AUDIT COMMITTEE
MEETING AGENDA

December 4, 2014

10:00 A.M.

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

CALL TO ORDER

- Adoption of Minutes October 2, 2014 — Ms. Emily A. Youssouf
- Adoption of Minutes November 12, 2014 — Ms. Emily A. Youssouf

ACTION ITEMS

- KPMG June 30, 2014 Management Letter — Ms. Maria Tiso

INFORMATION ITEMS

- Internal Audits Update — Mr. Chris Telano
- Compliance Update — Mr. Wayne McNulty

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE **MEETING DATE: October 2, 2014**
TIME: 11:00 AM

COMMITTEE MEMBERS
Emily A. Youssouf, Chair
Josephine Bolus, RN

STAFF ATTENDEES
Antonio Martin, Executive Vice President/COO
Barbara Keller, Deputy Counsel, Legal Affairs
Deborah Cates, Chief of Staff, Chairman's Office
Randall Mark, Chief of Staff, President's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
Lynette Sainbert, Assistant Director, Chairman's Office
Marlene Zurack, Senior Assistant Vice President/CFO, Corporate Finance
Jay Weinman, Corporate Comptroller
Martin Genee, Deputy Corporate Comptroller
Marshall Bondy, Deputy Corporate Comptroller
Nelson Conde, Senior Director, Central Office
Gassenia Guilford, Assistant Vice President, Finance
Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits
Wayne McNulty, Corporate Compliance Officer
Nelson Conde, Senior Director, Professional Services & Affiliations
James McManus-Perez, Director, Professional Services & Affiliations
Kathleen McGrath, Senior Director, Communications & Marketing
Alice Berkowitz, Assistant Director, Central Office Budget
Darren Ng, Systems Analyst, Central Office Budget
Wayne Hanus, Controller, MetroPlus
Devon Wilson, Senior Director, Office of Internal Audits
Steve Van Schultz, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Delores Rahman, Audit Manager, Office of Internal Audits
Frank Zanghi, Audit Manager, Office of Internal Audits
George Asadoorian, Senior Auditor, Office of Internal Audits
Cynthia McIntosh, Senior Auditor, Office of Internal Audits
Roger Novoa, Senior Auditor, Office of Internal Audits
Armel Sejour, Senior Auditor, Office of Internal Audits
Luba Dovjenko, Senior Auditor, Office of Internal Audits
Jean Saint-Preux, Staff Auditor, Office of Internal Audits
Barbarah Gelin, Staff Auditor, Office of Internal Audits
Satish Malla, Staff Auditor, Office of Internal Audits
Gillian Smith, Staff Auditor, Office of Internal Audits
Guzal Contrera, Staff Auditor, Office of Internal Audits
Denise Soares, Senior Assistant Vice President, Gen + Northern Manhattan Healthcare Network
Caswell Samms, Chief Financial Officer, Gen + Northern Manhattan Healthcare Network
Dorothy Buzzeo, Associate Executive Director, Finance, Lincoln Hospital Center
Robert Sussingham, Associate Executive Director, Gouverneur
Kiho Park, Associate Executive Director, Queens Health Network
Milenko Milinic, Controller, Queens Health Network
David Guzman, Deputy Chief Financial Officer, Metropolitan Hospital Center
Rick Walker, Chief Financial Officer, North/Central Brooklyn Network
Anthony Saul, Senior Associate Director, Finance, Central Brooklyn Health Network
Ronald Townes, Associate Director, Kings County Hospital Center
Paul Pandolfini, Chief Financial Officer, South Brooklyn/Staten Island Network
Alex Scourfaras, Associate Executive Director, North Bronx Heath Network
Sandra Maldonado, Associate Executive Director, North Bronx Health Network
Walter Otero, Director, North Bronx Health Network

OTHER ATTENDEES
KPMG: James Martell, Partner; Maria Tiso, Partner; Joseph Bukzin, Senior Auditor
PAGNY: Reginal Odom, Chief of Human Resources; Walter Ramos, General Counsel; Anthony Mirdita, Chief Financial Officer; Allan Vergara, Chief Affiliation Officer (Lincoln); Robert McKenna, Chief Affiliations Officer (Harlem); Howard Nelson, Chief Affiliations Officer (Metropolitan); Ellen Giesow, Chief Affiliation Officer (NBHN); Zabina Zak, Chief Operating Officer (Coney Island)

OCTOBER 2, 2014
AUDIT COMMITTEE MEETING MINUTES

An Audit Committee meeting was held on Thursday, October 2, 2014. The meeting was called to order at 11:00 A.M. by Ms. Emily Youssouf, Audit Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee held on September 11, 2014. The minutes were unanimously adopted by the Committee. Ms. Youssouf then introduced the first information item regarding the Fiscal Year 2014 Financial Statement and Related Notes.

Ms. Marlene Zurack, Corporate Financial Officer stated that she was going to introduce this section because we have some unique process steps this year that requires a little bit of flexibility and forbearance on the part of the Committee. We are hoping to be able to work out a plan that is satisfactory to both parties. There is a major new accounting requirement in this year's financial statement audit related to pension. Because of that, the City Actuary is doing a major analysis which will have a significant affect to our financial statements. What we are presenting to you now are draft financial statements without this major change. We need for the Committee to vote on those so that we can submit the draft to the City so they can finish their audit. We would like to present this, get the approval to submit and then come back to present the final financial statements and the management letter.

Ms. Youssof stated that the Committee can find a date mutually agreeable to schedule a meeting in November.

Mr. Jay Weinman, Corporate Comptroller, was introduced by Ms. Zurack to present the Committee a draft overview of the Corporation's financial performance for the fiscal year which ended June 30, 2014.

Mr. Weinman reported that KPMG has almost completed its audit of the Corporation's financial statements and is expected to issue an unqualified opinion. An unqualified opinion states that the financial statements are presented fairly in all material respects. Mr. Weinman explained that the following statements reflect changes in reporting and required a restatement of the 2013 financial statements:

- GASB 65 – reporting items previously reported as assets
  - Requires gain or loss on refunding to be classified as deferred outflow rather than an asset
  - Costs of issuance to be expensed rather than amortized over the life of the bonds
- GASB 68 – accounting of pensions
  - Changes the measurement for liability recognition. The pension liability which currently is zero on our books because we pay exactly what the actuary calculates us to pay. The actuary's office will now be required to estimate the liability required for us to put on our books that is equivalent to what is the present value of that liability. We expect that it to be a larger number than we have. We are waiting for the report to come out.

Mr. Weinman reported that overall, the Corporation's net deficit position increased by $509 million in 2014. For 2013, net deficit increased by $380 million. Mr. Weinman then proceeded to provide highlights of the Fiscal Year 2014 financial statements, as follows:

Balance Sheet (Statement of Net Positions)

Assets

- Patient Accounts Receivable Net – decreased $67 million and 10 days due to an increase in collection efforts, 2014 patient service cash increased by $406 million while increasing patient service revenue. That comes close to the state-wide average of about 65 days – we are currently at 72.
  Mrs. Bolus asked what a comfortable amount of days to have is. Ms. Tiso responded that typically in New York some have been 20 to 30 days, it varies based on their financial position.
- Estimated third party-payor settlements - increased $580 million due to the payment delay of $540 million of earned UPL revenue for state fiscal years beginning with 2012.

- Grants receivable - decreased $223 million due to the receipt of $183 million in CDBG revenue accrued at the 2013 year-end, and the receipt of $20 million of IAAF (Interim Access Assurance Fund) funds for fiscal year 2015.
- Assets restricted as to use - decreased $28 million due to use of the Construction Fund for various capital projects.
- Capital assets, net - increased $140 million for:
    - Gouverneur Healthcare Services major modernization project ($42 million)
    - Harlem Hospital Center major modernization project ($13 million)
    - Henry J. Carter major modernization project ($82 million)

Deferred Outflows

- Unamortized refunding cost - Represents the amortization of loss on bond refunding and is newly reported as per GASB 65. This was previously reported as a reduction to HHC's long term bond debt. Decreased$ 4 million from 2013; representing the amortization.

Liabilities

- Accrued salaries, fringe benefits, and payroll taxes - increased $105 million for estimated collective bargaining settlements.
- Accounts payable and accrued expenses - increased $23 million primarily due to increases in vendors' payable due to cash flow.
- Estimated pools payable - increased $415 million primarily due to the receipt of State Fiscal Year 2015 DSH Max and Supplemental SLIPA funds.
- Due to City of New York - increased $310 million as the Corporation and the City agreed to delay payments until 2015 to maintain adequate cash flows.
- Long-term debt - decreased $52 million due to the payment of current debt obligations. The statements have been adjusted for GASB 65 and loss on refunding is reported as deferred outflows.
- Postemployment benefits obligation, other than pension (OPEB) – increased $98 million related to the New York City Office of the Actuary revised assumptions for OPEB costs. The actuarial cost method has changed and resulted in a decrease to the liability and amortized over 10 years.
  Ms. Youssouf asked if the actuarial analysis have on impact on this. To which Mr. Weinman responded that part of the test work kPMG does is on the census work. If there are any reported changes, it could have change, possibly to the OPAR but probably will not be material.
- Other current liabilities - decreased $17 million as FICA refunds received were paid out to medical residents.

Income Statement
(Statement of Revenues, Expenses and Changes in Net Position)

Operating Revenue

- Net patient service revenue - increased $419 million due to:
    - Increased patient revenue of $118 million
    - UPL revenue increases of $76 million
    - DSH Max increase of $104 million
    - Other third party retro revenue of $120 million
- Appropriations from the City of New York - increased $14 million mainly due to an increase of $17 million of interest paid by The City.
- Grants revenue - decreased $280 million due to:

- $256 million in FEMA and CDBG revenue for storm related expense reimbursement accrued in FY 2013.
- $10 million in reduced Meaningful Use.

Operating Expenses

- Personal services - increased $130 million or 5.4% and FTE's are consistent. The increase is due to collective bargaining settlements and expected settlements of $115 million.
- Other than personal services - increased $92 million or 6.4% primarily due to the increased cost of pharmaceuticals ($19 million), temporary workers and nurse fees ($32 million), and other general cost increases.
- Fringe benefits and employer payroll taxes - increased $43 million due to
  - Health benefit increases of $18 million or 3.6%
  - Pension expense increase of 18 million or 4.3%
  - FICA increase of $10 million
- Postemployment benefits, other than pension (OPEB) - decreased $95 million as the New York City Office of the Actuary actuarial gain experience. Also, since the actuarial cost method was adjusted in 2013, the change in unfunded actuarial accrued liability is being amortized over a 10 year period.
- Affiliation contracted services - increased $7 million or less than 1% for market adjustments and enhanced services and is consistent with the prior year's growth.

Operating Loss

- Operating loss is $708 million compared to $668 million in 2013.

Non-operating revenue

- Interest expense - increased $7 million from 2013 to 2014 as the interest paid by The City increased by $17 million and capitalized interest of City funded debt decreased by $13 million.

Other changes in net assets

- Capital contributions funded by City of New York - decreased $89 million due to fewer continuing major modernization projects. Last year we did have some projects funded by the City for reconstruction of Bellevue and Coney Island.

MetroPlus

- Cash and cash equivalents - increased $77 million due to positive operating results.
- Premium receivable - increased $65 million for unpaid supplemental managed care of $49 million.
- Accounts payable and accrued expenses - increased $71 million due to the impact of the Medicaid redesign (low birth weight newborns, disabled infants, homeless and personal care) and growth in lines such as NY Exchange, and Medicare.
- Premium revenue - increased $133 million. Premium growth is mainly new NYS Health Exchange products, Medicare ($15 million), HIV/SNP ($15 million), Managed Long Term Care ($18 million) and NYS Health Exchange ($65 million).
- Other than personal services - increased $163 million for medical expenses related to increased services and growth for the above.

Mr. Weinman stated that that concludes the summary of both the balance sheet and the income statement.

Ms. Maria Tiso, KPMG Engagement Partner, introduced the audit team members consisting of Joe Bukzin, Engagement Senior Manager and Jim Martell, Healthcare Industry Resource Partner. Ms. Tiso proceeded to summarize significant issues as provided within the Overview of 2014 Audit Results & Required Communications.

Ms. Tiso said that she is not going to touch upon every slide. There are a lot of things that we went over in Planning and she is going to hit some of the key items to save time. We plan on issuing the financial statements, the management letter and our required communications to those charged with governance. There is a change related to GASB 68. The City auditors are requesting a procedure letter from us regarding our test work of the census data. They want us to give them assurance that the census data that was in the actuary report was appropriate; we are in the process of selecting samples. We know that there were no material errors, irregularities or illegal acts. If there were any, we would report it to the committee. As Mr. Weinman mentioned, we now issue an unmodified opinion, it used to be an unqualified opinion, but they changed the terminology. Regarding the management letter, we have sent our comments to management and they are in the process of addressing them. We do not envision any significant deficiencies or material weaknesses in the comments that we have given to management.

Ms. Tiso continued by stating that there are a handful of transactions that KPMG audited as part of this year's audit. They are all included and disclosed in the financial statements and Mr. Bukzin will speak on some of them briefly.

Mr. Bukzin saluted everyone and reported on the upper payment limit balance. This is a receivable on the balance sheet and it has decreased substantially from last year to this year. HHC has a history of receiving funds from the state – it has been submitted to CMS for approval. The meaningful use incentive describes the accounting policies actually recorded in grants revenue. The Interim Access Assurance Fund is to assist large public hospitals and they work towards integration in connection with Delivery System Reform Incentive Payment Program (DSRIP) – HHC was awarded $152 million. During the fiscal year HHC received $35 million in cash on a net basis. $15 million of that was recorded as revenue and about $20 million has been recorded as deferred. In surrendering the property known as Goldwater, there was a loss recorded of about $23 million in the financial statements as a component of the depreciation expense captured.

