AGENDA

FINANCE COMMITTEE

MEETING DATE: APRIL 14, 2015
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER — BERNARD ROSEN

ADOPTION OF THE MARCH 10, 2015 MINUTES

SENIOR VICE PRESIDENT'S REPORTS — MARLENE ZURACK

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS — KRISTA OLSON/FRED COVINO

ACTION ITEM — MARLENE ZURACK/LINDA DEHART

AUTHORIZING AND APPROVING THE ADOPTION OF THE RESOLUTION PROVIDING FOR THE FINANCING OF EQUIPMENT IN AN AGGREGATED OUTSTANDING PRINCIPAL AMOUNT NOT TO EXCEED $60,000,000 FROM TIME TO TIME FOR THE PURPOSE OF FINANCING EQUIPMENT, VARIOUS RELATED CAPITAL PROJECTS AND EXPENDITURES AT HHC FACILITIES.

OLD BUSINESS
NEW BUSINESS
ADJOURNMENT — BERNARD ROSEN

MINUTES

MEETING DATE: MARCH 10, 2015

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on March 10, 2015 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Bernard Rosen
Ramanathan Raju, MD
Josephine Bolus, RN
Mark Page
Patsy Yang, (Representing Deputy Mayor Lilliam Barrios-Paoli in a voting capacity)

OTHER ATTENDEES

J. Cassidy, Analyst, NYC OMB
K. Cherny, Unit Head, NYC OMB
T. DeDubio, Analyst, OMB
M. Dolan, Senior Assistant Director, DC 37
R. McIntyre, Account Executive, Cerner
K. Raffaele, Analyst, OMB
J. Wessler

HHC STAFF

M. Brito, CFO, Coler/Hank Carter Hospital & Nursing Facility
M. Beverley, Assistant Vice President, Corporate Finance/Managed Care
M. Beverly, Assistant Vice President, Corporate Managed Care/Finance
L. Brown, Senior Vice President, Corporate Planning, Community Health & Intergovernmental Rel
T. Carlisle, Associate Executive Director, Corporate Planning
D. Cates, Chief of Staff, Board Affairs

D. Collington, Assistant Director, Coney Island Hospital
E. Cosme, CFO, Gouverneur Specialty Care Facility
F. Covino, Corporate Budget Director, Corporate Budget
J. Cuda, CFO, MetroPlus Health Plan, Inc.
L. Dehart, Assistant Vice President, Corporate Reimbursement Services
N. Doyle, Senior Assistant Vice President, Corporate Human Resources
R. Fischer, Associate Executive Director, Bellevue Hospital Center
V. Fleming, Director, Corporate Office of Medical Affairs
L. Free, Assistant Vice President, Corporate Managed Care
K. Garramone, CFO, North Bronx Health Care Network
M. Genee, Deputy Corporate Comptroller, Corporate Comptroller's Office
T. Green, CFO, Metropolitan Hospital Center
G. Guilford, Assistant Vice President, Office of the Senior Vice President/Finance/Managed Care
J. John, Corporate Comptroller, Corporate Comptroller's Office
L. Johnston, Senior Assistant Vice President, Medical & Professional Affairs
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
P. Lockhart, Secretary to the Corporation, Office of the Chairman
N. Mar, Director, Corporate Reimbursement Services/Debt Financing
A. Marengo, Senior Vice President, Corporate Marketing/Communications
R. Mark, Chief of Staff, Office of the President
A. Martin, Executive Vice President/COO, Office of the President
M. Novzen, Senior Associate Director, North Brooklyn Health Network
K. Olson, Assistant Vice President, Corporate Budget
P. Pandolfini, CFO, Southern Brooklyn/Staten Island Health Network
C. Parjohn, Director, Office of Internal Audits
K. Park, Associate Executive Director, Queens Health Network
S. Ritzel, Associate Director, Kings County Hospital Center
S. Russo, Senior Vice President/General Counsel, Office of Legal Affairs
L. Sainbert, Assistant Director, Office of the Chairman
A. Saul, Deputy CFO, Central Brooklyn Health Network
C. Samms, CFO, Generations Plus/Northern Manhattan Network
W. Sanders, Assistant Vice President, Corporate Intergovernmental Relations
P. Slesarchik, Assistant Vice President, Labor Relations
B. Stacey, Chief Financial Officer, Queens Health Network
L. Villalon, Deputy CFO, Coler Specialty/Nursing Facility
J. Wale, Senior Assistant Vice President, Office of Behavioral Health
J. Weinman, CFO, South Manhattan Network
M. Williams, Senior Assistant Vice President, EEO/Affirmative Action
R. Wilson, Senior Vice President/CMO, Medical & Professional Affairs
M. Zurack, Senior Vice President/CFO, Corporate Finance

CALL TO ORDER **BERNARD ROSEN**

The meeting of the Finance Committee was called to order at 9:10 a.m. The minutes of the February 10, 2015 were approved as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

SENIOR VICE PRESIDENT'S REPORT **MARLENE ZURACK**

Ms. Zurack informed the Committee that Julian John, who was the CFO for the Central Brooklyn Health Network had been appointed to replace Jay Weinman, Corporate Comptroller. Mr. John has worked for HHC for fifteen years. Prior to coming to HHC he worked at Kingsbrook Jewish Medical Center and has worked primarily in hospital accounting. Additionally, Elsa Cosme was appointed CFO of Gouverneur Healthcare Services. Ms. Cosme comes from the voluntary sector and has experience in healthcare finance.

Ms. Zurack informed the Committee that HHC had received a grant funded by the United Hospital Fund (UHF) for a project that was put together by HHC at the request of Patsy Yang, of the Deputy Mayor's Office. The project is funded at $144,000 to support research on utilization as well as focus groups with patients to determine if HHC should do something to change its HHC Options program to make it more aligned with healthcare reform to better meet the needs of its patients for better care coordination. The current Options program is based on a fee-scaling process consistent with fee-for-service reimbursement. HHC will work with CUNY who were named in the grant and will do the research on behalf of HHC. The next item in the reporting, HHC's cash on hand (COH) was at 19 days as of March 6, 2015 and is projected to increase to 36 days by June 30, 2015 which is based on HHC's receipt of all the UPL payments that are currently outstanding and HHC making all its payments to the City and pension fund. The final item included the State budget. Governor Cuomo issued the State Executive Budget and some of the highlights that related to HHC would be presented to the Committee. First, the budget includes language to support the State's change in the UPL payment to allow the New York State Department of Health (NYSDOH) flexibility to comply with the Centers for Medicare/Medicaid Services (CMS) and to expand the distribution of the payments to more hospitals at HHC than had been prior which is a precursor to getting the payment that is reflected in the cash flow.

