff Auditor, Office of Internal Audits
Conny Lizarazo, Executive Secretary, Office of Internal Audits
Michael Rawlings, Chief Operating Officer, NYC H + H/Bellevue
Tracy Green, Chief Financial Officer, NYC H + H/Metropolitan

OTHER ATTENDEES

PAGNY: Reginald Odom, Chief Human Resources Officer; Diana Voigt, General Counsel; Anthony Mirdita, Chief Financial Officer; Liliana Rodriguez, Affiliation Officer

SEPTEMBER 13, 2017
AUDIT COMMITTEE MEETING
MINUTES

An Audit Committee meeting was held on Wednesday, September 13, 2017. The meeting was called to order at 1:03 P.M. by Mr. Gordon Campbell, Member. Mr. Campbell then asked for a motion to adopt the minutes of the Audit Committee meeting held on June 13, 2017. A motion was made and seconded with all in favor to adopt the minutes. An additional motion was made and seconded to hold an Executive Session of the Audit Committee to discuss matters of personnel and potential litigation.

Mr. Gordon then stated that I have asked our two main presenters, Mr. Telano and Mr. McNulty that we need to finish at 1:50 PM, which they assured me they can.

Mr. Campbell directed the meeting to Mr. Telano for an audit update.

Mr. Telano saluted everyone and began with the summary of External Audit being conducted by the City Comptroller's Office of the Electronic Medical Record System or Epic. The audit will be coming to close soon, we hope to receive a draft. It began in September of last year, and we hope that it is winding down.

Mr. Page asked if you have had a discussion with them along the way to get a sense of where they are.

Mr. Telano responded yes we have, they are finished with their fieldwork. They are preparing the report and the preliminary feedback is very positive, they have minor findings.

Moving on to the Audit of the Nurses' Qualifications by the State Comptroller's Office. They have reviewed nurses' files in five different sites. Then they returned to the site to review the temporary agency staff files and any documents we have related to them. One of the areas they are exploring more recently is the process of how Health + Hospitals is informed when nurses are arrested. We are looking into those types of things and fingerprints and those types of background.

Mr. Russo asked if this is for any arrest for anything we're supposed to hear about it. An arrest doesn't mean a conviction. So to be aware of if somebody is going forty in a twenty-mile an hour zone, it is one thing. Whatever action we have to seriously consider we'll hear about it?

Mr. Telano answered that that's what they're exploring, as to how we can hear about it. I'm not aware of how we do hear about it myself.

Mr. Russo commented that lurking there potentially is a real problem, not the extremes that we're talking about. We learn about things through these various registries around the country. They can be of significant matter relative to nurse practice and that is true, of all of our medical professions, not just nurses, not just singling them out. There are issues with time lags, there are issues with monitoring those registries. And so the issue itself is one that's worthy of attention. In its extremes, it's a little silly, but not the general crux of it. In fact, it's a lot of work.

Mr. McNulty added that, we screen all vendors every month on the Green Exclusion List, one state and two federal. If the act that they committed is significant enough, they will probably end up excluded from participating in Federal Health Care programs, in which case we would learn about it.

Mr. Telano continued on to the completed audits section. The audit of wire transfers, he asked Mr. Weinman to address these issues. I will go through the three findings quickly. (a) Wire transfer payments can be made to vendors who are not setup or established within the wire transfer system. This is a free form type of payment with no vendor template. There are emergency situations in which the payment needs to be issued. However, we went back two years, and we could not find one of those emergency payments. We also believe, with the development of the corporate-wide supply chain process, that the need for an emergency payment would be minimized. (b) As you can see from the chart below there are numerous conflicting user roles and authority levels.

Title	Create Templates	Approve Templates	Initiate Template Payments	Approve Template Payments	Initiate Free Form Payments	Approve Free Form Payments
Sr. Director - Cash Management	X	X	X	X	X	X
Fixed Asset Director	X	X	X	X	X	X
Deputy Corporate Controller	X	X	X	X	X	X
Sr. Management Consultant	X		X	X	X	X

For example, if you took at the second to last column, Initiated Free Form Payments, which is the issue I mentioned in the first finding, the Deputy Corporate Comptroller could initiate a free form payment and have these other three individuals approve it. These individuals are of lower title. They may not report to him directly, but they would adhere to a request from him. So we have requested that some of this access be removed. (c) There was no written procedures for wire transfers that could be used as a training tool.

Mr. Weinman said thank you, and stated that I do appreciate the audit. It did highlight some of the areas that we have some problems with approval paths. But I want to address what we've changed so far as what we had in the past. It was really two people; one would initiate the wire transfer, the other would approve. One of the two would also release it to the transfer. So that's really three processes. Even though we have the ERP system and it gives us the ability to eliminate that last function, we're retaining that. We look at the compensating adjustments we have made in approval and it should address all these issues. The process of the initiation, there will be three people responsible for the initiation. Three different people responsible for the approval of it, and three different people to initiate the free-form. This will allow us to have three people getting all the transactions that go through the wire transfers. We've already written a policy for unusual transactions above the Senior VP it's either/or, the Senior VP of Finance or myself would review all unusual transactions. By doing this we think will eliminate the possibility of anything going through that hasn't been reviewed by at least three different people.

Mr. Page asked what do you mean by unusual transactions?

Mr. Weinman answered that unusual would be anything that is done through the free form. So you could do a template which requires two days to get approval from the bank. In an emergency, as Mr. Telano points out correctly that in the last two years we haven't had an emergency, but if we did or had -- and I last remember we had one after Sandy, so if we wanted to make an immediate payment, it still requires three people. Plus it will require either Mr. Anantharam or myself for review. Most payments are repetitive payments and we already have templates setup for these vendors and they go through the normal course.

Mr. Page commented that I guess my concern was, I had not heard from what you said that you had actually addressed the question of what happens when, in a hierarchy of the supervision, when somebody up here initiates the transaction and asks somebody down here under him or her to approve. And I had not heard how you were dealing with that. So I think when it becomes yourself ultimately approving, to me you don't initiate these things yourself. I mean, maybe not, I don't really know.

Mr. Weinman stated that on all three categories, the initiation, the approval and the all of lower titles. They do not report to each other. So there is no situation where one may tell the other, you know, process this and I'll approve it.

Mr. Telano moved onto the review of the Affiliation Operations of PAGNY and New York City Health + Hospital/Metropolitan. He asked for the representatives to approach the table and introduce themselves. They did as follows: Luis Marcos, CEO; Reginal Odom, Chief Human Resources Officer; Liliana Rodriguez, Affiliate Operating Officer.

Mr. Telano stated that I will go through the five issues first, and then you can respond. The first three issues have to do with the subcontractors that are hired by PAGNY. (a) The first one is being paid without submitting timesheets. (b) The second one was still working and being paid under an expired contract; although, they were in the process of trying to renew one. (c) We found two subcontracted physicians that did not have their medical clearances on a timely basis, sixty-nine to one hundred twenty-nine days. Moving on to (d) The Radiology and Psychiatry Departments, they do not maintain revised or updated schedules to indicate the real hours that physicians and others worked. And that updated schedule is to be compared to the timesheets to ensure that the timesheet is accurate and legitimate. Lastly, the recalculation process is inefficient resulting in delays.

Mr. Marcos commented that obviously, that statement requires an explanation because if we just leave it like that, it really sounds bad. Let's start with the first one. The standard physicians are getting paid without submitting timesheets.

Mr. Odom stated, thank you for all your work and for your team's work; we appreciate that. Starting off with the issue of the ADV Pediatrics. The issue there, I guess it's important to note, there was no improper payment to this group of employees. We have corrected the issue that was identified. The issue was that the group was being paid without the benefit of the timesheets. What we were using as support was the schedules from the individual groups. Our Chiefs of Service, for the location, were verifying that the hours being done by the particular contractor. But as of July 1st, we've corrected that issue, and we're receiving the timesheets for them going forward, so that should no longer be an issue.

The second issue is a complicated and difficult one. It relates to a protracted negotiation, which you're absolutely right, it took a long time for us to work through with the group of Orthopedics that provided services not only at

Metropolitan Hospital, but also Coney and Lincoln Hospitals. We were trying to negotiate one contract to create efficiency for the system as opposed to doing it individually. We thought we could save cost, and at the end, we don't feel like we were successful in doing that. As a result of that, it did take too long. At this point, though, Metropolitan has reached an agreement with the group to address the concern that they had. Metropolitan, during the time of the negotiation, wanted to lower the payment. With the support of Ms. Tracy Green and her great team at Metropolitan, we worked with the contractor to reach an agreement to address any concerns about payment.

Bottom line is that the contractor would not agree to our reduction, but at the end, we kind of forced through the reductions we thought were appropriate. During the time we were disputing the issue, we didn't feel that it was appropriate to make adjustments to the payment because we didn't want to have any negative impact on patient care for this important service. We set a process in place that would account for and recoup those payments that we made during the negotiation period. So we feel that it is in a positive place going forward.

Mr. Campbell asked that is what you put in place at Metropolitan, is that something that you have in place in the other hospitals you're affiliated with or plan to?

Mr. Odom responded yes, the negotiation was an attempt to do them all together.

Mr. Campbell asked system-wide? To which Mr. Odom answered yes, as opposed to the individuals. Metropolitan has locked-in now, and we are trying to lock up the other two following the same format and we think it will be more efficient.

The third issue that you mentioned regarding contractor was that we realized that we need to be a little bit tougher, a little bit more diligent about our approach. I think there were two subcontractors who had not gotten their wage clearance for a prolonged period of time. One of the things I think is important to note is often these subcontractors are people who work in other hospitals. So sometimes they're a little difficult because they see our efforts as duplicative of what they have to do, for example, one works at Mount Sinai. They have to do it at Mount Sinai, they have to do it again so they see our efforts as duplicative so they're not always as responsive as we want them to be. So what we put in place is a plan to start the process earlier, communicate with them earlier and often and at the end to be a little tougher, to kind of insist, at a certain point, if they're not getting this done then they're not going to be able to work. So we're going to increase the pressure we're putting on the contractors to correct the issues that occurred with these two individuals.

I believe the other issue you mentioned was one that I guess we've seen at several of the PAGNY facilities, so we feel that it is an issue we need to address across the Board. There is a consistent problem with scheduling, in any given department when you put a schedule out, probably not an hour later, the schedule is changed because somebody wants to switch a day and somebody wants to change the schedule. What we found is that some departments are much better at reconciling the schedule, and others move on to other items, and once they got the schedule out, they don't go back. The key thing is that, we are not making payments to our employees based on that schedule. The payments are made based on their timesheets. So we are accurately paying people based on the time they actually worked. And that is being verified and signed off by the individual Chief of Service or the appropriate supervisor for all of the employees. So we feel that is an issue that we want to tackle. We are taking a look at some systems to maybe implement across PAGNY facilities to better help the departments who struggle with scheduling. Some of them

frankly tell us that they struggle with the time it takes to go back and reconcile. We know there are a bunch of changes, some people write it in on paper, but we feel that if we move to an electronic system we may be able to make it more efficient. Then the next time around, hopefully when Mr. Telano and his team come in, we can show you nice schedules that line up nicely with our timesheets. That is our goal.

Mr. Page asked if they don't actually amend the rest of the schedule, how do they actually see that they're not either overlapping or leaving gaps, how do they do that without a schedule?

Mr. Odom responded that the payment piece is coming off the timesheet. The Chief of Service or their individual division chiefs are the ones who are responsible to make sure that people are in the places that they're supposed to be. Some of them scribble a lot of notes and they don't go back to the master schedule and produce the final product. They make the changes along the way, but they don't take it to the finish line. So they're doing the work, but they're not completing the project so that we can say to Mr. Telano, here's the nice neat schedule that we actually see. We often say, here is the schedule that we started with, but it had all these variations so it doesn't always line up. I appreciate that you are bringing up this important challenge because we want to make sure we close that gap and that there aren't errors. The division heads manage that on behalf of the employer. They make sure that the people are there when they're supposed to be and that the hours they are signing off on their timesheet are accurate with what they've actually worked and what the plan was.

Mr. Brezenoff asked did you mention that you were trying, perhaps, to do some kind of electronic accommodation here. I mean, it would be nice if you had a system that was actually useful for the person trying to manage it, as well as providing the auditable information in terms of yes, the person is actually there.

Mr. Odom replied yes, we are looking at a particular system that some of the other affiliates are using, it is called AM I ON. They found that it's been helpful to them in terms of how they manage the scheduling. They have told me they do not have the same issues that we have when it comes to audit time because they are able to manage the process of correcting the schedules in a timely manner. So we have been investigating and have spoken to the other affiliates, and we are looking at doing that across the PAGNY facilities.

Mr. Telano continued on to the summary of the audits we are currently conducting. Then stated that that concludes my presentation.

Mr. Campbell then turned the meeting over to Mr. Wayne McNulty for the Corporate Compliance Update.

Mr. McNulty saluted everyone and stated that in the interest of time, I'm going to go through the key findings.

We performed a review throughout the system of business associate agreements that are required. A Business Associate Agreement is an agreement between the system and a third-party that provides services on our behalf that involve the use access disposal or transmission of protected health information. We took a look at the Institutional Review Boards that provide research oversight in review on behalf of the system to see whether or not those Institutional Review Boards with us have a Business Associate Agreement in place or require a Business Associate Agreement. Our review, in pertinent part, show that the agreements lack specificity for us to even determine whether or not a Business Associate Agreement was required. That necessitated us to do a review of the agreement itself to

ensure that the Institutional Review Board agreements had the adequate internal controls to mitigate certain risks that may arise from the conduct of human subject research.

Listed below is a list of different Institutional Review Boards that we utilized:

Albert Einstein College of Medicine;
Biomedical Research Alliance of New York;
Maimonides Medical Center;
Mount Sinai School of Medicine;
National Cancer Institute;
New England Institutional Review Board;
New York Medical College;
New York University School of Medicine;
SUNY Downstate Medical Center; and
Western Institutional Review Board

We have one internal IRB which is Lincoln, and we have nine or ten external IRBs that we utilize to review, provide oversight and approve of research throughout our system. So we found a number of findings in the IRB authorization agreements that we highlighted as deficiencies. Finding one was that the agreements did not reference any requirements to meet New York Law. There are specific requirements in New York Law that must be in all agreements. Except for the BRANY agreement, none of the other agreements had this specific language that was required to be in them. The research regulations and guidance is very specific, that they do not preempt the State Law, that you must also follow State Law. That's part of the research guidance that the Office of Human Research Protections provides.