Ms. Youssouf asked who came up with the $23 million. To which Mr. Weinman responded that the loss is calculated on our book value. We had a book value of the building and any of the assets located within the building as we got rid of it. Whatever we had as net value had to be written-off -- Ms. Zurack added that we have to depreciate what might be fair market value for replacement of buildings, etc.

Mr. Bukzin continued stating that the next item is the collective bargaining settlements and the expected settlements. The amount is about $124 million, of which a substantial portion of that, about $102 million, relates to prior periods. There are two pieces to that – what's been settled and agreed to and using that as a basis for estimating the expected payouts under similar contracts. We do consider the quality of the accounting pronouncements, they have been consistently applied and footnote disclosures are appropriate. Management, as well as KPMG is required to assess and evaluate subsequent events as part of the audit.

Ms. Youssouf asked if we know the subsequent events regarding pension. Mr. Bukzin answered yes, that that will be a major change in the financial statements and the disclosure as well.

Mr. Bukzin continued with page 11 where they spend a significant portion of their time during the audit in terms of challenging management's judgments and estimates. These are consistent with the prior year with the exception of GASB 68. Once that report is finalized, we will engage one of our KPMG actuary professionals to assist in reviewing the report. Several of these items are a matter of us doing an independent evaluation. The valuation of receivables for example, we will use our computer-assisted audit tools and do hindsight and projections and compare to what management has recorded. All these balances are reasonably stated in the financial statements.

Ms. Tiso added that page 12 relates to audit differences. The first bullet states that there were no uncorrected misstatements proposed and not recorded by the client. The second bullet, audit and post-closing adjustments – we start our audit in mid-July and at this point in time the books and records are still not closed. During the course of the audit, management makes certain adjustments to the books and records. From the time we start the audit and the time the books and records were closing, barring the GASB 68 adjustment, there was a net impact to the P&L of about $112 million. $144 million of that related to revenue and $32 million related to expenses. The last bullet on page 15 talks about the attestation

report that needs to be completed and given to the City as it relates to the accuracy of the census data. Page 17 discusses some of the unpredictable procedures that we did as it relates to the audit. We wanted to give a fresh look to some of the things we have done in the past.

Mr. Bukzin highlighted some of the unpredictable items during the audit. First, we choose to meet with certain members at the local level, divisional CFOs and asked some questions around the risk of fraud, where they see risk, financial reporting in the organization. Second item, scanning through the vendor master listing to see if there are any employees on that list. There should not be any – we did find a handful.

Ms. Youssouf asked if this can be an issue. Ms. Tiso responded no, some may make it into the management level comment that we will discuss with the committee.

Mr. Bukzin continued with page 18, next steps. We are working through wrapping up the financial statements obviously in connection with GASB 68. There is one item on the balance sheet that management is looking into in terms of classification of receivables and liabilities related to third parties. We have received the supporting documentation on the Medicaid-Admin grant and have been finalized. The subsequent events that I eluded to earlier, debt covenant calculations, we have a preliminary calculation. Management is meeting those covenant requirements, but it will be updated in the finalization of the financial statements and we issue a debt covenant compliance letter in connection with our review of those calculations.

Ms. Tiso stated that because there is going to be big span between the time we discussed these financial issues to the time that we issue the final financial statements, we have do a subsequent event review. If there is anything significant that happened in the organization from this in time, there may be some additional disclosures.

Ms. Youssouf asked KPMG to give the Committee their viewpoint on what is going on.

Mr. Martell stated that locally I see quite a few things. Obviously the major not-for-profits academics are actually branching out outside of Manhattan into the geographic areas and, acquiring a lot of the community hospitals. These hospitals are creating networks where most of them had certain tentacles out there but now they are all pretty much doing that. We are seeing a significant impact of the exchanges. The organization is trying to understand them and see how they are going to impact the organization. HHC is at the forefront with DSRIP and how that is going to change the revenue stream going forward and strategic alliances going forward.

Ms. Zurack asked the committee's permission to submit the draft financial statements to the City.

Ms. Youssouf asked for a motion and seconded by all. She then turned the meeting over to Mr. Telano for internal audit updates.

Mr. Telano saluted the committee and stated that Internal Audit serves as the liaison between HHC and audits done by external agencies. The first audit currently being conducted by the city comptroller's office is the Lincoln Affiliation Agreement. That audit began on July 2013 and it is ongoing – representatives from HHC have not heard from the auditors in almost three months. The other audit is the Patient Revenue Accounts Receivables; this audit began on October 22, 2013. The only noteworthy fact about this audit is that they had requested reports from Bellevue related to patient information. Before documents are sent out, it goes through Internal Audit for review. We noticed that there was patient protected health information on these reports. We asked Corporate Compliance and General Counsel to determine whether these reports could go forward and it was determined that they should not and we gave them an example of what a report would like if the information was redacted. There is nothing on the report, just the title of the report. As Mr. McNulty has educated me on this, there are 18 identifiers of patient health information and once they are crossed out, there is nothing they could use in this report. However, this was escalated to the City Comptroller's legal department and a meeting was held with the division head of audit at the comptroller's office. The meeting was attended by Mr. Russo, Mr. McNulty, myself with some audit staff and someone from Bellevue who provided this report. They still want to go forward in obtaining this information. Although we were pretty clear that this information is not available.

Ms. Youssouf asked if what the plan is.

Mr. McNulty stated that when we met with City Comptroller, it was explained to them that once we redacted these 18 identifiers, this information will not be useful for them. We are going to reconvene to determine if there is another way that they could get some limited information that would enable them to go forward.

Mr. Telano added that the comptroller's office would regroup and determine if they have a solution to this problem and they were going to get back to us.

Ms. Youssouf asked Counsel has anything to add. To which Ms. Keller responded that Mr. Russo was involved. On the Comptroller's side, they brought someone in from counsel's office that we know and respect very highly. She addressed that the issue is that their charter mandates to do this type of audit, they are looking for a way to make it work.

Mr. Telano continued by stating that the other two audits that are outstanding are ones conducted by City Comptroller's office of Bellevue Hospital's Emergency Operations Plan. That audit began in August and they are in the process of obtaining information. The last audit involves a follow-up audit of the management and control of overtime being conducted by the New York State Office of the Comptroller. The original audit was started in 2009, but the final report was not issued until 2011. This audit is in its infancy stages also; they have met with corporate finance, and the budget director of HHC. I attended that meeting and at this point they are looking to obtain information.

Mr. Telano continued and said that at today's meeting we will only be discussing 5 PAGNY affiliation audits. During our audit, we found instances in which the same issues were noted.

Ms. Youssouf asked for PAGNY's representatives to approach the table and introduce themselves. They did as follows: Reginald Odom, Chief Human Resources Officer; Anthony Mirdita, Chief Financial Officer; Nelson Conde, Senior Director of Affiliations at HHC.

Mr. Telano said that he is going to review some commonly found issues throughout these five audits. As a result of this discussion, we will not need to discuss the audits of Metropolitan, Coney Island or Lincoln because these are the three findings that were noted at those three locations. The first finding has to do with the recalculation document not being finalized since the inception of PAGNY.

Ms. Youssouf asked Mr. Telano to give a brief explanation of what the recalculation document is. Mr. Telano said that is a reconliation of the payments that HHC provides to PAGNY with the expenses that they actually incur. This is done on an annual basis for each facility.

Mr. Nelson added that we follow the terms of the contract to determine our recalculation. Mr. Telano stated that a comment is needed regarding this first finding. To which Ms. Youssouf said yes, since we have not seen any in two of them, since pre-2011.

Mr. Odom stated that he is the newest member of the PAGNY executive team. He proceeded to identify some of the other people from PAGNY representing the organization. They were as follows: Walter Ramos, General Counsel; Ellen Giesow from North Bronx Health Network; Robert McKenna from Harlem; Allan Vergara from Lincoln, Sabina Zak from Coney Island and Howard Nelson from Metropolitan.

Mr. Odom continued by stating that he wanted to briefly thank the Committee for the time and effort and particularly Mr. Telano and his team for all the hard work they put into this. We know that audits sometimes can be contentious for us but at the end of the day I do not think any of us disagrees with the fact that the purpose of the audit is to make the organization better. PAGNY feels that the efforts that his team has put in have helped us to look at our internal operations and to help us strive to get better in what we are doing. We are seeing significant progress in getting the six divisions of PAGNY to work more efficiently together and our hope is to continue to strive forward and do those things in the future. We feel we are making significant contributions to the community in extending our services. We are also extending services to some of the other organizations that are not part of our affiliation, for example, Henry Carter. We are providing physicians at Woodhull and Coler as well. With the help and guidance of HHC we look forward to continue to improve as we move forward.

Mr. Mirdita reported that on the recalcs this audit covers 2011, 2012 and 2013. In total we are looking at 12 recalcs. Let me take 2011 and 2012 first as a bulk. Then we have Metropolitan, Lincoln and North Central Bronx Network.

Mrs. Bolus said that she rather take 2011 first by itself because it seems to stand out.

Mr. Mirdita said that on the 2011 we will be moving over with signing off on the Coney Island by October 15th. For Harlem we are working through some disallowance issues, we do not have a date when we will be able to sign off on that.

Mrs. Bolus asked why it is taking so long, we are almost finished with 2014 and you are way back in 2011.

Mr. Mirdita responded that there are some issues of disallowance and some disagreements in terms of what the recalcs show.

Ms. Youssouf stated if they have not been submitted, she is not sure what the disallowances are. To which Mr. Mirdita responded that have all been completed for 2011 and 2012.

Ms. Youssouf asked if they have been submitted.

Mr. Conde answered that they have not been submitted for payment, but they have been submitted for review.

Ms. Youssouf asked when they were submitted. To which Mr. Conde replied that we have been getting them over time.

Ms. Youssouf asked if he got them when he was supposed to. Mr. Conde said that there was a delay in obtaining the documents, but again, that is due to issues in getting prepared for the first time in the organization and being clear what information had to be clear. It was a process that we had to work through to get to this point.

Ms. Youssouf stated that I am sorry, but understand how, from out advantage point sitting here, it seems like you are not being clear. The answers are for whatever reasons, whether you did not like the contract or you did not feel you had to do it, I do not know what happened, but for these kinds of delays, it is very distressing when we are here and we are responsible for the fiduciary responsibility and this is not a private company. I am sure you are aware that we are dealing with taxpayer money that affords us to pay you. I am trying to understand, and as my colleague is, why did you not do them on time and why you have not submitted them. I think this is very direct question - please, could you give us some kind of direct response, it would be greatly appreciated.

Mr. Mirdita responded that they have been submitted.

Ms. Youssouf asked if they were submitted in 2011. To which Mr. Mirdita answered that 2011 was submitted sometime in October 2013.

Mrs. Bolus confirmed: 2011 was submitted in October 2013?

Mr. McKenna, affiliation officer for Harlem, said that he came on board in 2012 and these things were outstanding. We tried to work through them as quickly as possible.

Ms. Youssouf asked Mr. McKenna if he was an HHC employee. He responded PAGNY. Then Ms. Youssouf stated that I am having a very difficult time understand it. I am not trying to pick on any one person, but obviously there is something seriously wrong, and the excuse that somebody is new has nothing to do with this. Still, 2011 did not get submitted until 2013 and neither did 2012. I do not understand what is going on because it just looks like PAGNY is saying to HHC too bad – you paid us, we are going to keep the money. We do not want a recalc – is that what it is, are you unhappy with your contract. It seems like it is just a total disregard for a huge contract with HHC. I would really like to understand if that is the case. If so, do we need to go to some kind of mediation? I do not expect you, sir, to answer it because you are one institution, but I would think people from PAGNY central should be the appropriate people, you have been there long enough now, to actually figure out what the issues are.

Mr. Mirdita said that 2011 and 2012 have been done as a package because it is a lot easier. Coney has been done the same way.

Mrs. Bolus stated that it is not easier for us because each year should have been done separately; they all have their own time frame. 2011 should have been done in 2012 and then you work on that from 2012 to 2013. It is not a matter of you going to bundle them together. Did you come and ask us to bundle them together? No. Did you at one point say we are going to be late with 2011 and we are not going to do it until we get around to doing 2011 and 2012 together? Or did you arbitrarily decide we will skip 2011, start with 2012 and at some time or another do them together?

Mr. Mirdita stated that the reason why they are pretty late is once they are completed, we hand it off to the site at each one of the hospitals. Then Ms. Youssouf asked when you hand it off to the site, are you handing it off to a PAGNY? Mr. Mirdita responded No, to the finance folks at each site.

Mrs. Bolus asked if they got the 2011 and 2012.

Ms. Youssouf added in 2013 they received it.

Mrs. Bolus asked when they received it. Mr. Mirdita answered October 2013.

Ms. Youssouf added that I think we are asking a very direct, simple question and we are getting kind of lost in the noise here. Could you please just say if there is a fundamental problem that the Board of HHC needs to be aware of between PAGNY, the way it treats HHC, in holding up its end of the responsibility when it comes to financial matters and us. If the Board needs to be aware of this it is critical that we know. Or else I can tell you this looks very likely to be the next thing that would be audited from an outside source. Because In the Comptroller's office in the State and the City, if I saw this, I would go in PAGNY tomorrow and do a major audit. I want to understand if in fact we can give some reason that makes some sense about what is happening.

Mr. Mirdita responded that there is a lot of back and forth that goes on once the submission has taken place and has taken place.

Ms. Youssouf added that the submission was two years late.

Mr. Odom added that while I was not here during some of these periods of time, this goes back to the origins of PAGNY and the changes in leadership that took place and there have been a lot of changes in the organization. In the last couple of years there has been stability in the executive team. I being the last person being brought on board, I think that is when there has been a stronger push to move these things forward. Dr. Marcos has made a significant effort in pushing us forward to get us to the point where we are. I cannot speak to what happened in 2010 or 2011 or 2012, but I think since our new leadership team has come on board significant effort has been made and we have been moving forward in the progress. I think there have been some fundamental differences of view in the finances that have held things up, but I think that is normal back and forth that goes on between the sites and affiliates.