Mr. Rosen asked when those payments are expected to flow to HHC. Ms. Zurack stated that by April 2015; however, CMS approval is required and must be obtained by the State. In the State budget there are proposed changes in the indigent care methodology for NYS. The indigent care methodology drives the Disproportionate Share (DSH) payment to HHC. As previously reported as part of the Affordable Care Act (ACA), beginning in FY 2018, NYS will see massive reductions in its DSH allocations from the federal government. The current process or rule for the distribution of DSH amongst the different hospitals in NYS included a series of conditions adopted over the years that include various pieces of state law that included the creation of the following: the indigent care pool; the public hospitals adjustment pool; the IGT; the DSH maximization for public hospitals other than HHC. There is a

provision that allows HHC to get its maximization if there is room in the State allocation after all those items have been satisfied. If there is no room HHC does not get its maximization. HHC's DSH maximization has been from $550 - $600 million per year. HHC is the last priority in the current State law. Accordingly in HHC's financial plan if the DSH cuts are passed down to the State, the entire first two years of DSH cuts would come exclusively to HHC which would be a major problem. Additionally, as part of the ACA there was discussion that the HHS Secretary was to setup a methodology for allocating the national DSH cuts to states and that methodology should favor states that treat the most Medicaid and uninsured patients. NYS current methodology for the DSH maximization, the $600 million that HHC gets represents 35 – 40 percent of State's DSH and the other publics also get a fair amount of the total dollars distributed. A large portion goes to the high Medicaid and uninsured hospitals. However, if the State does not change its allocation of the DSH in law, when the cuts are passed down that would go away given that the highest DSH hospitals are the first to get cut based on those old statues. Included in the State budget is language that would allow the SDOH to delegate that authority to change those methodologies to the SDOH in response to the federal cuts.

Mr. Rosen stated that it would appear that the State is trying to anticipate the loss of the federal DSH and mitigating that loss.

Ms. Zurack stated that the State is trying to move the discussions away from the legislature and have it be exclusively the SDOH in order to have the flexibility to adapt to the unknown. In October 2013 the HHS Secretary issued regulations on how the DSH cuts would be done. However, at that time there were issues relative to the data on the uptake of insurances for the ACA. Therefore, the Secretary only put forth temporary regulations that expire with the anticipation that new ones would be done at the end of calendar year 2015, whereby a more permanent methodology would be developed on how the DSH cuts would be done effective 2018. At some point the State will need to have a discussion with the federal government regarding this issue. The language in the State budget delegates it to the Governor's administration and therefore it would not make it a subject of the legislature process. Prior to the MRT, the formulas for the distribution of the payments were very detailed. From an HHC perspective, discussions have been done with the SDOH who understands the importance of retaining the federal share. HHC has asked that there be language that would be more inclusive of the process and involvement by HHC in the issuance of regulations or rules that would allow for HHC to comment on those changes.

Dr. Raju added that as Ms. Zurack had stated, HHC has expressed its concerns to the State regarding the issues relative to the DSH maximization. It is important to note that what HHC is proposing is not only for HHC but it would be beneficial to the State as well. There must be a process and the concept of the allocation relative to Medicaid and the uninsured. HHC has had discussions with the various stakeholders, politicians, and communities and leaders regarding this issue and will keep the Committee updated on the status.

Ms. Zurack that that the most important part of the State budget included an extension of the Medicaid global cap indefinitely, setting the maximum increases at the consumer's price index at 3.6%. Any projected savings below the cap can be shared with providers. This is another example that there are some proposed rate increases and restoration of some rate adjustments/cuts. If passed, the

preventable complications rate adjustment would be worth $3.5 million for HHC. In addition there was an implementable MRT obstetric reimbursement reduction designed to fund the malpractice reform but is being proposed to be restored that is worth $4 million to HHC. There is an item in the State budget that allows for the creation of a basic health plan that is a provision of the ACA that allows states to create a publically sponsored plan similar to a Medicaid managed care plan that would allow the State to get the benefit of what would have been the tax subsidy to the individual purchasing their own health insurance on the exchange. There is a population in NYS of immigrants that due to a lawsuit that HHC was also a participant, are given state only Medicaid due to the provision of the Personal Responsibility Act (PRA).

Mr. Page asked how that would work with the local participation of the Medicaid cost. Ms. Zurack stated that due to the county cap on Medicaid expenses there is no county share because the state is paying over the cap with the amount in savings it is possible to go below the cap.

Mr. Page asked if the local share was exempted from the cap.

Ms. Zurack stated that it is not clear at this time if that would apply for that population. However, it is not clear how this one works but would do some research and report back to the Committee on the findings. As part of the ACA, from the Medicaid perspective the Medicaid expansion that was the single adults between 87% of poverty and 138% are now eligible for Medicaid as part of the ACA. That new population gets a federal matching rate that varies each year from 85% to 92% as part of the federal matching rate for the entire country. When the ACA was passed the cost sharing for the Medicaid expansion was much lower than what it had been for regular Medicaid that resulted in significant savings for the State and was a positive for HHC. There was a potential cut in the State budget for crossover payments for individuals with both Medicaid and Medicare. The combined payment between Medicare and the crossover cannot exceed what Medicaid would have paid for the same services. That is a potential $92 million statewide cut to all providers in the state and HHC's share of that cut is yet to be determined. The State budget includes $290 million for safety net providers to apply for vital access grants dollars of which HHC will receive a small amount. Also included in the State budget is $1.4 billion for capital of which $700 million is for central and east Brooklyn. Ms. Zurack deferred to Dr. Raju for further elaboration.

Dr. Raju stated that HHC has been a part of the discussions on how the $700 million in capital for central and east Brooklyn should be distributed and have suggested that it should follow the DSRIP transformation process under the capital component so as to expand ambulatory and improve access to care. HHC also proposed that there should be public involvement in the process of how those funds should be applied. Essentially, HHC's positon is that central Brooklyn lacks adequate access to care and those funds could assist in improving that disparity through the Governor's involvement in putting more funding resources in central Brooklyn. However, it is important that those funds are used appropriately in addressing some of the major health access issues facing that community for the uninsured and under insured.

Mrs. Bolus asked if the basic health plan would have an impact on MetroPlus.

Ms. Zurack stated that it would in that MetroPlus will be able to participate and have a product that will help in increasing enrollment which is a major part of HHC's strategic agenda to assist MetroPlus in driving market share to HHC. The reporting was concluded.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS **KRISTA OLSON/FRED COVINO**

Mr. Rosen informed the Committee that given the lengthy agenda, the Key Indicators and Cash Receipts and Disbursements Reports would be submitted into the record.

ACTION ITEMS **MARLENE ZURACK/ANTONIO MARTIN**

1. Authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation ("HHC" or the "Corporation") and Base Tactical Disaster Recovery, Inc. ("Base Tactical") to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency ("FEMA") for expenses incurred by the Corporation in connection with damages caused by Super Storm Sandy. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016, for an amount not to exceed $2,500,000.

2. Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and Arcadis U.S., Inc. and Parsons Brinckerhoff, Inc. to provide professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities, which were damaged as a result of the Super Storm Sandy disaster. The Contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed $5,000,000.

At the request of Ms. Zurack, the two resolutions were read consecutively given that the presentation would be done jointly by her and Mr. Martin.