Finding two was that except for two agreements, the other agreements were not reviewed by the Office of Legal Affairs, which is are required under Operating Procedure 180-9 on Human Subject Research Protection Program.

Finding three was that most of the agreements were deficient from an internal control standpoint. Although, five of the ten had specific information which would reduce certain risks, they did not have enough detail with respect to IRB's roles and responsibilities to reduce risks, to address the full spectrum of risks necessary to serve as effective internal controls that will most likely mitigate the corresponding risks to a desirable level from a compliance perspective.

Deficiencies - deficiency one was the IRB authorization agreement. They weren't specific with respect to having the IRBs be registered with OHRP or the FDA. So even though some provided the IRB registration number, they weren't specific that they had to be registered, and that registration had to be maintained throughout the life of the agreement. The BRANY agreement had that and the others did not. Deficiency two was also the registration with FDA, and possibly, if necessary, registration with the New York State Department of Health. The agreements did not address that other than the BRANY agreement. Deficiency three was compliance for our federal-wide assurance. In order for us to conduct research, we have agreement with the Office of Human Subject Research Protection Administration. That particular agreement has terms of assurance that we have to meet. If we are going to contract with external IRBs, we have to then pass along those obligations to the external IRBs. Because one of the conditions of the term of assurance is that, even when we use the external IRBs, we remain fully responsible for all research oversight. So we would at least have to contractually pass along all those obligations to the IRB.

We should list all the principles that we will follow. We follow the Belmont Principles, an ethical principle of the system. That should be in this agreement that the principles that the IRB would have to look at when they're taking a look at human subject research. This is probably the biggest contract deficiency, it is a notice of unanticipated problems. That should be very specific in the agreement. The guidance under OHRP divides the unanticipated problems into two categories; one being serious adverse events, and the other being no-serious adverse events, and the way you will respond to these two different categories would be different. The contract should layout who specifically will be notified and what time period and so forth. That it's not a provision that is followed -- found in the regulations, so to simply say in the contract that we will follow the regulations would not cover these particular provisions.

Another important provision is knowledge of local research context, and that the IRB has the sufficient membership to represent the cultural sensitivity of the community in which the research is being performed. It is a very important portion of the agreement that should be specific. We found that other than the BRANY agreement, and the National Cancer Institute Agreement that none of the other agreements were specific as to the local research context.

Confidentiality of the subject information. We determined that only that BRANY IRB required a Business Associate Agreement because the other IRBs were only specifically performing research related activities. Although a couple of the IRBs had performed privacy board functions for us, they are still specifically related to research activity, so a Business Associate Agreement is not needed. However, there is specific privacy terms under New York Law that the agreement should address. Specifically, Civil Rights Law as it relates to genetic information, Public Health Law as it relates to HIV information, and General Business Law as it relates to private information. If there's a data breach, who would cover the cost of the particular data breach and so forth. That information should be in the agreement. It's only in the BRANY Agreement with respect to those specific categories. And the Western IRB also had some confidentiality provisions in there.

Again, contract deficiency eight, did not contain the requisite language that is required under New York Law. With respect to conflict of interest, only the BRANY and Maimonides Agreement were very specific as to the conflicts of interest provision.

With respect to standard legal terms and conditions, other than the BRANY and the Western Agreements, none of the other agreements went into detail with respect to the insurance, indemnification, term and termination, choice of law, venue, and other miscellaneous provisions, including force majeure and survival. So we found that the agreements were deficient from that standpoint.

We have three recommendations – one, that the IRB Authorization Agreements that exist should be renegotiated as expired or amended to include the key contract terms that we described. Some of the IRB Authorization Agreements were signed almost ten years ago, three or four of them were nine years old. Recommendation two, that the services provided by the IRB should be reviewed, and we did that review. We already made a determination that only one requires a BAA, but there should be specific provisions in the agreement that make it clear what services they're providing so that if there's an audit, you can tell readily whether or not the services that require a BAA would be needed. Recommendation three is that all agreements should be reviewed by the Office of Legal Affairs before they are executed. Management agrees with the three recommendations, and management responds to also add that, with respect to the oversight of all human subject research, that the system follows all research policies and procedures.

Then I just would like to also add that nothing in the report or nothing that the Office of Corporate Compliance found shows that there was any harm to any particular patients or any patient rights were, in any way, violated.

With respect to our summary of compliance report, we received eighty compliance reports for the second quarter, from April 1st to June 30, 2017. No Priority "A" reports. We had fifty-three Priority "B" reports and forty-one Priority "C" reports. Fifty-one percent of the reports come through our confidential compliance help line, which is anonymous if the reporter does not provide their particular name.

Moving along to the monitoring of excluded providers. As I discussed earlier, we perform exclusion searches on all workforce members and vendors on a monthly basis on two federal databases in the Office of Medicaid Inspector General state database.

Since the last time the Audit Committee convened, we have two reports to provide to the Audit Committee. On July 6th, the Office of Corporate Compliance was informed that a physician on the system's list of community physicians who referred home care patients to NYC Health and Hospitals at home was excluded by OMIG effective June 5, 2017, but this particular physician had not referred any patients to that home since 2016. So we do not have an overpayment with the respect to that particular provider.

The second incident, starting on June 22, 2017 when the Office of Corporate Compliance was informed that a health care professional at Gotham East New York Diagnostic Treatment Center was suspended for two months, effective May 24, 2017, but that provider, for whatever reason, came in the day of his or her suspension and saw three patients on that day. So we will have to make adjustments with respect to the billing with respect to those three patients.

We found no workforce members on the Death Masters list or on the Office of Foreign Assets Control list. Finally, this is a status update. We had to brief the Audit Committee in April and June on our compliance efforts with respect to our role in the Delivery System Reform and Incentive Payment Program as a PPS lead. We sent out attestations to our one hundred and ninety-three partners for them to complete regarding whether or not they performed compliance training, whether or not they were certified with OMIG and OIG, and whether or not they screened excluded providers. All one hundred and ninety-three have responded and provided the attestations back so we have a hundred percent rate with the respect to that regard. We're now doing analysis on the data we received.

One important point is that, eleven of the one hundred ninety-three have informed us that they do not screen their providers on a monthly basis with respect to exclusions. So we will be providing education to all the partners on their responsibility with respect to exclusions, and we will be following up with those eleven providers specifically to make sure going forward that they screen all of their providers.

We will report back to the Audit Committee on our risk analysis with respect to the data that we received in the attestations.

Mr. McNulty said that if there were not any questions, that concludes his report.
(The executive session was held.)

There being no other business, the meeting was adjourned at 1:45 PM.

NYC Health + Hospitals

Audit results

Financial statements for the year ended June 30, 2017

October 25, 2017

Agenda

With you today

Maria Tiso
Lead Engagement
Partner

Mike Breen
Engagement Partner

Joe Bukzin
Engagement
Senior Manager

Jim Martell
Healthcare Resource
Partner

Barbara Siochi
Partner, Watson
Rice

Deliverables

— Auditor's reports on the NYC Health + Hospitals' financial statements

— Debt compliance letter

— Required communications

Other deliverables:

— Completeness and accuracy of census data attestation (pension related deliverable) done on a periodic basis (every 3 years as requested by the City Pension Plan Auditors) – issued September 27, 2017

— Management Letter to the Audit Committee and management on our recommendations regarding internal controls and other operational matters – in progress to be issued in December 2017

— Various Regulatory Reports (diagnostic and treatment centers and skilled nursing facilities cost reports) – expected to be issued in 2017/2018

— MetroPlus Health Plan (Calendar year end) – expected to be issued in 2018

— HHC Insurance Company, Inc. (Calendar year end) – expected to be issued in 2018

— HHC ACO, Inc. – expected to be issued in 2018

Required communications

Required communications	Application to NYC Health + Hospitals

Auditor's report	— We expect to issue an unmodified auditor's report
	— Audit report include:
	  — Emphasis of matter paragraph included as it relates to the new accounting standard GASB 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*
	  — Other matters paragraph included regarding required supplementary information
	— Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

Required communications (continued)

Required communications	Application to NYC Health + Hospitals
Accounting Estimates & Significant Audit Areas	*Valuation of hospital patient accounts receivable* — Management's estimates is based on an analysis of historical collection experience — KPMG utilized data and analytics tool to perform independent analysis of historical collections and compared to management's estimate — Adjustments were recorded in the financial statements. See slide 11. *Valuation of third party receivables/liabilities (UPL, DSH, IPRO)* — Management estimates based on regulations, correspondence from third parties, and historical experience — KPMG utilized a third party subject matter professional to review key assumptions — As of June 30, 2017, NYC Health + Hospitals had a DSH receivable for which correspondence was received from the NYS Department of Health indicating that payment of DSH funds would be made in three installments between now and the end of the year *Valuation of MetroPlus claims payable* — Management utilized an actuarial firm to perform actuarial calculation — KPMG utilized an actuarial professional to review the calculation and key assumptions *Valuation of pension plan and post-employment benefits other than pension (OPEB) liabilities* — Management obtains actuarial calculations from the Office of the Actuary, City of New York — KPMG utilized an actuarial professional to review the calculations and key assumptions *Management override of controls* — Inquiries of senior management — Assess appropriateness of changes compared to the prior year to the methods and assumptions used to prepare accounting estimates Amounts are reasonably stated within the financial statements

Required communications (continued)

Required communications	Application to NYC Health + Hospitals

Significant Audit Areas, continued	**Liquidity**
	▪ GASB 56 — Codification of Accounting and Financial Reporting Guidance Contained in the AICPA Statements on Auditing Standards requires that financial statement preparers have a responsibility to evaluate whether there is substantial doubt about a government's ability to continue as a going concern for 12 months beyond the financial statement date.
	• The following were considerations:
	  • Income (loss) from operations trends
	  • Working capital
	  • Net deficit position
	  • Debt covenant compliance
	  • Management plans
	  • Board and Finance Committee meeting minutes
	  • Transforming Health + Hospitals report (one New York: Healthcare for Our Neighbors)
	  • Fiscal 2017 budget to actual results (reliability of budgeting process)
	  • Ending cash balance compared to budget
	  • Financial Plan approved by the City
	  • The Mayor's commitment through the Transformation Plan as well as the City of New York's commitment for the success of NYC Health + Hospitals through its flexibility and historical financial support through its appropriations of funds, contribution for capital, forgiveness of obligations, and timing of requesting payment of certain obligations demonstrates the continued commitment to delivering the best care to New York City
	▪ Based on the facts noted above, management concluded and KPMG agreed that there was not substantial doubt about NYC Health + Hospitals ability to continue as a going concern

Required communications (continued)

Required communications	Application to NYC Health + Hospitals
Other significant transactions	The following transactions occurred during fiscal year 2017: *Grants Revenue recognized in 2017:* — Delivery System Reform Incentive Payment Program (DSRIP): $200 million — Value Based Payment – Quality Improvement Program (VBP-QIP): $240.0 million — Care Restructuring Enhancement Pilots (C.R.E.P.S): $163.0 million *Appropriations from The City of New York (the City):* — The City assumed Fiscal Year 2017 commitments of amounts owed from NYC Health + Hospitals for debt service, thereby alleviating amounts owed to the City of $145.8 million — $723 million of appropriations were received from the City for the year ended June 30, 2017
Information Technology General Controls	System selected for testing: — Infor System: General Ledger — PSMS (Personal Services Management System): Employee Time Keeping — OTPS (Other than personal service): Purchasing General IT Control areas evaluated: — Access to Programs and Data - Key areas include administrator access as well as user access rights — Change Management - Key areas include documentation, testing, and approvals of changes to in scope systems — Computer Operations - Key areas include job processing and incident management

Required communications (continued)

Required communications	Application to NYC Health + Hospitals
Significant accounting policies/quality of accounting principles	— NYC Health + Hospitals' significant accounting policies are summarized in note 1 to the financial statements — As described in note 1, three new accounting pronouncements were adopted — GASB 75, Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions (includes retrospective application) — GASB 80, Blending Requirements for Certain Component Units — GASB 82, Pension Issues
Subsequent events	— As discussed in note 7(g), on July 31, 2017 NYC Health + Hospitals drew down the remaining $50 million on its JP Morgan equipment financing loan and converted it to a fixed rate loan
Consultation with other accountants	— To the best of our knowledge, management has not consulted with or obtained opinions (written or oral) from other independent accountants
Major issues discussed with management prior to retention	— No matters to report
Difficulties encountered in performing the audit	— No matters to report
Material written communications	— Material written communications between management and KPMG include: – Engagement letter – Management representation letter – Management letter
Significant deficiencies and material weaknesses in internal control	— There were no material weaknesses identified to date — Management Letter to be issued in December 2017

Required communications (continued)

Required communications	Application to NYC Health + Hospitals
Other information in documents containing audited financial statements	— Not applicable as the audited financial statements are not included in other documents
Changes to initial 2017 Audit Plan	— There were no significant changes to the initial 2017 audit plan
Disagreements with Management	— No matters to report
Independence	— In our professional judgment, we are not aware of any relationships between KPMG and NYC Health + Hospitals and persons in a financial reporting oversight role, that may reasonably be thought to bear on our independence
Related party transactions	— Related party transactions with The City of New York are disclosed in the financial statements
Litigations, claims, & assessments	— None other than normal course of business
Illegal acts or fraud	— We are unaware of any actual or suspected fraud, illegal acts, or noncompliance with laws and regulations that would result in a material misstatement of the financial statements. Audit procedures performed included inquiries of senior management and external legal counsel and involvement of a KPMG's forensics professional and professional practice partner

Required communications (continued)

Required communications	Application to NYC Health + Hospitals
Adjustments	**The following adjustments were recorded in the financial statements:** Statements of Revenue, Expenses, and Changes in Net Position (in millions) *Operations:* Patient accounts receivable valuation (revenue) $ 20 Grant revenue $(40) MetroPlus stop loss (expense) $(5) Total decrease to operations: $(25) Several statement of financial position reclassifications between current and long term assets and liabilities were recorded as of June 30, 2017, including accrued compensated absences ($284 million), stop-loss receivable ($15 million), and due to The City of New York ($62 million). The net impact on working capital is an increase of $331 million based upon the draft financial statements. **In connection with our audit, there were no significant financial statement misstatements that have not been corrected.**

Next steps (as of 10/20/17)

- Finalize concurring partner review
- Finalize footnotes, MD&A, and statement of cash flows as well as support
- Sample selections open relating to patient accounts receivable
- Finalize subsequent event procedures required until issuance
  - Inquiries with management
  - Inspection of subsequent minutes, if any
- Management representation letter

KPMG resources

KPMG's Audit Committee Institute (ACI)

- KPMG's commitment to communicating with Audit Committee members and other participants in the financial reporting process
- ACI Web site: **www.kpmg.com/aci**
- ACI mailbox: **auditcommittee@kpmg.com**
- ACI hotline: **1-877-KPMG-ACI (576-4224)**
- Publications
  - Directors Quarterly
  - Global Boardroom Insights
  - On the 2017 Audit Committee and Board Agendas
  - Global Audit Committee Survey

kpmg.com/socialmedia

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of The City of New York)

Financial Statements

June 30, 2017 and 2016

(With Independent Auditors' Reports Thereon)

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

Table of Contents

Independent Auditors' Report

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

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation (NYC Health + Hospitals), a component unit of The City of New York, as of and for the years ended June 30, 2017 and 2016, and the related notes to the financial statements, which collectively comprise the NYC Health + Hospitals' basic financial statements for the years then ended 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 U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement. The financial statements as of and for the years ended June 30, 2017 and 2016 of MetroPlus Health Plan, Inc., a discretely presented component unit, and HHC Insurance Company, Inc., a blended component unit, were not audited in accordance with *Government Auditing Standards*.