Ms. Youssouf stated that we do not have that problem with other affiliates. I do not agree with you that it is a normal thing that goes on.

Mr. Odom said that I am talking about the back and forth that happens when make a submission and there are issues that the site will see.

Ms. Youssouf stated that the back and forth is not the problem. Maybe for the tenth time I am going to say that these things were years late; it is a major issue. The staff of HHC works incredibly hard to make sure, as you can tell from the financials we just went through, that we do this stuff on time, professionally and get it done. PAGNY is a group of physicians all very well educated, great doctors but what is going on? We have to report this to the full board – what are you going to say? Tony did you want to say something.

Mr. Martin stated that I think it was mentioned before PAGNY has had some significant growing pains. I do feel confident that they do have a solid leadership team in place. I have been in communication with Dr. Marcos and let him know the seriousness of this issue. As a result of those communications we got commitments for a number of these recalcs for the 15th and then we will also commit to having the rest done by the next meeting of this board, which will be December. You are right, this is totally unacceptable. I have communicated that to Dr. Marcos and I think there is culpability all across the board in many different areas why this has happened. I make a commitment to you Mr. Youssouf and Mrs. Bolus that this will be resolved and will be taken care of by the next meeting.

Ms. Youssouf asked if we have a commitment from PAGNY. Mr. Odom responded, absolutely.

Mr. Telano continued with the audit update by stating that the next issue which was found at most of the sites had to do with the subcontractor agreements not being adequately controlled. Some of the issues that we found were the contracts did not have expiration dates; they had clauses for indefinite automatic renewals. Many of the contracts have not been

renewed or renegotiated since PAGNY assumed the agreements from the previous affiliate. At one site a couple of contracts cannot be located and some contracts had expired. Most of these issues were noted during last year's audit.

Ms. Youssouf said that this was noted last year and obviously nothing was done to correct it.

Mr. Odom responded that while we have not completed the process to clear up all the issues with the contracts, we made significant progress as about a third of the contracts have been completed. There is probably another third of those contracts we have out with our different vendors at different sites to make sure they have signed off on it. Two thirds of the agreements are well on their way. There is probably another third of the agreements that are still outstanding. We brought on a general counsel just about a year ago and he has been helping us move this process along to establish some new procedures and controsl to address some of these specific issues. We did probably assume the agreements from the previous affiliates; our commitment is that we will have this cleared up no later than March of 2015. We are working through the process diligently now and we are committed to getting it completed.

Mrs. Bolus asked Mr. Odom if his name is on all the papers. To which Mr. Odom responded no, still in process. Then Mrs. Bolus asked how long that will take. Mr. Odom answered that we think there are about two-thirds that are completed and another third that we are working on.

Mrs. Bolus asked do you know long that will take. It seems to me if you are going to do that work you should have your name there. Mr. Odom said that our intent is to have it completed by March.

Ms. Youssouf asked how many are there that it will take so long to get completed. Mr. Odom said that most of these contracts are for providers of services. We do not want to stop the service to the facility. We are working with our individual chiefs and chairs and the different services to modify the terms of the agreement. We make quick fixes to the documents and the details, but then we have to go back and forth with the particular vendors.

Ms. Youssouf asked how many are there. Mr. Odom answered that I believe somewhere around 30 or so more that have not been completed, and there are other still in the process.

Mrs. Bolus asked if we have the names of those. To which Mr. Odom answered that he did not have a complete list.

Mr. Conde added that there were 140.

Mrs. Bolus asked if they still waiting for name change in some of the contracts that have expired.

Mr. Odom said that they are beyond just name change, there is a renegotiation that has to go on. The name change is the quick, easy part, it is a matter of we have to go back and renegotiate with the particular vendor and sometimes there are other changes. We need to clarify the scope and types of services that are being provided.

Mrs. Bolus asked if they could get the names of the vendors and what the problem is. Mr. Odom answered sure.

Mr. Telano continued by stating that the last issue found throughout the numerous facilities was system access not always being removed timely for terminated affiliate employees. We found this, especially for the HHC medical records system, which was QuadraMed and HHC's email system which is Groupwise. In addition, we found for the many ex-employees there was no accountability for their ID cards being confiscated once there were terminated. This issue is not limited to PAGNY, it involves both parties communicating and when the employees are terminated from PAGNY they must notify HHC's HR and IT and hospital police. There are numerous parties involved in this.

Ms. Youssouf asked what PAGNY is doing to address that.

Mr. Odom responded that as Mr. Telano indicated, it is a communication issue. They were very helpful in providing us good feedback and comments on suggestions on how to move forward on this. At each of the sites there is a more organized process and better communication, sometimes daily and no less than weekly communication about the status of employees who were terminated. Also, there is more follow-up, which I think was a piece sometimes missing. There is better coordination at each of the sites, there are systems in place to make sure that we follow-up on everybody that was terminated going forward.

Mr. Telano stated that I am going to speak about Jacobi and Harlem specifically and asked for the representatives to Jacobi to approach the table. Ms. Ellen Giesow, Chief Affiliation Office from Jacobi introduced herself. During this audit

there seemed to be a disconnect between the auditors and the PAGNY staff in relation to the request for information. This audit took eight weeks to complete. On April 9th we initially gave a list of about 18 different documents that we needed and that list was updated on April 22nd - throughout the course of the audit, we request documents. By the time we left on June 5th there were many instances in which the documents were still outstanding – that is an eight week period. From our perspective, we have to conclude that these documents do not exist. However, at the exit conference on July 22nd, which was seven weeks later – now is a total of 15 weeks, we were given documents and then were asked to continue our audit and look over these documents and remove audit findings. When we leave the field – that is when we basically conclude our audit and if documents have not been given to us by then and maybe a week later, have to conclude that they do not exist. Many of the findings that we came across and find in sections A and B and other ones, was mostly because we did not receive documents timely or we received different documents than we requested. In finding A we had requested documentation related to employees being terminated and hired. We assumed that we were going to receive personnel requisition forms, but instead we received personnel action forms and we were told they were legitimate documents. However, subsequent to the audit being completed we noted that the signatures on those forms and approval signatures on those forms were incorrect. Some of those forms were currently dated and they were approved by employees that no longer are employed by PAGNY and vice versa. There were older forms that were signed off by employees only currently working or more recently working for PAGNY. Then later we were informed that was as a result of these forms being printed out by this ACS computer system which has a signature name plate and automatically embeds the signature. We were not informed about this throughout the course of the audit which was the reason we accepted these personal action forms as legitimate. Looking at it now, we are saying that these forms were not actually approved because the person did not really sign them by hand – they were signed by this machine. As a result of that, we concluded that the system should not be utilized in that respect going forward.

Ms. Youssouf asked if this system has been removed. Mr. Odom answered that we removed the names off the system. Right now the system is in the process of being decommissioned within the next month or so. Unfortunately, PAGNY at this moment does not have an HR system across the enterprise. Jacobi, NCB was the one system that had a home grown system built many years ago. As a result of this process, we have these built in signature plates on the system. We are moving into a new ADP system across PAGNY enterprise, they will be up and running by the beginning of the year to eliminate the use of all of these systems that created some of those documents that the HR folks relied upon as opposed to, appropriately, using the PR document, which is the right document. As Mr. Telano said that should have been the document referred to. The practice has been that they take those documents and they enter information to the system and regularly use the information from that system as the action purposes. They tend to think that the action that they create on the system is the right action.

Mrs. Bolus asked what will be done with the ones missing – since you have all of those that have previously been signed. Mr. Telano responded that at this point, we never received the personnel requisition forms. I guess in our follow-up, we will be looking for them.

Ms. Geisow said that we went through all the files and they are available. Mr. Odom added that all the forms they asked for are available. Unfortunately, we did not produce them at the time of the audit.

Ms. Youssouf stated that Internal Audit and Compliance are in place to try to help before something becomes critical and before something becomes a headline in the New York Post – they are not your enemy. They are saying this is wrong that that is wrong. You guys need to fix it to be in compliance. Unfortunately, everything I have read and heard it seems like PAGNY has an attitude that internal audit is an enemy and somebody they are not cooperating with. There is no reason to hold back documents, no reason not to do things on a timely basis. I can tell you with all honesty, if I had a contract like this in front of me in private industry, I would get rid of that company immediately. There is no excuse for these types of things – I find this unconscionable

Mr. Telano continued and said that the next comment is related to documentation we requested for the faculty practice plan. We had requested bank statements, audit financial statements, accounting records, collections and listing of physicians. We made that request on May 20th; when we left the site on June 5th we still had not received anything except for the address to the lock box. On June 10th we received some summary of charges but we could not verify the source. Once again at the exit conference on July 22nd, eight weeks after our initial request, we received certain items, bank statements and some other items. This resulted in a finding stating that we find these documents did not exist.

Ms. Giesow commented that when I first arrived last June, I realized that the faculty practice billing company was not providing to either us or to HHC the documents they needed. I tried during the year to work with them to get them to produce the kind of information we needed. They are a well-intention good billing company, but they are not capable of doing the kinds of things PAGNY need an FPP group to do. As this became more evident and a struggle to getting what we got to Mr. Telano, I approached the chairs of the departments. We met with the local governing counsels, and looked at different companies. They have decided that we should go with Phycare who does the billing for all other faculty practice plans. I think they can produce the kind of reports that we need and they can probably increase the revenue.

Mr. Telano moved onto issue B related to the Bronx VA resident subcontractor that PAGNY is not a party between North Central Bronx and the Bronx VA although the physicians provide services under PAGNY's oversight. The medical board office did not have documents confirming credentialing for five physicians and ID cards for terminated Bronx VA residents were not collected.

Ms. Giesow said that the contract is between the North Central Bronx Network and the Veterans Hospital. We were not a party to it although we were in the position where we were to pay the residents and the residents are on the opening contract roster. When the auditors brought this to our attention we asked HHC if we should be a party to that agreement and they said we should. We are working with it now to make sure we get put on that contract with everybody else. As far as the credentialing, the Medical Staff Affairs Office did not have the proper documents from the VA. They contacted them right away and they now have a system for getting those credentials as residents rotate. The IDs, to our knowledge, our human resources does not collect them. The administrator for medicine collects them and gives them to the hospital police at North Central Bronx, to our knowledge they did that.

Mr. Telano continued with the Harlem issues and asked for the Harlem representative to approach the table. Mr. Robert McKenna introduced himself as Chief Affiliation Officer. Mr. Telano continued and stated that this is in line with the last comment related to Jacobi that nine subcontractors medical clearances were not on file and the expiration date of those clearances were from 37 to 435 days old. There seemed to be a weakness in the communication of the hospital and HHC and PAGNY.

Mr. McKenna reported that as I recall, the comment was generally towards the Medical Staff Affairs Office of the hospital. PAGNY was also indicated in that comment. My response was that our general purpose or role there is to facilitate the access to our providers. I had no communication from the hospital asking for such assistance and I am certainly making myself available to do that in cases in the future.

Ms. Youssouf asked Mr. Telano if this is something he alerted to the hospital. To which Mr. Telano responded that the director of credentials at Harlem Hospital is currently changing their process to ensure that this is done timely.

Mr. Telano moved onto the issue C – checks requests were processed and paid without sufficient documentation to support the check request. For example, $20,000 was paid to Advance Trauma Life Support for certifications for 2011, 2012 and 2013 without detailing the individuals who received the certifications and there was instance where approximately $7,000 was reimbursed for a review course based upon quotation rather than an exact invoice.

Mr. McKenna stated that this is true, we have a small office. Our accounts payable person did not properly attach the documents to the request and they were not available at the time of the audit. However, once we were informed of that by the auditors we were able to assemble the documents and attached them to the request and they were all received. The point was made because we did not have them on the day of the request.

Mr. Telano said that the last issue he will discuss related to Harlem is the lack of segregation of duties within the HR department. Two individuals in PAGNY's HR department had access to enter and access data within the payroll system. Since PAGNY HR has the ability to add employees, there was a risk created when you have the ability to enter hours worked, rates of pay or total earnings.

Mr. Odom reported that unfortunately, PAGNY does not have a separate HR system. They only have a payroll system from ADP – they granted access to HR people and payroll people. The HR people were utilizing the payroll system to add demographic information because there was nowhere else to store that. That is something we are fixing with the implementation of our new upgrade ADP system. We made it very clear to people that the responsibilities have to be separate to avoid the issues Mr. Telano pointed out.

Mr. Telano said that the issues noted at Coney Island, Lincoln and Metropolitan were already discussed and we can pass on that. He then said that that concludes his presentation.

Ms. Youssouf stated that this is the second or third time PAGNY has been here since the change that was mentioned. Unfortunately, from the perspective of the Committee things have not gotten better. In fact, the more we do the worse it gets. I am hoping that all of these things and these dates are going to be fulfilled. That it is not going to continue to be a problem. The attitude has to change and the understanding that if you are in a contract with someone you are supposed to uphold your end of the contract and it seems like that has not been the attitude. It is very distressing from our vantage point and we are going to be asking Internal Audit to check up to see if any of these things are corrected. We are also going to talk to the rest of the Board members about this because I think these are very serious issues. We have been told things were going to change every time PAGNY has been here. Apparently nothing has changed.

Mrs. Bolus added that we have to figure out what we are going to do. There has to be some recourse when they do not do anything.

Mr. Odom stated that I want you to understand that we take these issues very seriously and it is our commitment to make improvements and to fix the issues you laid out before us. We recognize and you will absolutely see improvement. I look forward to sitting back in front of you again with a different tenor the next time.