Ms. Zurack informed the Committee that she would do the first resolution for extension of Base Tactical consultancy services and Mr. Martin would address the second resolution relative to the architectural and engineering services provided by Arcadis and Parsons Brinckerhoff. Via way of background which would explain why it is necessary to extend the contracts, the brief presentation which was a revision of the one previously distributed as part of the Committee's package would cover the FEMA process and the architectural and engineering services. In the middle of the storm in 2012 it became apparent to the leadership of HHC that there was a need to have a FEMA consultant on site immediately. There was an emergency declared by the federal government and HHC. Through that process emergency procurement rules were allowed for securing the necessary services and as a result of that process base Tactical had its own architectural and engineering service firms to assist in the initial assessment process during the early stages of the process. The contract for Base Tactical for that engagement was for $2.7 million which covered architectural and engineering services and FEMA work. Subsequently an RFP was issued in November 2012 and a contract was awarded to Base Tactical and

presented to the Board in January 2013 for an amount not to exceed $4.4 million from February 2013 through July 31, 2014. As part of that engagement Base Tactical worked with HHC on the project worksheets and payback for some of the emergency work, restoration at Bellevue and Coney Island and in getting those two facilities back up and running at their levels prior to the storm. A second extension of Base Tactical contract was done to assist HHC in its efforts to complete hazardous mitigation from August 2014 to July 31, 2015 for an amount not to exceed $2.6 million. The current extension is for another year to complete the current scope from the original RFP and at this stage it would not be in the best interest of the Corporation to change consultants to get through the project work. However, if in the near future there is a need for HHC to continue this service, an RFP will be issue at that time. HHC in response to the Committee's request will present the process for managing the cost of construction relative to the FEMA allocation of $1.7 billion.

Mr. Martin continuing with the second half of the presentation stated that the work to be performed under this one year extension included: continued preparation of FEMA documents to support the $1.7B grant and environmental assessments at Bellevue, Coler, Coney Island and Metropolitan Hospitals; design mitigation projects which include mechanical infrastructure raised to higher elevations; design major mitigation projects including floods walls, new elevators, generator platforms and water pumping stations; assist in procurement packages by issuing scope and responding to bidder questions; review and approve shop drawings; and provide overall construction observation activities.

Ms. Zurack stated that the numbers of steps involved in the process of getting the FEMA reimbursement for the $1.7 billion for the projects that must be undertaken were outlined on the last slide of the presentation. It is anticipated that there might be a need for some ongoing FEMA consultancy imbedded in that process. The steps involved in securing those FEMA dollars and the potential need going forward for those services as part of that process. The information included in the presentation was prepared by Base Tactical.

The resolutions were approved for the full Board's consideration.

INFORMATION ITEM **FRED COVINO**
PS KEY INDICATORS REPORT 2ND QUARTER FY 15

Mr. Covino informed the Committee that HHC is transitioning to a new monitoring process for FTEs. Historically, the reporting was done by various categories; however, going forward the reporting will include all categories this will be global FTEs. Global FTEs include, full time, part time, hourly, overtime, agency temps and affiliation. As part of that process the workload was benchmarked with the global FTEs across the Corporation that resulted in a net reduction of 1,000 FTEs over the next eighteen months based on workload. FTE targets have been developed by facility and those targets were reviewed with the facilities for FY15 and FY 16. The monitoring and reporting of the facilities performances against those targets will begin in March 2015 and reported in April 2015 to the Committee.

Mrs. Bolus asked for clarification of the change from the various categories to an expansion of those categories.

Mr. Covino explained that both a dollar and FTE cap as part of the global FTE was developed with the expectation that the facilities will reduce their reliance on agency temps and move those staff into either hourly or full time positions.

Ms. Zurack further explained that the former approach included having an FTE cap compared to a full time staff budget for the hospitals and managing within that budget, backfilling positions as vacancies occurred. The global FTE cap will allow the facilities the flexibility to manage their resources without having to go through central office. By creating a limit on certain resources, the facilities have opted to use other resources such as temps to meet their staffing needs, thereby circumventing the VCB process. The global cap allocation allows the facilities the opportunity to use their resources as needed in staffing their facilities by employing temps, hourly, full time, part time staff and affiliation. The goal is to create the most comprehensive way to measure and monitor the staffing at the facilities so that the hospitals can be managed by the Network leadership and held accountable for their overall performance against the global cap allocation.

Mrs. Bolus asked how the agency nurses were counted in the cap. Ms. Zurack stated that it was counted as part of the conversion of the usage and dollars spent for those services. Mr. Covino added that it is based on hourly.

Mr. Martin added that the goal is to reduce the use of agency temps by giving the Senior Vice President/ Executive Director for the network or facility the maximum amount of flexibility in determining the best way to manage their facilities. One of the things that is extremely important to the network leadership is to have the flexibility to manage their resources independent of central office and not being constrained by any given situation.

Mrs. Bolus stated that the concern is that one issue that is a constant response in the quality management meeting is that there is a need for additional staff and if central office is to assist in addressing that issue what role can the Board play in helping the facilities within the new global cap.

Dr. Raju stated that it was a valid point and by focusing only on the FTEs it forces the facilities to seek other options such agency temps to meet their needs. The global cap is a better methodology given that it allows for greater flexibility in being able to make decisions about how to staff the facilities. Oftentimes, it is not about the lack of resources but rather how those resources are managed and deployed. This allows greater opportunity to deploy resources needed to operate the day-to-day operations without central office intervention. There is a level of accountability as well in managing those resources.

Ms. Zurack stated that a lot effort on the part of Krista Olson, Assistant Vice President, Corporate Budget and her staff went into the completion of this project and the methodology. The targets were developed using workload. For any particular hospital the workload is up; however, there are fewer staff doing the work and at some point it does normalize, in that, the cap relates to the amount of workload. It is a new methodology and is not full proof but it is not arbitrary.

Mrs. Bolus stated that there is a concern in there being a positive outcome by using that methodology given the various situations that occur within the hospitals relative to delivering patient care.

Ms. Zurack stated that there are some things that are not included in the cap that would be added to the budget such as collective bargaining and any new programs/grants.

Mr. Russo added that the unions have expressed concerns regarding the use of temporary staff as opposed to hiring full time staff and HHC is moving in that direction of having a more realistic approach in meeting the needs of the facilities as oppose to just tracking the headcount.

Mr. Martin stated that the facilities will have the flexibility to make the types of decisions necessary to manage and operate their facilities based on their targets. If there is a need to intervene in the process there is a mechanism to do so through his office. While the facilities will be held accountable, central office is aware that there might be some extenuating circumstances. It is important to note that the purpose of this methodology is not to penalize any given facility but rather there are discussions and negotiations with the facilities on an ongoing basis with his office and finance.

Dr. Raju stated that in terms of the core issue, corporate has questioned the network affiliations on the jobs that are budgeted but are not filled. There are some recruitment issues that must be addressed as opposed to a budgetary issue. This has been the thrust of the discussions with the facilities relative to recruiting and staffing appropriately with the available resources. The facilities focus has to be more global in recruiting staff. Within HHC there are a number of qualified personnel that can be utilized by the facilities in meeting their needs and this issue must be addressed by the networks.

