NEW ISSUE – Book Entry Only

Moody's: "Aa1"
S&P: "AA+"
(See "RATINGS" herein)

DAC Bond

$135,845,000
DORMITORY AUTHORITY OF THE STATE OF NEW YORK
MAIMONIDES MEDICAL CENTER
FHA-INSURED MORTGAGE HOSPITAL REVENUE BONDS, SERIES 2020

Dated: Date of Delivery **Due: As shown on the inside cover**

Payment and Security: The Series 2020 Bonds will be special obligations of the Dormitory Authority of the State of New York (the "**Authority**") payable solely from, and secured by a pledge of (i) the payments to be made under the Loan Agreement dated as of July 17, 2019 (the "**Loan Agreement**"), between the Authority and Maimonides Medical Center (the "**Institution**"); (ii) the funds and accounts (except the Arbitrage Rebate Fund and any amounts on deposit in the Mortgage Payment Fund in certain short periods each year, constituting excess mortgage payments made by the Institution, as more fully described herein) created under the Authority's Maimonides Medical Center FHA-Insured Mortgage Hospital Revenue Bond Resolution, adopted by the Authority on July 17, 2019 (the "**General Resolution**"), and under the Series Resolution authorizing the issuance of up to $165,000,000 of Series 2020 Bonds, adopted by the Authority on July 17, 2019 (the "**Series Resolution**" and together with the General Resolution, the "**Resolutions**"); (iii) investment income on the foregoing funds and accounts (less any fees of the Qualified Financial Institution issuing an investment agreement), other than investment income on moneys deposited by the Institution in the Insurance and Condemnation Account of the Construction Fund (as defined in the General Resolution); (iv) payments to be made by the Institution under the 2020 Note (as defined herein) insured by the U.S. Department of Housing and Urban Development ("**HUD**"), acting by and through the Secretary ("**Secretary**"), under Section 241 of the National Housing Act, and in the event of a default by the Institution thereunder, from the Mortgage Insurance Benefits (defined in the General Resolution); and (v) the 2020 Mortgage (as defined herein) pursuant to which the Institution has granted to the Authority a mortgage lien on and security interest in certain of its real and personal property.

The Series 2020 Bonds will not be a debt of the State of New York nor will the State be liable thereon. The Authority has no taxing power. The Series 2020 Bonds do not constitute an obligation or indebtedness of, and the payment of the Series 2020 Bonds is not insured or guaranteed by, the United States of America or any agency or instrumentality thereof, including HUD.

Description: The Series 2020 Bonds will be issued as fully registered bonds in denominations of $5,000 or any integral multiple thereof. Interest (due on February 1, 2021, and on each February 1 and August 1 thereafter) will be payable by check or draft mailed to the registered owners of the Series 2020 Bonds as of the Record Date, as described herein. Principal, Sinking Fund Redemptions, and Redemption Price of the Series 2020 Bonds will be payable upon surrender of the Series 2020 Bonds at the principal corporate trust office of U.S. Bank National Association, the Trustee and Paying Agent.

The Series 2020 Bonds will be issued initially under a Book-Entry Only System, registered in the name of Cede & Co., as nominee for The Depository Trust Company ("**DTC**"). Individual purchases of beneficial interests in the Series 2020 Bonds will be made in book-entry form (without certificates). So long as DTC or its nominee is the registered owner of the Series 2020 Bonds, payments of the principal and Redemption Price of and interest on such Series 2020 Bonds will be made directly to DTC or its nominee. Disbursement of such payments to DTC participants is the responsibility of DTC and disbursement of such payments to the beneficial owners is the responsibility of DTC participants. See "PART 3 - THE SERIES 2020 BONDS - Book-Entry Only System" herein.

Redemption: The Series 2020 Bonds are subject to redemption prior to maturity as more fully described in this Official Statement. All redemptions shall include accrued interest to the date of such redemptions.

Tax Matters: In the opinion of Harris Beach PLLC, as Co-Bond Counsel to the Authority, based on existing statutes, regulations, court decisions and administrative rulings, and assuming compliance with the tax covenants described herein, interest on the Series 2020 Bonds is excluded from gross income for federal income tax purposes under Section 103 of the Internal Revenue Code of 1986, as amended (the "Code"). Furthermore, Harris Beach PLLC is of the opinion that interest on the Series 2020 Bonds is not an "item of tax preference" for purposes of the federal alternative minimum tax imposed on individuals. Co-Bond Counsel are further of the opinion that, based on existing statutes, interest on the Series 2020 Bonds is exempt from personal income taxes imposed by the State of New York and any political subdivision thereof. See "PART 15 – TAX MATTERS" herein regarding certain other tax considerations.

The Series 2020 Bonds are offered when, as and if issued and received by the Underwriters. The offer of the Series 2020 Bonds may be subject to prior sale or may be withdrawn or modified at any time without notice. The offer is subject to the approval of legality of the Series 2020 Bonds by Harris Beach PLLC, New York, New York, and Lewis & Munday, A Professional Corporation, New York, New York, Co-Bond Counsel, and to certain other conditions. Certain legal matters will be passed upon for the Underwriters by their counsel, Tiber Hudson LLC, Washington, D.C.; for the Institution by its counsel, Arent Fox LLP, New York, New York; and for the Mortgage Servicer by its counsel, Krooth & Altman LLP, Washington, D.C. The Authority expects to deliver the Series 2020 Bonds in definitive form in New York, New York, on or about August 6, 2020.

BofA Securities **Citigroup**

July 16, 2020

$135,845,000
DORMITORY AUTHORITY OF THE STATE OF NEW YORK
MAIMONIDES MEDICAL CENTER
FHA-INSURED MORTGAGE HOSPITAL REVENUE BONDS,
SERIES 2020

MATURITIES, AMOUNTS, INTEREST RATES, YIELDS, PRICES, AND CUSIP NUMBERS

$72,845,000 SERIAL BONDS

Maturity	Principal Amount	Interest Rate	Yield	Price	CUSIP[1] Number
02/01/2024	$1,450,000	5.00%	0.57%	115.269	64990GY89
08/01/2024	1,485,000	5.00	0.63	117.175	64990GY97
02/01/2025	1,520,000	5.00	0.71	118.909	64990GZ21
08/01/2025	1,560,000	5.00	0.76	120.706	64990GZ39
02/01/2026	1,600,000	5.00	0.85	122.198	64990GZ47
08/01/2026	1,640,000	5.00	0.91	123.775	64990GZ54
02/01/2027	1,680,000	5.00	1.01	124.988	64990GZ62
08/01/2027	1,725,000	5.00	1.04	126.617	64990GZ70
02/01/2028	1,770,000	5.00	1.11	126.079†	64990GZ88
08/01/2028	1,815,000	5.00	1.16	125.696†	64990GZ96
02/01/2029	1,860,000	4.00	1.37	117.464†	64990G2A9
08/01/2029	1,895,000	4.00	1.39	117.318†	64990G2B7
02/01/2030	1,935,000	4.00	1.44	116.956†	64990G2C5
08/01/2030	1,975,000	4.00	1.47	116.739†	64990G2D3
02/01/2031	2,015,000	4.00	1.51	116.450†	64990G2E1
08/01/2031	2,055,000	4.00	1.56	116.090†	64990G2F8
02/01/2032	2,095,000	4.00	1.63	115.589†	64990G2G6
08/01/2032	2,140,000	4.00	1.67	115.303†	64990G2H4
02/01/2033	2,185,000	4.00	1.75	114.735†	64990G2J0
08/01/2033	2,230,000	4.00	1.80	114.381†	64990G2K7
02/01/2034	2,275,000	4.00	1.85	114.029†	64990G2L5
08/01/2034	2,320,000	4.00	1.87	113.888†	64990G2M3
02/01/2035	2,365,000	4.00	1.93	113.467†	64990G2N1
08/01/2035	2,415,000	4.00	1.95	113.328†	64990G2P6
02/01/2036	2,465,000	4.00	1.99	113.049†	64990G2Q4
08/01/2036	2,515,000	4.00	1.99	113.049†	64990G2R2
02/01/2037	2,565,000	4.00	2.01	112.909†	64990G2S0
08/01/2037	2,615,000	3.00	2.30	104.493†	64990G2T8
02/01/2038	2,655,000	4.00	2.04	112.701†	64990G2U5
08/01/2038	2,710,000	3.00	2.35	104.165†	64990G2V3
02/01/2039	2,750,000	4.00	2.08	112.424†	64990G2W1
08/01/2039	2,805,000	3.00	2.38	103.968†	64990G2X9
02/01/2040	2,850,000	4.00	2.12	112.147†	64990G2Y7
08/01/2040	2,910,000	3.00	2.41	103.772†	64990G2Z4

$18,635,000 4.00% Term Bond Due August 1, 2043 Priced to Yield 2.18%† CUSIP No. 64990G3A8
$44,365,000 3.00% Term Bond Due February 1, 2050 Priced to Yield 2.57%† CUSIP No. 64990G3B6

---

[1] CUSIP® is a registered trademark of the American Bankers Association. CUSIP Global Services ("*CGS*") is managed on behalf of the American Bankers Association by S&P Global Market Intelligence, a part of S&P Global Inc., and are provided solely for the convenience of the holders of the Series 2020 Bonds. The Authority, the Institution, and the Underwriters are not responsible for the selection or uses of these CUSIP numbers, nor is any representation made as to their correctness on the Series 2020 Bonds or as indicated above. The CUSIP numbers are subject to change after the issuance of the Series 2020 Bonds as a result of various subsequent actions including, but not limited to, a refunding in whole or in part of the Series 2020 Bonds.

† Priced to the first optional call date of August 1, 2027.

REGARDING USE OF THIS OFFICIAL STATEMENT

No dealer, broker, salesperson or other person has been authorized by the Authority, the Institution, or the Underwriters to give any information or to make any representations with respect to the Series 2020 Bonds, other than the information and representations contained in this Official Statement. If given or made, such information or representations must not be relied upon as having been authorized by any of the foregoing.

This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy nor shall there be a sale of the Series 2020 Bonds by any person in any jurisdiction in which it is unlawful for such person to make such offer, solicitation, or sale.

The Series 2020 Bonds have not been registered under the Securities Act of 1933, as amended, and the Resolutions have not been qualified under the Trust Indenture Act of 1939, as amended, in reliance upon exemptions contained in such acts. The registration or qualification of the Series 2020 Bonds in accordance with applicable provisions of securities laws of the states in which the Series 2020 Bonds have been registered or qualified and the exemption from registration or qualification in other states cannot be regarded as a recommendation thereof. Neither these states nor any of their agencies have passed upon the merits of the Series 2020 Bonds or the accuracy or completeness of this Official Statement. Any representation to the contrary may be a criminal offense.

Certain information in this Official Statement has been supplied by the Institution and the Mortgage Servicer. The Authority does not guarantee the accuracy or completeness of such information, and such information is not to be construed as a representation of the Authority. The Underwriters have provided the following sentence in this Official Statement. The Underwriters have reviewed the information in this Official Statement in accordance with, and as part of, its responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriters do not guarantee the accuracy or completeness of such information.

The Institution has reviewed the parts of this Official Statement describing the Institution, the Project, estimated sources and uses of funds, estimated debt service schedule, general factors and regulatory changes and Bondholder's Risks that may affect the Institution, Appendix B, and Appendix C. The Institution shall certify, as of the dates of sale and delivery by the Authority of the Series 2020 Bonds, that such parts of this Official Statement do not contain any untrue statements of a material fact and do not omit any material fact necessary to make the statements made therein, in light of the circumstances under which the statements are made, not misleading. The Institution makes no representation as to the accuracy or completeness of any other information included in this Official Statement.

The Mortgage Servicer has reviewed the parts of this Official Statement describing the Mortgage Servicer, the Mortgage Insurance, and the FHA Documents and shall certify, as of the dates of sale and delivery by the Authority of the Series 2020 Bonds, that such parts of this Official Statement as they relate to the Mortgage Servicer, the Mortgage Insurance, and the FHA Documents do not contain any untrue statements of a material fact and do not omit any material fact necessary to make the statements made therein, in light of the circumstances under which the statements are made, not misleading. The Mortgage Servicer makes no representation as to the accuracy or completeness of any other information included in this Official Statement.

The information set forth in PART 1 – INTRODUCTION – *The Authority and PART 12 – THE AUTHORITY regarding the Authority has been supplied by the Authority. All other information herein has been obtained by the Underwriters from the Institution and other sources deemed to be reliable by the Underwriters, and such information should not be construed as a representation by the Authority. In*

addition, the Authority does not warrant the accuracy of the statements herein relating to the Institution nor does it directly or indirectly guarantee, endorse, or warrant (i) the creditworthiness or credit standing of the Institution, (ii) the sufficiency of the security for the Series 2020 Bonds, or (iii) the value or investment quality of the Series 2020 Bonds.

References in this Official Statement to the Act, the Resolutions, the Servicing Agreement, the FHA Documents, and the Loan Agreement, do not purport to be complete. Refer to the Act, the Resolutions, the Servicing Agreement, the FHA Documents and the Loan Agreement for full and complete details of their respective provisions. Copies of the Resolutions and the Loan Agreement are on file with the Authority and the Trustee. Copies of the Servicing Agreement and the FHA Documents are on file with the Authority.

The order and placement of material in this Official Statement, including its appendices, are not to be deemed a determination of relevance, materiality or importance, and all material in this Official Statement, including the appendices, must be considered in its entirety.