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

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

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

Management's Discussion and Analysis (Unaudited)

June 30, 2017 and 2016

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component unit of NYC Health + Hospitals as of June 30, 2017 and 2016, and the respective changes in financial position, and where applicable, cash flows thereof for the years then ended, in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 1 to the financial statements, in 2017, NYC Health + Hospitals adopted Governmental Accounting Standards Board (GASB) Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. Our opinions are not modified with respect to this matter.

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 70, 71 and 72, respectively, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated Octobe25, 2017 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 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.

(signed) KPMG LLP

October 25, 2017

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

Management's Discussion and Analysis (Unaudited)

June 30, 2017 and 2016

Financial Analysis

Summary of Statements of Net Position

June 30, 2017, 2016, and 2015

(In thousands)

	2017 Business-type Activities – HHC	2016 Business-type Activities – HHC (As Adjusted)	2015 Business-type Activities – HHC (As Adjusted)
Assets:			
Current assets	$ 2,233,423	2,506,602	2,485,085
Capital assets, net	3,395,964	3,401,861	3,432,430
Other assets	151,480	162,777	118,444
Total assets	5,780,867	6,071,240	6,035,959
Deferred outflows:			
Net differences between projected and actual earnings on pension plan investments and other changes, net	13,794	480,191	—
Unamortized refunding cost	10,537	12,785	15,349
Liabilities:			
Current liabilities	2,444,027	2,637,985	2,945,003
Long-term debt, net of current installments	776,783	868,626	882,848
Other noncurrent liabilities	340,600	296,811	296,811
Pension, net of current portion	2,514,409	3,031,476	2,334,651
Postemployment benefits obligation, other than pension, net of current portion	4,622,435	5,037,778	4,735,487
Total liabilities	10,698,254	11,872,676	11,194,800
Deferred inflows:			
Net differences between projected and actual earnings on pension plan investments	—	—	258,287
Net differences between expected and actual experience and changes in actuarial assumptions in postemployment benefits obligation, other than pension	684,300	35,951	—
Net position:			
Net investment in capital assets	2,553,374	2,514,112	2,521,077
Restricted	153,319	154,926	149,231
Unrestricted	(8,284,049)	(8,013,449)	(8,072,087)
Total net deficit position	$ (5,577,356)	(5,344,411)	(5,401,779)

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)

June 30, 2017 and 2016

Financial Analysis

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

Years ended June 30, 2017, 2016, and 2015

(In thousands)

	2017 Business-type Activities – HHC	2016 Business-type Activities – HHC (As Adjusted)	2015 Business-type Activities – HHC (As Adjusted)
Operating revenue:			
Net patient service revenue	$ 5,611,114	5,812,049	5,729,197
Appropriations from City of New York, net	723,425	1,405,091	140,597
Grants revenue	863,808	362,339	526,673
Other revenue	95,287	103,080	61,264
Total operating revenue	7,293,634	7,682,559	6,457,731
Operating expenses:			
Personal services, fringes benefits, and employer payroll taxes	3,628,339	3,607,126	3,423,547
Other than personal services	1,842,665	1,753,336	1,561,411
Pension	426,325	502,374	285,111
Postemployment benefits, other than pension	289,166	447,783	175,288
Affiliation contracted services	1,069,545	1,050,535	994,294
Depreciation	310,325	302,530	291,729
Total operating expenses	7,566,365	7,663,684	6,731,380
Operating (loss) income	(272,731)	18,875	(273,649)
Nonoperating expenses, net	(115,994)	(112,910)	(125,067)
Loss before other changes in net deficit	(388,725)	(94,035)	(398,716)
Other changes in net deficit:			
Capital contributions	155,780	151,403	106,915
(Decrease) increase in net deficit	(232,945)	57,368	(291,801)
Net deficit position at beginning of year	(5,344,411)	(5,401,779)	(5,109,978)
Net deficit position at end of year	$ (5,577,356)	(5,344,411)	(5,401,779)

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)

June 30, 2017 and 2016

This section of 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, 2017 and 2016. 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 statements of net position, statements of revenue, expenses, and changes in net position, statements of cash flows, and notes to financial statements. These statements present, on a comparative basis, the financial position of NYC Health + Hospitals at June 30, 2017 and 2016, and the changes in net position and its financial activities for each of the years then ended. The statements of net position include all of NYC Health + Hospitals' assets and liabilities in accordance with U.S. generally accepted accounting principles. The statements of revenue, expenses, and changes in net position present each year's activities on the accrual basis of accounting, that is, when services are provided or obligations are incurred, not when cash is received or bills are paid. The financial statements also report the net position of NYC Health + Hospitals and how it has changed. Net position, or the difference between assets and liabilities, deferred inflows and deferred outflows, is a way to measure the financial health or position of NYC Health + Hospitals'. The statements of cash flows provide relevant information about each year's cash receipts and cash payments and classify them as to operating, noncapital financing, capital and related financing, and investing activities. Notes to financial statements explain information in the statements and provide more detailed data.

Overall Financial Position and Operations

NYC Health + Hospitals total net deficit position increased by $232.9 million from June 30, 2016 to June 30, 2017, and an increase of $57.4 million from June 30, 2015 to June 30, 2016, as adjusted. Net investment in capital assets increased by $39.3 million and decreased by $7.0 million in 2017 and 2016, respectively, as the major modernization projects neared completion and NYC Health + Hospitals continued to pay down debt. NYC Health + Hospitals' unrestricted net deficit position increased to $8.284 billion at June 30, 2017, from $8.013 billion at June 30, 2016 as adjusted. NYC Health + Hospitals ended the fiscal year June 30, 2017 with an operating loss of $272.7 million compared with operating income of $18.9 million for the year ended June 30, 2016, as adjusted. NYC Health + Hospitals net deficit position benefited from $135.4 million and $150.1 million in capital contributions from The City of New York (The City) in 2017 and 2016, respectively.

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

Management's Discussion and Analysis (Unaudited)

June 30, 2017 and 2016

Significant financial ratios are as follows:

	2017	2016	2015
Current ratio	0.91	0.95	0.84
Quick ratio	0.48	0.46	0.42
Days' cash on hand	30.18	26.61	35.10
Net days' revenue in patient receivables	58.31	66.87	63.78

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 2017 amounts compared to 2016 and, where appropriate, 2016 amounts compared to 2015. 2016 and 2015 amounts have bee adjusted for the retrospective application of GASB 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions.*

Statements of Net Position

Cash and cash equivalents - Increased by $66.0 million from June 30, 2016 to June 30, 2017 mainly due to management of the accounts payable and available cash during the last quarter of the fiscal year end. Cash and cash equivalents decreased $67.3 million from June 30, 2015 to June 30, 2016 to $543.6 million mainly due to yearly operations.

Patient accounts receivable, net - Decreased $99.4 million from 2016 to 2017 mainly due to additional reserves for long-term in-house patients, decreases in risk incentive pools receivables, and decreased patient care services. Patient accounts receivable, net increased $36.4 million from 2015 to 2016 due to an increase in the risk incentive pool receivable from MetroPlus to NYC Health + Hospitals.

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. Estimated third-party payor settlements, net increased $31.9 million from June 30, 2015 to June 30, 2016 representative of revised estimates in anticipated UPL receivables for 2016.

Grants receivable – Grants receivable increased $68.0 million from June 30, 2016 to June 30, 2017 mainly due to the recognition of $8.8 million related to the Value Based Payment Quality Improvement Program (VBP QIP) in fiscal year 2017 and increases in receivable related to the Delivery System Reform Incentive Payment (DSRIP) program funds, mental health and New York State Department of Health (NYSDOH) family health grant. Grants receivable increased $118.4 million from June 30, 2015 to June 30, 2016 mainly due to the recognition of $73.9 million related to DSRIP program funds and $20.7 million receivable for Federal Emergency Management Agency (FEMA) funds related to Super Storm Sandy.

Assets restricted as to use – Decreased $14.7 million due to the use of equipment financing to buy equipment in fiscal year 2017 and increased $29.7 million from June 30, 2015 to June 30, 2016 due to NYC Health + Hospitals' obtaining funds for equipment financing through Citibank, JP Morgan, and Key Bank.

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

Management's Discussion and Analysis (Unaudited)

June 30, 2017 and 2016

Other current assets – Increased $14.0 million from June 30, 2016 to June 30, 2017 primarily due to affiliate payment or performance indicators based on prior year's experience offset by a $2.3 million decrease in inventory, and decreased $6.3 million from June 30, 2015 to June 30, 2016 primarily due to a decrease of funds held on account (advance) with a medical surgical supplies vendor offset by an increase in inventory of $2.3 million.

Capital assets, net – Remained fairly consistent with prior year and decreased $30.6 million from 2015 to 2016 as depreciation outweighed the new additions in fiscal year 2016.

Accrued salaries, fringe benefits, payroll taxes, and accrued compensated absences (current and long-term) – Decreased $33.8 million from June 30, 2017 to June 30, 2016 due to staff restructuring and attrition in the fiscal year and remained consistent for reporting years 2016 versus 2015 amounts.

Accounts payable and accrued expenses – Increased $74.7 million from June 30, 2016 to June 30, 2017 primarily due to increases in vendor payable balances due to cash flow. Increased $86.9 million from June 30, 2015 to June 30, 2016 primarily due to increases in vendors payable of $94.6 million coincided with a decrease in per diem nurses payable of $7.2 million representative of efforts to pay agencies more timely.

Estimated third-party payor settlements, net payable – Decreased by $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. Decreased by $43.1 million from June 30, 2015 to June 30, 2016 due to a re-estimation of third-party anticipated settlements for Medicaid and Medicare rate changes.

Estimated pools payable, net – Estimated pools payable, net, decreased $265.6 million from June 30, 2016 to June 30, 2017 primarily due to recording of State Fiscal Year 2016-2017 Disproportionate Share Hospital Maximum (DSH Max) program receivable which has not been paid as of June 30, 2017. Estimated pools payable, net, decreased $143.5 million from June 30, 2015 to June 30, 2016 primarily due to a $142.9 million decrease in the State's advance payments of DSH Max funds.

Due to City of New York, net (current and long term) – Increased $112.3 million from June 30, 2016 to June 30, 2017 mainly due to medical malpractice liability in the amount of $112.9 million that had not been paid by June 30, 2017. Decreased $277.1 million from June 30, 2015 to June 30, 2016 mainly due to payments of 2014 liability related to malpractice and debt service of $126.9 million and $153.2 million, respectively, which coincided with no increase of related amounts which were assumed by City for $125.3 million and $165.2 million for malpractice and debt service, respectively, for the year ended June 30, 2016. These are no longer obligations of NYC Health + Hospitals for fiscal year 2016 (note 8 to the financial statement).

Long-term debt (includes current installments)– 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. Long-term debt decreased $2.2 million from June 30, 2015 to June 30, 2016 due to a continuation of scheduled principal payments during fiscal year 2016 partially offset by new equipment financing arrangements entered into during the year (note 7 to the financial statements).

Pension (current and long-term) – Decreased $520.4 million from June 30, 2016 to June 30, 2017 and increased $749.7 million from June 30, 2015 to June 30, 2016 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 9 to the financial statements).

Postemployment benefits obligation, other than pension (current and long-term) – Decreased $404.8 million from June 30, 2016 to June 30, 2017 and reported an adjusted increase of $326.0 million from June 30, 2015 to June 30, 2016 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 10 to the financial statements).

Changes in Components of Net Position

Net investment in capital assets – Increased $39.3 million from June 30, 2016 to June 30, 2017 as capital assets, net, decreased by $2.4 million, and expendable for specific operating activities marginally improved by $0.8 million. Decreased $7.0 million from June 30, 2015 to June 30, 2016 as capital assets, net, decreased by $30.6 million, related assets restricted as to use increased by $24.0 million, and related debt decreased by $2.1 million, and deferred outflows decreased by $2.5 million.

Restricted – Restricted net assets decreased $1.6 million from June 30, 2016 to June 30, 2017 mainly due to a $2.4 million decrease in restricted funds for debt service. Restricted net assets increased $5.7 million from June 30, 2015 to June 30, 2016 mainly due to a $5.2 million increase in restricted funds for debt service.