Ms. Youssouf thanked him and turned the meeting over to Mr. McNulty.

Mr. McNulty began his update by saluting the Audit Committee (the "Committee") and directing them to section one of the Corporate Compliance Report (the "Report") - the Deficit Reduction Act of 2005. Mr. McNulty explained that HHC is required, as a condition of participation in the Medicaid program, to establish written policies and procedures that inform its workforce members, contractors, and agents of HHC's internal policies covering the prevention and detection of fraud, waste and abuse; the Federal False Claims Act and any similar law of the State of New York that governs false claims; and whistleblower protections under Federal and New York State ("State") law. Continuing, he stated that HHC is required to certify its compliance with the Deficit Reduction Act on an annual basis. He advised that, as Chief Compliance Officer, he would certify HHC's compliance with the same in December of this year.

Mr. McNulty continued by reviewing several policies and procedures that HHC has in place to comply with the Deficit Reduction Act. He started with HHC's Corporate Compliance Plan (the "Plan") by explaining that the Plan outlines the eight elements of a compliance program that HHC is required to follow under State regulations. He further explained that the Plan outlines all of HHC's policies and procedures with respect to detecting fraud, waste, and abuse. He advised the Committee that HHC's Corporate Compliance Program follows the Office of the Inspector General's ("OIG") guidance for hospitals with regard to compliance programs and it also follows the federal sentencing guidelines with regard to an effective compliance program.

Mr. McNulty continued by advising the Committee that Operating Procedure 50-1 - Corporate Compliance Program – provides for a Chief Compliance Officer, who: (i) is charged with oversight and implementation of the program; and (ii) is required to report at least quarterly to the Chairperson of the Committee and HHC's President and Chief Executive Officer. He advised, in summary, that the Corporate Compliance Program calls for the good faith participation in the Compliance

Program and the reporting of any issues related to fraud, waste and abuse. He next discussed HHC's Principals of Professional Conduct ("POPC"), which he explained was a brief guide that directs all HHC workforce members to conduct official business in an ethical and lawful manner. He gave the following examples of violations of professional conduct: (i) improper billing practices; (ii) accepting gifts from vendors; (iii) inappropriate patient referrals; (iv) breaches of patient confidentiality; and (v) failure to adhere to HHC policies concerning patient care. He then discussed HHC's Guide to Compliance (the "Guide"), which he explained was a 12-page pamphlet that the OCC provides to all employees. He explained that the Guide provides a summary with regard to the terms fraud, waste and abuse, and covers certain topics such as the Federal and State False Claims Acts; HHC's policy on retaliation; and compliance reporting procedures.

Mrs. Bolus asked if they got it. To which Mr. McNulty responded yes. He stated that he utilized the payroll department to send out notices to all workforce members. These notices outlined the requirements with Deficit Reduction Act; all of HHC's policies and procedures concerning fraud, waste and abuse; and provided a link to HHC's public website. Mr. McNulty advised that he sent out by email, to all workforce members, the different requirements under the Deficit Reduction Act and how this information may be accessed on the HHC public website or the OCC intranet website. He stated all vendors that provide health care products or services to HHC were sent notices informing them of these particular policies. He closed by stating that all employee handbooks are required cover the Deficit Reduction Act and an overview of HHC's policies and procedures related to fraud, waste and abuse.

Mr. McNulty continued on to discuss a recent data breach at the East New York Diagnostic and Treatment Center ("East New York"). He explained that on August 11th the OCC, along with HHC's information data security contractor - Tekmark Global Solutions - conducted a privacy and security audit walk-through to assess compliance with Meaningful Use Certification regulations and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). During the walk-through, he stated, the OCC observed inappropriate storage of multiple unsecured boxes -- 198 in total -- in an East New York employee parking garage. He advised the Committee that the OCC directed the boxes to be secured sent to Citi Storage, which is HHC's offsite storage vendor. He informed the Committee that the OCC launched an investigation into this matter, which revealed that these boxes contained the medical and dental records from several closed HHC clinics, including the Howard Houses Child Health Clinic; the Brevoort Houses Child Health Clinic; the Fifth Avenue Child Health Clinic; and dental records from the closed dental clinic at the Brownville Child Health Clinic. He further advised that, to date, there were over 5,000 patients affected with regard to this data breach. He advised that the investigation into this matter was ongoing. In response to this breach, he advised the Committee that the OCC developed a written policy on how medical records and other sensitive information should be handled if any other HHC facility closes. He stated that in the event that an acute care facility, nursing home or D & TC or any other clinic closes, all corresponding HHC's records would be appropriately secured and transferred to the receiving facility; sent to a secured offsite location; appropriately archived into an electronic record; or stored appropriately. He explained that, going forward, as part of the subject policy, the Executive Directors charged with the administrative oversight of a closing facility will be responsible for coordinating the secure storage, transfer, and preservation of all corresponding facility records. These coordinating efforts, he explained further, shall be conducted in conjunction with the Network Security Officer; the facility Record Management Officer; the facility Privacy Officer; and the Health Information Management department. He advised that the Human Resources department, Finance department, and any unit head or chief of service responsible for the records at the facility planned for closure will also participate in the coordinating efforts. He added that the policy also calls for the corporate Record Management Officer to be kept apprised of the aforementioned activities. He informed the Committee that quarterly privacy and security walk-through audits at all of the D & TCs would occur over the next several months. Additionally, he stated, all facility privacy officers would be required to perform periodic privacy and security walk-through audits at all other HHC offsite clinic locations.

Ms. Youssouf asked if any information of the affected patients had been stolen. Mr. McNulty answered, in summary, that he was unaware if any of the known 5,000 affected patients' information was taken. He continued by stating that the

patient notification process would commence probably the next day. He stated that all affected patients would be provided with the opportunity to have credit monitoring and identify theft services at no cost.

Mrs. Bolus asked what the estimated cost is.

Mr. McNulty responded that the estimated cost to provide notification letters, set up a call center for the affected patients, and to provide identity theft and credit monitoring services, was $28,000. In summary, he added that, although there was no indication that the records were ever accessed, these services were necessary in an abundance of caution given that some of the records were stored in the aforementioned location for over three years. He informed the Committee that HHC would be required to provide notification to: (i) the Department of Health and Human Services Office of Civil Rights; and (ii) state-wide media in the form of a public release. He told the Committee that said information would also require posting on HHC's public website and the Network facility website. He generally commented that the Senior Vice Presidents responsible for East New York and the other D & TCs support the performance of quarterly walk-throughs by the facility privacy officers.

Ms. Youssouf asked if there are other facilities or clinics that this has raised your antenna. Mr. McNulty replied in the affirmative and stated walk-throughs of all of the offsite clinics would be performed as a result and that he would personally go to all of the D & TCs. He told the Committee that he would review all facilities that closed in the past five years to ensure that those records are either in Citi Storage or were appropriately transferred to the Medical Records or Human Resources departments.

Mrs. Bolus asked if this had any impact on FQHC. To which Mr. McNulty responded no.

Mr. Martin added that it does not affect the status. It is just sloppy of the facility to put those records in a very public place.

Mr. McNulty said that the Chairperson of the Gotham Health FQHC was informed of the incident, noting that he briefed her again earlier in the week.

Mr. McNulty moved on to the next item in his report and informed the Committee that the OCC had not received or uncovered any reports with regard to an excluded provider since the Audit Committee last convened on September 11, 2014.

Mr. McNulty continued by discussing the Gotham Health FQHC and Compliance Oversight. He informed the Committee that the OCC was in the process of scheduling a compliance training session for the Gotham Board of Directors. He commented that the training was scheduled to take place in October, but the Gotham Board requested the rescheduling of the same. He stated that the training would take place either in November or December. He explained, essentially, that the training would cover the elements of a compliance program and issues concerning fraud, waste, and abuse; record management; and patient privacy.

Mr. McNulty continued with the External Audits item in his report concerning the Department of Health and Human Services Office of Civil Rights ("OCR"). He explained to the Board that this was a follow-up audit. He stated that, in March, the OCC received an OCR notice calling for the review of Metropolitan Hospital Center's ("Metropolitan") compliance with certain federal civil rights and health information technology laws and practices related to: (i) meaningful access to services and programs for limited English proficient individuals and individuals with HIV; and (ii) the privacy and security of individuals' protected health information ("PHI") and their rights with regard to such information. He reminded the Committee that in June the OCC responded to OCR's request. He further reminded the Committee that OCR subsequently requested additional information with regard to HHC's risk analyses on its information systems. He stated that OCR was informed that HHC performed a HIPAA risk analysis with respect to its QuadraMed system and engaged the services of an outside information technology vendor to perform a risk assessment and HIPAA GAP analysis at the HHC acute care facilities. He advised the Committee that on September 16th the OCC received another request from OCR that focused on the access of services for individuals with limited English proficiency. He advised that OCR had requested to interview members from the following departments at Metropolitan Hospital: (i) HIV Counseling and Testing Department; (ii) Inpatient

Medicine and Mental Health; (iii) Walk-in Testing; (iv) Satellite Clinic on East 120th Street; and (v) the coordinator of Language Access Services. He stated that the interviews were tentatively scheduled to take place on October 16th, commenting, in general, that the coordination process was ongoing. He informed the Committee that HHC is required to provide OCR with a list of all the employees and OCR will select the employees they wish to interview. Lastly, he advised the Committee that, earlier in the morning, he received another request from OCR regarding several questions about the information systems at Bellevue Hospital Center. Mr. McNulty advised the Committee that he had to take a closer look at the subject OCR request and that he would report back to the Committee with regard to the same. Mr. McNulty stated that this was very unique; commenting that, although OCR has jurisdiction on both privacy matters and matters concerning civil rights of individuals, this was the first time OCR performed a joint review of both matters and that this was the first time that he could recall OCR wanted to interview HHC employees.

Ms. Youssouf asked if there were any complaints on the hotline in relation to any of these items. Mr. McNulty responded no and commented that OCR's review was random. He advised that, in pertinent part, back in March, OCR informed the OCC that its review was a research survey. He added that it appears now to be more of an investigation.

Mr. McNulty then discussed the OCC's midyear 2014 compliance program assessment. He informed the Committee that, in 2013, the Bureau of Compliance at the Office of the Medicaid Inspector General ("OMIG") published guidance on how compliance programs may assess whether or not they are meeting the eight elements of a compliance program. He stated that OMIG provided an audit tool and instructed all compliance programs to perform a self-evaluation process twice a year - - once during the summer and once in December. He explained that the December assessment is used as the basis of the certification to OMIG that an effective compliance program exists. Mr. McNulty stated that the OCC performed the summer review and believed all eight elements were met. He further stated that the OCC would be performing another review in December, the findings of which will be disclosed to the Audit Committee and with HHC President and CEO Dr. Raju. Thereafter, he explained, Dr. Raju would certify via OMIG's website that HHC/OCC has an effective compliance Program.

Mr. McNulty informed the Committee that the audit tool basically requires the collection of documentation to satisfy each element in the audit. He added that the collection of documentation results in a two or three inch binder of evidence, which he explained must be kept ready for a possible OMIG effective compliance program audit. He stated that OMIG performs a set number of audits throughout the State annually. He closed his report by adding that the OCC is ready if HHC is audited. After asking the Committee if they had any questions, Mr. McNulty concluded his report.

There being no further business, the meeting was adjourned at 12:48 P.M.

Submitted by,

Emily Youssouf
Audit Committee Chair

MINUTES

SPECIAL AUDIT COMMITTEE **MEETING DATE: November 12, 2014**
TIME: 9:00 AM

COMMITTEE MEMBERS
Emily A. Youssouf, Chair
Josephine Bolus, RN

OTHER BOARD MEMBERS
Bernard Rosen
Mark Page

STAFF ATTENDEES
Salvatore Russo, General Counsel, Legal Affairs
Deborah Cates, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
Lynette Sainbert, Assistant Director, Chairman's Office
Randall Mark, Chief of Staff, President's Office
Lauren Johnston, Senior Assistant Vice President, Medical & Professional Affairs
Marlene Zurack, Senior Assistant Vice President/CFO, Corporate Finance
Jay Weinman, Corporate Comptroller
Wendy Saunders, Assistant Vice President, Corporate Planning
Gassenia Guilford, Assistant Vice President, Finance
Krista Olsen, Assistant Vice President, Finance
Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits
Wayne McNulty, Corporate Compliance Officer
Carol Parjohn, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Eunice Casey, Assistant Director, Corporate Planning
Jazmine Uruchima, Assistant Director, Managed Care
Manuela Brito, Chief Financial Officer, Coler/Carter
Aaron Cohen, Chief Financial Officer, South Manhattan Health Network
John Cuda, Chief Financial Officer, MetroPlus Health Plan
Tracy Green, Chief Financial Officer, Metropolitan Hospital Center
Julian John, Chief Financial Officer, Kings County Hospital Center
Rick Walker, Chief Financial Officer, Woodhull Medical & Mental Health Center
Ronald Townes, Associate Director, Kings County Hospital Center

OTHER ATTENDEES
KPMG: Maria Tiso, Partner; Joseph Bukzin, Senior Auditor
OMB: Tyler DeRubio, Analyst; Kristyn Raffelle, Analyst
DC 37: Moira Dolan, Senior Associate Director

NOVEMBER 12, 2014
SPECIAL AUDIT COMMITTEE MEETING
TALKING POINTS

A Special meeting of the Audit Committee was held on Wednesday, November 12, 2014. The meeting was called to order at 9:00 AM by Ms. Emily A. Youssouf, Committee Chair.

Ms. Youssouf then stated that we are having an update so we can approve and release the audited financials. We have spent a lot of time on these in prior meetings and there are a few changes that we are going to have KPMG highlight for us. She then turned the meeting over to Mr. Jay Weinman, Corporate Comptroller.