Under no circumstances shall the delivery of this Official Statement, or any sale made after its delivery, create any implication that the affairs of the Authority, HUD, or the Institution have remained unchanged after the date of this Official Statement.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS IN THIS OFFICIAL STATEMENT

Certain statements included or incorporated by reference in this Official Statement constitute projections or estimates of future events, generally known as forward-looking statements. These statements are generally identifiable by the terminology used such as "may," "believe," "will," "expect," "project," "intend," "estimate," "anticipate," "plan," "continue," "budget" or other similar words. These forward looking statements are based on the current plans and expectations of the Institution and are subject to a number of known and unknown uncertainties and risks, many of which are beyond the control of the Institution, that could significantly affect current plans and expectations and Institution's future financial position and results of operations. These risk factors include, but are not limited to, (i) the highly competitive nature of the health care business, (ii) the efforts of insurers, health care providers, and others to contain health care costs, (iii) possible changes in the Medicare and Medicaid programs that may affect reimbursements to health care providers and insurers, (iv) changes in federal, state, or local regulations affecting the health care industry, (v) the implementation of health care reform, (vi) the ability to attract and retain qualified management and other personnel, including affiliated physicians, nurses, and medical support personnel, (vii) liabilities and other claims asserted against the Institution, (viii) changes in accounting standards and practices, (ix) changes in general economic conditions, (x) future divestitures or acquisitions that may result in additional changes, (xi) changes in revenue mix and the ability to enter into and renew managed care provider arrangements on acceptable terms, (xii) the availability and terms of capital to fund expansion plans of the Institution and to provide for ongoing capital expenditure needs, (xiii) changes in business strategy or development plans, (xiv) delays in receiving payments, (xv) the ability to implement shared services and other initiatives and realize decreases in administrative, supply, and infrastructure costs, (xvi) the outcome of pending and any future litigation, (xvii) the Institution's continuing efforts to monitor, maintain, and comply with appropriate laws, regulations, policies, and procedures relating to its status as a tax-exempt organization as well as its ability to comply with the requirements of the Medicare and Medicaid programs, (xviii) the ability to achieve expected levels of patient volumes and control the costs of providing services, (xix) results of reviews of the Institution's cost reports, (xx) the Institution's ability to comply with recently enacted legislation and/or regulations, and (xxi) the risks set forth under the heading "PART 11 – BONDHOLDERS' RISKS" herein. As a consequence, current plans, anticipated actions, and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of the Institution. Investors are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this Official Statement. In addition to those factors described specifically in connection with the forward-looking statements, *see* "PART 11 – BONDHOLDERS' RISKS" herein and "APPENDIX B - CONSOLIDATED FINANCIAL STATEMENTS OF MAIMONIDES MEDICAL CENTER AS OF DECEMBER 31, 2019 AND 2018 AND FOR THE YEARS THEN ENDED, WITH INDEPENDENT AUDITOR'S REPORT" and "APPENDIX C - UNAUDITED INTERIM CONSOLIDATED FINANCIAL STATEMENTS OF MAIMONIDES MEDICAL CENTER AS OF APRIL 30, 2020 AND FOR THE FOUR-MONTH PERIODS ENDED APRIL 30, 2020 AND APRIL 30, 2019" attached hereto.

The achievement of certain results or other expectations contained in such forward-looking statements involves known and unknown risks, uncertainties, and other factors that may cause actual results, performance or achievements described to be materially different from any future results, performance, or achievements expressed or implied by these forward-looking statements. The Institution does not plan to issue any updates or revisions to those forward-looking statements if or when changes in its expectations, or events, conditions, or circumstances on which such statements are based, occur.

Table of Contents

DORMITORY AUTHORITY OF THE STATE OF NEW YORK
515 BROADWAY, ALBANY, N.Y. 12207
REUBEN R. McDANIEL, III – PRESIDENT **ALFONSO L. CARNEY, JR. – CHAIR**

OFFICIAL STATEMENT RELATING TO

$135,845,000
DORMITORY AUTHORITY OF THE STATE OF NEW YORK
MAIMONIDES MEDICAL CENTER
FHA-INSURED MORTGAGE HOSPITAL REVENUE BONDS, SERIES 2020

PART 1 – INTRODUCTION

Purpose of the Official Statement

The purpose of this Official Statement, including the cover page and appendices hereto, is to set forth certain information concerning the Dormitory Authority of the State of New York (the "**Authority**") and its $135,845,000 MAIMONIDES MEDICAL CENTER FHA-INSURED MORTGAGE HOSPITAL REVENUE BONDS, SERIES 2020 (the "**Series 2020 Bonds**" or the "**Bonds**").

The following is a brief description of certain information concerning the Series 2020 Bonds, the Authority, and MAIMONIDES MEDICAL CENTER, a New York not-for-profit corporation (the "**Institution**"). A more complete description of such information and additional information that may affect decisions to invest in the Series 2020 Bonds are contained throughout this Official Statement, which should be read in its entirety. Certain terms used in this Official Statement are defined in the Resolutions (as defined below).

The Authority

The Authority is a public benefit corporation of the State of New York (the "**State**"), created for the purpose of financing and constructing a variety of public-purpose facilities for certain governmental, educational, and not-for-profit institutions. *See* "PART 12 – THE AUTHORITY" herein.

Purpose of the Issue

The proceeds of the Series 2020 Bonds, together with certain other available funds, are being used to (i) finance the Costs of the Project (as described in the General Resolution (defined below)), (ii) fund the Reserve Account of the Debt Service Reserve Fund in an amount equal to the Debt Service Reserve Fund Requirement less an amount equal to the Collateral Account Requirement, if any, and (iii) pay certain Costs of Issuance of the Series 2020 Bonds. See "PART 2 - PLAN OF FINANCING." and "PART 7 - ESTIMATED SOURCES AND USES OF FUNDS." The proceeds of the Series 2020 Bonds will be loaned by the Authority to the Institution pursuant to that certain Loan Agreement dated as of July 17, 2019, between the Institution and the Authority (the "**Loan Agreement**") and the portion to be applied to the Costs of the Project will be disbursed by the Authority, as FHA mortgagee, pursuant to the provisions of the Building Loan Agreement and the Servicing Agreement (as defined in the General Resolution).

Authorization of Issuance

The Series 2020 Bonds will be issued pursuant to the Act, the Maimonides Medical Center FHA-Insured Mortgage Hospital Revenue Bond Resolution, adopted by the Authority on July 17, 2019 (the "**General Resolution**"), and the Maimonides Medical Center Series Resolution Authorizing Up To $165,000,000 Maimonides Medical Center FHA-Insured Mortgage Hospital Revenue Bonds, Series 2020, adopted by the Authority on July 17, 2019 (the "**Series Resolution**" and, together with the General Resolution, the "**Resolutions**"). The General Resolution authorizes the issuance of multiple Series of Bonds pursuant to separate series resolutions for the sole benefit of the Institution. Each Series of Bonds is to be separately secured by: (i) the funds and accounts (other than the Arbitrage Rebate Fund and any amounts on deposit in the Mortgage Payment Fund (A) between January 20 and January 31 of each year, constituting excess mortgage payments made by the Institution during the immediately preceding six (6) month period, and (B) between July 20 and July 31 of each year, constituting excess mortgage payments made by the Institution during the immediately preceding six (6) month period) established pursuant to the Series Resolution, and (ii) certain revenues received by the Authority from payments to be made under a note insured by U.S. Department of Housing and Urban Development ("**HUD**"), acting by and through the Secretary ("**Secretary**") under Section 241 of the National Housing Act (the "**NHA**") and, in the event of a default, from Mortgage Insurance Benefits (as defined herein). Pursuant to the General Resolution, neither the funds and accounts established under any series resolution, nor any loan agreement or mortgage entered into in connection with one Series of Bonds, shall secure any other Series of Bonds. Each Series of Bonds must be secured by a mortgage insured under the National Housing Act, as amended. The Series Resolution authorizes the issuance of the Series 2020 Bonds in an amount not to exceed $165,000,000. See "Description of Plan of Finance" below for a discussion regarding priority of mortgage liens and cross defaults. All references to funds and accounts in this Official Statement are to those funds and accounts authorized to be created pursuant to the General Resolution and so designated and established by the Series Resolution. See "PART 3 - THE SERIES 2020 BONDS."

Description of Plan of Finance

The proceeds of the Series 2020 Bonds, together with other available moneys, including the Institution's equity contribution, will provide funds to (1) finance the Costs of the Project, (2) fund the Reserve Account of the Debt Service Reserve Fund in an amount equal to the Debt Service Reserve Fund Requirement less an amount equal to the Collateral Account Requirement, and (3) pay certain costs relating to the issuance of the Series 2020 Bonds. As evidence of the loan to be disbursed to the Institution pursuant to the Building Loan Agreement, the Institution will deliver to the Authority, as FHA mortgagee, a Supplemental Hospital Note in the principal amount of $141,202,000.00 (the "**2020 Note**"). To secure payment of the 2020 Note, the Institution will deliver to the Authority a Supplemental Hospital Mortgage, Assignment of Leases, Rents and Revenue and Security Agreement (the "**2020 Mortgage**") on the Institution's main campus (the "**Mortgaged Property**") in an amount equal to the 2020 Note, and a security interest in certain personalty located on the Mortgaged Property.

The 2020 Mortgage constitutes a third mortgage lien on the Mortgaged Property and is subordinate to the mortgage on the Mortgaged Property that is insured by HUD pursuant to Section 242 of the NHA and the mortgage on the Mortgaged Property that is insured by HUD pursuant to Section 241 of the NHA. A default with respect to the 2020 Note or the 2020 Mortgage will not cause a default with respect to such prior mortgages on the Mortgage Property. However, a default with respect to such prior mortgages on the Mortgaged Property shall, at the sole option of HUD, constitute a default with respect to the 2020 Note or the 2020 Mortgage. For a description of the prior FHA-insured loans and the cross-default provisions among the mortgages securing the prior FHA-insured loans and the 2020 Mortgage, See "PART 10 – EXISTING FHA-INSURED LOANS OF THE INSTITUTION."

The Authority will assign to the Trustee all of the Authority's rights in the Trust Revenues (as defined in the General Resolution). The Authority also pledges and grants to the Trustee, in connection with the Series 2020 Bonds, a security interest in the FHA Documents except for the HUD Regulatory Agreement (as defined below in PART 6 - CERTAIN PROVISIONS OF THE FHA DOCUMENTS - The HUD Regulatory Agreement). Upon the occurrence of a default under the 2020 Note or the 2020 Mortgage resulting in an assignment to HUD, the Authority has further covenanted that all Mortgage Insurance Benefits received by the Authority, as FHA mortgagee, with respect to the 2020 Note will, upon receipt, be transferred to and deposited with the Trustee to be applied in accordance with the General Resolution.

Pursuant to the Commitment for Insurance of Advances, dated November 22, 2019, in the amount of $141,202,000.00 (as amended, the "**Commitment**") issued to Bank of America, N.A., as the originating mortgagee (and which will be assigned to the Authority, as FHA mortgagee, at the Closing), HUD has agreed to insure advances of funds under the 2020 Note pursuant to Section 241 of the National Housing Act, as amended, and the regulations promulgated thereunder. Under applicable HUD regulations, Mortgage Insurance Benefits are payable following assignment of the 2020 Note and the 2020 Mortgage to HUD upon a default by the Institution under the 2020 Note and the 2020 Mortgage, in the form of cash, FHA debentures, or any combination thereof, at the option of HUD. To the extent that the Mortgage Insurance Benefits are paid in cash, such benefits will be applied to the Extraordinary Mandatory Redemption of the Series 2020 Bonds. Pursuant to the Commitment, HUD has agreed to pay Mortgage Insurance Benefits in connection with the 2020 Note in the form of cash. See "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION." See "PART 2 - PLAN OF FINANCING - Payment of Mortgage Insurance Benefits" and "PART 5 – MORTGAGE INSURANCE" for more details concerning Mortgage Insurance Benefits and the methods and conditions of payment.

Mortgage Payments received from the Mortgage Servicer (representing the monthly amount paid by the Institution to the Mortgage Servicer under the 2020 Note and the 2020 Mortgage less the Servicing Fee) will initially be deposited by the Trustee in the Mortgage Payment Fund before being transferred to the Mortgage Account of the Construction Fund. Pursuant to the terms of the Resolution and the Servicing Agreement, the Authority, as FHA mortgagee, will advance funds from the Mortgage Account of the Construction Fund to the Institution in accordance with the Resolutions, the Building Loan Agreement, the Loan Agreement, and the Servicing Agreement to pay for Costs of the Project. Under the Servicing Agreement, the Authority is engaging the Mortgage Servicer to administer the 2020 Note, the 2020 Mortgage, and the Building Loan Agreement on its behalf. Pursuant to the Servicing Agreement, the Mortgage Servicer will supervise disbursements to be made under the Building Loan Agreement, collect all payments due from the Institution under the 2020 Note and forward to the Trustee the required payments on the 2020 Note after deduction of the Servicing Fee, late charges, and Mortgagee Advances, if any. Additionally, in the event of a default by the Institution under the 2020 Note or the 2020 Mortgage, the Mortgage Servicer will assist the Authority in obtaining Mortgage Insurance Benefits.