Unrestricted – Net position activities, other than those mentioned above, resulted in a increase of $300.5 million and a decrease of $156.9 million in unrestricted net assets for years 2017 and 2016 as adjusted, respectively. Please see the statements of revenue, expenses, and changes in net position.

Capital Assets, Net and Long-Term Debt Activity

Capital Assets, Net

At June 30, 2017, NYC Health + Hospitals had capital assets, net of accumulated depreciation, of $3.396 billion compared to $3.402 billion at June 30, 2016 and $3.432 billion at June 30, 2015, representing a decrease of 0.2% from 2016 to 2017 and a decrease of 0.9% from 2015 to 2016, as shown in the table below (in thousands of dollars):

		2017	2016	2015
Land and land improvements	$	27,969	29,111	29,159
Buildings and leasehold improvements		2,075,173	2,157,515	2,265,891
Equipment		827,178	844,084	833,143
Construction in progress		465,644	371,151	304,237
Total	$	3,395,964	3,401,861	3,432,430

2017's major capital asset additions include the following:

- Development of the electronic medical record (EMR) system continued with increases of approximately $53.7 million in 2017, which includes in-house payroll amounts of $11.3 million associated with direct implementation. During 2017, portions of the project totaling $20.0 million were placed in use.
- Continued development of the Enterprise Resource Planning (ERP) system with an approximate increase of capitalized costs of $15.3 million in 2017. Included in that amount is in-house payroll amounts of $2.1 million associated with direct implementation.
- Construction has been mostly completed on the major modernization of Gouverneur Healthcare Services, with additional amounts capitalized of $4.0 million in 2017. During 2017, portions of the project totaling $15.0 million were placed in use.
- Energy Efficiency Measures upgrade projects' managed by New York Power Authority (NYPA) have continued at multiple facilities with $14.0 million capitalized in 2017.
- Construction continued on a new Diagnostic and Treatment Center facility in Staten Island, with the addition of $2.5 million in 2017.
- FEMA funded projects at multiple facilities are in-design and under construction. 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 2017.

2016's major capital asset additions included the following:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional amounts capitilzed of approximately $3.7 million in 2016. During 2016, portions of the project totaling $20.0 million were placed in use.
- Construction has been mostly completed on the major modernization of Harlem Hospital Center, with additional amounts capitalized of approximately $0.4 million in 2016.
- Construction has been mostly completed on the major modernization of Henry J. Carter Center, with additional amounts capitalized of approximately $1.6 million in 2016.
- Construction of the new Ida G. Israel Community Health Center continued, with amounts capitalized of $0.7 million in 2016.
- Developing the EMR system continued with spending of $37.7 million in 2016.
- Boiler replacements and repairs at multiple facilities with $30.0 million of spending in 2016.
- Construction costs related to the major modernization project at Coney Island Hospital of approximately $17.5 million capitalized in 2016.
- Construction projects of $2.2 million at Metropolitan Hospital in 2016.

2015's major capital asset additions included the following:

- Construction continued on the major modernization of Gouverneur Healthcare Services, with additional amounts capitalized of $9.9 million in 2015.
- Construction has been mostly completed on the major modernization of Harlem Hospital Center, with additional amounts capitalized of $1.9 million in 2015.
- Construction has been mostly completed on the major modernization of Henry J. Carter Center, with additional amounts capitalized of $11.0 million in 2015.
- Construction of the new Ida G. Israel Community Health Center continued, with amounts capitalized of $7.1 million in 2015.
- Developing the EMR system continued with amounts capitalized of $52.3 million in 2015.

NYC Health + Hospitals 2018 capital budget projects spending of $466.0 million, which includes acquisition of medical equipment, information techonology upgrades, continued additions to the EMR system, and construction work on Rehab-Infrastructure projects. The 2018 capital budget is expected to be primarily financed by NYC Health + Hospitals' approved JP Morgan 2015 equipment financing, NYC Health + Hospitals' approved Citibank funds, Transitional Finance Authority Bonds, and other funding.

More detailed information about the NYC Health + Hospitals capital assets is presented in note 5 to the financial statements.

Long-Term Debt

At June 30, 2017, NYC Health + Hospitals has approximately $845.6 million in long-term debt financing relating to its capital assets, as shown with comparative amounts at June 30, 2016 and 2015 (in thousands of dollars):

		2017	2016	2015
Bonds payable	$	756,939	814,342	870,466
New York Power Authority (NYPA) financing		—	—	217
Equipment and renovation financing		—	—	135
Clinical bed financing		—	80	518
Henry J. Carter capital lease obligation		27,217	48,254	48,254
New Market Tax Credit		14,700	14,700	14,700
Key Bank CISCO leases		21,260	28,216	—
Oracle ERP financing		3,923	6,540	—
JP Morgan Equipment financing		10,000	10,000	—
Revolving loan (Citibank)		10,000	10,000	—
Total	$	844,039	932,132	934,290

At June 30, 2017, NYC Health + Hospitals' outstanding bonds at par are 79.6% uninsured fixed and 20.4% 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 September 8, 2017, 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 7 to the financial statements.

Statements of Revenue, Expenses, and Changes in Net Position

Net patient service revenue – Net patient service revenue, which makes up a little more than 75% of total revenues, decreased $200.9 million from June 30, 2016 to June 30, 2017 reflecting utlization declines and retroactive Disproportionate Share Hospital (DSH) revenues recorded in fiscal year 2016. Increased $82.9 million from June 30, 2015 to June 30, 2016 mainly due to an increase in UPL revenue.

Appropriations from City of New York, net – Decreased $681.7 million from June 30, 2016 to June 30, 2017 mainly due to subsidies received late in fiscal year 2016 that had been expected in fiscal year 2017. The City's assistance to the System is also reflected in City contributions for the local share of grant revenues related to DSRIP, VBP-QIP and CREP's (see below grants revenue). Increased $1.264 billion from June 30, 2015 to June 30, 2016 mainly attributable to The City funding of collective bargaining of $135.0 million, Correctional Health Services of $164.7 million, maintenance of DSH UPL support of $204.0 million and additional support of $581.0 million ($181.0 million provided during the year and $400.0 million provided at 2016).

Grants revenue – 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 Care Restructuring Enhancement Pilots (CREPs) of $163.0 million. Decreased $164.4 million from June 30, 2015 to June 30, 2016 due to a decrease in Interim Access Assurance Fund (IAAF) grant revenue as the program ended in fiscal year 2015, along with a decrease in DSRIP of $38 million.

Other revenue – This is relatively consistent with the prior year. Increased $41.8 million primarily due to increase of $18.0 million in miscellaneous revenues and $12.2 million increase in 340B pharmaceutical program revenue from June 30, 2015 to June 30, 2016.

Personal services – Remained consistent from June 30, 2016 to June 30, 2017 mainly due to efforts to control headcount (full-time equivalent employees). Increased $146.6 million, or approximately 6%, from June 30, 2015 to June 30, 2016 mainly due to continued collective bargaining salary increases, which represents $67.9 million, increases of approximately $41.0 million related to regular earnings of increased salary, and an increase of $34.1 million for the addition of Correctional Health Services (CHS) to NYC Health + Hospitals (note 15 to the financial statements).

Other-than-personal services – Increased $89.3 million, or 5.1% from June 30, 2016 to June 30, 2017, and remains consistent with increase from prior years. Increased $191.9 million, or 12.3% from June 30, 2015 to June 30, 2016 primarily due to the addition of CHS to NYC Health + Hospitals, which were transferred over from Department of Health and Mental Hygiene in the amount of $155.4 million.

Fringe benefits and employer payroll taxes – Increased $22.4 million or approximately 2.6% from June 30, 2016 to June 30, 2017 mainly due to health benefit increases of $22.0 million (6.8%). Increased $37.0 million or approximately 5% from June 30, 2015 to June 30, 2016 mainly due to an increase in health benefits costs of $61.0 million or 12.3% and an increase in welfare benefits expense of $19.0 million or 19.2%.

Pension – Decreased $76.0 million from June 30, 2016 to June 30, 2017, as computed by the New York City Office of the Actuary. Pension increased $217.3 million from June 30, 2015 to June 30, 2016, mainly due to less than projected earnings on pension plan investments. Pension plan expense as of June 30, 2017 and 2016 respectively, is determined by the New York City Office of the Actuary (note 9 to the financial statements).

Postemployment benefits, other than pension – Decreased $158.6 million from June 30, 2016 to June 30, 2017 as calculated by the New York City Office of the Actuary as GASB 75 was implemented. The 2016 expense has been adjusted retroactively. Increased $272.5 million from June 30, 2015 to June 30, 2016, mainly due to a change in a post-retirement mortality assumption, HMO aging adjustment, Welfare Fund contribution trend, and restatement of the reported fiscal year 2016 amounts due to implementation of GASB75. Postemployment benefits, other than pension as of June 30, 2017 and 2016 respectively, are determined by the New York City Office of the Actuary (note 10 to the financial statements).

Affiliation contracted services – Increased $19.0 million or 1.8% from June 30, 2016 to June 30, 2017 mainly attributable to service enhancements added to the clinical programs since prior year and market adjustments. Affiliation contracted services increased $56.2 million or 6% from June 30, 2015 to June 30, 2016 primarily due to market adjustments and enhancement of services.

Capital contributions funded by The City of New York – Decreased $14.7 million from June 30, 2016 to June 30, 2017 due to the start of FEMA storm mitigation projects. Increased $44.4 million from June 30, 2015 to June 30, 2016 due to fewer continuing major modernization projects.

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 New York City to increase capital and contain expenses
- Shifting from a fee-for-service payment system to a managed care system which includes value-based payment structure

NYC Health + Hospitals has responded to these challenges by embarking on an ambitious transformation effort to comprehensively redesign the public health system and to build a competitive, sustainable organization. Shedding its' federated network structure, NYC Health + Hospitals, at the onset of fiscal year 2017, has aligned its management along lines of service (hospitals, post-acute care, ambulatory care) to 1) promote standardization of quality care; 2) leverage strengths in the system; 3) promote the use of primary care in less urgent settings, 4) improve continuity of care, and 5) maximize the potential of its various lines of business through vertical integration.

Additional strategies to meet the challenges include: 1) continuing close coordination with City, State and Federal partners; 2) designing and implementing an enterprise resource system to support organizational change through modern business processes; 3) increasing capacity for data analytics; and, 4) reinforcing the City's partnership and commitment by increasing the City's investments in NYC Health + Hospitals through capital investments in primary care clinics and acceptance of a majority of NYC Health + Hospitals' debt obligations. NYC Health + Hospitals will continue to adapt and respond to meet its mandate to improve the health of New Yorkers and its communities.

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 for the purposes of obtaining designations as Federally Qualified Health Center(s) (FQHC). This type of Federal designation provides for enhanced reimbursement rates for care to 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 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 the 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. Plachikkat V. Anantharam, Senior Vice President – Finance, 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)

Statements of Net Position

June 30, 2017 and 2016

(In thousands)

	2017				2016 (As Adjusted)			
Assets	Business-type Activities – HHC	Discretely Presented Component Unit-MetroPlus	Eliminations	Total	Business-type Activities – HHC	Discretely Presented Component Unit-MetroPlus	Eliminations	Total
Current assets:								
Cash and cash equivalents (note 2)	$ 609,647	574,396	—	1,184,043	543,618	568,385	—	1,112,003
U.S. government securities (note 16)	—	89,832	—	89,832	—	76,859	—	76,859
Patient accounts receivable, net (notes 4 and 11)	571,810	—	(217,437)	354,373	671,250	—	(252,974)	418,276
Premiums receivable (note 16)	—	214,993	(2,376)	212,617	—	149,134	(2,337)	146,797
Estimated third-party payor settlements, receivable (notes 4 and 11)	603,900	—	(146,255)	457,645	922,202	—	(88,036)	834,166
Grants receivable (note 13)	329,408	201	—	329,609	261,441	68	—	261,509
Assets restricted as to use and required for current liabilities (notes 6 and 7)	31,020	—	—	31,020	34,405	—	—	34,405
Other current assets	87,638	42,103	—	129,741	73,686	52,658	—	126,344
Total current assets	2,233,423	921,525	(366,068)	2,788,880	2,506,602	847,104	(343,347)	3,010,359
Assets restricted as to use, net of current portion (notes 6 and 16)	140,819	143,342	—	284,161	152,116	134,439	—	286,555
U.S. government securities (note 16)	—	333,758	—	333,758	—	329,047	—	329,047
Other receivable	10,661	14,749	—	25,410	10,661	—	—	10,661
Capital assets, net (note 5)	3,395,964	6,288	—	3,402,252	3,401,861	6,808	—	3,408,669
Total assets	5,780,867	1,419,662	(366,068)	6,834,461	6,071,240	1,317,398	(343,347)	7,045,291
Deferred Outflows of Resources								
Net differences between projected and actual earnings on pension plan investments and other changes, net	13,794	339	—	14,133	480,191	11,455	—	491,646
Unamortized refunding cost	10,537	—	—	10,537	12,785	—	—	12,785
	$ 5,805,198	1,420,001	(366,068)	6,859,131	6,564,216	1,328,853	(343,347)	7,549,722
Liabilities								
Current liabilities:								
Current installments of long-term debt (note 7)	$ 67,256	—	—	67,256	63,506	—	—	63,506
Accrued salaries, fringe benefits, and payroll taxes	518,167	6,214	(2,376)	522,005	830,887	15,820	(2,337)	844,370
Accounts payable and accrued expenses (notes 12 and 16)	592,221	711,198	(363,692)	939,727	517,568	650,206	(341,010)	826,764
Estimated third-party payor settlements, net payable (notes 4 and 11)	59,175	—	—	59,175	107,800	—	—	107,800
Estimated pools payable, net (notes 4 and 11)	43,200	—	—	43,200	308,800	—	—	308,800
Current portion of due to City of New York, net (note 8)	555,464	—	—	555,464	208,091	—	—	208,091
Current portion of pension (note 9)	482,816	11,873	—	494,689	486,118	11,597	—	497,715
Current portion of postemployment benefits obligation, other than pension (note 10)	125,728	1,232	—	126,960	112,215	2,749	—	117,964
Total current liabilities	2,444,027	730,517	(366,068)	2,808,476	2,637,985	680,372	(343,347)	2,975,010
Long-term debt, net of current installments (note 7)	776,783	—	—	776,783	868,626	—	—	868,626
Accrued compensated absences	278,910	5,402	—	284,312	—	—	—	—
Due to City of New York, net of current portion (note 8)	61,690	—	—	61,690	296,811	—	—	296,811
Long-term pension, net of current portion (note 9)	2,514,409	61,830	—	2,576,239	3,031,476	64,066	—	3,095,542
Postemployment benefits obligation, other than pension, net of current portion (note 10)	4,622,435	41,249	—	4,663,684	5,037,778	52,063	—	5,089,841
Total liabilities	10,698,254	838,998	(366,068)	11,171,184	11,872,676	796,501	(343,347)	12,325,830
Deferred Inflows of Resources								
Net differences between expected and actual experience and changes in actuarial assumptions in postemployment benefits obligation, other than pension	684,300	10,159	—	694,459	35,951	884	—	36,835
	11,382,554	849,157	(366,068)	11,865,643	11,908,627	797,385	(343,347)	12,362,665
Commitments and contingencies (note 11)								
Net position								
Net investment in capital assets	2,553,374	6,315	—	2,559,689	2,514,112	6,808	—	2,520,920
Restricted:								
For debt service	138,854	—	—	138,854	141,235	—	—	141,235
Expendable for specific operating activities	13,537	—	—	13,537	12,763	—	—	12,763
Nonexpendable permanent endowments	928	—	—	928	928	—	—	928
For statutory reserve requirements	—	347,342	—	347,342	—	134,439	—	134,439
Unrestricted	(8,284,049)	217,187	—	(8,066,862)	(8,013,449)	390,221	—	(7,623,228)
Total net deficit position	(5,577,356)	570,844	—	(5,006,512)	(5,344,411)	531,468	—	(4,812,943)
	$ 5,805,198	1,420,001	(366,068)	6,859,131	6,564,216	1,328,853	(343,347)	7,549,722

See accompanying notes to the basic financial statements.