Mr. Weinman saluted everyone and said that since the October Audit Committee meeting, there have been three major changes and one minor change that I briefly want to discuss. I have handed out a one-page summary, along with the copies of financial statement pages for the balance sheet and income statements for you to follow along.

The first is KPMG did issue an unmodified opinion. That means that the financial statements were presented fairly in their opinion in all material respects. The following changes were made since the October meeting.

- An agreement with the City that HHC would not reimburse the City for the 2013 malpractice ($121.4 million) and debt service ($150.4 million) and other fringe benefits and expense payable ($28 million).
    - $299.8 million reduction to Due to The City of New York.

Ms. Youssouf stated that that is really good news and we thank the City very much.

Mr. Weinman continued with the second major change:

- Funding from the City for collective bargaining settlements of $118 million

Mr. Weinman said that the third one is GASB 68 – I had mentioned in October that the new pension guidelines, actually impact the financial statement materially. There were a couple of changes; one is that we recorded a liability of $2.5 billion as of 2014 that is reflected as a newly disclosed liability. We never carried the liability before and the expenses were $229 million. This is slightly different than what we actually fund, so that is a change due to the GASB and is reflected on the balance sheet on page 15 with a new category called “Deferred Inflows”. This is a representative difference between what is earned on a pension fund and what was projected.

Mr. Weinman stated that lastly, there was a change in the recording for third-party liabilities. We previously netted them out; we have done this in the past to be more consistent with some of KPMG other clients. We separated the liabilities and recorded $182 million in the liabilities section rather than netting the receivables.

Ms. Marlene Zurack, Senior Vice President, Finance/Chief Financial Officer, added that KPMG had handed out a brief statement. Ms. Youssouf then asked the representatives to introduce themselves. They introduced themselves as follows: Maria Tiso, Engagement Partner and Joe Bukzin, Senior Manager.

Ms. Tiso stated that Mr. Weinman covered everything on page three, the audit update which discusses the three significant issues. On page four we put together a summary of significant subsequent adjustments and how they impacted each of the categories on the financial statements. On item 1, total assets was impacted by $183 million and that increased by moving the receivables down to liabilities. On total liabilities there was an increase of $2.3 billion that

was the GASB 68 adjustment, a decrease due to the City in the collective bargaining adjustment and an increase to the third-party liabilities.

The deferred inflow of resources, a new line item on the balance sheet is $724 million. At the end of the day, the total net deficit position decreased by $2.8 billion which largely resulted from the GASB 68 adjustment. Total operating revenue increased by $390 million from the last the statement and is due to the appropriations from the City and the collective bargaining accrual. A total operating expense, which is good news, decreased by $234 million and that resulted from a decrease in the pension expenses from GASB 68.

Ms. Tiso added that we wanted to show at high level the unmodified opinion, and we worked diligently with the team of HHC as well as the team from the City of New York to implement the GASB 68. We had five days to have it implemented and HHC was the first in the country to have early adopted so kudos to HHC.

Ms. Zurack said that I would also like to give kudos to KPMG because they really pulled the resources on weekends and nights and made an effort to review a 318-page actuarial statement in a couple of days, and Mr. Weinman and his team as well had to do similar 11th-hour work and got it done on time, so kudos to all of them.

Ms. Youssouf remarked that I think this is great and this helps our new-cash position.

Ms. Zurack added that two pieces help – the pension piece does not help. The pension change looks like an improvement, but from a cash perspective there is no difference.

Mr. Mark Page, Board Member said that the pension change is due to the way the actuarial funding works, if you make changes, it increases your liability. You basically borrow from the pension system an amount to cover the liability and you pay it back over a scheduled period of time and you pay back interest and principal to amortize the loan. This change is saying that you recognize as an expense the interest but you no longer recognize as an expense the payment of principal. So it changes what our inflow/outflow presentation is. It does not actually change how much money we are obliged to pay for this actuarial need.

Ms. Youssouf thanked the City for what they have helped us with, and extended thanks and appreciation to KPMG and especially HHC staff for getting the financial statement out in such a timely fashion given that it was a lot of additional work involved.

Ms. Youssouf asked for a motion to approve the financial statement, it was seconded and approved by the Committee.

There being no further business, the meeting was adjourned at 9:09 A.M.

Submitted by,

Emily Youssouf
Chairperson
Audit Committee

KPMG LLP
345 Park Avenue
New York, NY 10154-0102

December 3, 2014

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

Ladies and Gentlemen:

In planning and performing our audit of the financial statements of New York City Health and Hospitals Corporation (the Corporation), a component unit of the City of New York, as of and for the year ended June 30, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered the Corporation's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we do not express an opinion on the effectiveness of the Corporation's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Corporation's financial statements will not be prevented, or detected and corrected on a timely basis.

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

During our audit, we noted certain matters involving internal control and other operational matters that are presented for your consideration. These comments and recommendations, all of which have been discussed with the appropriate members of management, are intended to improve internal control or result in other operating efficiencies and are summarized as follows:

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

Matrix of Observations

June 30, 2014

Network	Facilities Audited in 2014	External Financial Reporting Package Review	Accrued Expenses	Affiliation Contracts	Capitalization of Software Costs	Centralization	Vendor List	Accounts Payable Subledger to General Ledger Reconciliation	Fixed Assets	Account Analysis	Custodial Funds	Information Technology	Industry Issues
Corporate		X	X	X	X	X	X	X		X		X	X
Generations + Northern Manhattan	Lincoln Medical & Mental Health Center		X										
South Manhattan	Goldwater Memorial Hospital		X						X				
North Bronx	North Central Bronx Hospital		X										
Central Brooklyn	Kings County Hospital Center		X										
	East New York D&TC		X										
	Dr. Susan Smith McKinney (no site visit)										X		
South Brooklyn	Coney Island Hospital		X						X				
Queens	Queens Hospital Center		X										

Corporate

External Financial Reporting Package Review

Observation

HHC is required to upload their quarterly financial reporting packages to the Electronic Municipal Mark Access (EMMA) database in accordance with their bond obligations. Although management has several levels of review prior to presenting the financial reporting package to the Finance Committee for approval, management does not currently ensure that the version presented to the Finance Committee is the version that is posted to the EMMA website.

Recommendation

We recommend that management ensure that the version posted externally to the EMMA website is compared to the version that was approved by the finance committee and those in charge of governance.

Management Response

The Corporate Comptroller's office will view the EMMA website and verify that the web posting is consistent with the version presented to the Finance Committee.

Accrued Expenses

Observations

Management's policy does not require the network facilities to perform a detailed analysis and review of accrued expenses and adjust accruals quarterly. Accrued expenses are generally adjusted annually and are subsequently reversed in the following fiscal year end.

Management also identified invoices for approximately $8.8 million that were not accrued as expense on a timely basis and resulted in a post-closing adjustment to the financial statements.

Recommendation

In light of regulators' heightened scrutiny of financial reporting and the Corporation's required quarterly financial statements reporting to the Electronic Municipal Market Access (EMMA) database, we recommend that management adjust accruals quarterly.

Management should ensure that there is adequate communication between the various departments and the finance department for the recording of accrued expenses. Management may also consider centralizing the accounts payable process to possibly avoid delays processing expenses timely.

(Continued)

Management Response

The Corporate Comptroller's office instructs facilities to accrue appropriate expenses at year-end. Management agrees that the Corporation should accrue expenses at least quarterly to be reflected in its internal quarterly financial statements. Management will explore the best method to ensure that all appropriate costs are recorded on an accrual basis.

Affiliation Contracts

Observation (Repeat Comment)

Affiliation contracted services is a significant expense for the Corporation and the monitoring of the expenses associated with these contracts requires the cooperation of various departments both within and outside the Corporation.

We noted the following during the course of our test work in conjunction with the review of the compliance audits performed by HHC's Internal Audit:

- Several of the contracts were executed after the commencement of the contract period.
- Recalculation documents are not prepared on a timely basis resulting in potential future adjustments.
- Independent financial statement audits were not conducted in a timely manner in accordance with the contract.
- Similar to the prior year, the compliance audits identified a lack of documentation surrounding background checks which led to instances of the inability to verify performance of background checks, and terminated employees retained access to various systems. Additionally, in the current year the following findings were noted:
  - Incomplete human resource files (i.e. no offer letters, no resignation letters, no exit checklists, there was inconsistent payroll data for new hires, clearance wasn't obtained from Occupational Health Services (OHS) for certain employees, and expired medical clearance forms)
  - Standardized time sheets are not utilized. This could result in improper recording of salary
  - Graduate Medical Education (GME) time studies were incomplete and inconsistent with payroll records.
  - Subcontractor agreements were expired or missing, payments lacked supporting and appropriate documentation, and payments were not in accordance with the contracts.

(Continued)

— HHC employee ID badges were not timely activated / deactivated for current and former employees

2014 Observation

An internal audit review of the corporate Physician Affiliate Group of New York, PC (PAGNY) related expenses during fiscal 2014 was not performed in accordance with the affiliation agreements. The audit was not performed due to the lack of cooperation by PAGNY senior executive management.

Recommendations

KPMG recommended that:

- Affiliation contracts should be executed prior to commencement of the contract period.
- Reconciliations between the affiliate and the facilities should be performed timely in accordance with the contract.
- Independent financial statement audits should be performed within the time frame set forth in the contract
- Management should enforce the contract terms whereby the Affiliate is required to provide complete and accurate time sheets for service providers working under the affiliation contract as well as the completion of all required forms and reports. Subcontractor agreements should be reviewed annually to ensure validity and all payments to subcontractors should have appropriate and sufficient supporting documentation. Additionally, all terminated employees' access to system should be removed upon termination.

2014 Recommendation

Given the nature and size of the contract and expenses, we recommend that a review of these expenses at PAGNY corporate be performed by the internal audit department.

Management Response

HHC continues to strive to have all affiliation extension agreements executed before the beginning of the contract term. With the exception of PAGNY agreements, all 2013 contracts have been executed. During 2013, HHC and PAGNY have executed a Letter of Intent outlining the terms of the fiscal year 2013-2015 contract. The contract will be executed shortly.

Management agrees that final settlement reconciliations (recalculations) should be completed in a timely manner. During fiscal year 2013, HHC executed the fiscal year 2012 reconciliation with Mount Sinai School of Medicine, SUNY Downstate, and the fiscal year 2011 January-June NYU

(Continued)

Woodhull/Cumberland settlement. Due to Super Storm Sandy, the fiscal year 2012 NYU reconciliation was delayed. Draft recalculation documents are completed and should be executed shortly. HHC and PAGNY are working to complete the fiscal year 2011 and 2012 recalculation documents by the first quarter of calendar year 2014. The fiscal year 2013 settlement documents will be completed by the end of fiscal year 2014.

The facilities, Central Office, and outside legal counsel are working with prior affiliates to complete the final settlement recalculations and the disaffiliation process by the end of fiscal year 2014.

Management and one of its affiliates have developed an interactive computerized budget management system to facilitate the electronic reconciliation of payroll data and expedite the budget reconciliation process. This system should be in effect during fiscal year 2014.

HHC will continue to work with affiliation senior management to ensure that contract terms are met.

Management Response Update (2014)

Contracts for the 2013-2015 fiscal years have been executed with PAGNY and all other affiliate agreements are current. Recalculation settlements for 2012 are complete for Mount Sinai School of Medicine, SUNY Downstate and NYU. The SUNY Downstate, Mount Sinai and Coler/Carter NYU 2013 recalculations are complete and the remainder of the NYU recalculations for 2013 is in various stages of review and completion.

PAGNY recalculations are in process for 2011 and 2012 and are expected to be complete by the end of calendar year 2014.

Management recognizes the difficulties in preparing recalculations for PAGNY and is working with them to maintain an interactive computerized budget management system to facilitate the electronic reconciliation of payroll data and expedite the budget reconciliation process.

Central Office, facilities and outside legal counsel are working with prior affiliates to complete the final settlement recalculations and the disaffiliation process.

HHC's Office of Internal Audits (OIA) concurs with KPMG's finding and recommendation. OIA made attempts to initiate the audit in January, March and June 2014. Finally, In September 2014, after eight months of negotiating with and accommodating Corporate PAGNY, they agreed to allow this audit to begin. The audit is expected to be completed by the end of the calendar year 2014.

(Continued)

Capitalization of Software Costs

Observation

The Corporation is currently implementing its electronic medical record system. During fiscal year end 2014, the Corporation incurred approximately $5 million of payroll and payroll related costs relating to the implementation of the electronic medical record system. We noted that these costs were expensed rather than capitalized.

Recommendation

We recommend that management review all costs incurred with the implementation of the electronic medical records project to ensure that all costs are monitored and appropriately classified as capital or expense since the ongoing project costs will be substantial in subsequent years.

Management Response

Management agrees with the finding and is currently working with Enterprise I.T. Services to capture all capitalized payroll through the use of weekly time allocation surveys currently being developed.

Centralization

Observation

The Corporation can potentially be enhanced through centralization and system integration. Currently, the Corporation has several functions that are centralized which include Information Technology services, procurement, treasury management, financial statement preparation (including receivable valuation), managed care rate negotiation, reimbursement rate reviews, billing and other finance systems maintenance. Other functions within the Corporation that are decentralized and performed at the facility locations include accounts receivable billing, accounts payable, payroll, reimbursement, and budget management and reporting. We also noted that during fiscal year 2014, the Corporation has centralized its procurement function and has appointed a Chief Procurement Officer.

Recommendation

We recommend that the Corporation consider centralizing various functions. Moving towards a system of integration and centralization of functions such as accounting and accounts payable may enhance controls, reduce and contain costs, effectuate cross-training of employees, improve communication, reduce risk, and allow for effective decision making.