The Mortgage Insurance does not constitute a guaranty of timely or total payment of the principal of, Redemption Price or interest on the Series 2020 Bonds. Mortgage Insurance Benefits will not be available immediately upon a default under the 2020 Note and the 2020 Mortgage and assignment thereof to HUD. In addition, processing claims for Mortgage Insurance Benefits may involve certain time delays and such Mortgage Insurance Benefits may be subject to certain deductions. To provide a source of funds for the timely payment of the principal of and interest on the Series 2020 Bonds prior to the receipt of Mortgage Insurance Benefits, the Debt Service Reserve Fund has been established and funded at the Debt Service Reserve Fund Requirement. The use of the Debt Service Reserve Fund, its limitations and the application of Mortgage Insurance Benefits and other moneys if there are insufficient funds to pay the maturing principal of and interest on all Series 2020 Bonds Outstanding are described below under "PART

2 - PLAN OF FINANCING - Payment of Mortgage Insurance Benefits," "PART 11 – BONDHOLDERS' RISKS," and "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION." For a discussion of how the Mortgage Insurance Benefits may be paid in an amount that is less than the outstanding principal amount of the Series 2020 Bonds, and the consequences thereof, see "PART 5 – MORTGAGE INSURANCE" and "PART 11 – BONDHOLDERS' RISKS."

As further security for the Series 2020 Bonds, and subject to the qualifications set forth in the General Resolution, the Authority will assign and pledge to the Trustee certain of its rights under the Loan Agreement, including the right to receive payments on the 2020 Note; provided, however, that so long as no event of default has occurred, the Authority shall retain all rights and obligations as mortgagee under the FHA Documents and may give any consents or approvals permitted or required to be given by, and exercise all rights granted, to the mortgagee under the FHA Documents, subject in all respects to the provisions of the General Resolution. In addition, the Authority will pledge and grant a security interest to the Trustee in the Trust Revenues and all moneys, securities, and instruments held from time to time under the Debt Service Fund (other than the Purchase Fund), the Construction Fund (other than the Equity Account and the Insurance and Condemnation Account and subject to certain conditions in the General Resolution), the Mortgage Payment Fund (other than any amounts on deposit therein (A) between January 20 and January 31 of each year, constituting excess mortgage payments made by the Institution during the immediately preceding six (6) month period, and (B) between July 20 and July 31 of each year, constituting excess mortgage payments made by the Institution during the immediately preceding six (6) month period), the Debt Service Reserve Fund (subject to certain conditions in the General Resolution), and the Redemption Account. For a further description of all of the items to be pledged to the Trustee, see "PART 3 - THE SERIES 2020 BONDS – Security for the Series 2020 Bonds" herein and "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION."

The Series 2020 Bonds are special obligations of the Authority and under the Resolutions are payable solely from the Trust Revenues pledged for the Series 2020 Bonds including moneys derived from payments of principal and interest under the 2020 Note, the Mortgage Insurance Benefits in the event of a default under the 2020 Note or the 2020 Mortgage and the assignment thereof to HUD, and certain funds held by the Trustee, including the Debt Service Reserve Fund and the investment income thereon, net of amounts, if any, (i) applied to the Arbitrage Rebate Fund and (ii) on deposit in the Mortgage Payment Fund during the short periods noted in the preceding paragraph constituting excess mortgage payments made by the Institution. Pursuant to the terms of the General Resolution, the funds and accounts established by the Series Resolution secure only the Series 2020 Bonds, and do not secure any other Series of Bonds issued under the General Resolution regardless of their dates of issue.

The Authority shall not be obligated to pay the principal of, or interest on, the Series 2020 Bonds except from the Trust Revenues and funds pledged therefor under the Resolutions. Neither the faith and credit nor the taxing power of the State of New York or any municipality or political subdivision thereof is pledged to the payment of the principal of, redemption premium, if any, or interest on the Series 2020 Bonds. The Authority has no taxing power.

The Series 2020 Bonds do not constitute an obligation or indebtedness of, and the payment of the Series 2020 Bonds is not insured or guaranteed by, the United States of America or any agency or instrumentality thereof, including the Department of Housing and Urban Development. In the event of conflict between the provisions of the FHA Documents and the General Resolution, the Series Resolution or the Loan Agreement, the FHA Documents will control.

Included in this Official Statement as appendices are APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION and APPENDIX F - SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT. Such summaries do not purport to be complete and

reference is hereby made to these documents in their entirety for a complete description of all of the terms and provisions thereof. Copies of the General Resolution and the Loan Agreement are available at the offices of the Trustee and the Authority.

The Series 2020 Bonds

The Series 2020 Bonds will be dated their date of delivery and will bear interest from such date, payable on February 1, 2021, and on each February 1 and August 1 thereafter until the maturity or earlier redemption thereof, at the rates set forth on the inside cover page of this Official Statement. See "PART 3 - THE SERIES 2020 BONDS."

The Institution

Maimonides Medical Center is a non-profit, acute care hospital located at 4802 Tenth Avenue, Brooklyn, New York (the "**Main Campus**"). The Institution is a New York not-for-profit corporation that is exempt from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "**Code**"). See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER."

The Project

The Project consists of: (A) the renovation and construction of the Institution's (i) modernized emergency department, (ii) modernized neonatal intensive care unit, (iii) post-anesthesia care unit, (iv) cardiac catheterization laboratories, and supporting pre- and post-procedure areas, (v) cardiothoracic intensive care unit, and (vi) various infrastructure projects, including electrical, plumbing, mechanical, and emergency generator support systems; and (B) the acquisition of updated information systems and medical equipment for the Institution. The Project will be located at the Main Campus. See "PART 9 - THE PROJECT."

PART 2 - PLAN OF FINANCING

Application of Series 2020 Bond Proceeds and Other Moneys

Proceeds of the Series 2020 Bonds will be deposited (1) in the Mortgage Account of the Construction Fund to pay Costs of the Project; (2) in the Mortgage Account of the Construction Fund to pay interest on the Series 2020 Bonds during construction for a period of approximately 35 months, (3) in the Reserve Account of the Debt Service Reserve Fund in an amount equal to the Debt Service Reserve Fund Requirement for the Series 2020 Bonds less an amount equal to the Collateral Account Requirement; and (4) in the Costs of Issuance Account of the Construction Fund to pay certain Costs of Issuance of the Series 2020 Bonds. Upon completion of the Project, the balance of the moneys, if any, remaining in the Construction Fund not needed to pay Costs of the Project then unpaid shall be applied in accordance with the Resolutions.

Upon delivery of the Series 2020 Bonds, the Institution is required to deliver or cause to be delivered to the Trustee an amount equal to the Collateral Account Requirement for deposit into the Collateral Account of the Debt Service Reserve Fund. The deposit of proceeds of the Series 2020 Bonds to the Reserve Account plus the Institution's delivery of the Collateral Account Requirement will satisfy the Debt Service Reserve Fund Requirement. The Collateral Account Requirement may be met with cash, a Letter of Credit, a surety bond, or any combination thereof. For a description of the purpose and application of moneys in the Collateral Account, see "Payment of Mortgage Insurance Benefits" below.

The Loan Agreement further requires that, upon delivery of the Series 2020 Bonds, the Institution deliver to the Trustee an amount equal to the Investment Income Account Requirement for deposit into the Investment Income Account of the Construction Fund. The amount of such required deposit is equal to the maximum amount that may be required to pay interest on the Series 2020 Bonds prior to Final Endorsement (as defined herein) of the 2020 Note, less the sum of: (a) the amount to be earned on investment of certain bond proceeds; and (b) the amount to be received as interest on the 2020 Note.

The Investment Income Account Requirement and the Collateral Account Requirement, if any, will be initially funded with the proceeds of a term loan from TD Bank and/or original issue premium from the sale of the Series 2020 Bonds.

To the extent not previously incurred, the Institution is also required to deliver to the Authority, at or prior to the time of delivery of the Series 2020 Bonds, the Institution's equity contribution to the Project, in the form of a cash contribution, prepaid expenses, or any combination thereof or, in lieu thereof, a letter of credit acceptable to the Authority. See "PART 7 - ESTIMATED SOURCES AND USES OF FUNDS." If such equity contribution together with other amounts in the Mortgage Account of the Construction Fund is not sufficient to complete the Project, the Institution is required to provide all additional amounts needed to ensure completion.

The portion of the Debt Service Reserve Fund Requirement deposited in the Reserve Account of the Debt Service Reserve Fund from the proceeds of the Series 2020 Bonds and the funds deposited in the Mortgage Account of the Construction Fund will be, pending disbursement, invested in Permitted Investments authorized by the Resolutions. The General Resolution provides that net interest income on the Reserve Account will be deposited (i) prior to HUD finally endorsing the 2020 Note for Mortgage Insurance (the "**Final Endorsement**"), to the credit of the Investment Income Account of the Construction Fund and (ii) after Final Endorsement, to the credit of the Debt Service Account of the Debt Service Fund. Amounts available therefor in the Investment Income Account will be applied, if needed, together with interest payments on the 2020 Note, to payment of interest on the Series 2020 Bonds. Net investment income on the Mortgage Account will be deposited prior to Final Endorsement to the credit of the Investment Income Account of the Construction Fund.

In the event that the Institution determines after the date of delivery of the Series 2020 Bonds to enter into one or more Investment Agreements with respect to any moneys in any Fund or Account held by the Trustee, the Resolutions require that the Institution first obtain a confirmation from each Rating Service that such Investment Agreement(s) will not cause the rating then in existence from such Rating Service on the Series 2020 Bonds to be lowered or withdrawn.

Construction Fund Disbursements

Concurrently with or prior to the delivery of the Series 2020 Bonds, HUD will initially endorse the 2020 Note for Mortgage Insurance (the "**Initial Endorsement**"). Each month during the construction period, the Institution will submit to the Mortgage Servicer, on behalf of the Authority, as FHA mortgagee, an "Application for Insurance of Advance of Mortgage Proceeds" for payment of the Costs of the Project including interest on the amount of the 2020 Note outstanding during the preceding month. This application, together with certain other documentation, will be submitted by the Mortgage Servicer to HUD for approval, which approval is necessary in order for the advance to be entitled to the benefit of the Mortgage Insurance. Upon receipt of HUD's approval of the advance, the Mortgage Servicer will deliver to the Authority the HUD-approved advance and other documents or notifications required under the Servicing Agreement, and the Authority will cause payments to be made to the Institution from the Construction Fund for the Costs approved for such advance; provided, however, that the portion of such

Costs representing interest on the 2020 Note, less the Servicing Fee, shall be credited to the Investment Income Account.

Moneys in the Construction Fund shall be disbursed pursuant to the Resolutions as follows:

(a) from the Mortgage Account and the Equity Account to the Institution pursuant to the Building Loan Agreement, the Loan Agreement, and the Servicing Agreement, for payment of Costs of the Project, including certain costs incurred in connection with the issuance of the Series 2020 Bonds;

(b) from the Costs of Issuance Account for payment of certain costs incurred in connection with the issuance of the Series 2020 Bonds; and

(c) from the Investment Income Account to the Debt Service Account on the last business day preceding an Interest Payment Date until final endorsement of the 2020 Note, such amount as may be required, together with the amount then on deposit in the Debt Service Account to pay interest becoming due on the Series 2020 Bonds.

Further, in the event of a default under the 2020 Note and the 2020 Mortgage and assignment of the 2020 Note and the 2020 Mortgage to HUD, moneys in the Construction Fund shall be transferred from the Mortgage Account and the Equity Account to HUD, if HUD so requires. If HUD does not require such a transfer, any undisbursed balance in the Construction Fund shall be applied to the Extraordinary Mandatory Redemption of the Series 2020 Bonds. See "PART 3 - THE SERIES 2020 BONDS – Redemption of the Series 2020 Bonds."

Procedures Upon Completion of Project

Upon the completion of the Project in accordance with the Building Loan Agreement and applicable HUD regulations and Final Endorsement, the Institution is required to furnish to the Trustee, the Mortgage Servicer, and the Authority, a certificate certifying that the Project has been substantially completed as to permit its efficient use in the operations of the Institution, that all insurance required by the Commitment and in the FHA Documents is in full force and effect, and that all Costs of the Project have been paid, or stating the amounts to be reserved for the payment of any unpaid Costs.

In the event that the Institution is obligated by HUD to prepay or reduce the 2020 Note in connection with the Project Cost certification process and the amounts available in the Construction Fund for application to such prepayment or reduction is less than that portion of the 2020 Note which the Institution is so obligated to prepay or reduce, the Institution shall promptly pay the amount of such deficiency to the Authority. Any payment of a prepayment or reduction deficiency by the Institution described in the preceding sentence, whether or not received prior to Final Endorsement, will be credited as a prepayment or reduction of the 2020 Note and deposited in the Redemption Fund and applied to the Special Mandatory Redemption of the Series 2020 Bonds.

Payment of the 2020 Note and the Series 2020 Bonds

The HUD Mortgage Loan is being insured by HUD pursuant to the Commitment. Amortization of the principal of the 2020 Note is required to begin no later than August 1, 2023 (the "**Commencement of Amortization**").

Up to and including thirty (30) days prior to the Commencement of Amortization, the Institution will make monthly payments of interest at the rate of 6.0% per annum (the "**Construction Note Rate**") on

amounts disbursed from the Mortgage Account pursuant to the Building Loan Agreement. Thereafter, the 2020 Note provides that interest shall be paid monthly at the rate of 3.05% per annum (the "**Permanent Note Rate**"), although at Final Endorsement it is expected that the interest rate on the 2020 Note may be further reduced but in no event to a rate that would not be sufficient to pay the principal of and interest on the Series 2020 Bonds as the same shall become due. See "PART 4 - SCHEDULE OF PRINCIPAL, INTEREST, AND ESTIMATED SINKING FUND REDEMPTIONS." Furthermore, in the event that Final Endorsement has not occurred by July 1, 2023, an additional amount of interest may be charged with respect to the 2020 Note sufficient to pay the Series 2020 Bonds at such a rate of interest above the Permanent Note Rate (but not exceeding 6.0%) until Final Endorsement.