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

Statements of Revenue, Expenses, and Changes in Net Position

Years ended June 30, 2017 and 2016

(In thousands)

	2017				2016 (As Adjusted)			
	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 (notes 4 and 11)	$ 5,611,114	—	(741,688)	4,869,426	5,812,049	—	(795,073)	5,016,976
Appropriations from City of New York, net (notes 1 and 11)	723,425	—	—	723,425	1,405,091	—	—	1,405,091
Premium revenue (note 16)	—	3,018,676	(28,864)	2,989,812	—	2,781,103	(24,958)	2,756,145
Grants revenue (notes 11, 13, and 14)	863,808	960	—	864,768	362,339	70	—	362,409
Other revenue	95,287	8,223	—	103,510	103,080	329	—	103,409
Total operating revenue	7,293,634	3,027,859	(770,552)	9,550,941	7,682,559	2,781,502	(820,031)	9,644,030
Operating expenses:								
Personal services	2,753,026	78,712	—	2,831,738	2,754,201	71,733	—	2,825,934
Other than personal services	1,842,665	2,868,589	(741,688)	3,969,566	1,753,336	2,700,031	(795,073)	3,658,294
Fringe benefits and employer payroll taxes	875,313	19,945	(28,864)	866,394	852,925	20,595	(24,958)	848,562
Pension (note 9)	426,325	10,445	—	436,770	502,374	12,052	—	514,426
Postemployment benefits, other than pension (note 10)	289,166	7,384	—	296,550	447,783	11,038	—	458,821
Affiliation contracted services	1,069,545	—	—	1,069,545	1,050,535	—	—	1,050,535
Depreciation (note 5)	310,325	2,446	—	312,771	302,530	2,397	—	304,927
Total operating expenses	7,566,365	2,987,521	(770,552)	9,783,334	7,663,684	2,817,846	(820,031)	9,661,499
Operating (loss) income	(272,731)	40,338	—	(232,393)	18,875	(36,344)	—	(17,469)
Nonoperating revenue (expenses):								
Investment (loss) income	(143)	(962)	—	(1,105)	3,335	9,054	—	12,389
Interest expense	(116,653)	—	—	(116,653)	(117,162)	—	—	(117,162)
Contributions restricted for specific operating activities	802	—	—	802	917	—	—	917
Total nonoperating (expenses) revenue, net	(115,994)	(962)	—	(116,956)	(112,910)	9,054	—	(103,856)
(Loss) income before other changes in net position	(388,725)	39,376	—	(349,349)	(94,035)	(27,290)	—	(121,325)
Other changes in net position:								
Capital contributions funded by City of New York, net	135,395	—	—	135,395	150,069	—	—	150,069
Capital contributions funded by grantors and donors	20,385	—	—	20,385	1,334	—	—	1,334
Total other changes in net position	155,780	—	—	155,780	151,403	—	—	151,403
(Decrease) increase in net position	(232,945)	39,376	—	(193,569)	57,368	(27,290)	—	30,078
Net deficit position at beginning of year	(5,344,411)	531,468	—	(4,812,943)	(5,401,779)	558,758	—	(4,843,021)
Net deficit position at end of year	$ (5,577,356)	570,844	—	(5,006,512)	(5,344,411)	531,468	—	(4,812,943)

See accompanying notes to the basic financial statements.

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

Statements of Cash Flows

Years ended June 30, 2017 and 2016

(In thousands)

	2017 Business-type Activities – HHC	2016 Business-type Activities – HHC
Cash flows from operating activities:		
Cash received from patients and third-party payors	$ 5,714,629	5,557,115
Cash appropriations received from City of New York	635,686	987,957
Receipts from grants	793,613	243,873
Other receipts	93,517	110,336
Cash paid for personal services, fringe benefits, employer payroll taxes, and OPEB	(3,688,128)	(3,741,148)
Cash paid for pension	(492,161)	(497,715)
Cash paid for other than personal services	(1,690,682)	(1,513,447)
Cash paid for affiliation contracted services	(1,073,755)	(1,048,052)
Net cash provided by operating activities	292,719	98,919
Cash flows from noncapital financing activity:		
Proceeds from contributions restricted for specific operating activities	802	917
Net cash provided by noncapital financing activity	802	917
Cash flows from capital and related financing activities:		
Purchase of capital assets	(256,611)	(256,562)
Capital contributions by grantors and donors	1,169	1,334
Capital contributions by City of New York	131,341	165,769
Cash paid for capital retainage	(1,486)	(2,134)
Payments of long-term debt	(63,506)	(58,237)
Proceeds from the issuance of long-term debt	—	55,358
Interest paid including capitalized interest	(53,286)	(50,835)
Net cash used in capital and related financing activities	(242,379)	(145,307)
Cash flows from investing activities:		
Purchases of assets restricted as to use	(1,657)	(28,037)
Proceeds from sales of assets restricted as to use	15,300	2,686
Interest received	1,244	3,480
Net cash provided by (used in) investing activities	14,887	(21,871)
Net increase (decrease) in cash and cash equivalents	66,029	(67,342)
Cash and cash equivalents at beginning of year	543,618	610,960
Cash and cash equivalents at end of year	$ 609,647	543,618
Supplemental disclosure:		
Change in fair value of assets restricted as to use	$ (2,431)	1,196
Capital lease incurred	—	7,847
Capital assets included within accounts payable and accrued expenses	29,942	—

See accompanying notes to the basic financial statements.

(Continued)

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

Statements of Cash Flows

Years ended June 30, 2017 and 2016

(In thousands)

	2017 Business-type Activities – HHC	2016 Business-type Activities – HHC (As Adjusted)
Reconciliation of operating (loss) income to net cash provided by operating activities:		
Operating (loss) income	$ (272,731)	18,875
Adjustments to reconcile operating (loss) income to net cash provided by operating activities:		
Depreciation	310,325	302,530
Provision for bad debts	579,350	482,724
Changes in assets and liabilities:		
Patient accounts receivable, net	(479,910)	(519,163)
Estimated third-party payor settlements, net	269,677	(75,003)
Estimated pools payable, net	(265,600)	(143,500)
Grants receivable	(67,967)	(118,466)
Other current assets	(13,952)	6,285
Accrued salaries, fringe benefits, payroll taxes, and compensated absences	(33,810)	471
Pension	(53,972)	11,233
Accounts payable and accrued expenses	51,994	79,117
Due to City of New York	25,796	(288,820)
Postemployment benefits obligation, other than pension	243,519	342,636
Net cash provided by operating activities	$ 292,719	98,919

See accompanying notes to the basic financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

(A Component Unit of The City of New York)

Notes to Financial Statements

June 30, 2017 and 2016

(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, on behalf of The City, comprehensive medical and mental health services to City residents regardless of 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 of one another.

The current 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. This re-alignment of the delivery of services was established to enhance and improve the efficiencies achieved under the former network model through better alignment of services.

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

The accompanying financial statements include the operations of the following component units, which are blended with the accounts of Business-type Activities - HHC:

- 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 by NYC Health + Hospitals as a public benefit corporation, of which NYC Health + Hospitals is the sole member, in 2003. The license was renewed on July 1, 2015. HHC Insurance underwrites medical malpractice insurance for NYC Health + Hospitals' attending physicians who specialize in the areas of Neurosurgery, Obstetrics, and Gynecology. HHC Insurance also provides access to the excess insurance coverage available in the New York State Excess Liability Pool.

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

insurer of last resort for medical malpractice coverage in the State and is a joint underwriting facility, not a separate legal entity. The members of MMIP are all the licensed medical malpractice carriers in New York State. As an MMIP member, HHC Insurance recognizes its allocable share of the premium, loss, underwriting expense, and administrative expense activities of MMIP.

- The HHC Physicians Purchasing Group, Inc. (HHC Purchasing), a public benefit corporation, was formed in 2003 to act as a purchasing group within the State. The business of HHC Purchasing is to obtain on behalf of its members, who are employees of NYC Health + Hospitals or NYC Health + Hospitals' affiliates, primary insurance for medical malpractice from HHC Insurance. HHC Purchasing was registered and approved for operations by the New York State Department of Insurance on August 31, 2005. NYC Health + Hospitals is the sole voting member of HHC Purchasing.
- HHC Risk Services Corporation (Risk Services), a public benefit corporation, was granted a license on December 30, 2003 to operate by the Vermont Department of Banking, Insurance, Securities, and Healthcare Administration. NYC Health + Hospitals is the sole member. Risk Services did not conduct business (no policies were issued). Risk Services ceased operations as an insurance company in November 2011 and returned the insurance license to the State of Vermont in December 2011. It has been dormant since December 2011.
- HHC ACO Inc. (HHC ACO), a New York not-for-profit corporation was formed in June 2012 by NYC Health + Hospitals as a membership entity with NYC Health + Hospitals as its sole member and 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.
- HHC Assistance Corporation (HHCAC), a membership not-for-profit corporation was formed in October 2012 by NYC Health + Hospitals, in which NYC Health + Hospitals is the sole 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 7(f)). 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 11(d)).

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

The financial statements also include MetroPlus, which is a discretely presented component unit. MetroPlus is a public benefit corporation, created by NYC Health + Hospitals, in which NYC Health + Hospitals is the sole member. 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 for the purpose of providing managed healthcare services on a prepaid basis and establishing and operating organized health maintenance and healthcare delivery systems.

MetroPlus' major lines of business include Medicaid, 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 beginning January 1, 2014 or later, through the New York State of Health Plan Marketplace (Exchange). Such plans are the result of the Patient Protection and Affordable Care Act (ACA) signed into law in March 2010. Effective January 1, 2016, the Essential Plan (EP), a new product line, became available to members through the Exchange.

MetroPlus has contractual agreements with the New York State Department of Health (NYSDOH), to provide comprehensive medical services to members of the Medicaid, EP 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 New York State 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 programs.

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

Certain primary care medical services, provided by physicians associated with NYC Health + Hospitals and certain other non-NYC Health + Hospitals physicians and provider groups, are capitated for all primary care services, which refers to reimbursement at a per member per month value based on the number of members assigned to the respective hospital's primary care physicians.

Supplementary disclosures for MetroPlus are presented beginning with note 16 of the financial statements.

MetroPlus and HHC Insurance issue separate statutory annual financial statements as of December 31, which are available through the Office of the Corporate Comptroller, 160 Water Street, Room 642, New York, New York 10038. Additionally, while not a statutory requirement, HHC ACO issues fiscal year end financial statements as of June 30, 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 statements of net position at June 30, 2017 and 2016. 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 milllion are held in perpetuity, as nonexpendable permanent endowments, at June 30, 2017 and 2016. 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 $160.2 million and $407.1 million for the years ended June 30, 2017 and 2016, 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, which promotes quality and value of health care services. 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 $579.3 million in 2017 and $482.7 million in 2016.

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, 2017 and 2016 was approximately $663.9 million and $573.1 million, respectively.

(g) Appropriations from 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 11(g)).
- Patient care rendered to prisoners (note 15), 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 negotiated annually and paid by The City on behalf of NYC Health + Hospitals. In 2017 and 2016, the medical malpractice and general liability settlements paid by The City were $112.9 million and $125.3 million, respectively. Malpractice amounts owed to The City at June 30, 2017 consist of the 2017 amount of $112.9 million plus the remaining amounts owed from 2015 of $123.4 million, of which $61.7 million is not due until after June 30, 2018 and is recorded as long term liability. NYC Health + Hospitals has agreed to reimburse The City $112.9 million for 2017, which is recorded as a current liability at June 30, 2017. During 2016, the City had assumed Fiscal Year 2016 commitments, thereby alleviating amounts owed to the City of $125.3 million. The amounts reported as long term liability for malpractice at June 30, 2016 was $123.4 million, which consisted of malpractice amounts owed from 2015. 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 11(g)).
- Debt service (interest and principal), negotiated annually, related to debt, which funded NYC Health + Hospitals capital acquisitions and paid by The City on behalf of the NYC Health + Hospitals. In 2017 and 2016, the debt service paid by The City was $145.8 million and $165.2 million, respectively. During 2017 and 2016, the City assumed Fiscal Year 2017 and 2016 commitments, respectively, thereby alleviating amounts owed to the City of $145.8 million and $165.2 million for 2017 and 2016, respectively. NYC Health + Hospitals has agreed to reimburse The City $145.8 million for 2015, which is recorded as a current liability at 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 8 of the financial statements for balances owed to The City of New York 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.