Mr. Covino continuing with the report stated that the budgeted increase in FTEs is 325 compared to the year-end staffing level for FY 14. The allocation of that increase include: 90 FTEs for Gouverneur to staff the opening of 160 beds; 76 FTEs for enterprise IT for EMR trainers, 36 and 40 consultant conversions; 50 FTEs for multiple facilities for the hospital medical home grant; 33 FTEs at North Central Bronx for staffing the labor and delivery services; 27 FTEs at Bellevue for the Ebola virus preparedness and readiness; 24 FTEs multiple facilities for the CMMI grant, Healthcare Innovation Award; 17 FTEs residents at Coney Island and 8 FTEs for the re-opening of Homecrest. If the workload increases the targets will be adjust accordingly.

Mr. Rosen asked if by the end of the FY 15 the FTE headcount would be higher by the 325 increase. Mr. Covino stated that it would not due to some reductions that were factored in as part of the right-sizing of the FTEs based on workload.

Ms. Zurack added that the 1,000 FTE reduction target is for June 30, 2016; therefore there will be some ups and downs in the FTE count.

Mr. Covino stated that the PS disbursements through January 2015, expenses were $4.1 million over budget; FTEs were 299 higher than last year due primarily to the budgeted FTEs. However, there were some significant increases outside of that budgeted increase. In addition to the EBOLA FTEs, Bellevue was up by 97 FTEs of which 61 FTEs were for nurses; 9 dental residents and 12 medical records

specialist. Lincoln was up by 63 FTES due to the new emergency department and psych unit. Gouverneur is up by 52 FTEs for the staffing of the new units and the Queens's network is up 100 FTEs due to the shifting away from using temp services and moving to full time staff. The 299 FTE increase by major category included an increase of 149 nurses; 118 managers; 49 tech/spec; 16 environmental/hotel; 15 residents; 9 aides and orderlies; 2 physicians and a decrease of 58 clericals. Overtime versus actual was flat against the budget; however, compared to last year it is up by $200,000. It is important to note that of the current year-to-date actual $5 million is related to prior year for collective bargaining and by excluding that expense the current YTD is better than the prior year. Nurse registry was up by $8.3 million due to new contract terms with the vendors to pay within 90 days. Bellevue had a significant increase due to the conversion process of agency nurses to full time staff. The increase in allowances was due to the facilities efforts to reduce the usage of temp series and the conversion to full time staff. In addition to that transition there are overtime expenses, $6 million included due to a shift in the usage of those staff. The reporting was concluded.

INFORMATION ITEM **FRED COVINO**
FINANCIAL PLAN

Mr. Covino stated that HHC's Financial Plan is part of the City's budget process; therefore, there are iterations of the plan each year. The November Plan which was passed, the preliminary budget which is what is being presented to the Committee and finally the Executive budget that result in the adoption of the budget. HHC's Plan includes actual results for the prior FY 14, the budgets for FY 15 and 16 and the Corporation's plan for FY 17 through FY 19. Each year an overview of the January Plan which is presented to this Committee and forwarded to the State in compliance with the Public Authority Accountability Act (PAAA) which is due May 1, 2015. The financial plan is comprised of three sections receipts, disbursements forecasts over the life of the plan and corrective actions. Beginning with the receipts, one of the major developments in the plan is the transition between Medicaid fee-for-service and Medicaid managed care. As behavioral health long term care transition from fee-for-service to managed care there is a significant reduction beginning in FY 15 of $7 million growing to approximately $304 million as the transition progresses in the out years. The shift is dollar for dollar with no reduction in workload. However, that transition to managed care will impact the UPLs. As the dollars are moved to managed care which is not eligible for UPL calculations only fee-for-services it has a significant reduction on the UPL payments beginning in FY 16 maintaining the City's share and solely focusing on the loss of the federal share of $67 million reduction, increasing to $150 million by FY 19. Also the actual for FY 14 and the projections for FY 15, the DSH for FY 14 was significant and some funds were advanced from FY 15 to cover for the cash flow problem in FY 14. Consequently last year the UPL was very low only $205 million compared to approximately $2 billion for FY 15 of which $1.25 billion of the UPL for this year is retroactive which has been reported monthly at this Committee relative to HHC's cash flow.

Mr. Rosen asked if it is a one-time expense. Mr. Covino stated that it is non-recurring. In terms of the ACA, there are several items that will have an impact HHC's revenues. First, the Medicaid DSH reductions beginning in FY 18 is a loss of $305 million growing to $314 million in FY 19. Over the life of the plan the Medicare DSH impact is reduced; therefore, in FY 15 the projection is $330 million and as the ACA grows with more people getting insured, the projection reduces to $161 million. Medicare

payment reforms are projected to be approximately $13 million in FY 15 growing to a $35 million reduction in FY 19. The health care exchanges are projected at $40 million positive to the current plan growing to $50 million by FY 19. Overall there is a positive impact of $263 million; however, in the latter part of the plan that positive trend will decrease significantly by a loss of $130 million each year. The current plan has incorporated all of the collective bargaining settlements to-date. There is an additional payroll included in FY 17 of $90 million. OTPS and medical malpractice increase in FY 15 due to the carryover of City payments that reflect two years of payments that are reflected in debt service, OTPS, and medical malpractice. In FY 15 receipts versus disbursements there is a positive $343 million due to $1.25 billion in prior years UPL payments. In the beginning of FY 16 those payments are projected as a negative from $750 million due to the non-recurrence of the UPL and in FY 17-19 the projection grows from $1 billion to $1.5 billion as the DSH and UPL declines. This is a major impact on HHC financial plan. The below the line items which reflect HHC's corrective action plan. There are two new items included in the plan that are more detailed. First the plan recognizes $152 million received as part of DSRIP. Those funds are above the line in the grant section of the plan as part of the receipts and are no longer carried below the line. DSRIP was projected at $400 million per year over a five year period. Included in the current plan is a $2 billion receipt net receipts of $1.3 billion including the Interim Access Assurance Fund (IAAF) through 2020. Therefore, the totals are $1.5 billion in receipts less $250 million projected expenses. The second item is the MetroPlus enrollment projected to increase to 1 million enrollments by June 2020. Currently, MetoPlus membership totals 470,000 and the projected increase for that initiative is expected to increase business to HHC. It is HHC's expectations that these corrective actions are all achievable.

Mr. Page commented that the additional HHC and the state and federal actions are a significant amount and asked what was included in those numbers.

Mr. Covino stated that the current HHC actions of $200 million for FY 15 includes revenue process transformation projected at $72 million; $75 million for the right-sizing of the staff based on workload initially projected at $53 million but expect that half of that amount will be achieved. The state and federal actions are still in the planning and development stages.

Mr. Rosen stated that overall it is a good plan; however, as an observation, generally there are no corrective actions in the current FY which would not be needed but would be for the out years. In terms of how all financial plans are developed it is important for people to understand the assumptions that are reflected as part of that plan based on what HHC expects to transpire over the years.