During construction of the Project, such interest payments made on the 2020 Note shall be made from the Mortgage Account of the Construction Fund. Moneys in the Mortgage Account that may be advanced for interest on the 2020 Note may not exceed the sum of $15,140,563.00, the figure approved in the Commitment for capitalized interest, or such other amount as HUD may approve. In the event a credit therefor is not available from the Mortgage Account or from funds held in the Investment Income Account, the Institution is expected to make interest payments on the 2020 Note from its own resources. Upon Commencement of Amortization, mortgage payments made on the 2020 Note, after deduction of the Servicing Fee, will be deposited in the Mortgage Payment Fund. Payments made on the 2020 Note, less Servicing Fees, plus other available funds, will be used to make payments on the Series 2020 Bonds.

The maturity and final payment date of the 2020 Note is July 1, 2048. Mortgage payments will be collected by the Mortgage Servicer on behalf of the Authority and will then be paid by the Mortgage Servicer, after deduction of the Servicing Fee and Mortgagee Advances, if any, to the Trustee for deposit initially into the Mortgage Payment Fund and thereafter, shall be transferred by the Trustee in accordance with the Resolutions. Following Final Endorsement, net investment income from the Debt Service Reserve Fund (except the portion of the Collateral Account representing the Institution's contribution to such Fund) will also be transferred to the Debt Service Account.

The General Resolution provides that on the last business day prior to each Interest Payment Date, the Trustee shall pay out of the Debt Service Account the following: (i) interest due on the Series 2020 Bonds on such Interest Payment Date; (ii) principal of the Series 2020 Bonds maturing on such Interest Payment Date; (iii) if the 2020 Note and the 2020 Mortgage have been assigned to HUD due to a payment failure by the Institution, fees and expenses, as applicable, of the Authority and the Trustee; and (iv) to the extent required by the General Resolution, amounts to be applied to Sinking Fund Redemptions. All net investment earnings in the Debt Service Account shall be used to fund the Surplus Account. Funds in the Surplus Account will be used to pay the Trustee's annual fee and all fees and expenses of the Authority; any excess in the Surplus Account over $52,000 will, at the direction of the Authority, be periodically transferred back to the Debt Service Account so long as the Institution is not in default of any of its obligations under the FHA Documents and the Loan Agreement.

Payment of Mortgage Insurance Benefits

Pursuant to the terms of the Resolutions, if a payment default occurs under the 2020 Note and continues for thirty (30) days subject to the HUD requirements described in "PART 5 – MORTGAGE INSURANCE - Default and Payment of Mortgage Insurance Benefits," the 2020 Note and the 2020 Mortgage shall be assigned to HUD in order to receive Mortgage Insurance Benefits. Upon such event and until final payment by HUD of all Mortgage Insurance Benefits, unless and until such default is waived in accordance with the Resolutions, the Trustee shall transfer from the Reserve Account of the Debt Service Reserve Fund to the Debt Service Account on the second Business Day preceding each Interest Payment Date an amount sufficient, together with moneys then on deposit in the Debt Service Account, to pay

interest and principal then due on the Series 2020 Bonds Outstanding. See "PART 6 - CERTAIN PROVISIONS OF THE FHA DOCUMENTS."

No assurance can be given that moneys in the Collateral Account or the Reserve Account of the Debt Service Reserve Fund will be sufficient to make all payments of debt service on the Series 2020 Bonds from the time a payment default occurs until final payment of Mortgage Insurance Benefits is made. See "PART 5 – MORTGAGE INSURANCE" and "PART 11 – BONDHOLDERS' RISKS." The procedure to be followed by the Authority in filing claims for Mortgage Insurance Benefits and the application of Mortgage Insurance Benefits are described in the General Resolution. See "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION."

In the event of a default under the 2020 Note or the 2020 Mortgage resulting in an assignment of the 2020 Note and the 2020 Mortgage to HUD and the receipt of Mortgage Insurance Benefits, the Authority shall cause there to be prepared by a Financial Consultant a Cash Flow Statement for the Series 2020 Bonds that applies such Mortgage Insurance Benefits and other available funds in such manner as to provide for the timely payment of the principal of and interest on all the Series 2020 Bonds if the Authority in its discretion determines that such a Cash Flow Statement is appropriate. The Authority shall direct such revenues received with respect to a default under the 2020 Note or the 2020 Mortgage to be applied to the redemption of the Series 2020 Bonds, all in accordance with the provisions of the Resolutions.

Generally, Mortgage Insurance Benefits may be paid in cash or debentures or any combination thereof at the discretion of HUD. However, in the Commitment, HUD has stated that the Mortgage Insurance Benefits will be paid in cash rather than in FHA debentures. See "PART 2 - PLAN OF FINANCING — Payment of Mortgage Insurance Benefits" and "PART 5 – MORTGAGE INSURANCE" for more details concerning Mortgage Insurance Benefits and the methods and conditions of payment. Mortgage Insurance Benefits paid by HUD pursuant to a "cash lock" agreement are expected to be paid in two installments. See "PART 5 – MORTGAGE INSURANCE- General."

If cash Mortgage Insurance Benefits, together with all amounts then on deposit in all the funds and accounts (other than the Arbitrage Rebate Fund, the Mortgage Account, and the Equity Account of the Construction Fund) established under the Resolutions including any unused portion of any Letter of Credit, are sufficient to redeem the Series 2020 Bonds, with interest to the redemption date and to pay all accrued and estimated fees and expenses of the Authority, the Trustee, and the Mortgage Servicer, then any Investment Agreement or investment permitted by the Resolutions in which moneys on deposit in any fund or account have been invested shall be liquidated or sold, and the proceeds thereof together with the proceeds of the Mortgage Insurance Benefits and other available moneys shall be used to pay such fees and expenses and the balance shall be deposited in the Redemption Fund and used to redeem the Series 2020 Bonds.

In the event that Mortgage Insurance Benefits are received from HUD in more than one cash installments, the General Resolution provides that the Authority shall cause each cash installment to be allocated first for the deposit to the Debt Service Account to pay any maturing principal and interest due on the Series 2020 Bonds on or prior to the Extraordinary Mandatory Redemption date established for any such cash installment received and second for the deposit to the Redemption Account to redeem Series 2020 Bonds pursuant to an Extraordinary Mandatory Redemption. See "PART 3 - THE SERIES 2020 BONDS— Redemption of the Series 2020 Bonds."

In the event of a default under the 2020 Note, it is anticipated that the Mortgage Insurance Benefits, together with the Trust Revenues and any reserves held pursuant to the Resolutions, will be sufficient to pay, on a timely basis, the maturing principal of and interest on the Series 2020 Bonds. The Mortgage Insurance, however, does not constitute a guarantee or assurance of the timely payment of the principal or

Redemption Price of, and interest on, the Series 2020 Bonds. Furthermore, Mortgage Insurance Benefits, together with other Trust Revenues and any reserves held on deposit under the Resolutions, may not be sufficient to pay the principal or Redemption Price of, and interest on, the Series 2020 Bonds depending upon the amount, if any, of the offsets made in calculating the payment of a claim for Mortgage Insurance Benefits. See "PART 5 – MORTGAGE INSURANCE."

Prepayment of Note from Hazard Insurance or Condemnation Proceeds

The Loan Agreement provides that hazard insurance proceeds and condemnation awards that are paid to the Authority, as FHA mortgagee, under the 2020 Mortgage upon a complete or partial destruction or condemnation (including eminent domain) of the Mortgaged Property shall, to the extent not applied for the repairing, replacing, or rebuilding of the Mortgaged Property as may be permitted pursuant to the terms of the FHA Documents, the Loan Agreement, and the Resolutions, be applied to the prepayment of the 2020 Note. For information concerning redemption of Series 2020 Bonds from Note prepayments, see "PART 3 - THE SERIES 2020 BONDS – Redemption of the Series 2020 Bonds."

PART 3 - THE SERIES 2020 BONDS

Description of the Series 2020 Bonds

The Series 2020 Bonds will be issued as fully registered bonds in the initial aggregate principal amount set forth on the cover page hereof. The Series 2020 Bonds will be dated their date of delivery and will bear interest from such date payable on February 1, 2021, and on each February 1 and August 1 thereafter and will bear interest at the rates and mature on the dates set forth on the inside cover page hereof. Interest on the Series 2020 Bonds shall accrue based upon a 360-day year of twelve 30-day months.

The Series 2020 Bonds will be issued in denominations of $5,000 or any integral multiple thereof. The Series 2020 Bonds will be registered in the name of Cede & Co., as nominee of DTC, pursuant to DTC's Book-Entry Only System. Purchase of beneficial interests in the Series 2020 Bonds will be made in book-entry form, without certificates. If at any time the Book-Entry Only System is discontinued for the Series 2020 Bonds, the Series 2020 Bonds will be exchangeable for other fully registered Series 2020 Bonds in any other authorized denominations of the same maturity without charge except the payment of any tax, fee, or other governmental charge to be paid with respect to such exchange, subject to the conditions and restrictions set forth in the General Resolution. See "Book-Entry Only System" herein and "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION."

The principal of and interest on the Series 2020 Bonds will be payable in lawful money of the United States of America. The principal or Redemption Price of the Series 2020 Bonds will be payable at the principal corporate trust office of U.S. Bank National Association, the Trustee and Paying Agent. Interest on the Series 2020 Bonds will be payable by check or draft mailed to the registered owners thereof at their addresses as shown on the registration books held by the Trustee. Interest is payable to the registered owners who are such registered owners at the close of business on the fifteenth day of the calendar month next preceding an Interest Payment Date. In the event that the Series 2020 Bonds are no longer held in book-entry only form, Bondholders of $1,000,000 or more aggregate principal amount of Series 2020 Bonds may receive interest by wire transfer to the wire transfer address, within the continental United States specified by such Bondholder, upon the written request of such Holder received not less than 20 days prior to the next Interest Payment Date, which written request may apply to multiple Interest Payment Dates. In such event, such Bondholders may also receive the Redemption Price by wire transfer at the address in the continental United States specified by such Bondholder in a written request to the Trustee upon presentation and surrender to the Trustee of the Series 2020 Bond to be redeemed.

Security for the Series 2020 Bonds

The principal or Redemption Price of and interest on the Series 2020 Bonds are payable: (1) from payments to be made by the Institution under the 2020 Note (other than the Servicing Fee and Mortgagee Advances or late payment charges) which corresponds to amounts payable under the Loan Agreement; (2) from Mortgage Insurance Benefits, in the event of a default by the Institution under the 2020 Note and the 2020 Mortgage and assignment thereof to HUD; and (3) from certain funds and accounts held by the Trustee pursuant to the Resolutions and certain investment income thereon. The Series 2020 Bonds will be separately secured from all other bonds issued under the Resolutions and the obligations of the Institution under the 2020 Note are secured by the 2020 Mortgage from the Institution to the Authority, granting to the Authority a lien on the Mortgaged Property, including, but not limited to, certain personalty, revenues, and accounts receivable associated therewith. For further description of the Mortgage Insurance Benefits, see "PART 5 – MORTGAGE INSURANCE."

The General Resolution authorizes the issuance by the Authority, from time to time, of bonds in one or more series, each such series to be authorized by a separate series resolution and to be separately secured from each other series of bonds. The Holders of bonds of a series shall not be entitled to the rights and benefits conferred upon the Holders of bonds of any other series, including the Series 2020 Bonds.

The Resolutions provide for the establishment of a Debt Service Reserve Fund with respect to the Series 2020 Bonds which includes the following accounts: (a) the Reserve Account, funded from the proceeds of the Series 2020 Bonds, in an amount equal to, as of any particular date of computation, not less than the sum of (i) the maximum principal amount of the Series 2020 Bonds constituting Serial Bonds and interest thereon anticipated to come due in any 12 month period; (ii) an amount equal to the maximum amount of interest on the Series 2020 Bonds constituting Term Bonds coming due in any 12 month period; (iii) the greater of: (A) one month's principal and interest on the 2020 Note; or (B) one month's interest only at the Construction Note Rate on the face amount of the 2020 Note; and (iv) the Collateral Account Requirement, which may be funded by the Institution with cash, a surety bond, or a Letter of Credit in an amount, if any, equal to the Collateral Account Requirement.

The Series 2020 Bonds do not constitute an obligation or indebtedness of, and the payment of the Series 2020 Bonds is not insured or guaranteed by, the United States of America or any agency or instrumentality thereof, including HUD. The Series 2020 Bonds will not be a debt of the State of New York nor will the State be liable thereon. The Authority has no taxing power.

Redemption of the Series 2020 Bonds

Sinking Fund Redemption

The Series 2020 Term Bonds maturing August 1, 2043, and February 1, 2050, are subject to Sinking Fund Redemption on an Interest Payment Date in direct order of maturity (and within a maturity by lot) at a Redemption Price of 100% of the principal amount thereof plus interest accrued to the date of redemption from funds in the Debt Service Account and available for such purpose under the Resolutions after providing for the payment of maturing principal and interest then due on the Series 2020 Bonds. Since the amount of funds available to be applied to make Sinking Fund Redemptions may vary, the Resolutions do not require that Sinking Fund Redemptions be made in any specific amount, but only to the extent that funds are available in the Redemption Account therefor.

Notwithstanding the foregoing, all of the Series 2020 Bonds shall also be subject to redemption to the extent Mortgage Insurance Benefits are on deposit and available therefor in accordance with the General

Resolution, at a Redemption Price equal to the principal amount to be redeemed on each February 1 and August 1 from funds in the Debt Service Account after providing for the payment of interest then due on the Series 2020 Bonds. Redemption from such amounts shall be in direct order of maturity of the Series 2020 Bonds and within a maturity by lot or in such other manner as the Authority may direct to permit the timely payment of principal of or interest on all Series 2020 Bonds.