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 balance sheets as follows:

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

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

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

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

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

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

Capital assets under capital lease obligations are depreciated over either the lease term or the estimated useful life 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, 2017 and 2016.

(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 $4.8 million and $4.3 million as of June 30, 2017 and 2016, respectively. These amounts are included in other current assets and accounts payable and accrued expenses in the accompanying statements of net position. At June 30, 2017 and 2016, 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 to provide patient care services at its facilities and reimburses the affiliate for expenses incurred in providing such services. Under the terms of those contract(s), each of the affiliate(s) 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(s). In addition, the affiliate(s) submit an annual recalculation document which reconciles allowable contract costs to the expense(s) incurred by the affiliate(s). 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 affiliate's reported expenditures are also subject to subsequent audit by NYC Health + Hospitals' Internal Audit Department

The amounts due to/from the affiliates are based upon estimates of expenses, which include adjustments for patient care service modifications, and are included in accounts payable and accrued expenses (note 12) 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. MetroPlus is 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 11d, 11e, and 11f). 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* consist of capital assets net of accumulated depreciation and reduced by outstanding borrowings used to finance the purchase or construction of those assets. *Restricted for debt service* consists of assets restricted, by each revenue bonds' official statement, for expenditures of principal and interest. *Restricted expendable for specific operating activities* are 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(a). *Restricted nonexpendable permanent endowments* consist of the principal portion of permanent endowments. *Restricted for statutory reserve requirements* are MetroPlus' investments required by the NYSDOH Rules and Regulations for the protection of MetroPlus' enrollees. *Unrestricted net position* is remaining net position that does not meet the definition of *Net investment in capital assets or restricted.*

(o) Compensated Absences

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 current rate. Most employees earn sick leave at a fixed rate; however, the rate can vary depending on years of service and the contractual terms for their title. There is no accumulation limit on sick leave. Depending on length of service and contractual terms for their title, employees separating from service are paid for sick leave at varying rates. 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 2017, NYC Health + Hospitals adopted new accounting standards as follows:

GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* (GASB 75) replaces the requirements of Statements No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions,* and No. 57, *OPEB Measurements by Agent Employers and Agent Multiple-Employer Plans,* for other postemployment benefits (OPEB). GASB 75 establishes standards for recognizing and measuring liabilities, deferred outflows of resources, deferred inflows of resources, and expense/expenditures. For defined benefit OPEB, GASB 75 identifies the methods and assumptions that are required to be used to project benefit payments, discount projected benefit payments to their actuarial present value, and attribute that present value to periods of employee service. GASB 75 requires additional disclosures, which are included within note 10 to the financial statements, as well as other required supplemental information. NYC Health + Hospitals has early adopted this GASB 75 for the year ended June 30, 2017 and applied it retrospectively to all periods presented, as required by this standard.

GASB Statement No. 80, *Blending Requirements for Certain Component Units – An Amendment of GASB Statement No. 14* (GASB 80), amends the blending requirements established in paragraph 53 of Statement No. 14, *The Financial Reporting Entity*. GASB 80 adds an additional criterion which requires blending of a component unit incorporated as a not-for-profit corporation in which the primary government is the sole corporate member. NYC Health + Hospitals has adopted this standard for the year ended June 30, 2017. The adoption of GASB 80 has no impact on the financial statements or disclosures.

GASB Statement No. 82, *Pension Issues – an amendment of GASB Statements No. 67, No. 68, and No. 73* (GASB 82), addresses issues regarding (1) the presentation of payroll-related measures in required supplementary information, (2) the selection of assumptions and the treatment of deviations from the guidance in an Actuarial Standard of Practice for financial reporting purposes, and (3) the classification of payments made by employers to satisfy employee (plan member) contribution requirements. NYC Health + Hospitals has adopted GASB 82 for the year ended June 30, 2017.

Due to the adoption of GASB 75, OPEB costs and the OPEB liability for the fiscal year 2016 financial statements have been adjusted for retrospective application. The impact on the net deficit at the beginning of the year for 2016 is $220.9 million.

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Statement of Net Position	June 30, 2016 as reported Total	Adjustments	June 30, 2016 (As adjusted) Total
Liabilities:			
Postemployment benefits obligation, other than pension, net of current portion	$ 4,883,995	$ 205,846	$ 5,089,841
Deferred inflows of resources:			
Net differences between expected and actual experience and changes in actuarial assumptions in postemployment benefits obligation, other than pension,	-	36,835	36,835
Net position:			
Unrestricted	(7,380,547)	(242,681)	(7,623,228)
Total net deficit position	(4,570,262)	(242,681)	(4,812,943)
Statement of Revenues, Expenses, and Changes in Net Position			
Operating expenses:			
Postemployment benefits, other than pension	437,028	21,793	458,821
Operating income (loss)	4,324	(21,793)	(17,469)
(Loss) income before other changes in net position	(99,532)	(21,793)	(121,325)
Increase in net position	51,871	(21,793)	30,078
Net deficit position at beginning of year	(4,622,133)	(220,888)	(4,843,021)
Net deficit position at end of year	$ (4,570,262)	$ (242,681)	$ (4,812,943)

(2) Cash and Cash Equivalents

Cash and cash equivalents include cash, certificates of deposit (CD's), 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, 2017 and 2016, almost all NYC Health + Hospitals cash and cash equivalents bank balances were either insured or 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):

	2017	2016
Charges foregone, based on established rates	$ 935,743	$ 974,465
Estimated expenses incurred to provide charity care	612,614	609,688

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

Most of the 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 allows 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, 2017 and 2016 is as follows (in thousands):

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	2017		2016	
Medicaid	$ 1,479,382	26.4 %	$ 1,459,265	25.1 %
Medicare	565,659	10.1	686,878	11.8
Bad debt/charity care pools	393,647	7.0	294,925	5.1
Disproportionate share supplemental pool (DSH)	949,800	16.9	1,164,509	20.0
Other third-party payors that include Medicaid and Medicare managed care	1,440,893	25.7	1,375,793	23.7
MetroPlus	741,688	13.2	795,073	13.7
Self-pay	40,045	0.7	35,606	0.6
	$ 5,611,114	100.0 %	$ 5,812,049	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):

	2017		2016	
Medicaid	$ 70,544	12.3 %	$ 90,640	13.5 %
Medicare	45,588	8.0	67,798	10.1
Other third-party payors, that include Medicaid and Medicare managed care	201,131	35.1	228,935	34.1
MetroPlus	217,437	38.0	252,974	37.7
Self-pay	37,110	6.6	30,903	4.6
	$ 571,810	100.0 %	$ 671,250	100.0 %

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(5) Capital Assets

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

	2017	2016
Land and land improvements	$ 56,971	56,657
Buildings and leasehold improvements	4,366,964	4,313,853
Equipment	3,526,013	3,623,133
	7,949,948	7,993,643
Less accumulated depreciation	5,019,628	4,962,933
	2,930,320	3,030,710
Construction in progress	465,644	371,151
Capital assets, net	$ 3,395,964	3,401,861

Capital assets activity for the years ended June 30, 2017 and 2016 was as follows (in thousands):

	Land and land improvements	Buildings and leasehold improvements	Equipment	Construction in progress	Total
June 30, 2015 balance	$ 55,234	4,287,073	3,496,203	304,237	8,142,747
Acquisitions, net of transfers	1,498	101,599	131,682	66,914	301,693
Sales, retirements, and adjustments	(75)	(74,819)	(4,752)	—	(79,646)
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

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Related information on accumulated depreciation for the years ended June 30, 2017 and 2016 was as follows (in thousands):

	Land and land improvements	Buildings and leasehold improvements	Equipment	Total
June 30, 2015 balance	$ 26,075	2,021,182	2,663,060	4,710,317
Depreciation expense	1,545	136,281	164,704	302,530
Sales, retirements, and adjustments	(74)	(1,125)	(48,715)	(49,914)
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

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, 2017 and 2016 was as follows (in thousands):

	2017	2016
Interest costs subject to capitalization	$ 17,884	18,786
Interest income	(290)	(1,580)
Capitalized interest costs, net	$ 17,594	17,206

NYC Health + Hospitals capitalized net interest costs on TFA debt and City General Obligation Bonds in both 2017 and 2016, 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 2017 and 2016 approximated $17.0 million respectively for both years. In addition, NYC Health + Hospitals capitalized net interest costs of $0.3 million in 2017 and $1.6 million in 2016 related to its 2008 and 2010 Series bonds.

NYC Health + Hospitals' construction project at Gouverneur Healthcare Services has been mostly completed, with additions to CIP of approximately $3.6 million at June 30, 2017, and a projected $2.0 million into fiscal year 2018. Portions of this project in amounts of approximately $15.0 million were transferred out of CIP and placed into service.

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 2017 addition to CIP related to this project is $53.7 million; which is inclusive of capitalizable expenditures of $42.4 million and capitalized payroll amounts of $11.3 million. Total CIP is reported as $142.8 million and $165.0 million as of June 30, 2017 and 2016, respectively.

NYC Health + Hospitals continues the development of an Enterprise Resource Planning (ERP) system with an addition to CIP of $15.3 million in 2017. 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 approximate increase in CIP of $14.0 million for fiscal year ended June 30, 2017, with a total budget assignment of $39.6 million for completion; continued construction of a new diagnostic and treatment center on Staten Island with additions to CIP of $2.5 million for fiscal year ended June 30, 2017 and contains a budget for completion of approximately $17.0 million; and projects at multiple facilities for priority mitigation projects and major work components representing $15.0 million of additions to CIP in 2017, with an estimated costs to complete of $1,158.6 million.

(6) Assets Restricted As to Use

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

	2017	2016
Under bond resolutions (a):		
Construction funds	$ 2,990	3,725
Capital reserve funds	87,775	87,439
Revenue funds	46,630	49,270
	137,395	140,434
New Market Tax Credit (b)	198	276
By donors for specific operating activities and permanent endowments (c)	14,465	13,690
Equipment financing (d)	19,781	32,121
Total assets restricted as to use	171,839	186,521
Less current portion of assets restricted as to use	31,020	34,405
Assets restricted as to use, net of current portion	$ 140,819	152,116

(a) Assets restricted as to use under the terms of the bond resolutions (note 7) are to provide for debt service requirements and the acquisition of capital assets. Terms of the bond resolutions provide that assets be maintained in separate funds held by the trustee. The construction funds are invested in an interest-bearing negotiable order of withdrawal (NOW) account, which is fully collateralized. The capital

reserve funds are invested primarily in a ten-year U.S. Treasury note and a three-year U.S. Treasury note. Security maturity date decisions are based on the final maturity of the specific Bond series, potential need for liquidity due to refunding, and/or an assessment of the current market interest rate conditions. The majority of the revenue funds are invested in U.S. 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 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 7f).

(c) The donor-restricted funds, through March 2, 2017, were invested in certificate of deposits through the Certificate of Deposit Account Registry Service (CDARS). Thereafter, funds were transferred to an interest-bearing certificate of deposit account, and remain at June 30, 2017. The CDARS were in effect for all of fiscal year ending June 30, 2016. The CDARS are designated to satisfy the Federal Deposit Insurance Corporation (FDIC) requirements for pass-through deposit insurance coverage. At June 30, 2017, $7.0 million was invested in CD's and $7.5 million in collateralized checking accounts. At June 30, 2016, $7.0 million was invested in CD's and $6.7 million in collateralized checking accounts.

(d) The equipment financing escrow funds are mostly invested in United States Treasury Money Market Fund accounts (note 7(g)(h) and (i)).

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 2017.

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, 2017 and 2016 (in thousands):

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

			June 30, 2016	
		Fair value	Level 1	Level 2
U.S. government obligations and securities	$	139,270	12,629	126,641

Included within assets restricted as to use are CD's of approximately $11.3 million for both 2017 and 2016, and cash and cash equivalents of $28.1 million and $29.0 million for 2017 and 2016, respectively.

NYC Health + Hospitals does not have any assets or liabilities based upon Level 3 inputs.

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(7) Long-Term Debt

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

		2017	2016
Bonds payable:			
2013 Series A Fixed Rate Health System Bonds – weighted average interest of 2.44%, payable in installments to 2023:			
Uninsured Bonds (a)	$	121,847	124,941
2010 Series A Fixed Rate Health System Bonds – weighted average interest of 3.89%, payable in installments to 2030:			
Uninsured Bonds (b)		392,440	433,725
2008 Series A Fixed Rate Health System Bonds – weighted average interest of 4.51%, payable in installments to 2026:			
Uninsured Bonds (c)		92,842	101,006
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)		149,810	154,670
Total bonds payable		756,939	814,342
Clinical bed financing		—	80
Henry J. Carter capital lease obligation (e)		27,217	48,254
New Market Tax Credit (f)		14,700	14,700
JP Morgan Equipment Financing (g)		10,000	10,000
Revolving Loan (Citibank) (h)		10,000	10,000
Key Bank CISCO Leases (i)		21,260	28,216
Oracle ERP Financing (j)		3,923	6,540
Total long-term debt		844,039	932,132
Less current installments		67,256	63,506
Total long-term debt, net of current installments	$	776,783	868,626

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Long-term debt activity for the years ended June 30, 2017 and 2016 was as follows (in thousands):

	June 30, 2016 balance	Additions	Reductions	June 30, 2017 balance	Amounts 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

	June 30, 2015 balance	Additions	Reductions	June 30, 2016 balance	Amounts due within 1 year
Long-term debt:					
Bonds payable	$ 870,466	—	(56,124)	814,342	51,195
NYPA financing	217	—	(217)	—	
Equipment and renovation financing	135	63,205	(8,584)	54,756	9,568
Clinical bed financing	518	—	(438)	80	80
Henry J. Carter capital lease obligation	48,254	—	—	48,254	2,663
New Market Tax Credit	14,700	—	—	14,700	—
	$ 934,290	63,205	(65,363)	932,132	63,506

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, 2017 (in thousands):

		Principal	Interest	Total
Years:				
2018	$	675	5,244	5,919
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
2023–2024		37,850	1,145	38,995
Total		110,715	24,250	134,965
Unamortized premium on 2013 Bonds		11,132	—	11,132
	$	121,847	24,250	146,097

(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, 2017 (in thousands):

	Principal	Interest	Total
Years:			
2018	$ 39,616	18,042	57,658
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
2023–2027	116,770	45,153	161,923
2028–2031	114,514	9,407	123,921
Total	380,480	127,016	507,496
Unamortized premium on 2010 Bonds	11,960	—	11,960
	$ 392,440	127,016	519,456

(c) 2008 Series A Bonds

During 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 7(a)).