(Continued)

Management Response

Management agrees that centralization of certain functions may result in cost savings for the Corporation. Management will conduct a study to determine the feasibility of centralized functions and the opportunities to reduce costs and encourage efficiencies. Best practices within the industry will be examined for possible implementation at the Corporation.

Vendor Listing

Observation

The Corporation routinely hires full time independent contractors, such as temporary nurses, doctors and experts who provide service to the Corporation. During our testwork, KPMG identified fourteen employees at various facilities who were independent contractors and were subsequently hired by the Corporation but remained on the vendor listing.

Recommendation

We recommend that management institute policies and procedures to ensure that these individuals are removed from the vendor listing timely prior to the beginning of their employment in order to eliminate potential duplicate and erroneous payments and employee fraud.

Management Response

Management will implement a policy that requires departments to notify Materials Management to remove the independent contractor from the vendor listing when the individual is hired by the Corporation.

Accounts Payable Sub Ledger to General Ledger Reconciliation

Observation

During our audit, KPMG noted that central office does not have a detailed accounts payable sub-ledger report that reconciles to the general ledger.

Recommendation

We recommend that management obtain a detailed accounts payable sub-ledger report that is periodically reconciled to the general ledger to ensure accuracy of the accounts payable balance. Any unusual reconciling items should be investigated and addressed timely.

(Continued)

Management Response

Through testing, management has already determined that the sub-system's transactions are properly captured by the general ledger. However, management recognizes the importance of a reconciliation process with detailed sub-ledger reports. The Corporate Comptroller's Office will work with IT to develop a report that will reconcile the total vendors payable to the general ledger. Balances in the OTPS Management System (the sub-ledger) will be established and compared to the general ledger and adjustments proposed.

Account Analysis Received from Other Departments

Observation

Management routinely receives account analysis from other departments in order to update and adjust the financial records. During our review of the pollution remediation accrual account analysis, we noted that the accrual was recorded in the general ledger system inappropriately and resulted in an overstatement of the accrual by approximately $56 million. In addition, management also identified an overstatement related to recording of pool payments as revenue that pertain to fiscal year 2015. Management subsequently adjusted the financial statements for the errors identified as a post-closing adjustment.

Recommendation

We recommend that management develop policies and procedures to ensure that account analysis from other departments are reviewed by the appropriate department supervisor and that a detailed analytical review is performed by an individual other than the preparer of the analysis.

Management Response

Accounting staff have been trained to review external account analyses more critically. Knowledge of area undergoing the review will be focused on so staff can more readily recognize errors or inconsistencies with account analyses. Additional training has begun on fundamentals of testing data for inaccuracies. Training will continue commensurate with level of experience.

(Continued)

Information Technology

Terminated Users

Observation

During our testing of removal of terminated users, the following issues were noted:

- One (1) terminated user inappropriately maintained access to data center.
- Two users out of a sample of 25 were not disabled from the active directory in a timely manner.

Recommendation

The workflow and policies needs to be developed by HHC EITS Team along with the HR department to centralize this process and inform respective parties immediately about the changes of each user's status and address the gaps in above mentioned controls.

Management Response

Human Resources and EITS is working on developing a process for department head notification to EITS when an employee no longer requires system access. Integration with PeopleSoft is currently under a testing phase as a method for communicating system access terminations as well as ID/equipment issued to individuals that need to be returned.

Site Visits

Fixed Assets

Observation

KPMG identified one fixed asset at Coney Island Hospital which was inappropriately marked as received in the Other Than Personnel Services (OTPS) System as of March 31, 2014. Prior to physically receiving the asset, the facility recorded the asset on its fixed asset system and began depreciation in order to pay the vendor.

Recommendation

We recommend that management implement controls and updated policies and procedures to address the process that should be followed when an asset is returned to a vendor and payments to vendors for an asset prior to its actual receipt.

Management Response

Management recognizes that this was an isolated instance due to Super Storm Sandy. Hospital policy dictates that no payment is to be made until assets are received, installed and verified that they are functioning in working order. Equipment had been previously received, but removed by the vendor in order to reconstruct the room designated for the equipment that was damaged by Super Storm Sandy. Since the equipment was housed by the vendor as a courtesy to the facility, the vendor required payment, and it was inadvertently recorded as a depreciable asset. The hospital's Controller is working with department heads and materials management to ensure that equipment not put into service is recorded as construction in progress rather than as a depreciable asset. The fixed asset liaison will work with material management in strengthening internal controls for the issuance of asset tag numbers and the recording of depreciable fixed assets.

Goldwater Movable Equipment Disposal

Observation

Subsequent to the closure of the Goldwater Facility, $2.5M of the $5.3M of equipment book value was distributed to the Henry J. Carter and Coler Memorial facilities. The remaining assets were transferred to various other facilities and disposed of completely. However, KPMG was unable to obtain a listing of these assets to verify their amounts and which facilities the assets were transferred to.

Recommendation

We recommend management develop specific policies and procedures as it relates to the transfer of assets from to other facilitates. This process should ensure that there is accurate record keeping of assets transferred including specific characteristics such as tag number and item description.

(Continued)

Management Response

Policies and procedures for transfer of assets between facilities currently exist and processing is completed only at the Corporate Comptroller level. Changes are processed in the system after the required transfer forms have been submitted by the facilities. Prior to the audit, the facility began the process of transferring control of the fixed assets duties from Materials Management to the Finance Division, reporting directly to the facility's Controller to gain greater control of asset reporting.

The facility Controller is working with the Corporate Comptroller's Office to disseminate these corporate-wide policies and procedures for the transfer of assets between facilities to staff members. In addition, the Corporate Comptroller's office will continue educational sessions with fixed asset staff members across the Corporation. The Facility Controller, in conjunction with the Fixed Asset Manager and the Facility's Materials Management Director, will periodically review for compliance when transfers occur.

Custodial Funds

Observation

During our audit, KPMG noted that Dr. Susan Smith McKinney Nursing & Rehabilitation Center changed the policies and procedures relating to custodial funds without previous approval by the Corporation. This resulted in an incorrect accounting of the custodial funds of approximately $700,000 which was not considered material to the financial statements.

Recommendation

Although the adjustment of $700,000 was not material to the overall financial statements, we recommend that facilities request approval from the Corporation's Central Office prior to implementing any new accounting and policy changes.

Management Response

Management agrees with the recommendation and will ensure prior approval is received from the Corporation's Central Office before the implementation of any new accounting and policy change. As a result, the facility will revert to the previously approved accounting policy, where the custodial account will be utilized for recording all of the related transactions, effective November 1, 2014.

Prior Years Comments Cleared

During the course of our testwork, we noted several areas in which the prior year management letter recommendations were adopted. These remediated comments are listed below.

Corporate

Construction Management

Observations – Repeat Comment

There have been several major construction projects conducted by the Corporation that have resulted in significant cost over-runs from the original established budgets for the projects.

Recommendation

KPMG recommended that management analyze all aspects of the construction management process and determine ways to eliminate and/or reduce cost over-runs.

Management Response

The Office of Facilities Development (OFD) has now implemented new processes that validate scope and construction elements. Standard work has been developed for reviewing the scope of the project, the program plan, the bidding documents, and the estimation of costs. Management also revised its operating procedures to include OFD's review of construction procurements. In addition, HHC is exploring the use of risk-oriented contract management services to mitigate any potential construction cost over-runs.

Resolution

The Office of Facilities Development continues with its process improvement. OFD has undertaken a series of "Breakthrough" events in collaboration with HHC's Networks, and developed a "Scorecard Tool" to identify program and scope issues early. The tool is now in use on projects and has been the primer for the new, developing Enterprise wide capital plan, now in the final evaluation process. The bid document and cost evaluation have been standardized and is working as planned. "At Risk" contracts are being considered for FEMA funded mitigation projects. Validations of scope and cost estimates on substantive projects are now being evaluated by outside consultants.

Observation

During the course of our test work, we noted that the construction in progress balance at year end did not include approximately $16 million of expenditures incurred related to construction on the major modernization of Henry J. Carter Center.

(Continued)

Recommendation

KPMG recommended that management implement a process to monitor all construction projects in order to ensure that all expenditures related to the projects are included in construction in progress and properly capitalized when the project is complete.

Management Response

Management has developed several new procedures to ensure updated records are used for recording project expenditures. The new procedures include stronger communication between the Office of Facilities Development and the Corporate Comptroller's Office on the status of project completion. This will ensure that HHC accrues all related construction appropriately.

Resolution

The Office of Facilities Development (OFD) has been routinely meeting with the Corporate Comptroller's office to reconcile construction in progress. Both parties are working together with outside construction management companies to obtain all current construction data and to ensure that all information is up-to-date. This process allows management to assess the completeness of submitted data and to agree on any necessary adjustments to information received. All relevant construction in progress has been captured and recorded as a result of this process.

Materials Management

Observations

During the course of our test work, we noted that purchased items are received at the departmental level and there is no centralized receiving department to ensure that the items that were delivered correspond with the purchase order. KPMG noted that in many cases, the individual receiving the asset items is the same individual who orders the items, resulting in a lack of segregation of duties. KPMG notes this could allow for delivery of incorrect/unauthorized items.

Recommendation

KPMG recommended that management implement a process to ensure proper segregation of duties between the individuals who order asset items and the individuals who check-in items when they are received.

(Continued)

Management Responses

Management recognizes the importance of ensuring segregation of duties as it is imperative to maintaining proper internal control. The Corporate Comptroller's Office has begun to educate senior leadership in the finance and supply chain departments on the importance of this control. Education on basic internal controls related to segregation of duties will continue through the Corporate Comptroller's Office. In addition, the Office of Internal Audits will add a review of this internal control to their audit program.

Resolution

Education on this process is ongoing. Many cost center managers have adopted new procedures in order to segregate duties in the receiving and payment approval process. Feedback from facilities notes Managers continue to be in-serviced regarding segregation of duties.

The Office of Internal Audits (OIA) will review the Materials Management area after the full implementation of the Centralized Procurement processes has been completed.

Observation

During the course of our test work, we noted one instance in which an item related to a grant was stamped as received and recorded as an expense and a payable in June 2013, however, the item was not received or invoiced until August 2014. The item related to fiscal year 2014, and therefore should not have been recorded as an expense in June 2013. When management brought this to the attention of KPMG, the expense was reversed.

Recommendation

KPMG recommended that management implement a process to ensure that all items are received prior to being stamped as received and recorded as an expense in the period in which the expense is incurred.

Management Response

Management has trained departmental staff in the process of receiving and has separated the ordering and receiving functions among staff for better internal control. Verification of received goods requires the signature of an individual that validates the actual receipt and ensures that expenses are properly recorded in the correct period.

Resolution

Management has trained departmental staff on the process of ordering and receiving, and the department has since been re-organized. Management believes that the new processes adequately prevent erroneous receiving practices.

(Continued)

Site Visits

Observations

During the course of our test work, we noted the following errors in compliance that did not rise to the level of control deficiencies and therefore, did not alter our planned audit approach:

- Payroll and Human Resources

    1. One manager at Woodhull Medical and Mental Health Center worked two consecutive tours of duty and was overpaid for one hour over the 35 weekly hours permitted for managers. KPMG noted that this resulted in inappropriate payment.

- Materials Management

    1. A fixed asset item at Woodhull Medical and Mental Health Center was disposed of but remained on the fixed asset subledger. KPMG noted that this resulted in an improper fixed asset balance.

Management Responses

- Payroll and Human Resources

Management has determined that overpayments may occur for the Administrators on Duty (AOD) that are paid on an hourly basis. Training of all AOD will be conducted on the proper completion of time sheets when multiple shifts are worked. Additionally, management will periodically check on the adherence to this process.

- Materials Management

Since the recent transition of personnel in the Finance department, new procedures have been developed to include the preparation and approval of the Relinquishment Form. This will be reviewed by the facility Controller's Office and requires the physical observation of the equipment and reconciliation to the Fixed Asset Management System.

(Continued)

Resolution

- Payroll and Human Resources

The AOD Department Head has been instructed that the time sheet should not have any hours in excess of the 7 hour per tour maximum. Additionally, Group 11 employee time sheets undergo a weekly review by the Payroll supervisor after initial timekeeper review and input to ensure compliance with this policy.

- Materials Management

Physical observation of equipment is reconciled to the FAMS. The Fixed Asset Reconciliation form is reviewed quarterly by the facility's Controller's office and any discrepancy is followed up and resolved.

Industry Comments

Internal Audit Reporting

Internal Audit is structured so as to enable both the maintenance of independence and objectivity, as well as proximity to the business so as to establish and maintain relationships with and comprehensive understanding of the business. The Chief Internal Auditor currently reports internally to the Chief Operating Officer. We recognize that the Chief Internal Auditor also reports directly to the Audit Committee. Best practice would allow for the Chief Internal Auditor to administratively report directly to either the Chief Executive Officer or Chief Financial Officer. We recommend that management evaluate the reporting structure of the internal audit department.

New York State's Delivery System Reform Incentive Payment (DSRIP) Program

Over the next 5 years, many healthcare providers throughout the state will be significantly impacted by New York State's Delivery System Reform Incentive Payment (DSRIP) program. DSRIP will address critical issues throughout the State's safety net providers and allow for comprehensive care delivery reform. The DSRIP program will promote community-level collaborations and focus on clinical integration, with the stated goal to achieve a 25% reduction in avoidable hospital admissions and Emergency Room visits over the next five years. Eligible participants will be required to collaborate with other entity types to implement innovative projects focusing on system transformation, clinical improvement and population health improvement to meet their respective community's health needs.

Collaborating providers associated with a new emerging Performing Provider System (PPS) will be tasked with addressing their community's health care needs based on multi-stakeholder input and objective data through a DSRIP Project Plan. Providers should be aware and consider the strategic risks associated with participation in a PPS and Project Plan. Some key risks to be aware of are:

- Partner selection process: PPS leads and participants need to carefully consider selecting appropriate partners to meet DSRIP requirements. With the stringent reporting that will be requires to obtain and maintain the awarded funding, partner ability to meet program goals and reporting requirements will be a key determinant of success.