Although the final maturity date of the Series 2020 Bonds is February 1, 2050, the payments of principal and interest under the 2020 Note have been scheduled to provide sufficient funds, together with funds in the Debt Service Reserve Fund and certain investment earnings thereon, so that in the absence of a default under the 2020 Note and the 2020 Mortgage, all Series 2020 Bonds Outstanding are expected to be redeemed pursuant to Sinking Fund Installments by August 1, 2048. "PART 4 - SCHEDULE OF PRINCIPAL, INTEREST, AND ESTIMATED SINKING FUND REDEMPTIONS" sets forth the estimated Sinking Fund Installments for the Series 2020 Bonds. Redemption from such amounts shall be in direct order of maturity of the Series 2020 Bonds and within a maturity by lot, or in such other manner as the Authority may direct to permit the timely payment of the principal of or interest on all Series 2020 Bonds.

Optional Redemption

The Series 2020 Bonds maturing on or prior to August 1, 2027, are not subject to optional redemption prior to maturity. The Series 2020 Bonds maturing on or after February 1, 2028, are subject to Optional Redemption prior to maturity by the Authority, but only upon the request of the Institution, on or after August 1, 2027, in whole or in part at any time at a Redemption Price equal to the principal amount to be redeemed, plus interest accrued to the redemption date.

Special Mandatory Redemption

The Series 2020 Bonds are subject to Special Mandatory Redemption prior to maturity, in part, on the earliest practicable redemption date or dates following Final Endorsement of the 2020 Note from the deposit into the Redemption Account (1) of moneys remaining in the Mortgage Account and the Investment Income Account and (2) of funds required to be deposited in the Redemption Account by the Institution pursuant to the Loan Agreement, at a Redemption Price of 100% of the principal amount to be redeemed, plus interest accrued to the redemption date. See "PART 4 - SCHEDULE OF PRINCIPAL, INTEREST, AND ESTIMATED SINKING FUND REDEMPTIONS."

Extraordinary Mandatory Redemption

The Series 2020 Bonds are subject to Extraordinary Mandatory Redemption in whole or in part at any time prior to maturity at a Redemption Price of 100% of the principal amount to be redeemed, plus interest accrued to the redemption date, on the earliest practicable date following:

1. the deposit into the Redemption Account upon the conditions specified in the Resolutions of proceeds of casualty insurance on, or condemnation of, the Mortgaged Property and other available moneys received by the Authority pursuant to the Loan Agreement as are not applied to the repair, rebuilding, or restoration of the Mortgaged Property;

2. the deposit into the Redemption Account, upon the conditions specified in the General Resolution, of amounts of Mortgage Insurance Benefits and certain amounts held in the funds and accounts established under the General Resolution; or

3. the deposit into the Redemption Account, upon the conditions specified in the Resolutions, of proceeds of a refinancing and prepayment under the 2020 Note following a default thereunder and a determination by HUD that refinancing of the 2020 Note resulting in such prepayment will avoid a claim for Mortgage Insurance Benefits. It is possible that HUD could require a refinancing of all or a portion of the 2020 Note. If this occurs, an Extraordinary Mandatory Redemption in whole or in part of the Series 2020 Bonds may occur.

Purchase in Lieu of Optional Redemption

In lieu of redeeming the Series 2020 Bonds, the Trustee at the direction of the Authority upon the request of the Institution may call such Series 2020 Bonds for purchase in whole or in part at any time pursuant to the terms and conditions of the Series Resolution or Bond Series Certificate. Notwithstanding any provision of the General Resolution to the contrary, in the event the Series 2020 Bonds are called for purchase in lieu of a redemption, such purchase shall not operate to extinguish the indebtedness of the Authority evidenced by such Series 2020 Bond or modify the terms of any such Series 2020 Bonds and such Series 2020 Bonds need not be cancelled, but shall remain Outstanding hereunder and in such case, shall continue to bear interest. See "Selection of Series 2020 Bonds to be Redeemed" below.

Selection of Series 2020 Bonds to be Redeemed

Unless otherwise provided in the Bond Series Certificate, if less than all of the Bonds Outstanding of a Series shall be called for Optional Redemption, Special Mandatory Redemption, or Extraordinary Mandatory Redemption, upon the written direction of the Authority, which direction shall be given in accordance with the General Resolution, the Trustee shall, if Non-Asset Bonds are then Outstanding, select for redemption a principal amount of Bonds of such Series, such that the Non-Asset Bond Ratio after the redemption is as nearly as practicable the same as the Non-Asset Bond Ratio prior to such redemption and shall select for such redemption a principal amount of the Bonds of such Series of each maturity to be so redeemed (which may, at the option of the Authority, be based on a revised Cash Flow Statement) in an amount as nearly as practicable in the proportion that the aggregate principal amount of the Bonds of such Series then Outstanding of each maturity bears to the aggregate principal amount of all the Bonds then Outstanding of such Series, and within a maturity by lot or in such manner as the Authority shall direct in order to permit the timely payment of the principal and interest on all the Bonds Outstanding of such Series. Unless otherwise provided in respect of a Series of Bonds, if less than all the Bonds of a maturity of such Series are to be redeemed, the particular Bonds of such maturity of such Series to be called for redemption shall be selected by the Trustee in accordance with the procedure described in the General Resolution.

With respect to redemptions of the Series 2020 Bonds derived from prepayments by the Institution, the Trustee shall upon the written direction of the Authority call Series 2020 Bonds for Optional Redemption or Special Mandatory Redemption, but only to the extent such prepayment resulting in a Special Mandatory Redemption is required by the General Resolution and the Loan Agreement and only after it shall have received, in accordance with the timing and other provisions of the Loan Agreement and the 2020 Note: (i) notice from the Institution, if required, of the proposed prepayment; (ii) the corresponding prepayment and premium, if any, under the 2020 Note and the 2020 Mortgage and the Loan Agreement; and (iii) the Institution's certificate of non-bankruptcy. If the Authority receives notice from the Institution that the Institution proposes to make a prepayment, the Authority shall forthwith deliver a copy of such notice to the Trustee.

Whenever by the terms hereof the Trustee is required or authorized to redeem the Series 2020 Bonds from Sinking Fund Installments, the Trustee shall select the Series 2020 Bonds to be redeemed as specified by the Series Resolution or Bond Series Certificate. Whenever by the terms of the General Resolution the Trustee is required or authorized to redeem the Bonds other than pursuant to the General

Resolution and other than through Sinking Fund Redemption, the Authority shall select the maturities of the Bonds of such Series to be redeemed by notice thereof given to such Trustee at least ten (10) days prior to the date notice of redemption is to be mailed. The Trustee shall select the Series 2020 Bonds and maturities to be redeemed in the manner provided in the General Resolution, give the notice of redemption, and pay from moneys available therefor the Redemption Price thereof, together with interest accrued to the redemption date, to the appropriate Paying Agents in accordance with the terms of the General Resolution.

Notice of Redemption

Whenever the Series 2020 Bonds are to be redeemed, the Trustee shall give notice of the redemption of such Bonds in the name of the Authority, which notice shall be given by first-class mail, postage prepaid to the registered owners of the Series 2020 Bonds which are to be redeemed, at their last known addresses, if any, appearing on the registration books of the Authority not more than ten (10) Business Days prior to the date such notice is given, in each case at least thirty (30) days but not more than forty-five (45) days prior to the redemption date except that, with respect to any Extraordinary Mandatory Redemption, such notice shall be given not less than ten (10) but not more than thirty (30) days prior to the redemption date. The Trustee shall promptly certify to the Authority that it has mailed or caused to be mailed such notice to such Bondholders, and such certificate shall be conclusive evidence that such notice was given in the manner required hereby. The failure of any such owner to receive notice shall not affect the validity of the proceedings for the redemption of the Series 2020 Bonds with respect to which notice has been given in accordance with the General Resolution. Such notice shall specify: (i) the Series 2020 Bonds to be redeemed (including date of issue, interest rate, and maturity date); (ii) the redemption date; (iii) the Redemption Price; (iv) the source of the funds to be used for the redemption; (v) the numbers, any CUSIP number, and other distinguishing marks of such Bonds to be redeemed (except in the event that all of the Outstanding Bonds of the Series 2020 Bonds are to be redeemed); (vi) of each such Bond, the principal amount thereof to be redeemed; (vii) that such Bonds will be redeemed at the principal corporate trust office of the Trustee giving the address thereof and the person or customer service number of the Trustee to whom inquiries may be directed; and (viii) that no representation is made as to the correctness of the CUSIP number either as printed on the Series 2020 Bonds or as contained in such notice and that an error in a CUSIP number as printed on such Bond or as contained in such notice shall not affect the validity of the proceedings for redemption. If a redemption is a conditional redemption as described below, the notice so shall state. Such notice shall further state that on such date there shall become due and payable upon the Series 2020 Bonds to be redeemed the Redemption Price thereof, together with interest accrued to the redemption date if other than an Interest Payment Date, and that from and after such date, payment having been made or provided for, interest thereon shall cease to accrue.

Any notice of redemption may state that the redemption to be effected is conditioned upon the receipt by the Trustee on or prior to the redemption date of moneys sufficient to pay the principal of, if any, and interest on the Series 2020 Bonds to be redeemed or that the Authority retains the right to rescind such notice of redemption on or prior to the scheduled redemption date and that if such moneys are not so received or if the notice of redemption is rescinded such notice shall be of no force or effect and such Bonds shall not be required to be redeemed. In the event that such notice contains such a condition and moneys sufficient to pay the principal, premium, if any, and interest on such Bonds are not received by the Trustee on or prior to the redemption date, the redemption shall not be made and the Trustee shall within a reasonable time thereafter give notice, in the manner in which the notice of redemption was given, that such moneys were not so received, that the redemption did not occur and that the Series 2020 Bonds called for redemption and not so paid remain Outstanding. Any Series 2020 Bonds subject to a conditional redemption where redemption has not occurred shall remain Outstanding, and such failure to redeem shall not constitute an Event of Default.

In addition, the Trustee shall mail by first class mail a copy of the notice of redemption not less than thirty (30) days prior to the redemption or in the case of an Extraordinary Mandatory Redemption not less than ten (10) days prior to the redemption to: (i) the Depository for Book Entry Bonds; and (ii) to each Rating Service rating the Series 2020 Bonds. The Trustee shall also cause a copy of the notice of redemption to be electronically filed with the Electronic Municipal Market Access ("**EMMA**") system maintained by the Municipal Securities Rulemaking Board, as the sole repository for the central filing of electronic disclosure pursuant to Rule 15c2-12 under the Securities Exchange Act of 1934, as amended (or any successor electronic information system) within ten (10) Business Days after the occurrence of any redemption of the Series 2020 Bonds. Mailing or electronically filing such copies of such notice of redemption shall not be a condition precedent to such redemption and the failure to so mail or file or of a person to whom such copies were mailed or filed to receive such copy shall not affect the validity of the proceedings for the redemption of the Series 2020 Bonds.

Additional Indebtedness

The Authority, as FHA mortgagee under the 2020 Mortgage, may, upon satisfaction of certain requirements set forth in the General Resolution and the FHA Documents, consent to the Institution's incurring indebtedness in addition to the 2020 Note, secured by a lien on the Mortgaged Property. See "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION." Such bonds may be secured on parity with the Series 2020 Bonds or may be separately secured pursuant to the terms of a separate Series Resolution adopted pursuant to the Resolution.

Book-Entry Only System

The Depository Trust Company ("***DTC***"), New York, New York, will act as securities depository for the Series 2020 Bonds. The Series 2020 Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Series 2020 Bond certificate will be issued for each Series, maturity and, if applicable, interest rate, of the Series 2020 Bonds, totaling in the aggregate the principal amount of the Series 2020 Bonds, and will be deposited with DTC.

DTC is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity issues, corporate, and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants ("**Direct Participants**") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("**DTCC**"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("**Indirect Participants**"). The DTC Rules applicable to its Direct and Indirect Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of Series 2020 Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Series 2020 Bonds on DTC's records. The ownership interest of each actual purchaser of a Series 2020 Bond ("**Beneficial Owner**") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Series 2020 Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Series 2020 Bonds, except in the event that use of the book-entry system for such Series 2020 Bonds is discontinued.

To facilitate subsequent transfers, all Series 2020 Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Series 2020 Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not affect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Series 2020 Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Series 2020 Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time.

Redemption notices shall be sent to DTC. If less than all of the Series 2020 Bonds within a particular maturity of the Series 2020 Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Series 2020 Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Authority as soon as possible after the Record Date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Series 2020 Bonds are credited on the Record Date (identified in a listing attached to the Omnibus Proxy).

Principal, redemption premium, if any, and interest payments on the Series 2020 Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Authority or the Trustee on the payable date in accordance with their respective holdings shown on DTC's records. Payments by Direct and Indirect Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, the Underwriters, the Trustee, or the Authority, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal, redemption premium, if any, and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Authority or the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as depository with respect to the Series 2020 Bonds at any time by giving reasonable notice to the Authority or the Trustee. Under such circumstances, in the event that a successor depository is not obtained, the Series 2020 Bond certificates are required to be printed and delivered.

The Authority may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, the Series 2020 Bond certificates will be printed and delivered to DTC.

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the Authority believes to be reliable, but the Authority takes no responsibility for the accuracy thereof.