(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, 2017.

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 1.35% for 2017 and 0.80% for 2016.

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, 2017 (in thousands). The interest payments are based on the interest rate in effect at June 30, 2017:

	Principal	Interest	Total
Years:			
2018	$ 13,255	4,725	17,980
2019	13,720	4,321	18,041
2020	14,300	3,833	18,133
2021	14,950	3,318	18,268
2022	15,575	2,775	18,350
2023–2027	102,945	5,320	108,265
2028–2032	67,284	59	67,343
Total	242,029	24,351	266,380
Unamortized premium on 2008 Bonds	623	—	623
	$ 242,652	24,351	267,003

(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 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, 2017 (in thousands):

		Principal	Interest	Total
Years:				
2018	$	4,075	1,880	5,955
2019		3,232	1,584	4,816
2020		1,816	626	2,442
2021		1,877	565	2,442
2022		1,939	503	2,442
2023–2027		10,708	1,502	12,210
2028–2030		3,570	93	3,663
Total	$	27,217	6,753	33,970

(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, 2017 (in thousands):

		Principal	Interest	Total
Years:				
2018	$	—	179	179
2019		—	179	179
2020		324	181	505
2021		561	172	733
2022		568	165	733
2023–2027		2,947	719	3,666
2028–2032		3,131	534	3,665
2033–2037		3,328	338	3,666
2038–2042		3,536	129	3,665
2043–2044		305	1	306
Total	$	14,700	2,597	17,297

(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. Interest paid towards this agreement for fiscal year 2017 and 2016 was $128,073 and $99,774, respectively. The overall weighted average interest rate was 1.2807% and 1.0204% for the years ended June 30, 2017 and 2016, respectively.

(h) 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; of which is October 12, 2018. Debt for this equipment is secured by the equipment financed.

On October 14, 2015, NYC Health + Hospitals initiated a draw-down of $10.0 million at the initial interest rate of 0.77%. At both June 30, 2017 and 2016, NYC Health + Hospitals' outstanding revolving loan is $10.0 million, with a weekly variable interest rate of 1.66% and 1.18% as of June 30, 2017 and June 30, 2016, respectively. Interest paid for fiscal years 2017 and 2016 respectively is $142,373 and $66,381 with an average variable rate of 1.2014% and 0.8989%.

(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 noninterest 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. 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, 2017 (in thousands):

		Principal	Interest	Total
Years:				
2018	$	9,636	204	9,840
2019		18,394	138	18,532
2020		7,153	70	7,223
2021		—	—	—
2022		—	—	—
2023		10,000	—	10,000
Total	$	45,183	412	45,595

(8) Due to The City of New York

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

		2017	2016
FDNY EMS operations (a)	$	183,691	209,850
Medical malpractice payable (b)		236,320	123,380
Other accrued expenses (c)		51,363	25,892
Debt service (d)		145,780	145,780
	$	617,154	504,902

(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)) of which, $61.7 million is not due to The City until after June 30, 2018 and is recorded as long term liablity.

(c) Payable mainly represent 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)).

(9) Pension Plan

NYC Health + Hospitals participates in the New York City Employees Retirement System (NYCERS) Qualified Pension Plan, which is a cost-sharing, multiple-employer public employees' retirement system. NYCERS provides defined-pension benefits to 184,800 active municipal employees and 142,100 pensioners through $63.05 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, 2017 and 2016 are approximately $2.178 billion and $2.232 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.

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

NYCERS provides three main types of retirement benefits: service retirements, ordinary disability retirements (nonjob-related disabilities), and accident disability retirements (job-related disabilities) to members who are in different "Tiers." The members' Tier is determined by the date of membership. Subject to certain conditions, members generally become fully vested as to benefits upon the completion of 5 years of service. Employees may be required to contribute a percentage of their salary to the pension plan based on their Tier, determined by their date of membership in the plan. Annual pension benefits can be calculated as a percentage of final average salary 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. They may range between 0.00% and 7.46% of their annual pay. Statutorily required contributions (Statutory Contributions) to NYCERS, determined by the New York City Office of the Actuary in accordance with State statutes and City laws, are funded by the Employer within the appropriate fiscal year.

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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, 2017 and 2016, NYC Health + Hospitals reported a liability of $3.071 billion and $3.593 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, 2015 and June 30, 2014, and rolled forward to each respective fiscal year. 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 2017 and 2016, which was 14.788% and 14.789%, respectively. NYC Health + Hospitals made contributions of $492.2 million and $497.7 million for 2017 and 2016, respectively.

(a) Actuarial Assumptions

The total pension liability in the June 30, 2015 actuarial valuation was determined using the following actuarial assumptions:

Inflation	2.5%
Salary increases	In general, merit and promotion increases plus assumed general wage increase of 3.0% per annum.
Investment rate of return	7.0%, net of pension plan investment expense. Actual return for variable funds.
Cost of living adjustment	1.5% and 2.5% for various Tiers.

Mortality rates and methods used in determination of the total pension liability were adopted by the 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 web site (www.nyc.gov/actuary) under Pension information.

(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 Real Rates of Return for each major asset class are summarized in the following table:

Asset class	Target asset allocation	Arithmetic RROR by asset class	Portfolio component arithmetic RROR
U.S. public market equities	29.00 %	5.70 %	1.65 %
International public market equities	13.00	6.10	0.79
Emerging public market equities	7.00	7.60	0.53
Private market equities	7.00	8.10	0.57
Fixed invoice (Core, TIPS, High Yield, Opportunistic, convertibles)	33.00	3.00	0.99
Alternatives (real assets, hedge funds)	11.00	4.70	0.52
Portfolio long-term average arithmetic RROR	100.00 %		5.05 %

(c) Discount Rate

The discount rate used to measure the total pension liability as of June 30, 2017 and 2016, 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	$ 4.438	3.071	1.870

(d) Deferred Inflows and Outflows of Resources

The following are components of deferred inflows and (outflows) at June 30, 2017 and 2016 (in thousands):

	2017	2016
Differences between projected and actual earnings on pension plan investments	$ 123,196	(207,238)
Differences between expected and actual experience	81,939	101,993
Changes in Assumptions	(151,384)	(265,225)
Differences between employer contributions and proportionate share of contributions	(67,884)	(121,176)
	$ (14,133)	(491,646)

The deferred inflows and (outflows) of resources at June 30, 2017 will be recognized in expense as follows (in thousands):

	Amount
Year ended June 30:	
2018	$ 34,701
2019	99,761
2020	(20,084)
2021	(96,447)
2022	(3,798)
	$ 14,133

(e) Annual Pension Expense

NYC Health + Hospitals' annual pension expense for fiscal years ending 2017 and 2016, which includes contributions toward the actuarially determined accrued liability, including the information for MetroPlus, were approximately $436.8 million and $514.4 million, respectively.

(10) 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, 2016, the following employees were covered by the benefit terms:

Employees covered by benefit terms:	
Active	32,324
Inactive	3,910
Term Vested / Deferred	1,633
Retirees	21,140
Total	59,007

Contributions. NYC Health + Hospitals funds the postretirement benefits program on a pay-as-you go basis and as such there are no dedicated assets for the program. In 2017 and 2016, NYC Health + Hospitals' contributions were $56.1 million and $96.0 million, respectively. For the years ended June 30, 2017 and 2016, the NYC Health + Hospital's average contribution rate was 2.46 percent and 4.42 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, 2017 and 2016 of $4.791 billion and $5.208 billion, respectively, were determined by actuarial valuations as of June 30, 2016 and June 30, 2015, respectively.

(a) Actuarial Assumptions

The total OPEB liability in the June 30, 2016 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	7.84 percent for 2017, decreasing 0.5 percent per year to an ultimate rate of 5.0 percent for 2023 and later years
Medicare Plans	2.51 percent for 2017, increasing to an ultimate 5.0 percent for 2023 and later years
Welfare Fund Contributions	0.0 percent for 2017 and 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 website (www.nyc.gov/actuary).

(b) Changes in the Total OPEB Liability

		2017 Activity Total OPEB Liability	2016 Activity Total OPEB Liability
Balances at End of Prior Fiscal Year	$	**5,207,805**	**4,881,819**
Changes for the year:			
Service Cost		274,749	326,174
Interest		147,667	139,260
Difference between expected and actual experience		(122,396)	(43,448)
Change in assumptions		(661,094)	-
Actual benefit payments		(56,087)	(96,000)
Net changes	$	(417,161)	325,986
Balances at June 30, 2017 and 2016, respectively	$	**4,790,644**	**5,207,805**

(c) Discount Rate

The discount rate used to measure the total OPEB liability as of June 30, 2017 and 2016 was 3.13% and 2.71%, 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 3.13%, 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 (2.13%) or 1-percentage-point higher (4.13%) than the current rate (in billions):

		1% Decrease (2.13%)	Discount rate (3.13%)	1% Increase (4.13%)
NYC Health + Hospitals' total OPEB liability	$	5.583	4.791	4.163

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 (6.84% decreasing to 4.0%)	Healthcare Cost Trend Rates (7.84% decreasing to 5.0%)	1% Increase (8.84% decreasing to 6.0%)
NYC Health + Hospitals' total OPEB liability	$ 4.005	4.791	5.890

(d) Deferred Inflows of Resources

At June 30, 2017 and 2016, NYC Health + Hospitals reported $694.5 million and $36.8 million, respectively, as deferred inflows of resources mainly from the accumulated difference between expected and actual experience, and recognition of changes in assumptions. The deferred inflows of resources at June 30, 2017 will be recognized in expense.

The following are components of deferred inflows at June 30, 2017 and 2016 (in thousands):

	2017	2016
Differences between expected and actual experience	$ 133,988	36,835
Changes in Assumptions	560,471	-
	$ 694,459	36,835

The deferred inflows of resources at June 30, 2017 will be recognized in expense as follows (in thousands):

	Amount
Year ended June 30:	
2018	$ 125,866
2019	125,866
2020	125,866
2021	125,866
2022	123,022
Thereafter	67,974
	$ 694,460

(e) Annual OPEB Expense

NYC Health + Hospitals' annual OPEB expense for fiscal years ended 2017 and 2016, including the information for MetroPlus, were $296.6 million and $458.8 million, respectively.

(11) 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, the costs related to treating a disproportionate share of indigent patients, and some physician services are reimbursed on a cost basis. Due to these adjustments and other factors, final determination of the reimbursement settlement for a given year is not known until Medicare performs its annual audit. The earliest fiscal year for open Medicare cost report audit and final settlement for NYC Health + Hospitals facilities ranges from 2010 to 2016.

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, 2017.

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 nongovernmental 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 noncomparable costs are paid as flat-rate per discharge add-ons to the DRG rate. Certain psychiatric, rehabilitation, long-term acute care, and other services are excluded from this methodology and are reimbursed on the basis of per diem rates. 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 Alternate Payment Rate, which is related to the Medicaid rate. In addition, the State pays hospitals directly for graduate medical education costs associated with Medicaid HMO patients. NYC Health + Hospital's 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 provided for 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, i.e., fines, penalties, and possible exclusion from Medicaid and Medicare, in the event of noncompliance. In accordance with recent trends in healthcare financial operations, NYC Health + Hospitals has established a Corporate Compliance Committee and appointed 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 Medidare 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)

CMS enacted the RAC program in 2012, which primarily reviews medical necessity of inpatient admissions and hospital coding practices. CMS general policy, known as the "Two-Midnight" rule focuses on hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient, CMS' guidelines provide for "reasonable and necessary" is used to identify possible improper 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, during which time NYC Health and Hospitals RAC activity was minimal. Since the suspension has been lifted and CMS has resumed RAC audit activities, NYC Health and Hospitals has received RAC denials in June 2017; however, was rescinded in July 2017. NYC Health + Hospitals has estimated a liability for RAC audits.

(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. Provision has been made in the accompanying financial statements for any audit findings through SPRY 2013 of $37.2 million and is recorded as an estimated third-party payor settlement liability. This overpayment in the SPRY 2013 review was related to a change in the methodology related to UPL payments that had occurred after the DSH payments had already been made for that year. The SPRY 2014 audit is currently in progress, and based upon audit methodologies and calculations, no further adjustments are anticipated for SPRY's 2014 through 2017.

(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 2025.

(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 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 2016, OneCity Health filed two progress reports on milestones and performance measures with the NYSDOH. Review of these quarterly reports by the Independent Assessor assigned a value for each submission. OneCity Health was assigned distributions of $73.9 million related to fiscal year ended June 30, 2016, which is reported as grants receivable and grants revenue based on meeting the applicable eligibility requirements.

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 eligility requirements for DSRIP. In addition, NYC Health + Hospitals made a payment to 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, $214.1 million, was

recorded as grant revenue for the fiscal year ended June 30, 2017, based on meeting the applicable eligibility requirements.

(e) Value Based Quality Inprovement 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 facilties 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 final 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.

Agreements between NYC Health + Hospitals and NYSDOH and The City and NYSDOH related to IGT funding were executed in January 2017. In 2017, NYC Health + Hospitals recorded approximately $240.0 million related to meeting the eligibility requirements in accordance with the reporting and performance metrics by NYSDOH for years 1 and 2 as grants revenue for the year ended June 30, 2017.

(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 via HARP and Managed Long Term Care (MLTC). Under CREPs, selected public hospitals will assess HCBS needs and gaps for the HARP population, and to develop workforce training initiatives for both HCBS and MLTC. NYC Health + Hospitals has been awarded $400 million over four years beginning in April 2016.