Ms. Zurack stated that the goal was to imbed the vision going forward and also focus on some of the comments from the Committee that would be less technical and more strategic and focused on HHC's vision.

Mr. Page added that the FTE effort was more encompassing and focused on the issues.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 10:35 a.m.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORT

KEY INDICATORS
FISCAL YEAR 2015 UTILIZATION

Year to Date
February 2015

NETWORKS	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES/DAYS						
	FY 15	FY 14	VAR %	FY 15	FY 14	VAR %	ACTUAL	EXPECTED	FY 15	FY 14
North Bronx										
Jacobi	271,235	278,414	-2.6%	12,578	13,246	-5.0%	5.9	6.2	1.0124	0.9954
North Central Bronx	132,182	130,354	1.4%	3,388	3,019	12.2%	5.1	5.3	0.7928	0.8737
Generations +										
Harlem	202,209	218,155	-7.3%	7,422	7,350	1.0%	5.5	6.0	0.9646	0.9501
Lincoln	349,256	358,391	-2.5%	15,647	15,846	-1.3%	5.1	5.5	0.8479	0.8310
Belvis DTC	35,419	34,953	1.3%							
Morrisania DTC	53,600	53,606	0.0%							
Renaissance	29,020	31,408	-7.6%							
South Manhattan										
Bellevue	370,831	377,377	-1.7%	15,634	15,314	2.1%	6.3	6.3	1.1170	1.1068
Metropolitan	255,667	257,361	-0.7%	6,220	7,721	-19.4%	5.1	5.5	0.8456	0.7511
Coler				178,865	184,130	-2.9%				
Goldwater/H.J. Carter				76,162	78,053	-2.4%				
Gouverneur - NF				48,650	31,461	54.6%				
Gouverneur - DTC	166,288	176,447	-5.8%							
North Central Brooklyn										
Kings County	445,000	453,110	-1.8%	14,551	15,131	-3.8%	6.4	6.3	1.0288	0.9716
Woodhull	308,806	320,035	-3.5%	7,725	8,522	-9.4%	5.3	5.3	0.8408	0.7933
McKinney				75,175	75,913	-1.0%				
Cumberland DTC	52,917	55,412	-4.5%							
East New York	52,465	47,605	10.2%							
Southern Brooklyn / S I										
Coney Island	216,308	222,474	-2.8%	10,103	9,335	8.2%	6.8	6.2	0.9915	1.0068
Seaview				72,295	70,357	2.8%				
Queens										
Elmhurst	408,917	409,758	-0.2%	13,586	14,323	-5.1%	5.9	5.5	0.9290	0.8836
Queens	264,254	268,778	-1.7%	8,344	8,115	2.8%	5.4	5.3	0.8481	0.8514
Discharges/CMI-- All Acutes				115,198	117,922	-2.3%			0.9526	0.9246
Visits-- All D&TCs & Acutes	3,614,374	3,693,638	-2.1%							
Days-- All SNFs				451,147	439,914	2.6%				

Notes:

Utilization

Acute: discharges exclude psych and rehab; reimbursable visits include clinics, emergency department and ambulatory surgery
D&TC: reimbursable visits
LTC: SNF and Acute days

Average Length of Stay

Actual: discharges divided by days; excludes one day stays
Expected: weighted average of DRG specific corporate average length of stay using APR-DRGs

All Payor CMI

Acute discharges are grouped using the 2013 New York State APR-DRGs for FY 14 and FY 15 as of December 2013. Beginning in September 2014, FY 14 discharges are regrouped using the 2013 scheme.

FY 14 utilization at Coney Island reflects a gradual reopening of services following the temporary closure due to Hurricane Sandy in October 2012. All services were fully restored as of April 10, 2014.

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KEY INDICATORS

FISCAL YEAR 2015 BUDGET PERFORMANCE ($s in 000s)

Year to Date
February 2015

NETWORKS	FTE's VS 6/14/14	RECEIPTS actual	RECEIPTS better / (worse)	DISBURSEMENTS actual	DISBURSEMENTS better / (worse)	BUDGET VARIANCE better / (worse)	
North Bronx							
Jacobi	(27.5)	$ 390,479	$ (9,869)	$ 386,954	$ (12,083)	$ (21,952)	-2.8%
North Central Bronx	(10.5)	123,279	(7,007)	123,794	5,506	(1,501)	-0.6%
	(38.0)	$ 513,758	$ (16,876)	$ 510,748	$ (6,577)	$ (23,453)	-2.3%
Generations +							
Harlem	24.0	$ 251,064	$ 1,524	$ 253,650	$ (14,979)	$ (13,455)	-2.8%
Lincoln	56.0	396,452	12,251	350,185	11,803	24,053	3.2%
Belvis DTC	2.0	10,661	464	10,441	1,846	2,310	10.3%
Morrisania DTC	8.5	16,189	1,415	17,995	1,283	2,697	7.9%
Renaissance	(3.0)	12,782	3,219	14,205	385	3,603	14.9%
	87.5	$ 687,149	$ 18,872	$ 646,476	$ 337	$ 19,209	1.5%
South Manhattan							
Bellevue	92.5	$ 508,191	$ (10,432)	$ 524,631	$ (23,003)	$ (33,435)	-3.3%
Metropolitan	16.5	208,968	(19,670)	217,842	2,837	(16,832)	-3.7%
Coler	(36.5)	57,730	(7,439)	97,012	(8,902)	(16,341)	-10.7%
Goldwater/H.J. Carter	(12.5)	59,238	(18,215)	80,990	(8,232)	(26,447)	-17.6%
Gouverneur	55.5	58,123	(1,048)	68,998	985	(63)	0.0%
	115.5	$ 892,249	$ (56,804)	$ 989,474	$ (36,314)	$ (93,118)	-4.9%
North Central Brooklyn							
Kings County	(17.5)	$ 522,508	$ (2,109)	$ 482,646	$ 13,151	$ 11,042	1.1%
Woodhull	21.5	283,894	(3,477)	281,931	(9,287)	(12,764)	-2.3%
McKinney	2.5	38,432	4,708	32,545	137	4,845	7.3%
Cumberland DTC	(2.0)	17,345	(187)	18,140	1,992	1,805	4.8%
East New York	6.5	18,354	3,415	16,973	248	3,663	11.4%
	11.0	$ 880,532	$ 2,350	$ 832,236	$ 6,241	$ 8,591	0.5%
Southern Brooklyn/SI							
Coney Island	(24.5)	$ 231,145	$ (29,793)	$ 274,154	$ (6,433)	$ (36,226)	-6.9%
Seaview	0.5	34,802	(887)	37,515	2,015	1,128	1.5%
	(24.0)	$ 265,946	$ (30,680)	$ 311,669	$ (4,418)	$ (35,098)	-5.8%
Queens							
Elmhurst	49.5	$ 386,142	$ (1,252)	$ 390,071	$ (8,385)	$ (9,637)	-1.3%
Queens	38.0	260,202	(5,072)	254,473	(4,384)	(9,456)	-1.8%
	87.5	$ 646,344	$ (6,324)	$ 644,544	$ (12,770)	$ (19,093)	-1.5%
NETWORKS TOTAL	**239.5**	**$ 3,885,979**	**$ (89,462)**	**$ 3,935,147**	**$ (53,501)**	**$ (142,963)**	**-1.8%**
Central Office	(4.5)	83,349	6,451	192,420	2,734	9,185	3.4%
HHC Health & Home Care	(5.0)	9,438	(11,945)	26,508	(4,347)	(16,292)	-37.4%
Enterprise IT	33.0	10,076	(808)	126,471	11,889	11,081	7.4%
GRAND TOTAL	**263.0**	**$ 3,988,842**	**$ (95,764)**	**$ 4,280,546**	**$ (43,225)**	**$ (138,988)**	**-1.7%**