Each person for whom a Direct Participant or Indirect Participant acquires an interest in the Series 2020 Bonds, as nominee, may desire to make arrangements with such Direct Participant or Indirect Participant to receive a credit balance in the records of such Direct Participant or Indirect Participant, and may desire to make arrangements with such Direct Participant or Indirect Participant to have all notices of redemption or other communications to DTC, which may affect such persons, to be forwarded in writing by such Direct Participant or Indirect Participant and to have notification made of all interest payments.

So long as Cede & Co. is the registered owner of the Series 2020 Bonds, as nominee for DTC, references herein to the Bondholders or registered owners of the Series 2020 Bonds (other than under "PART 15 – TAX MATTERS" and "PART 21 – CONTINUING DISCLOSURE") mean Cede & Co., as aforesaid, and do not mean the Beneficial Owners of the Series 2020 Bonds.

When reference is made to any action which is required or permitted to be taken by the Beneficial Owners, such reference will only relate to those permitted to act (by statute, regulation, or otherwise) on behalf of such Beneficial Owners for such purposes. When notices are given, they will be sent by the Trustee to DTC only.

For every transfer and exchange of Series 2020 Bonds, the Beneficial Owner may be charged a sum sufficient to cover any tax, fee, or other governmental charge that may be imposed in relation thereto.

The Authority, in its sole discretion and without the consent of any other person, may terminate the services of DTC with respect to the Series 2020 Bonds if the Authority determines that (i) DTC is unable to discharge its responsibilities with respect to the Series 2020 Bonds, or (ii) a continuation of the requirement that all of the Outstanding Bonds be registered in the registration books kept by the Trustee in the name of Cede & Co., as nominee of DTC, is not in the best interests of the Beneficial Owners. In the event that no substitute securities depository is found by the Authority or restricted registration is no longer in effect, Series 2020 Bond certificates will be delivered as described in the Resolution.

NONE OF THE AUTHORITY, THE INSTITUTION, THE UNDERWRITERS, OR THE TRUSTEE WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO DIRECT PARTICIPANTS, TO INDIRECT PARTICIPANTS, OR TO ANY BENEFICIAL OWNER WITH RESPECT TO (I) THE ACCURACY OF ANY RECORDS MAINTAINED BY DTC, ANY DIRECT PARTICIPANT, OR ANY INDIRECT PARTICIPANT, (II) ANY NOTICE THAT IS PERMITTED OR REQUIRED TO BE GIVEN TO THE OWNERS OF THE SERIES 2020 BONDS UNDER THE RESOLUTION; (III) THE SELECTION BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY PERSON TO RECEIVE PAYMENT IN THE EVENT OF A PARTIAL REDEMPTION OR PURCHASE IN LIEU OF REDEMPTION OF THE SERIES 2020 BONDS; (IV) THE PAYMENT BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY AMOUNT WITH RESPECT TO

THE PRINCIPAL OR REDEMPTION PREMIUM, IF ANY, OR INTEREST DUE WITH RESPECT TO THE SERIES 2020 BONDS; (V) ANY CONSENT GIVEN OR OTHER ACTION TAKEN BY DTC AS THE OWNER OF THE SERIES 2020 BONDS; OR (VI) ANY OTHER MATTER.

PART 4 - SCHEDULE OF PRINCIPAL, INTEREST, AND ESTIMATED SINKING FUND REDEMPTIONS

The following table sets forth the debt service schedule for the Series 2020 Bonds, including interest payments to be made on the Series 2020 Bonds, principal payments to be made at maturity of the Series 2020 Bonds, and estimated Sinking Fund Redemptions for the Series 2020 Bonds. This schedule is based on the following assumptions: (i) that the first payment of principal of the 2020 Note will be made no later than the Commencement of Amortization; (ii) that no event of default will occur under the 2020 Note or the 2020 Mortgage requiring the Authority to assign the 2020 Note and the 2020 Mortgage to HUD; (iii) that no interest income will be earned on either the Reserve Account or the Mortgage Account of the Construction Fund; (iv) that the interest rate on the 2020 Note will be the Construction Note Rate up to and including one month prior to the Commencement of Amortization of the 2020 Note and the Permanent Note Rate thereafter, although at Final Endorsement it is expected that the interest rate on the 2020 Note may be further reduced but in no event to a rate that would not be sufficient to pay the principal of and interest on the Series 2020 Bonds as the same shall become due; (v) that monthly construction draws from the Mortgage Account will proceed in accordance with an estimated schedule provided by the Institution; and (vi) that no prepayments are made on the 2020 Note and the Series 2020 Bonds are not refunded in whole or in part. See "PART 6 - CERTAIN PROVISIONS OF THE FHA DOCUMENTS – The 2020 Note." The interest rates utilized for preparing the following schedule reflects the Institution's current assumptions of monthly construction draws at the rate at which the 2020 Note will bear interest at Initial Endorsement together with the interest earnings on the Investment Agreements. (See "PART 6 - CERTAIN PROVISIONS OF THE FHA DOCUMENTS – The 2020 Note"). Under the Resolutions, the Authority may consent to an amendment of the 2020 Note to reduce the interest rate following Final Endorsement and, in such event, the actual Sinking Fund Installments in any Bond Year may be reduced. In no event shall any such reduction result in the payment of the interest on the Series 2020 Bonds later than the dates on which the same shall become due or the payment of the principal of each Series 2020 Bond later than its respective maturity date.

[remainder of page intentionally left blank]

Date	Principal Payments on Series 2020 Serial Bonds	Estimated Sinking Fund Installments on Series 2020 Term Bonds Maturing 08/01/2043	Estimated Sinking Fund Installments on Series 2020 Term Bonds Maturing 02/01/2050	Interest on Series 2020 Bonds	Other Debt Service of Institution†*	Total Debt Service
02/01/2021	$--	$--	$--	$2,451,069	$11,510,684	$13,961,753
08/01/2021	--	--	--	2,521,100	10,199,787	12,720,887
02/01/2022	--	--	--	2,521,100	10,000,520	12,521,620
08/01/2022	--	--	--	2,521,100	8,919,255	11,440,355
02/01/2023	--	--	--	2,521,100	7,928,614	10,449,714
08/01/2023	--	2,290,000	--	2,521,100	7,284,374	12,095,474
02/01/2024	1,450,000	--	--	2,475,300	7,154,525	11,079,825
08/01/2024	1,485,000	--	--	2,439,050	7,080,269	11,004,319
02/01/2025	1,520,000	5,000	--	2,401,925	6,843,765	10,770,690
08/01/2025	1,560,000	--	--	2,363,825	6,728,249	10,652,074
02/01/2026	1,600,000	--	--	2,324,825	6,716,327	10,641,152
08/01/2026	1,640,000	5,000	--	2,284,825	5,274,001	9,203,826
02/01/2027	1,680,000	5,000	--	2,243,725	4,314,949	8,243,674
08/01/2027	1,725,000	--	--	2,201,625	4,225,601	8,152,226
02/01/2028	1,770,000	--	--	2,158,500	4,205,521	8,134,021
08/01/2028	1,815,000	5,000	--	2,114,250	4,161,808	8,096,058
02/01/2029	1,860,000	--	--	2,068,775	4,119,795	8,048,570
08/01/2029	1,895,000	10,000	--	2,031,575	23,690,958	27,627,533
02/01/2030	1,935,000	5,000	--	1,993,475	3,320,150	7,253,625
08/01/2030	1,975,000	5,000	--	1,954,675	3,317,835	7,252,510
02/01/2031	2,015,000	5,000	--	1,915,075	3,317,355	7,252,430
08/01/2031	2,055,000	5,000	--	1,874,675	3,314,955	7,249,630
02/01/2032	2,095,000	10,000	--	1,833,475	3,314,836	7,253,311
08/01/2032	2,140,000	5,000	--	1,791,375	1,113,802	5,050,177
02/01/2033	2,185,000	10,000	--	1,748,475	--	3,943,475
08/01/2033	2,230,000	5,000	--	1,704,575	--	3,939,575
02/01/2034	2,275,000	5,000	--	1,659,875	--	3,939,875
08/01/2034	2,320,000	10,000	--	1,614,275	--	3,944,275
02/01/2035	2,365,000	10,000	--	1,567,675	--	3,942,675
08/01/2035	2,415,000	15,000	--	1,520,175	--	3,950,175
02/01/2036	2,465,000	10,000	--	1,471,575	--	3,946,575
08/01/2036	2,515,000	10,000	--	1,422,075	--	3,947,075
02/01/2037	2,565,000	10,000	--	1,371,575	--	3,946,575
08/01/2037	2,615,000	15,000	--	1,320,075	--	3,950,075
02/01/2038	2,655,000	15,000	--	1,280,550	--	3,950,550
08/01/2038	2,710,000	15,000	--	1,227,150	--	3,952,150
02/01/2039	2,750,000	20,000	--	1,186,200	--	3,956,200
08/01/2039	2,805,000	20,000	--	1,130,800	--	3,955,800
02/01/2040	2,850,000	20,000	--	1,088,325	--	3,958,325
08/01/2040	2,910,000	15,000	--	1,030,925	--	3,955,925
02/01/2041	--	2,970,000	--	986,975	--	3,956,975
08/01/2041	--	3,035,000	--	927,575	--	3,962,575
02/01/2042	--	3,095,000	--	866,875	--	3,961,875
08/01/2042	--	3,160,000	--	804,975	--	3,964,975
02/01/2043	--	3,225,000	--	741,775	--	3,966,775
08/01/2043	--	590,000	2,695,000	677,275	--	3,962,275
02/01/2044	--	--	3,345,000	625,050	--	3,970,050
08/01/2044	--	--	3,395,000	574,875	--	3,969,875
02/01/2045	--	--	3,450,000	523,950	--	3,973,950
08/01/2045	--	--	3,500,000	472,200	--	3,972,200
02/01/2046	--	--	3,555,000	419,700	--	3,974,700
08/01/2046	--	--	3,610,000	366,375	--	3,976,375
02/01/2047	--	--	3,665,000	312,225	--	3,977,225
08/01/2047	--	--	3,720,000	257,250	--	3,977,250
02/01/2048	--	--	3,780,000	201,450	--	3,981,450
08/01/2048	--	--	9,650,000	144,750	--	9,794,750
02/01/2049	--	--	--	--	--	--
08/01/2049	--	--	--	--	--	--
02/01/2050	--	--	--	--	--	--
Total	$72,845,000	$18,635,000	$44,365,000	$84,775,094	$158,057,935	$378,678,029

† Other Debt Service amounts for each date includes only current outstanding indebtedness and does not include unsecured Northwell liability of the Institution (see table in "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Discussion of Outstanding Indebtedness – Long-Term Debt").

* August 2029 includes a balloon payment on syndicate loans (see table in "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Long-Term Debt")

The actual Sinking Fund Redemption of the Series 2020 Bonds may vary from the estimated schedule set forth above for various reasons, including, but not limited to, the following:

1. If the principal amount of the 2020 Note approved by HUD at Final Endorsement is less than the principal amount of the 2020 Note approved at Initial Endorsement because the Costs of the Project as finally approved by HUD are less than originally approved, the remaining payments on the 2020 Note will be recast. In such event, each succeeding payment due on the 2020 Note will be adjusted to an amount which, when paid monthly and applied first to interest on the outstanding balance of the 2020 Note and the remainder to the reduction of principal, will be sufficient to pay the outstanding balance of the 2020 Note, as adjusted, over the remaining term thereof, and the Trustee shall redeem from the excess funds the Series 2020 Bonds as described in "*Special Mandatory Redemption*" of "PART 3 - THE SERIES 2020 BONDS," above.

2. If an event of default occurs under the 2020 Note and the 2020 Mortgage, and the 2020 Note and the 2020 Mortgage are assigned to HUD, certain funds held pursuant to the Resolutions and certain of the Mortgage Insurance Benefits, or the proceeds thereof when received, will be applied to pay the interest due on the Series 2020 Bonds, any maturing principal of the Series 2020 Bonds, the fees and expenses of the Trustee, the Authority, and the Mortgage Servicer, and Mortgagee Advances, and the balance will be applied to Sinking Fund Redemption of all of the Series 2020 Term Bonds. See "PART 3 - THE SERIES 2020 BONDS – Redemption of the Series 2020 Bonds – Sinking Fund Redemption." Sinking Fund Redemptions to be made under such circumstances will vary from the amounts set forth on the above schedule.

3. To the extent the Institution prepays the 2020 Note and provides other required funds, if any, the Trustee shall redeem Series 2020 Bonds and the remaining payments on the 2020 Note will be reduced, thus reducing the amounts available in each succeeding semiannual period for redemption of Series 2020 Bonds. In such event, each succeeding payment due on the 2020 Note will be adjusted to an amount which, when paid monthly and applied first to interest on the outstanding balance of the 2020 Note and the remainder to the reduction of principal, will be sufficient to pay the outstanding balance of the 2020 Note, as adjusted, over the remaining term thereof, and the Trustee shall redeem from the excess funds the Series 2020 Bonds as described in "PART 3 - THE SERIES 2020 BONDS – Optional Redemption*"* above.

4. Any such cash payment made with respect to an event of default under the 2020 Note, the 2020 Mortgage, and the Mortgage Insurance Benefits shall be applied to the Extraordinary Mandatory Redemption of Series 2020 Bonds, which would affect future Sinking Fund Redemptions.

5. To the extent the 2020 Note is prepaid with the proceeds of hazard insurance or condemnation, the Trustee shall redeem Series 2020 Bonds and the remaining payments on the 2020 Note will be reduced, thus reducing the amounts available in each succeeding semiannual period for redemption of Series 2020 Bonds. In such event, each succeeding payment due on the 2020 Note will be adjusted to an amount which, when paid monthly and applied first to interest on the outstanding balance of the 2020 Note and the remainder to the reduction of principal, will be sufficient to pay the outstanding balance of the 2020 Note, as adjusted, over the remaining term thereof, and the Trustee shall redeem from the excess funds the Series 2020 Bonds as described in "Optional Redemption" of "PART 3 - THE SERIES 2020 BONDS," above.