- Governance: PPS participants will be required to collaborate with other healthcare entities who are in many cases unaffiliated entities. A clear, effective governance structure will be needed to define relationships and responsibilities as these entities move forward in process that will drive both clinical integration and financial interdependence.

(Continued)

- Project selection process – Each PPS will need to work with its PPS partners to select projects which are in line with organizational priorities, meet community health needs and DOH objectives, and maximize funding opportunities. With many projects to choose from, finding the right combination of projects will be a key ingredient to maximize the benefits of DSRIP to the participating providers and the communities they serve.

- IT – The clinical integration that is a primary underlying objective of the DSRIP program will require extensive data sharing across potentially unrelated organizations. This may require significant capital investment to IT systems which is not funded by the DSRIP program. Facilities will need to find alternate sources of funding for these and any other capital investment that may be required in order to implement the projects.

The DSRIP program represents a significant opportunity to effect fundamental change in New York's healthcare delivery system, as well as a funding opportunity for individual providers to prepare themselves to serve their communities more effectively in the next era of healthcare delivery. It is critical for the management and boards of those entities to be engaged in the process and understand the risks and benefits so they can effectively steer their organizations through the changes to come.

Convergence in Healthcare

Over the last decade, the U.S. healthcare system has been struggling to redefine itself. What we know is that the current system is unsustainable, does not always deliver the highest standard of care, and is disjointed. As such, healthcare organizations should be thinking beyond healthcare transformation and focus on healthcare convergence. While transformation of current operations is likely going to be a business requirement, the real question for forward looking organizations is what role they plan to play in a new and more converged heath system. Today's transformation is inward looking – assembling the component parts, experimenting with new payment models, monitoring employer and consumer trends and understanding the role of new entrants. Tomorrow's transformation will be defined by collaborating with others, such as providers, payers and life science companies, coordinating care across the continuum and developing extended operating models, which is called Convergence. Healthcare convergence will offer leading organizations new ways to grow revenue, reduce costs, manage risk and deliver quality care. There are already signs of Healthcare convergence that is steadily beginning to affect organizations which include: volume declines and new metrics, health insurance exchanges coming online, reimbursement reductions, frequent questions on whether to build or buy a health plan and governance questions on the linkage of strategy and risk. As healthcare convergence evolves, organizations need to be aware of various risks that need to be managed which include:

- Acknowledging margin compression

(Continued)

- Evaluating the opportunity to disrupt or the risk of being disrupted given the velocity of local market changes, including physician and other provider alignment
- Preparing for revenue transformation as new revenue streams emerge around public and private exchanges, narrow networks, and other value based arrangements
- Understanding the payer response and monitoring employer and consumer attitudes/acceptance
- Evaluating "make or buy" decisions on the necessary tools, technology, and talent to operate in a risk-based environment
- Becoming agile around cost structures given declining volumes coupled with clinical transformation
- Conducting scenario planning, predictive modeling, and war gaming around market transformation and the impact on financial performance
- Assuring the integrity of clinical reporting and developing new metrics for the transition from volume to value
- Converting unstructured data into information for decision making to enable clinical, operational and financial benchmarking across the continuum of care along with real-time predictive clinical surveillance systems
- Managing increasingly complex compliance regimes and enhancing transparency in reporting

In addition, health reform initiatives will require hospitals and physicians to examine their historical relationships and align around patient-centered care and shared financial gain. In order to remain competitive within the market, the Hospital's management is continuing to refine its strategy related to physician integration and alignment. While various care models and/or reimbursement methodologies may emerge as healthcare reform and convergence evolves, the following considerations will affect the changing nature of the hospital/physician relationship:

- A shift in the location of services from acute to more efficient and cost-effective ambulatory settings
- A change in focus from volume versus value-driven reimbursement, resulting in service delivery rewarding quality, patient safety, patient satisfaction, and cost effectiveness

(Continued)

- Development of a team-based approach to care, with increased communication among providers throughout the continuum of care, supported by clinical integration and shared goals

- Increased role of physicians in health system governance and contribution to strategic discussions within the clinical enterprise

- Employment and/or alignment arrangements that are mutually beneficial to hospitals and physicians, which continue to meet legal and regulatory standards related to fair market value and commercial reasonableness,

- Compensation for employed physicians which reward experience and balance goals related to productivity, quality, and shared accountability for financial success.

The organization needs to continue its efforts towards the integration and alignment of its physician network.

Overall, organizations will need to see convergence at a strategic level to create new models and incentives; convergence at a system level to integrate data and IT; convergence at the patient level to deliver an integrated model of care; and convergence at the ecosystem level to ensure best practices and new approaches are tested and results shared. To achieve this, organizations will also need strong leadership. The reality is that the move towards a value-based system that encourages more accountable care capability requires long-term vision and the ability to collaborate across the value chain: payers, providers, life sciences organizations and patient groups will all need to apply equal leadership to create and implement a new model for our U.S. healthcare system.

Signs of leadership are already emerging with some networks across the country demonstrating that success can be achieved when payers and providers converge on mutual goals and approaches, as well as new care delivery and business models.

The next stage in the evolution of the healthcare industry reflects a convergence of interests among providers, payers, and life science companies; utilizing advanced analytics, enabled by new technologies to change the practice of medicine and the business of healthcare. Organizations that previously acted independently are going to be working together in new and innovative ways to deliver healthcare. Healthcare organizations should begin now to assess markets and capabilities as well as their financial preparedness.

(Continued)

Health Insurance Exchanges

The Affordable Care Act (ACA) presents significant revenue risks to providers that require immediate attention. Several provisions of the ACA that became effective January 1, 2014, will induce changes to the patient population that could reduce revenue if organizations are not well prepared. The ACA seeks to increase insurance coverage for 32 million uninsured individuals.

With the onset of the individual mandate and the online state health insurance exchanges, it is critical that organizations prepare for a new, larger population of patients with high-deductible plans and self-pay liabilities. Possibly adding to this population are many individuals with employer-sponsored insurance that may forego their current insurance and select insurance plans on the exchanges in order to take advantage of premiums. In light of these provisions, organizations must prepare for significant increases in self-pay liabilities from this new "high-deductible" patient population, or risk a reduced level of reimbursement. As such, organizations should reconsider their charity policies, review their current allowance methodologies, understand the different levels of patient liabilities, and reevaluate their revenue cycle.

Meaningful Use Documentation Imperatives

We recognize that management has already attested for meaningful use under Stage 1 at certain fallibilities. As the criteria for meaningful use attestation under Stage 2 becomes more complex and challenging to achieve, we continue to recommend that these best practices be followed. Furthermore, many hospitals, have already begun receiving audit requests for documentation related to their meaningful use attestation. Some common documentation best practices should be reviewed and implemented. These best practices include the following:

- Saving copies of certified EHR reports
- Creating copies of patient level detail
- Conducting reasonableness checks
- Converting reports to PDF format
- Supplementing EHR reports with relevant screen prints
- Supporting the data underlying both the numerator and denominator relating to the meaningful use criteria as it relates to core set objectives and quality measures
- The documentation must support the date range of the meaningful use reporting period.
- Patient level detail should be retained to demonstrate accuracy and completeness of the data used in the reporting process.

(Continued)

- Periodic sampling and validation tests should be conducted for each measure to help ensure that the data appears reasonable, that completeness and accuracy are sustained, and that improvement opportunities are exploited.

- Any assumptions or interpretations regarding the CMS rules and regulations that have been applied in data gathering and preparing calculations for attestation purposes should be documented. Therefore, written interpretations, workflow descriptions, and relevant policies should become part of the documentation retention strategy.

Where compliance is achieved, it is important to maintain current architecture diagrams that describe the key data exchanges and how that data is used for meaningful use reporting.

Sustainable Growth Rate and ICD-10 Extensions Approved by Senate

The Senate approved a bill on March 31, 2014 that prevents steep cuts to Medicare physician payments from going into effect for one year and delays the conversion to International Classification of Diseases 10 (ICD-10) diagnostic and procedure codes for at least one year (original transition date was by October 1, 2014). The Senate voted 64-35 in favor of the Protecting Access to Medicare Act of 2014. Assuming the president signs the legislation, it will be the 17th such patch that Congress has enacted since the so-called Medicare sustainable growth-rate formula (SGR) law in 1997.

It is important that the Hospital's management reassess their progress made to date toward addressing the impact of ICD-10 on operations, process and policy upgrades, and potential training issues and take the delay as an opportunity to ensure a smooth transition. ICD-10 conversion is considered to be a highly complex implementation and will lead to significant changes in people, processes, finance, and technology. If the Hospital is not prepared, there could be rejected claims, lower reimbursements, and longer payment cycles.

Privacy

HIPAA Compliance

The Department of Health and Human Services recently finalized the Omnibus in January 2013, which modifies the existing Privacy, Security, and Breach Notification Rules under HIPAA and HITECH. The Omnibus will be effective in March 26, 2013, with a compliance date of September 23, 2013.

The Omnibus codified the compliance monitoring required by the Office for Civil Rights (OCR), which was initially put forth in HITECH. In response to HITECH, OCR established an Audit Program that was executed across covered entities across the country in 2012. OCR has indicated that the Audit Program will continue, with the next round of audits to include business associates.

The Omnibus modifications represent significant changes to the Rules, particularly in the Privacy and Breach Notification Rule. Among the most significant changes brought forth by the Omnibus are the changes with respect to business associates and breach notification. The definition of business associates has changed to include a person or organization that creates, receives, maintains, or transmits protected health information (PHI) in the course of performing functions on behalf of a covered entity. Additionally, covered entities are now required to gain documented satisfactory assurances from the business associates regarding the safeguards for PHI.

The Omnibus further clarified the liability related to PHI and indicated that there is downstream liability. The requirements to safeguard PHI, adherence with the Security and Breach Notification Rule, and the terms agreed to in the business associate agreement run down stream to any vendor or subcontractor engaged by the business associate. Absent a business associate agreement, OCR has the authority to make the determination that a vendor is performing the functions of a business associate, thus imposing liability. Covered entities must perform a risk assessment of its vendors to adequately understand and mitigate potential risks.

The changes related to Breach Notification eliminated the threshold of harm standard. Previously, a covered entity engaged in a risk analysis to determine the significance of harm for any unauthorized access or disclosure of unsecured PHI to determine whether there was a significant risk of reputational, financial, or other harm, thus resulting in a breach. The standard has been lowered with the Omnibus, instituting a presumption of breach, unless a covered entity can demonstrate a low risk of harm based on factors identified by the Omnibus Rule.

There are also other changes to access to PHI, marketing, fund-raising, the definition of PHI, genetic information, deceased individuals, and research; all changes will require updates to the Notice of Privacy Practices as necessary and appropriate consistent with the requirements.

Under the Omnibus, penalty levels have been increased for noncompliance. Penalties are increased for noncompliance based on the level of negligence with a maximum penalty of $1.5 million per violation. In addition to monetary fines, noncompliant covered entities may be subject to loss of contracts, criminal and civil investigation, federal and state fines, cost of breach notification, and reputational risk.

As technology becomes further integrated with the delivery of care through medical records, sharing information on smart phones, texting, and cloud technology (see additional comments), we recommend that the System revisit its HIPAA compliance program to ensure that the organization is able to comply with the recently enacted HIPAA regulations. Healthcare organizations should consider the following:

- Does the organization engage in an annual documented HIPAA risk assessment of both the Security and the Privacy Rule under §164.308(a)(1)(A)?

- Does the organization know where all of its PHI is, including software, legacy systems, mobile devices, and unstructured data?

- Does the organization have controls in place to identify all vendors requiring a business associate agreement and to understand the information being disclosed to the vendors and by whom in the organization?

- What is the organization's plans to update its key HIPAA documentation and practices with respect to the Omnibus?

- The organization started to implement a certified meaningful use system; has the organization updated its risk assessment to meet meaningful use criteria?

Electronic Personal Health Information

The growing use of mobile devices in healthcare increases the risk to healthcare organizations that the security of their patient ePHI (electronic personal health information) could be breached. As such, healthcare organizations need to develop strategies to protect all ePHI accessed, stored, or transmitted via smart phones and tablets. This strategy may include a mobile security risk assessment, establishment of policies and procedures regarding mobile access, patient consent, and data storage on mobile devices, including encryption, transmission to and from mobile devices, and training programs, and implementing measures to prevent unauthorized access.

Data Analytics

Achieving actionable insights with data and analytics is critical in today's environment. The issue is no longer about owning the most data, but rather about how to gain the most insight from it and how to turn that data into insights and insights into real business advantage. Data and analytics will define the way business and organizations operate in the future.

Data Analytics could provide opportunities for organizations to improve internal operations in the areas of operating costs, resource management, identifying process or performance efficiencies, and identifying new business opportunities and ways to be innovative. Data analytics can drive improvements in care processes, delivery and management as well as support optimal revenue cycle performance and further achieve the organization's mission.

The Office of Inspector General and Centers for Medicare and Medicaid Services are launching data mining and analytics efforts aimed at identifying hospital errors. As a result of this increased scrutiny from the healthcare regulatory environment, data analytics will be an important tool to use to mitigate the potential financial risk against providers. Healthcare organizations are beginning to think of ways to analyze and connect meaningful data across several systems, such as financial, operational, and clinical systems.