Notes:

FY 14 utilization at Coney Island reflects a gradual reopening of services following the temporary closure due to Hurricane Sandy in October 2012. All services were fully restored as of April 10, 2014.

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New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2015 vs Fiscal Year 2014 (in 000's)
TOTAL CORPORATION

	Month of February 2015			Fiscal Year To Date February 2015		
	actual 2015	actual 2014	better / (worse)	actual 2015	actual 2014	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 73,697	$ 67,702	$ 5,995	$ 545,624	$ 561,954	$ (16,330)
Medicaid Managed Care	52,349	51,940	409	424,789	432,162	(7,373)
Medicare	45,618	44,007	1,611	389,041	370,723	18,319
Medicare Managed Care	24,161	26,805	(2,644)	222,503	200,150	22,354
Other	18,811	16,746	2,065	150,588	151,271	(683)
Total Inpatient	$ 214,636	$ 207,201	$ 7,435	$ 1,732,545	$ 1,716,259	$ 16,286
Outpatient						
Medicaid Fee for Service	$ 16,263	$ 11,874	$ 4,389	$ 131,636	$ 129,553	$ 2,082
Medicaid Managed Care	34,222	24,079	10,143	348,211	373,353	(25,143)
Medicare	4,216	3,949	267	41,698	34,133	7,565
Medicare Managed Care	5,967	5,203	763	64,197	64,651	(454)
Other	10,236	11,082	(846)	104,045	115,840	(11,794)
Total Outpatient	$ 70,904	$ 56,187	$ 14,717	$ 689,786	$ 717,530	$ (27,744)
All Other						
Pools	$ 5,354	$ 6,047	$ (693)	$ 241,671	$ 329,349	$ (87,678)
DSH / UPL	-	4,844	(4,844)	1,096,946	902,550	194,396
Grants, Intracity, Tax Levy	9,020	8,537	483	159,247	150,541	8,706
Appeals & Settlements	23,815	23,672	144	27,763	27,416	348
Misc / Capital Reimb	5,153	5,836	(683)	40,883	43,248	(2,365)
Total All Other	$ 43,342	$ 48,936	$ (5,594)	$ 1,566,510	$ 1,453,103	$ 113,407
Total Cash Receipts	**$ 328,881**	**$ 312,324**	**$ 16,557**	**$ 3,988,842**	**$ 3,886,893**	**$ 101,949**
Cash Disbursements						
PS	$ 196,921	$ 187,393	$ (9,528)	$ 1,813,583	$ 1,674,831	$ (138,752)
Fringe Benefits	86,914	65,634	(21,281)	776,836	762,989	(13,847)
OTPS	115,342	99,767	(15,575)	951,830	890,748	(61,082)
City Payments	-	-	0	35,100	19,403	(15,697)
Affiliation	80,931	70,329	(10,602)	649,481	626,150	(23,331)
HHC Bonds Debt	6,848	7,012	164	53,716	50,582	(3,134)
Total Cash Disbursements	**$ 486,957**	**$ 430,135**	**$ (56,821)**	**$ 4,280,546**	**$ 4,024,703**	**$ (255,843)**
Receipts over/(under) Disbursements	**$ (158,075)**	**$ (117,811)**	**$ (40,264)**	**$ (291,704)**	**$ (137,810)**	**$ (153,894)**

Notes:
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New York City Health & Hospitals Corporation
Actual vs. Budget Report
Fiscal Year 2015 (in 000's)
TOTAL CORPORATION

	Month of February 2015			Fiscal Year To Date February 2015		
	actual 2015	budget 2015	better / (worse)	actual 2015	budget 2015	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 73,697	$ 69,506	$ 4,191	$ 545,624	$ 593,986	$ (48,362)
Medicaid Managed Care	52,349	52,598	(249)	424,789	438,381	(13,592)
Medicare	45,618	43,803	1,815	389,041	401,675	(12,634)
Medicare Managed Care	24,161	25,276	(1,115)	222,503	225,171	(2,667)
Other	18,811	16,821	1,990	150,588	163,119	(12,532)
Total Inpatient	$ 214,636	$ 208,004	$ 6,631	$ 1,732,545	$ 1,822,333	$ (89,787)
Outpatient						
Medicaid Fee for Service	$ 16,263	$ 10,733	$ 5,531	$ 131,636	$ 132,195	$ (559)
Medicaid Managed Care	34,222	29,778	4,443	348,211	338,411	9,800
Medicare	4,216	4,495	(279)	41,698	39,967	1,731
Medicare Managed Care	5,967	7,537	(1,571)	64,197	61,923	2,274
Other	10,236	10,336	(100)	104,045	112,582	(8,537)
Total Outpatient	$ 70,904	$ 62,880	$ 8,024	$ 689,786	$ 685,077	$ 4,709
All Other						
Pools	$ 5,354	$ 6,448	$ (1,094)	$ 241,671	$ 247,756	$ (6,085)
DSH / UPL	-	-	0	1,096,946	1,096,946	0
Grants, Intracity, Tax Levy	9,020	10,613	(1,594)	159,247	153,001	6,246
Appeals & Settlements	23,815	35,159	(11,344)	27,763	35,159	(7,396)
Misc / Capital Reimb	5,153	5,306	(153)	40,883	44,333	(3,451)
Total All Other	$ 43,342	$ 57,526	$ (14,184)	$ 1,566,510	$ 1,577,196	$ (10,685)
Total Cash Receipts	**$ 328,881**	**$ 328,410**	**$ 472**	**$ 3,988,842**	**$ 4,084,606**	**$ (95,764)**
Cash Disbursements						
PS	$ 196,921	$ 194,539	$ (2,382)	$ 1,813,583	$ 1,807,021	$ (6,561)
Fringe Benefits	86,914	87,443	528	776,836	781,614	4,777
OTPS	115,342	116,687	1,345	951,830	910,029	(41,801)
City Payments	-	-	0	35,100	35,100	0
Affiliation	80,931	80,948	17	649,481	649,498	17
HHC Bonds Debt	6,848	6,882	34	53,716	54,059	343
Total Cash Disbursements	**$ 486,957**	**$ 486,500**	**$ (457)**	**$ 4,280,546**	**$ 4,237,321**	**$ (43,225)**
Receipts over/(under) Disbursements	**$ (158,075)**	**$ (158,090)**	**$ 15**	**$ (291,704)**	**$ (152,716)**	**$ (138,988)**