6. Any changes to the assumptions described in the first paragraph of this PART 4 - SCHEDULE OF PRINCIPAL, INTEREST, AND ESTIMATED SINKING FUND REDEMPTIONS.

PART 5 – MORTGAGE INSURANCE

General

The 2020 Mortgage will be insured by HUD pursuant to Section 241 of the National Housing Act, as amended ("**Section 241**"). The applicable HUD regulations regarding Section 241 are contained in Part 200, Part 241, and Part 242 of Title 24 of the Code of Federal Regulations, and, with certain exceptions, incorporate by reference the provisions of Subpart B, Part 207, all under of Title 24 of the Code of Federal Regulations covering mortgages, deeds of trust, and other similar instruments insured under the National Housing Act, as amended.

In the event of conflict between the FHA Documents and Resolutions or the Loan Agreement, the FHA Documents will control.

The National Housing Act, as amended, and the applicable regulations provide that claims for Mortgage Insurance Benefits under mortgages insured pursuant to Section 241 are to be paid in cash, debentures, or in any combination thereof, at the option of HUD. However, in the Commitment, HUD has stated that the Mortgage Insurance Benefits will be paid in cash rather than FHA debentures.

HUD regulations provide that the maximum insurable mortgage amount cannot exceed 90% of HUD's estimate of the cost of the property or project, including equipment to be used in its operation when the proposed improvements are completed and the equipment is installed, and the mortgage must have a maturity date no longer than 25 years from Commencement of Amortization. The 2020 Mortgage meets these requirements.

HUD Insurance Endorsement

HUD has issued a Commitment for insurance of advances for the Project. The Commitment evidences HUD's approval of the application for HUD insurance for the Project and establishes the terms and conditions upon which the 2020 Note and the 2020 Mortgage will be insured. HUD will evidence its initial insurance of the 2020 Note and the 2020 Mortgage at Initial Endorsement of such Note pursuant to Section 241 of the National Housing Act, as amended, and regulations thereunder. Insurance of the 2020 Note and the 2020 Mortgage includes insurance of construction loan advances to be made to the Institution pursuant to the Building Loan Agreement between the Institution and the Authority, as FHA mortgagee.

At Initial Endorsement, the Institution will execute the 2020 Note evidencing the loan and the 2020 Mortgage securing the 2020 Note. After HUD initially endorses the 2020 Note for HUD insurance, funds will be advanced to provide for initial fees and expenses, including title costs, and architect, attorney, inspection, and other related fees and expenses.

A mortgage insurance premium payable by the Institution in an annual amount equal sixty-five hundredths of one percent (0.65%) of the outstanding principal balance of the 2020 Note is charged by HUD and collected annually in advance prior to Final Endorsement and thereafter monthly by or on behalf of the Authority, as FHA mortgagee.

Construction

Construction of the Project is required to proceed in accordance with the Building Loan Agreement. (See below "PART 6 - CERTAIN PROVISIONS OF THE FHA DOCUMENTS – The Building Loan Agreement.") During construction, an architect hired by the Institution and a HUD inspector will make periodic inspections to ensure on-site conformity with HUD-approved plans and specifications. Under the

Building Loan Agreement, funds are disbursed on a percentage of completion basis with periodic requisitions for advances of funds. Prior to any disbursement, certain conditions, including the completion of certain inspections of the construction, updated title evidence satisfactory to the Authority, as FHA mortgagee, and HUD, and HUD approval of the advance, must be satisfied. Disbursements for advances continue for only so long as the Institution is not in default under the 2020 Note and the 2020 Mortgage and otherwise complies with the requirements for disbursement.

Changes to the plans and specifications that are approved by HUD at Initial Endorsement must be approved by the Institution, the Institution's architect, HUD, and the Authority, as FHA mortgagee, in the form of a written approval of a change order to the construction contract. In the event of a change order requiring net increases in construction costs, the Authority, as FHA mortgagee, is required to collect the amount of such increase from the Institution prior to disbursement of the next advance unless HUD waives the requirement. Such funds may be disbursed to the Institution and contractor as the additional work contemplated by the change order progresses and is approved by HUD.

Under the construction contract, the construction contractor has agreed to the timely completion of construction of the Project in accordance with plans and specifications approved by HUD and will provide payment and performance bonds in an amount approved by HUD and the Authority, as FHA mortgagee.

Upon completion of construction and subject to a cost certification process, HUD will again endorse the 2020 Note at Final Endorsement up to an amount which HUD committed to insure at Initial Endorsement pursuant to the Commitment. Amounts remaining to be advanced under the 2020 Note will be disbursed, contingent upon HUD approval, upon the receipt of acceptable title insurance endorsements and the fulfillment of certain other obligations of the Institution. HUD may consent to an increase in the 2020 Note amount and its insurance thereof prior to Final Endorsement under certain circumstances.

Default and Payment of Mortgage Insurance Benefits

HUD regulations define a default under a FHA-insured mortgage as (1) failure of the borrower to make any payment due under the mortgage, or (2) failure to perform any other covenant under the provisions of the mortgage, if the mortgagee, because of such failure, has accelerated the debt. In the event that there is a default under the HUD Regulatory Agreement and HUD so requests, the Authority, as FHA mortgagee, at its option, may declare the whole indebtedness due and payable. Furthermore, the regulations provide that upon notice of a violation of a mortgage covenant, HUD reserves the right to require the mortgagee to accelerate payment of the outstanding principal due in order to protect HUD's interest.

Under HUD regulations, the Authority, as FHA mortgagee is eligible to receive Mortgage Insurance Benefits in the event that the Institution has defaulted on the payment of the 2020 Note and such default, as defined in the regulations, has continued for a period of thirty (30) days, subject to the following requirements. If the default, as defined in the regulations, continues to exist at the end of a thirty (30) day grace period, the Authority, as FHA mortgagee is required to give HUD written notice of (1) the default within thirty (30) days after such grace period, and (2) its intention to file an insurance claim and of its election either to assign the mortgage or to acquire and convey title to HUD within forty-five (45) days after such grace period. Within an additional thirty (30) days after notifying HUD of such election, the Authority, as FHA mortgagee, must file its application form for Mortgage Insurance Benefits and effect such assignment, commence foreclosure proceedings or, with the approval of HUD, acquire title to the mortgaged property by means other than foreclosure, unless the time for taking action is extended by HUD. In addition to the above requirements, HUD provides that, in the event of a monetary default during the period when a prepayment premium in excess of one percent (1%) is payable under the 2020 Note, the Authority, as FHA mortgagee, must request an extension of a period of ninety (90) days of the requirement to file its intention and election to file a mortgage insurance claim in connection with such default. HUD

may approve such request for the ninety (90) day or a shorter period of time, or HUD may disapprove the request. The decision on such a request is at the sole discretion of HUD, based on its analysis of the financial condition of the borrower and the assessment by HUD of the feasibility of arranging a successful refinancing in whole or in part. HUD has stated that it will consider granting such an extension, during which time the Authority, as FHA mortgagee, will assist the Institution in refinancing the note only if (a) the operation of the mortgaged property has resulted in a net income deficiency which has not been caused solely by management inadequacy or lack of interest by the Institution, and is of such a magnitude that the Institution is currently unable to make required debt service payments, pay all operating expenses in connection with the mortgaged property and fund all required reserves, (b) there is a reasonable likelihood that the borrower can arrange to refinance the note at a lower interest rate or otherwise reduce the debt service payments through partial prepayment, and (c) refinancing the note at a lower rate or partial prepayment of the note is necessary to restore the operations of the mortgaged property to a financially viable condition and to avoid a mortgage insurance claim.

Notwithstanding the above timetable established by HUD, the General Resolution provides that if the Institution fails to make any payment required under the Applicable Note or the Applicable Mortgage (henceforth referred to as the 2020 Note and the 2020 Mortgage) and such failure continues for a period of thirty (30) days, or, if following a default by the Institution in the performance of any covenant in the HUD Regulatory Agreement or the 2020 Mortgage, HUD shall have requested, and the Authority shall have declared an acceleration of the unpaid principal balance of the 2020 Note, the Authority shall (not later than one (1) business day after the end of such thirty (30) day grace period or acceleration, as the case may be) give, or cause the Mortgage Servicer to give, written notice to HUD, the Applicable Trustee and the Rating Service(s) of: (1) the occurrence of such default, (2) the acts or omissions giving rise to the default, (3) the time period, if any, available to cure such default, (4) a schedule of remaining Interest Payment Dates and a schedule of debt service payments due on the Applicable Series of Bonds (henceforth referred to as the Series 2020 Bonds), (5) a schedule of the funds available to make payments as they become due on the Series 2020 Bonds, (6) the fact that the 2020 Mortgage was given to secure an issue of tax-exempt bonds, (7) the Authority's election to assign the 2020 Note and the 2020 Mortgage to HUD, and (8) the Authority's intention to file a claim for the Mortgage Insurance Benefits in accordance with the FHA regulations and the FHA Debenture Agreement or the FHA Cash Lock Agreement, as and if applicable (in the case of the Series 2020 Bonds, pursuant to a FHA Cash Lock Agreement). In filing such notice (the "**Notice of Assignment**"), the Authority or the Mortgage Servicer shall request priority processing of the Mortgage Insurance claim. Immediately upon the filing of such notice, the Authority or the Mortgage Servicer shall request (a) such forms and instructions relating to the assignment of the 2020 Mortgage and (b) the endorsement of the title insurance policy for the 2020 Mortgage showing the current status of any liens affecting the Mortgaged Property. Within five (5) Business Days of the receipt of such forms and instructions, the Authority shall submit the legal documentation for review to the Office of General Counsel of HUD. Upon receipt of the notice given by the Authority to HUD of the Authority's election to assign the 2020 Note and 2020 Mortgage to HUD, the Trustee shall mail notice to all of the Holders of the Series 2020 Bonds of the occurrence of the default by the Institution and the Authority's intent to file such claim with HUD. Unless directed in writing to the contrary by the Holders of 100% in aggregate principal amount of the Series 2020 Bonds Outstanding within twenty (20) days of the date such notice was sent to HUD, the Authority shall, except as described in the next paragraph, take all actions necessary to assign the 2020 Note and the 2020 Mortgage to HUD and to recover such claim on the Mortgage Insurance as provided in the Commitment and HUD regulations. Thereafter, the Authority shall continue with diligence to complete (not later than thirty (30) days after the date of recordation of the assignment to HUD) and submit for review to HUD the fiscal documentation and any additional legal documentation in consultation with the Multifamily Claims Branch of HUD. In the event the assignment of the 2020 Note and the 2020 Mortgage will be completed later than the last business day preceding the 30th day following the giving of notice to HUD, notice thereof shall be given by the Authority to each Rating Service.

Notwithstanding the provisions set forth above, the General Resolution provides that in the event of a monetary default under the 2020 Note and the 2020 Mortgage during a period when a prepayment premium in excess of one (1%) percent is payable under the 2020 Note, within one (1) Business Day following the lapse of the thirty (30) day grace period, the Authority, as FHA mortgagee under the 2020 Mortgage, shall, or shall cause the Mortgage Servicer to, (1) notify HUD and the Rating Service(s) of the default, and of the fact that the 2020 Mortgage was given to secure an issue of tax-exempt bonds rated by the Rating Service(s) such notice to be accompanied by a schedule of funds available to make payments as they become due, (2) file with HUD a request for a three (3) month extension of the time to file its notice of intention and election to file a claim for Mortgage Insurance Benefits in connection with such default, and (3) file a copy of such extension request with the Authority and each Rating Service. In filing such notice, the Authority shall, or shall cause the Mortgage Servicer to, state that it intends to request priority processing of the Mortgage Insurance claim and shall attach a copy of the June 23, 1987, letter from HUD to Standard & Poor's. Immediately upon the filing of such notice and request, the Authority shall, or shall cause the Mortgage Servicer to, request forms and instructions relating to the assignment of the 2020 Mortgage, and within five (5) Business Days of the receipt of such forms and instructions, the Authority shall, or shall cause the Mortgage Servicer to, submit legal documentation for review to the Office of General Counsel of HUD. The Authority will not request more than one (1) additional extension of the initial extension period approved by HUD and it will not make such request until it receives written confirmation from the Rating Service that the rating for the Series 2020 Bonds will not be affected by such request for extension. If the conditions for such further extension are not met, the Authority will proceed with processing the Mortgage Insurance claim in a timely fashion in the manner described in the paragraph above. If the request by the Authority for the extension is not approved, the Authority, as FHA mortgagee under the 2020 Mortgage, shall, or shall cause the Mortgage Servicer to, (1) file with HUD notice of the Authority's intention to file an insurance claim and its election to assign the Mortgage within two (2) Business Days of the receipt of the decision from HUD, (2) file a copy of such notice with the Authority and each Rating Service, and (3) thereafter proceed with the processing of the Mortgage Insurance claim in a timely fashion in the manner described in the above paragraph.