CREPs program funds are paid to participating facilities for completion of program metrics and deliverables. NYC Health + Hospitals reports all activities within the CREP program guidelines to Fidelis Care; NYC Health + Hospitals' paired Managed Care Organization (MCO). The responsibilities of NYC Health + Hospitals throughout the duration of this waiver program is to contract with its' paired MCO, adhere to contractual and programmatic requirements, and to provide timely accurate reports to the MCO demonstrating the achievements of the program deliverables and metrics. For its part, the MCO establishes the deliverables, reports, scorecards and other requirements, oversees program implementation and reviews the expected deliverables based on contract requirements, and distributes CREPs funds upon successful determination of the predefined metrics.

CREP program funds are derived from lump sum payments made by the NYSDOH to the participating MCO after an appropriate IGT transaction has occurred. After remitting the required IGT payment and receiving CREP funds from the paired MCO, NYC Health + Hospitals recorded net CREP funds of $163.0 million as grants revenue for the year ended June 30, 2017 for meeting certain metrics.

(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 $112.9 million for 2017 and $125.3 million for 2016. NYC Health + Hospitals has agreed to reimburse The City $112.9 million for 2017, which is recorded as a current liability within amounts due to The City. During 2016, The City had assumed Fiscal Year 2016 commitments, thereby alleviating amounts owed to The City of $125.3 million. 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 8(b)). 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 $40.7 million in 2017 and $38.7 million in 2016 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, 2017 (in thousands):

	Amount
Years:	
2018	$ 23,368
2019	21,974
2020	18,249
2021	17,014
2022	15,930
2023–2027	55,595
Total minimum payments required	$ 152,130

(12) Accounts Payable and Accrued Expenses

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

	2017	2016
Vendors payable	$ 437,219	353,047
Per diem nurses payable	47,866	58,090
Accrued interest	11,156	12,136
Affiliations payable	46,377	33,486
Affiliations vacation accrual	33,282	35,880
Pollution remediation liability	11,530	11,039
Other	4,791	13,890
	$ 592,221	517,568

(13) Super Storm Sandy

NYC Health + Hospitals, through the Federal Emergency Management Agency (FEMA), had applied for public assistance to cover the costs of repairs and replacements of facilities to pre-storm conditions and to make improvements to meet codes and standards. For years ended June 30, 2017 and June 30, 2016, NYC Health + Hospitals received $17.5 million and $18.3 million, respectively; and recognized grant revenues for $23.7 million and $20.1 million, respectively, related to FEMA Sandy related expenditures.

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

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). These provisions were designed to increase the use of Electronic Health Record (EHR) 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, 2017 and 2016, NYC Health + Hospitals recognized revenue of approximately $4.5 million and $23.7 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.

(15) Correctional Health Services

On August 9, 2015, NYC Health + Hospitals, via an MOU with The City of New York, 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 of New York was $199.3 million and an additional $56.0 million was funded through grants and intra-city agreements for a total funding for the year ended June 30, 2017 of $255.3 million. For the year ended June 30, 2016, $164.9 million expenses were funded through appropriations by the City of New York with an additional $42.4 million funded through grants and intra-city agreements for a total funding of $207.3 million.

(16) MetroPlus

(a) Cash and Cash Equivalents

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

(b) U.S. Government Securities

U.S. government securities consist of U.S. Treasury bills, U.S. Treasury notes, and U.S. Treasury zero-coupon strips . Such securities are stated at fair value 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 in the balance sheets. Securities presented as noncurrent assets mature after a year.

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

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

Year	Investment type	Fair value	Investment maturing in (years) Less than 1	1 to 3
2017	U.S. Treasury bills, notes, bonds, and strips	$ 423,590	89,832	333,758
2016	U.S. Treasury bills, notes, bonds, and strips	405,906	76,859	329,047

(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 Special Needs Plan (HIV-SNP) premiums are based upon several factors, including age, aid category, and health status of the enrollee; and plan premium rates are risk-adjusted to reflect historical experience. In addition, Medicaid makes one-time maternity and newborn supplemental payments for the delivery of each child born to a member of MetroPlus. Medicaid, CHP, and HIV-SNP premium revenue received from the NYSDOH represents a substantial portion of MetroPlus' premium revenue, and is subject to audit and adjustment by the NYSDOH.

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. A CSR deposit liability of $0.1 million at June 30, 2017 and $17.0 million at June 30, 2016 is included in accounts payable and accrued expenses. 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. MetroPlus reimbursed CMS for CSR overpayment of $17.0 million during fiscal year 2017. There was no reimbursement in fiscal year 2016.

MetroPlus established an Essential Plan (or EP) effective on January 1, 2016 under Health Care Reform, which is certified by the New York State Health Insurance Marketplace. The Essential Plan covers essential health benefits, including inpatient and outpatient care, physician services, diagnostic services and prescription drugs among others, with no annual deductible and low out-of-pocket costs. Preventive care, such as routine office visits and recommended screenings are free. Plan members with income at or below 150 percent of the federal poverty level do not pay any monthly premium. Plan members with income at 200 percent of the federal poverty level pay a monthly premium of $20. The Essential Plan is administered under an agreement between MetroPlus and NYSDOH and extends through December 31, 2020.

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

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, 2017 and 2016 was as follows:

	2017	2016
Medicaid	63 %	73 %
Essential Plan	12	4
HIV-SNP	8	8
HARP	8	5
Medicare	4	4
MLTC	2	2
Other *	3	4
	100 %	100 %

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

Medicaid, EP, HARP, HIV-SNP, Medicare, MLTC, CHP, and Fully Integrated Duals Advantage (FIDA) plan premiums revenue earned from the State of New York amounted to $2.917 billion in 2017 and $2.697 billion in 2016, representing a substantial portion of MetroPlus's revenues. These premiums are

subject to audit and adjustments by the NYSDOH and the NYSDFS. Premiums receivable from the State of New York were $210.1 million and $142.2 million at June 30, 2017 and 2016, respectively.

(d) Assets Restricted As to Use

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

		2017	2016
MetroPlus statutory reserve investments	$	143,342	134,439

NYSDOH 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 MetroPlus enrollees, and that this balance be maintained at the greater of 5% of the healthcare services expenditures, as defined, and projected for the following calendar year; or $0.1 million. The statutory reserve is calculated in accordance with the regulations.

The statutory reserve account of $143.3 million and $134.4 million at June 30, 2017 and 2016, 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 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, 2017 and 2016 was $347.3 million and $317.2 million, respectively.

(e) Change in Claims Payable

Accounts payable and accrued expenses include MetroPlus claims payable of $594.2 million and $535.5 million at June 30, 2017 and 2016, 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):

		2017	2016
Balance, July 1	$	535,471	504,533
Less drug rebates receivable		(20,387)	(18,885)
Net balance		515,084	485,648
Incurred related to:			
Current year		2,756,755	2,603,715
Prior years		19,106	21,489
Total incurred		2,775,861	2,625,204
Paid related to:			
Current year		2,237,585	2,102,546
Prior years		478,574	493,222
Total paid		2,716,159	2,595,768
Net balance at June 30		574,786	515,084
Plus drug rebates receivable		19,404	20,387
Balance, June 30	$	594,190	535,471

Net reserves for unpaid claims and claim adjustment expenses attributable to insured claims of prior years' increased by $19.1 million in 2017 and $21.5 million in 2016. 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 shifts all medical risk from MetroPlus to NYC Health + Hospitals, for most Medicaid, CHP, SNP, HARP, EP, and MetroPlus Gold, for 85% in EP and 88% in Medicaid, CHP, SNP, HARP, and MetroPlus Gold in risk year 2017 of the premium collected for those members. In 2016, the risk sharing agreement with NYC Health + Hospitals was at 89%. NYC Health + Hospitals is also entitled to 100% of the onetime maternity and newborn supplemental payments for those members. After the end of the calendar year risk period, both parties settle the net amount remaining after payment of all capitated and fee-for-service medical expenses 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 $ 143.8 million and $180.8 million at June 30, 2017 and 2016, respectively, pursuant to the agreement. NYC Health + Hospitals has reported a corresponding receivable at June 30, 2017 and 2016, respectively. Amounts are included in eliminations in the Statements of Net Position.

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

MetroPlus is required to participate in the three risk spreading programs under the ACA: permanent risk adjustment, temporary reinsurance, and temporary risk corridors. The risk adjustment program spreads risk of adverse selection among all QHP plans within the same state; the reinsurance program protects MetroPlus from unexpectedly high medical costs on individual QHP members; and under the risk corridors program, MetroPlus shares risks, associated with uncertainty in pricing during the initial years of the ACA implementation, with HHS. The temporary reinsurance and risk corridor programs were effective for MetroPlus calendar years 2014 through 2016. At June 30, 2017 and 2016, MetroPlus estimated a risk adjustment liability of $40.0 million and $47.6 million, respectively, which is included in accounts payable and accrued expenses. The 2016 calender benefit year estimate was settled in August of 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 and $250 in any one calendar year. Over $250, the coverage is increased to 100% of the cost over $250. Effective January 1, 2016, hospital inpatient expenses shall 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 Alcholism and Substance Abuse (OASAS) certified 14 NYCRR Part 818 Chemical Dependence Inpatient Rehabilitation and Treatment programs for all enrollees.
- Psychiatric and alcohol and substance abuse inpatient stays are covered for members who exceed 30 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 and $300 in any one calendar year. Over $300, the coverage is increased to 100% of the cost over $300. Effective January 1, 2016, hospital inpatient expenses shall 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 a 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 will reimburse MetroPlus 100% of payments for days in excess of a combined total of 30 days. For episodes of inpatient psychiatric care commencing on or after January 1, 2016, the State will reimburse MetroPlus for 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 a reinsurance company for stop-loss coverage for its CHP, MetroPlus Gold, and Medicare lines of business. The coverage has a per member threshold of $250 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 are reported within other than personal services expense. Premiums for the reinsurance coverage provided by the reinsurance company are reimbursed by NYC Health + Hospitals, for lines under the risk sharing agreement with NYC Health + Hospitals, and related recoveries on paid losses are passed through to NYC Health + Hospitals pursuant to the risk sharing agreement. Reinsurance recoverable, mainly from the State of New York, was $24.8 million and $25.8 million at fiscal year end June 30, 2017 and 2016, respectively.

MetroPlus has two years from the close of the benefit year to file a claim for all stop-loss coverages.

(i) Value Based Payment Quality Improvement Program (VBP QIP)

MetroPlus and NYC Health + Hospitals were selected to participate as part of VBP QIP administered by the NYSDOH. MetroPlus received $138.3 million through premium per member per month rate increases, inclusive of an administrative fee and surplus (5% and 1%, respectively) in March 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 $8.0 million for fiscal year ended June 30, 2017.

(j) Due to State of New York

The State of New York has advised MetroPlus of instances where MetroPlus will need to return premium payments to the State as a result of State audits and adjustments of its payments to MetroPlus based on subsequent membership adjustments. Management's estimate of such amounts, included in due to the State of New York and reported within vendors payable, is $22.0 million and $16.6 million at

June 30, 2016 and 2015, 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 the QHP, Medicare and Essential Plan meet specified minimums for fiscal year ended June 30, 2017 of 82%, 85%, and 85% respectively. The MLR represents the percentage of premium dollars spent on healthcare claims and quality improvement activities. No MLR liability was required at June 30, 2017 or 2016.

(l) Operating Leases

MetroPlus leases equipment and office space under various operating leases. Total rental expense for operating leases was approximately $11.4 million in 2017 and $10.0 million in 2016 and included in other than personal services in the accompanying financial statements.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)
Notes to Financial Statements
June 30, 2017 and 2016

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, 2017 (in thousands):

		Amount
Years:		
2018	$	3,977
2019		4,058
2020		3,670
2021		3,638
2022		3,362
2023–2027		5,079
Total minimum payments required	$	23,784

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

Schedule of NYC Health + Hospitals' Contributions
NYCERS Pension Plan

(Unaudited)

June 30, 2017, 2016, 2015, and 2014

(Dollar amounts in thousands)

		2017	2016	2015	2014
Contractually required contribution	$	492,161	497,715	443,386	435,678
Contributions in relation to the contractually required contribution		492,161	497,715	443,386	435,678
Contribution deficiency (excess)	$	—	—	—	—
HHC covered payroll	$	2,177,897	2,232,187	2,166,797	2,081,328
Contributions as a percentage of covered payroll		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 + Hospitals' Proportionate Share of the Net Pension Liability
NYCERS Pension Plan

(Unaudited)

June 30, 2017, 2016, 2015, and 2014

(Dollar amounts in thousands)

	2017	2016	2015	2014
HHC proportion of the net pension liability	14.788 %	14.789 %	14.030 %	13.991 %
HHC proportionate share of the net pension liability	$ 3,070,928	3,593,257	2,832,753	2,521,076
HHC covered payroll	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	141.00%	160.97 %	130.73 %	121.13 %
Plan fiduciary net position as a percentage of the total pension liability	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 + Hospitals' Changes in Total OPEB Liability and Related Ratios

(Unaudited)

June 30, 2017, and 2016

(Dollar amounts in thousands)

		2017	2016
Total OPEB Liability			
Service cost	$	274,749	326,174
Interest		147,667	139,260
Differences between expected and actual experience		(122,396)	(43,448)
Changes of assumptions		(661,094)	—
Benefit payments		(56,087)	(96,000)
Net Change in total OPEB liability		(417,161)	325,986
Total OPEB liability - beginning		5,207,805	4,881,819
Total OPEB liability - ending		4,790,644	5,207,805
Covered Employee Payroll	$	2,283,056	2,171,336
Total OPEB Liability as a Percentage of Covered Employee Payroll		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:

		3.13%	2.71%

See accompanying notes to the basic financial statements.

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

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

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities and the discretely presented component unit of New York City Health and Hospitals Corporation (NYC Health + Hospitals), a component unit of The City of New York, as of and for the years ended June 30, 2017 , 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 __, 2017. Our report included an emphasis of matter paragraph regarding NYC Health + Hospitals' implementation of GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*.

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 determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of NYC Health + Hospitals' 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 combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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

Compliance and Other Matters

As part of obtaining reasonable assurance about whether 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*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of 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 communication is not suitable for any other purpose.

(signed) KPMG LLP

October __, 2017