Notes:
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RESOLUTION

A RESOLUTION AMENDING A PREVIOUSLY ADOPTED RESOLUTION TO INCREASE THE AUTHORIZATION FOR ONE OR MORE BORROWINGS FROM AN AGGREGATE NOT TO EXCEED AMOUNT OF $40,000,000 TO A NEW NOT TO EXCEED AMOUNT OF $60,000,000

WHEREAS, the President of New York City Health and Hospitals Corporation (the "Corporation") has issued that certain Operating Procedure (40-58 Debt Finance and Treasury) (the "Operating Procedure") relating to the delegation of certain powers for the incurrence of debt for equipment financing to the Corporation's Chief Financial Officer by resolution to be adopted by the Board of Directors of the Corporation; and

WHEREAS, the Board of Directors of the Corporation, and the Finance Committee of such Board, pursuant to Section 4(f)(i) of the Operating Procedure, have determined that it is necessary and desirable to increase the authorization previously approved by the Board of Directors on July 25, 2013 for the incurrence of debt for equipment financing from an aggregate amount from time to time not exceeding $40,000,000, to an aggregate amount from time to time not exceeding $60,000,000, in the form of tax-exempt or taxable loans borrowed by the Corporation from time to time from one or more lenders (the "Lenders"), to provide funds to finance, refinance and reimburse the Corporation for the costs of equipment and various related capital projects and expenditures at the Corporation's facilities, and to carry out the purposes permitted by law and set forth herein and consistent with the Operating Procedure;

NOW, THEREFORE, BE IT RESOLVED, AS FOLLOWS:

Section 101. Authority. This Resolution is adopted pursuant to the authority contained in the New York City Health and Hospitals Corporation Act and in the Operating Procedure.

Section 102. Principal Amount. The incurrence of debt is hereby authorized in the aggregate principal amount of not more than $60,000,000, from time to time, for the purpose of financing equipment and various related capital projects and expenditures at the Corporation's facilities. Such debt may take the form of borrowings, loan agreements, installment purchase agreements or lease agreements, all as contemplated by the Operating Procedures.

Section 103. Interest. Such debt shall bear interest as determined by the Chief Financial Officer of the Corporation as authorized in the Operating Procedure.

Section 104. Authorization of Related Documents. The Corporation is authorized to enter into one or more debt contracts, such as loan agreements, notes, bonds, installment purchase agreements, rental arrangements or lease agreements. The form, terms and

provisions of the debt contracts, between the Corporation and a Lender, providing for the incurrence of such debt, shall be approved by an Authorized Officer (defined below) of the Corporation, as evidenced by his or her signature thereon. The President, the Senior Vice President of Finance/Chief Financial Officer or any other authorized officer of the Corporation under the by-laws of the Corporation (each an "Authorized Officer") is authorized and empowered for and on behalf of the Corporation to execute, acknowledge and deliver the debt contracts, and the Secretary or any other Authorized Officer of the Corporation is hereby authorized and empowered to affix the seal of the Corporation and to attest to the same for and on behalf of the Corporation.

The President, the Senior Vice President of Finance/Chief Financial Officer or any other Authorized Officer of the Corporation are each hereby authorized to take any action, execute any document, or give any consent which may from time to time be required by the Corporation under this Resolution or any such debt contracts. Any such action taken or document executed or consent given by such officer in his or her capacity of an officer of the Corporation shall be deemed to be an act by the Corporation.

Section 105. Effective Date. This Resolution shall take effect immediately upon its adoption by the Board of Directors of the Corporation, subsequent to its adoption by the Finance Committee of such Board.

Adopted: April 30, 2015 Board of Directors of the Corporation

April 14, 2015 Finance Committee of the Board of Directors

EXECUTIVE SUMMARY

Amending a Previously Adopted Resolution to Increase the Authorization for One or More Borrowings in an Aggregate not-to-exceed Amount from $40,000,000 to $60,000,000

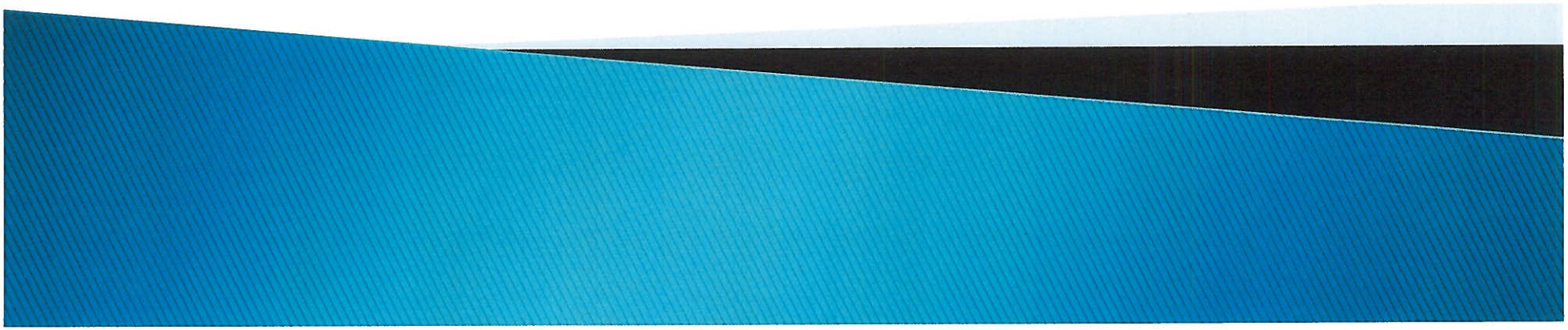
The resolution amends a resolution adopted on July 25, 2013 that authorized the Corporation to borrow from one or more lenders, from time to time an aggregate not-to-exceed amount of $40 million. This resolution increases that not-to-exceed amount to $60 million. The overall negotiation, execution, and management of the borrowing under this resolution are delegated to the Corporation's Chief Financial Officer (CFO). Any borrowing under this resolution will be reported quarterly by the CFO to the Finance Committee as described in Operating Procedure 40-58 (Debt Finance & Treasury), Section 4. F. (Equipment Financing)

The Corporation funds the vast majority of its major capital expenditures with the proceeds of tax-exempt bonds issued by the Corporation or the City of New York. Because bonds proceeds are best suited to finance assets with longer useful lives, the Corporation has determined that it is more suitable to finance assets with shorter useful lives, such as equipment, with loans provided by banks and/or leasing companies. This type of borrowing allows the Corporation to borrow in smaller amounts, as the need arises, incur minimal cost of issuance and minimizes investment risk on borrowed proceeds.