Once an organization has the ability to identify, capture and analyze data, the organization can not only start to see true causes and effects and identify opportunity to mitigate risk, but they can then use this insight to identify solutions to existing matters as well as possibly predict outcomes based on certain initial conditions and looking at probability based modeling scenarios. Predictive modeling and analyzing data will be critical for an organization's continued success. A data-driven organization would be highly capable of using data to manage its exposure to risk and identify opportunity, provide sharper insight into how their activities would impact top and bottom-line performance. And finance would no longer focus on analyzing why forecasts were missed and instead focus on providing insight on where the business can close the gap in order to meet or exceed upcoming financial goals. A fully embedded data and analytics strategy would mean that businesses and employees look first to data to guide their actions, that business decisions are made based on deeper insight and keener analysis, that opportunities are naturally identified and properly exploited through predictive analytics, and that business flexibility and responsiveness is enabled and enhanced. It is important that organizations be proactive instead of reactive in analyzing key metrics and information.

Social Media Risk: It's More than Just Technology

Many boards and finance committees of healthcare organizations are developing strategies in order to assess the organizations risk around social media. Reputation, data privacy, and security, among others, are social media risks that can significantly impact the organization if adequate processes are not in place to address these risks. Significant areas of risk include:

- Increased risk of legal liability if organizations or their employees use social media inappropriately
- Potential loss of data, including intellectual property and personally identifiable information via employees who are participating in social media channels using corporate accounts or as individual users
- Impact to the network, resulting from increased use of bandwidth by individual users who access social media web sites while at work
- Increased risk of malware exposure on the network and other forms of Web-based attacks

These risks present themselves through a number of avenues. Employees, volunteers, and third parties may access social media while accessing company and private networks. Communications with donors/beneficiaries may occur over social channels. In addition, there may be negative public forum discussions about the organization that impact reputation if the organization does not defend itself. Finally, new social media technologies are evolving that are outside of a company's direct control.

Organizations should develop a social media governance structure that incorporates protection of confidential data, intellectual property, and reputation. In addition, organizations must carefully consider how best to use the social media data they collect and disseminate so as to generate positive awareness and avoid reputation-damaging events. Organizations need to better understand the laws and regulations they need to follow. In addition, organizations need to find the right balance with respect to monitoring in order to protect the organization while, at the same time, avoiding a "big brother" reputation, which can undermine employee/volunteer trust.

Organizations should develop polices around social media technology. Policies should include, password management, access controls, authentication, application maintenance strategy, and network interfaces. For example, if a group of employees is permitted to "Tweet" in the company's name, each employee should have a separate ID, rather than using one shared ID. Additionally, those organizations employing monitoring technologies should consider the adequate level and techniques of data governance that may need to be utilized to protect this new information resource.

Having a well-defined social media governance structure is critical for organizations as they navigate the challenging environment of social media. Policies and procedures need to be revisited periodically to address new developments. Establishing and effectively utilizing a well-defined social media governance structure will help organizations mitigate risk and also harness the benefits of social media to advance the important mission of the organization.

Use of Cloud Computing in Healthcare*

Through many years of technological innovation, there is an awareness and heightened focus on the information technology environment. Cloud computing provides a more convenient way of sharing resources, networking, and implementation of new systems much more quickly. Cloud computing in simplest terms is similar to having an online e-mail account and being able to log in from anywhere to access information. Use of cloud computing in the healthcare environment provides for innovative ways to capture, manage, store, and share information with potential cost savings. Healthcare executives can use cloud computing to help innovate their organization in several ways.

Healthcare organizations should start thinking now about how cloud computing may impact revenue cycle, upgrades to existing systems versus cloud opportunities, integration with payors and suppliers, efficiently connecting with physician practices, and accelerating connections between primary care providers and home care. With change come more challenges to consider such as implementation costs, integration, security, and other operational and governance challenges. The management team should evaluate cloud computing as they look for new approaches to clinical and financial information systems.

(Continued)

Oversight*

Securities and Exchange Commission (SEC or the Commission) Review of Municipal Securities Market

The SEC conducted a comprehensive examination of the Municipal Securities Market in July 2012 and published their findings of this examination. The purpose of the examination was to identify issues and concerns related to municipal securities both from the perspective of the investor and the issuer. The Commission focused on two main areas, disclosure and market structure. The disclosure issues discussed arise in the primary offering and continuing disclosure contexts. For example, many participants raised questions related to the content and timeliness of financial information in primary offerings as well as the timeliness and completeness of filings and compliance with continuing disclosure agreements.

The examination resulted in the Commission providing several recommendations for potential further consideration, including legislative, rule-making, and enhancement of industry "best practices." These recommendations are designed to address various concerns raised by market participants and others and to provide avenues to improve the municipal securities market, including transparency for municipal securities investors.

The Commission believes that these recommendations could potentially help improve the municipal securities market and enhance investor protection; they are sensitive to changes in legal or regulatory standards that could lead to certain costs and believe that such costs should be considered in connection with the economic analysis conducted as appropriate in the context-specific proposals.

The Commission has proposed the following recommendations, among others:

- Make legislative changes that provide the Commission with additional authority to initiate changes to improve municipal securities disclosures made by issuers.
- Have market participants continue to strive for high-quality disclosure practices through development and enhancement of best practice guidelines.
- Require municipal issuers to prepare and disseminate official statements and disclosure during the outstanding term of the securities.
- Amend the municipal securities exemptions in the Securities Act and Exchange Act to eliminate the availability of such exemptions to conduit borrowers who are not municipal entities.
- Authorize the Commission to establish the form and content of financial statements for municipal issuers who issue municipal securities

(Continued)

- Permit the Internal Revenue Service to share with the Commission information that it obtains from returns, audits, and examinations related to municipal securities offerings in appropriate circumstances such as instances of suspected securities fraud.

- Provide mechanism to enforce compliance with continuing disclosure agreements and other obligations of municipal issuers to protect bondholders and authorize the Commission to require trustees or other entities to enforce the terms of continuing disclosure agreements.

Healthcare Rating Agency Metrics

In conjunction with the rapidly changing healthcare environment, rating agencies are beginning to look at new metrics for hospitals. Rating agencies have identified and are requesting new data points that include:

- Data points on new payment arrangements and new hospital reimbursement methodologies such as bundled payments, shared savings plans, diagnosis-related (DRG) reimbursement, etc., metrics on disaggregation of revenue streams by inpatient and outpatient and the number of covered lives via Medicare Accountable Care Organizations or other similar payor contracts

- Data points to measure patient demand including data on unique patients treated, readmission rates for Medicare and all payors, and total case mix index

- Data points on new physician relationships including number of employed physicians, and the number of active medical staff including independent and employed physicians.

Organizations will be required to begin reporting on these supplemental metrics. As healthcare organizations begin implementing new strategies and business models, rating agencies will utilize these metrics to assess the creditworthiness and financial health of the organizations, which could affect debt grading and/or access to future capital. In addition, costs of financing could increase, which will also increase future interest expense.

Sunshine Act

The Centers for Medicare & Medicaid Services (CMS) issued final regulations on the Physician Payment Sunshine Act (Sunshine Act), which requires manufacturers and or group purchasing organizations (GPOs) of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Programs to report annually to CMS certain payments or gifts provided to physicians or teaching hospitals. Manufacturers are required to collect and track payment, transfer and ownership information beginning August 1, 2013. Manufacturers will be required to submit the reports to the Centers for Medicare & Medicaid Services (CMS) on an annual basis. In addition, manufacturers and group purchasing organizations (GPOs) must report certain ownership interests held by physicians and their immediate family members.

We recommend that the organization develop strategies, if it has not done so already, to mitigate the potential risks associated with the Sunshine Act. In addition, the Audit Committee should ensure that its physicians are complying with internal policies regarding financial relationships within the industry.

* * * * * * *

We would be pleased to discuss these comments and recommendations with you at any time.

The Corporation's written responses to our comments and recommendations have not been subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

This communication is intended solely for the information and use of management, the Audit Committee, others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

KPMG LLP

AUDIT COMMITTEE OF THE HHC BOARD OF DIRECTORS

Corporate Compliance Report

December 4, 2014

Table of Contents

Agenda

I. Compliance Program Certification

Background

1) Pursuant to Social Services Law § 363-d and 18 NYCRR part 521, HHC is required to establish and maintain an effective compliance program aimed at detecting fraud, waste, and abuse. To accomplish this goal, HHC is required to implement and maintain appropriate systems and processes to detect and deter fraudulent and criminal conduct.

Effective Compliance Program Defined

2) To be effective, the program must cover the following seven areas: (i) billings; (ii) payments; (iii) medical necessity and quality of care: (iv) governance; (v) mandatory reporting; (vi) credentialing; and (vii) other risk areas that are or should with due diligence be identified by HHC.

3) In addition to the above, an effective compliance program must contain the following eight elements: (i) the development of written policies and procedures that, among other things, describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, and provide guidance to employees and others on dealing with potential compliance issues; (ii) the designation of an employee vested with responsibility for the day-to-day operation of the compliance program; (iii) the development and implementation of a training and education program concerning the compliance program, its expectations, and its scope of operation - such training and education must reach the governing body; (iv) establishment of direct communication lines to the employee vested with the day-to-day direction of the compliance program that are accessible to workforce members, including executives and the governing body, as well as persons associated with the provider; (v) establishment of disciplinary policies to encourage the good faith participation in the compliance program; (vi) implementation of a system designed to routinely identify, evaluate, and address corporate vulnerabilities and risks; (vii) establishment of a system designed to respond to compliance issues as they are raised and/or identified; and (viii) the creation of a policy that prohibits intimidation or retaliation for the good faith participation in the compliance program.

Certification Process

4) The Office of Corporate Compliance ("OCC") will perform an assessment of HHC compliance activities and thoroughly document HHC's compliance with the requirements found under New York State compliance program regulations. Said review is expected to be completed by Monday, December 12, 2014 in preparation for the December 2014 New York

State Office of the Medicaid Inspector General ("OMIG") compliance program certification to be performed by HHC President and Chief Executive Officer Ramanathan Raju, M.D.

II. Update on Data Breach at East New York Diagnostic and Treatment Center

1) As previously reported during the October 2, 2014 Audit Committee, the OCC and HHC information data security contractor Tekmark Global Solutions, conducted a privacy and security audit walk-through of the East New York Diagnostic and Treatment Center ("East NY") to assess East NY's compliance with Meaningful Use certification regulations and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In the course of performing this walk-through, the OCC observed that multiple unsecured boxes - - 198 in total - - of medical and dental records were inappropriately stored in an employee parking garage at that facility. At the direction of the OCC, the boxes were immediately secured and, on August 15, 2014, were moved to a secure location at Citi Storage, HHC's offsite storage vendor. OCC's investigation of this matter has revealed that these boxes contain the medical and/or dental records from several closed HHC clinics, including (1) the Howard Houses Child Health Center; (2) the Brevoort Houses Child Health Clinic; (3) the Fifth Avenue Child Health Clinic and (4) dental records from the closed dental clinic at the Brownsville Child Health Clinic

2) It was determined that the storage of these records constituted a breach under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations. As a result this breach, the following steps were taken under applicable law: (i) all 10,058 affected patients were provided with notice regarding the breach and were offered, at the sole cost to the Corporation, credit monitoring and identity theft restoration services through a third-party vendor; (ii) HHC notified the Office of Civil Rights of the U.S. Department of Health and Human Services; and (iii) HHC provided notice of the breach to the media and posted information regarding the notice on its public website.

3) The total cost to provide patient notification and credit monitoring services (if exercised by each affected patient) is $ 52,376.

III. Compliance Reporting Index for the Third Quarter of Calendar Year 2014 (CY2014)

Summary of Reports

1) For the third quarter CY2014 (July 1, 2014 to September 30, 2014) there were 110 compliance-based reports of which 1 was classified as a Priority "A" report, 51 (or 46.4%) were classified as Priority "B" reports, and 58 (or 52.7%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. Of the 110 reports received during this period, 55 (or 50%) were compliance complaints received on the OCC's anonymous toll-free compliance hotline.

Mode of Reporting

2) Below is a summary of how the OCC received the 110 CY2014 third quarter reports:

- 55 (50%) were received on the Help Line;
- 19 (17.3%) were received via E-Mail;
- 11 (10%) were received Face to Face;
- 11 (10%) were received via Telephone;
- 3 (2.7%) were received via Other;
- 3 (2.7%) were received via Web Submission;
- 2 (1.8%) were received via Mail;
- 2 (1.8%) were received via Website;
- 1 (0.9%) were received via Facsimile;
- 1 (0.9%) were received via Fraud & Abuse Form (e);
- 1 (0.9%) were received via Office Visit;
- 1 (0.9%) were received via Referral from other HHC Office.

Allegation Class Analysis

3) The breakdown of the allegation classes of the 110 reports received in the third quarter of CY 2014 is as follows:

- 36 (32.7%) pertained to Policy and Process Integrity;
- 23 (20.9%) pertained to Misuse or Misappropriation of Assets or Information;
- 21 (19.1%) pertained to Employee Relations;
- 17 (15.5%) pertained to Other;
- 8 (7.3%) pertained to Diversity, Equal Opportunity and Respect in the Workplace;
- 4 (3.6%) pertained to Environmental, Health and Safety;
- 1 (0.9%) pertained to Financial Concerns.

IV. Privacy Reporting Index for the Third Quarter of CY2014

Incident Reports and Investigations

1) A total of 29 incidents were reported via the HIPAA Complaint Tracking System during the 3rd Quarter of 2014 (July 1, 2014 through September 30, 2014). These reports were entered in the HHC HIPAA Complaint Tracking System, an HHC proprietary database.

2) Of the twenty-nine 29 complaints entered in the tracking system, 12 were found after investigation to be violations of HHC HIPAA Privacy Operating Procedures; 13 were found not to be a violation of HHC HIPAA Privacy Operating Procedures; and four are still under

investigation. Of the twelve confirmed violations, three were determined to be breaches and nine were determined not to be breaches.

V. Monitoring of Excluded Providers

1) The OCC has not received or uncovered any reports of excluded providers since the Audit Committee last convened on October 2, 2014.