Since FY 2000, HHC's average annual capital equipment expenditures are approximately $40 million, with useful life typically ranging from 5 to 10 years. The types of equipment the Corporation is expecting to purchase are primarily medical and laboratory equipment (including but not limited to anesthesia machines, adult/neonatal ventilators, blood gas analyzers, blood pressure monitors, blood culture system, bone densitometry machine, breast biopsy system, chemistry analyzers, CT scanner, dental X-ray machine, digital mammography machine, digital X-ray machine, EKG/EEG machines, hematology analyzers, IV pumps, infant incubators, infant warmers, feeding/infusion/IV pumps, fetal monitors, gamma camera, microscopes, MRI machine, operating room tables, patient beds, patient room pressure monitors, ultrasound machine, urine analyzers, etc.) and certain information technology purchases (including but not limited to computer servers, network switches, radiology information system, etc.).

Equipment Financing Program

April 14, 2015



Equipment Financing Program

- Goal
  - Establish a routine mechanism to secure access to capital financing for HHC's equipment needs with one or more banks over multiple years.
- Board of Directors authorization
  - In July 2013 the CFO was authorized to incur up to $40 million of debt to finance already identified equipment needs.
  - We are currently asking to increase that authorization to $60 million to meet anticipated equipment financing needs through Fiscal Year 2016.

Equipment Financing Program

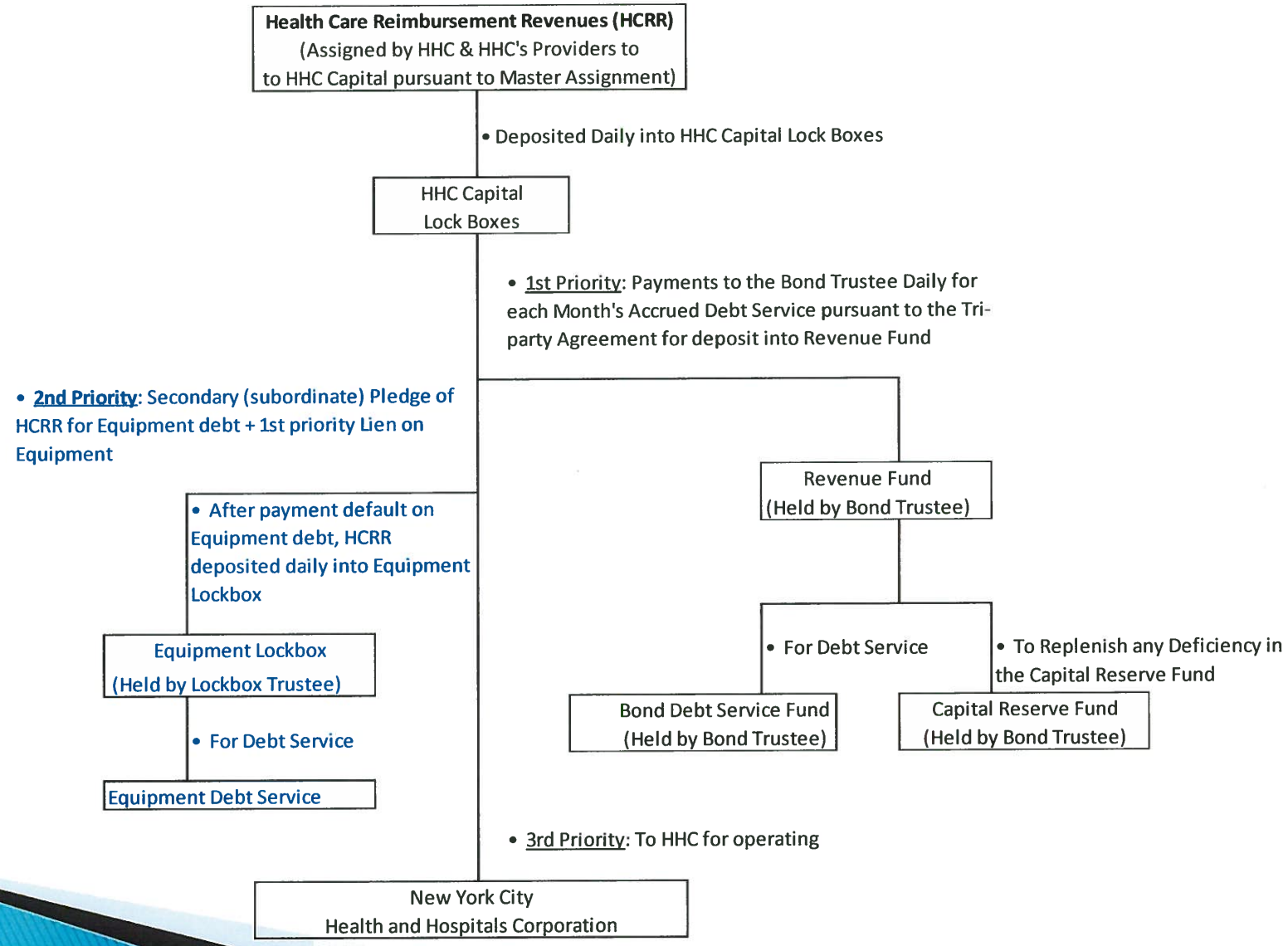
Secondary Lien Structure

- After unsuccessfully attempting to secure traditional equipment financing, a secondary Health Care Reimbursement Revenue lien security structure was developed, which has generated interest from lenders.

Current Status

- HHC recently signed a term sheet with JPMorgan to provide up to $60 million of tax-exempt financing for equipment purchases.
- Documents are being finalized by counsels for HHC and JPMorgan.
- Financing is expected to close by late April or early May 2015.

Equipment Financing Security Structure



JPMorgan Transaction

- HHC Debt Finance worked with Bond Counsel and the Financial Advisor to structure an equipment financing with JPMorgan.
  - Size: Up to $60 million
  - Uses: Upgrade, purchase and install of medical equipment and information technology systems; cover costs of issuance
  - Security: (A) a first lien security interest in equipment; (B) a secondary pledge of Health Care Reimbursement Revenues. In the event of a payment default, a requirement for revenues to be deposited into a daily lockbox will be triggered.
  - Term: 12 month drawdown period at a variable rate, converting to a six year fixed rate loan
    - Provides maximum drawdown flexibility
    - Minimizes negative arbitrage on borrowed, but unspent proceeds
  - Example* Interest Rates:
    - Drawdown Period: 0.9249%
    - Fixed Loan: 1.7062%
    - Rates set by formula. (*Example rates based on index rates as of 3/30/15.)

Next Steps

- Additional Capacity
  - This structure provides a framework for additional borrowing capacity with other lenders. Discussions are currently underway with other banks.
  - Securing additional financing agreements in the near term will give the Corporation flexibility in financing projects within existing Board authority, and will eliminate delays in meeting future equipment financing needs.
  - Total actual outstanding debt will never exceed amounts authorized by the Board.
- Reporting to Finance Committee
  - Per HHC's operating procedures for Debt Finance and Treasury (OP 40-58), the CFO will report to the Finance Committee on all borrowing activity under these authorizations on a quarterly basis.