During the extension period approved by HUD (which, except as provided below, shall not be longer than three months), the Authority, as FHA mortgagee, shall, or shall cause the Mortgage Servicer to, take the following actions, as appropriate: (1) assist the Institution in arranging a refinancing of the 2020 Note to cure the default and avert the filing of the claim for Mortgage Insurance; (2) report to HUD on a monthly basis the progress, if any, in arranging the refinancing; (3) cooperate with HUD and take all reasonable steps in accordance with prudent business practices to avoid filing the Mortgage Insurance claim; (4) if thirty (30) days prior to any Interest Payment Date the Authority determines that sufficient moneys will not be available to make the payments required on the Series 2020 Bonds, notify HUD of such deficiency and request the immediate payment of Mortgage Insurance Benefits in cash; and (5) if a determination is made by the Authority that the refinancing of the 2020 Note is not feasible (a) file a request with HUD for its concurrence in such determination, (b) submit to HUD a notice of intention and election to file a claim for Mortgage Insurance Benefits, (c) file a copy of such intention and election with the Trustee and each Rating Service, and (d) proceed with the processing of the Mortgage Insurance claim in a timely fashion in the manner followed for a monetary default, as described above.

To the extent a refinancing is arranged, and such refinancing is approved by HUD, the General Resolution provides that the 2020 Note shall be prepaid, in whole or in part, and the proceeds shall be applied to the Extraordinary Mandatory Redemption of the Series 2020 Bonds; provided, however, that the Authority, as FHA mortgagee, shall not consent to such refinancing until it has received written confirmation from each Rating Service that the rating for the Series 2020 Bonds will not be affected by such refinancing; provided further, that such refinancing will result in a prepayment of the 2020 Note prior to the expiration of the approved extension period. To the extent there is a partial prepayment of the 2020

Note pursuant to an approved refinancing, the Authority, as FHA mortgagee, shall consent to any subordinate or parity liens on the Mortgaged Property as may be required.

To the extent a refinancing is not approved by HUD, the Authority, as FHA mortgagee, shall, or cause the Mortgage Servicer to (i) file with HUD its intention to file an insurance claim and its election to assign the 2020 Mortgage within two (2) Business Days of the disapproval of the refinancing by HUD, (ii) file a copy of such intention and election with the Trustee and each Rating Service, and (iii) proceed with the processing of the Mortgage Insurance claim in a timely fashion in the manner described above. To the extent a refinancing cannot be completed within the approved extension period, the Authority, as FHA mortgagee, shall, or shall cause the Mortgage Servicer to (i) file with HUD its intention to file a Mortgage Insurance claim and its election to assign the 2020 Mortgage within two (2) Business Days of the disapproval of the refinancing by HUD, (ii) file a copy of such intention and election with the Trustee and each Rating Service, and (iii) proceed with the processing of the Mortgage Insurance claim in a timely fashion in a manner described above; provided, however, that at the option of the Authority, as FHA mortgagee, if a refinancing has been arranged and approved by HUD within the approved extension period, and such refinancing can be completed within an additional thirty (30) days, at the Authority's sole discretion, the refinancing will be accepted by the Authority if (1) confirmation is received from each Rating Service that the rating on the Series 2020 Bonds will not be affected, and (2) the 2020 Note and the 2020 Mortgage have not been assigned to HUD.

To the extent (i) HUD does not immediately pay a claim when requested by the Authority as described above, (ii) the processing of the Mortgage Insurance claim does not proceed as described in the preceding paragraphs or (iii) if each Rating Service does not provide confirmation that the rating on the Series 2020 Bonds will not be affected by a refunding accomplished as described in the preceding paragraphs, then the Authority shall proceed in a manner to preserve the Mortgage Insurance of the 2020 Note and the 2020 Mortgage, and otherwise protect the interest of the Bondholders.

The General Resolution further provides that if a non-monetary default by the Institution under the terms of the 2020 Mortgage shall have occurred, the Authority shall, within thirty (30) days after the occurrence of such default (or other grace period under applicable HUD regulations), (1) give notice of such default to HUD and each Rating Service, and (2) on the basis of its determination as to which course of action shall be in the best interest of the Bondholders, either:

(a) Declare, or cause the Mortgage Servicer to declare, an acceleration of the unpaid principal balance of the 2020 Note by notice in writing to the Institution, and shall within one (1) business day give, or cause the Mortgage Servicer to give, to HUD, the Trustee, and each Rating Service written notice of (i) the occurrence of such default; (ii) the acts or omissions giving rise to the default; (iii) the time period, if any, available to cure such default; (iv) a schedule of remaining Interest Payment Dates on the Series 2020 Bonds and a schedule of debt service payments due on the Series 2020 Bonds; (v) a schedule of the funds available to make payments as they come due on the Series 2020 Bonds; (vi) the fact that the 2020 Mortgage was given to secure an issue of tax-exempt bonds; (vii) the Authority's election to assign the 2020 Note and the 2020 Mortgage to HUD; and (viii) the Authority's intention and election to file a claim for the Mortgage Insurance Benefits in accordance with FHA regulations and the FHA Cash Lock Agreement. In filing such notice with HUD, the Authority or Mortgage Servicer shall request priority processing of the Mortgage Insurance claim. Immediately upon the filing of such notice, the Authority shall request (a) required forms and instructions relating to the assignment of the 2020 Mortgage and (b) an endorsement of the title insurance policy for the 2020 Mortgage showing the current status of any liens affecting the Mortgaged Property. Within five (5) Business Days of the receipt of such forms and instructions, the Authority shall submit or cause to be submitted the legal documentation for review by the Office of General Counsel

of HUD. Upon receipt of the notice given by the Authority to HUD of the Authority's election to assign the 2020 Note and the 2020 Mortgage to HUD, the Trustee shall mail notice to all Series 2020 Bondholders of the occurrence of such default and of the Authority's intent to file such claim. Unless directed in writing to the contrary by the Holders of 100% in aggregate principal amount of the Series 2020 Bonds Outstanding within twenty (20) days of the date such notice was sent to HUD, the Authority shall take all action necessary to assign the 2020 Note and the 2020 Mortgage to HUD and to recover such claim on the Mortgage Insurance in cash as provided in the Commitment and HUD regulations. Thereafter, the Authority shall continue with diligence to complete and submit for review to HUD (no later than thirty (30) days after the date of recordation of the assignment to HUD) fiscal documentation and any additional legal documentation in consultation with the Multifamily Claims Branch of HUD; or

(b) Give, or cause the Mortgage Servicer to give, written notice to HUD of the occurrence of such default and enter into an agreement with the Institution, approved by HUD, extending the time for curing such default; provided that the Authority shall not execute any such agreement unless the Authority: (i) has notified each Rating Service that the time for curing such default is being extended; and (ii) has received confirmation from each such Rating Service of its rating on the Series 2020 Bonds.

Prior to the date the 2020 Note and the 2020 Mortgage are assigned to HUD, the Institution may cure a monetary default, in which event the Authority shall withdraw its notice of assignment to HUD. In all cases, the Authority must have first received written confirmation from HUD that the withdrawal of any notice of assignment or election to receive Mortgage Insurance Benefits of the 2020 Note and the 2020 Mortgage will not adversely affect the Mortgage Insurance or be construed as a waiver or reduction thereof.

In connection with an assignment to HUD of the 2020 Note and the 2020 Mortgage, the Mortgage Insurance Benefits are payable in an amount equal to the aggregate of (1) the unpaid principal amount of the 2020 Note, computed as of the date of default; plus (2) the amount of all payments made by or on behalf of the Authority, as FHA mortgagee, with respect to taxes, special assessments, and water rates which are liens prior to the 2020 Mortgage, insurance on the property, mortgage insurance premiums paid after default, and an allowance for reasonable payments made by or on behalf of the Authority, as FHA mortgagee, with HUD approval, for the completion and preservation of the Mortgaged Property; plus (3) an amount equivalent to the FHA debenture interest which would have been earned on the Mortgage Insurance Benefits, if any, paid in cash, such interest being computed from the date of default to the date on which the Mortgage Insurance claim is settled in full (except that interest may be limited in the event that certain notices are not given to HUD within the prescribed time period or if certain action required in connection with the Mortgage Insurance claim is not taken). From the aggregate of the foregoing amount is deducted the total of (a) an assignment fee of 1% of the unpaid principal balance of the 2020 Mortgage as of the date of default, (b) certain amounts which have been realized by or on behalf of the Authority, as FHA mortgagee, on account of the 2020 Mortgage or from the Mortgaged Property after the date of default, (c) certain cash items held by or on behalf of the Authority, as FHA mortgagee, and not paid over to HUD, and (d) other offsets as described below. The proceeds of the Mortgage Insurance will also not include interest accruing on the 2020 Note for the month preceding the date of default on the 2020 Mortgage. Notwithstanding the foregoing, if HUD is requested to accept an assignment of a mortgage insured under the Act and it determines that a partial payment of insurance benefits would be less costly to the Federal Government than payment as set forth above, then HUD may request the mortgagee, in lieu of assignment, to accept a partial payment of the claim and recast the mortgage under such terms and conditions as HUD may determine. If the mortgagee accepts this option, the remaining principal balance of the 2020 Note will remain covered by the HUD Insurance.

Prior to actual assignment of the 2020 Mortgage to HUD and receipt of Mortgage Insurance Benefits, the Authority, as FHA mortgagee, must also satisfy certain legal requirements including submission of a title insurance policy showing that no liens or encumbrances (except those approved by HUD) are superior to the lien of the 2020 Mortgage. As part of the assignment process, the Authority, as FHA mortgagee, is also required to submit certain additional documentation to HUD within 45 days from the date the 2020 Note and the 2020 Mortgage are assigned to HUD. The documentation required to be supplied to HUD includes, but is not limited to, the 2020 Note, the 2020 Mortgage, financing statements, assurances of completion, a title insurance policy, and a hazard insurance policy, together with assignments of such documents to HUD. Upon receipt of the notification of default and an assignment to HUD in exchange for Mortgage Insurance Benefits, HUD reviews the documentation to determine compliance with its fiscal and legal requirements.

If the Authority, as FHA mortgagee, fails to give HUD notice of default or fails to take any action required of a mortgagee in connection with a Mortgage Insurance claim by the time stipulated in the regulations, and in a manner satisfactory to HUD, HUD may pay the Authority interest at the debenture rate on the amount of the Mortgage Insurance Benefits for that period only to the date on which the particular required action should have been taken or to which it was extended.

In connection with a claim for Mortgage Insurance Benefits, HUD may require delivery to it of certain cash items. Cash items are defined to include, among other things, any cash held by or on behalf of the mortgagee which has not been applied to reduce the mortgage, funds held by the mortgagee for the account of the borrower, and any undrawn balance under letters of credit used in lieu of a cash deposit. The mortgagee is responsible for all funds in its custody and must therefore obtain approval from HUD (and others when required) prior to release of any funds which may be in its possession. Failure properly to protect such funds, including letters of credit, may result in a deduction from the Mortgage Insurance Benefits in an amount equal to funds HUD asserts should have properly been held as a deposit.

When HUD pays Mortgage Insurance Benefits in cash, rather than in FHA debentures, its normal practice is to offset certain cash items against the amount of the Mortgage Insurance Benefits. If HUD were to require the delivery of certain cash items before paying the Mortgage Insurance Benefits, the General Resolution requires that the Trustee transfer to HUD the amount, if any, on deposit in the Construction Fund. Although HUD may require the reduction of the Mortgage Insurance Benefits by the amount of certain cash items, HUD will not require a reduction by the amount held in other funds and accounts held by the Authority.

HUD will make a partial settlement on cash claims filed for Mortgage Insurance Benefits no later than three (3) Business Days from the date that HUD receives the notice of the assignment the 2020 Mortgage. HUD pays up to 90% of the unpaid principal balance of the 2020 Note, plus accrued interest at the debenture rate from the date of default to the date of settlement, if the 2020 Mortgage is Finally Endorsed. HUD pays up to 70% of the unpaid principal balance of the 2020 Note, plus accrued interest at the debenture rate from the date of default to the date of settlement, if the project is not Finally Endorsed. The remainder of the Mortgage Insurance Benefits will be paid following HUD's review and approval of the claim submission, minus any curtailments.

The timing of payment by HUD is subject to change depending upon overall HUD policy considerations and workload. Mortgage Insurance payments may be delayed if disputes arise as to the amount of the payment, or for other reasons described under "PART 11 – BONDHOLDERS' RISKS" herein. Although the Debt Service Reserve Fund would be available to pay debt service on the Series 2020 Bonds during the period prior to payment by HUD in full of any Mortgage Insurance claim, there is no assurance that the Mortgage Insurance claim would be paid in full prior to exhaustion of the funds in the Debt Service Reserve Fund.

HUD is authorized to borrow from the United States Treasury amounts which it determines to be necessary to make cash payment under the National Housing Act, as amended. The National Housing Act, as amended, contains authorization to appropriate such sums as may be necessary to cover losses sustained by the HUD General and Special Risk Insurance Fund. Annual appropriation acts of the United States Congress have in the past appropriated such sums. No assurances can be given regarding future appropriations.

In order to receive the Mortgage Insurance Benefits, HUD requires, in the assignment process, that the mortgagee warrant that (1) no act or omission of the mortgagee has impaired the validity and priority of the mortgage; (2) the mortgage is prior to all mechanics' and materialmen's liens filed of record subsequent to the recording of the mortgage, regardless of whether such liens attached prior to the recording date; (3) the mortgage is prior to all liens and encumbrances which may have attached or defects which may have arisen subsequent to the recording of the mortgage except such liens or other matters as may be approved by HUD; (4) the amount stated in the instrument of assignment is actually due under the mortgage and there are no offsets or counterclaims against such amount; and (5) the mortgagee has a good right to assign the mortgage. In assigning its security interest in chattels, including materials, located on the premises covered by the mortgage, or its security interest in building components stored either on-site or off-site at the time of assignment, the mortgagee is required to warrant that (a) no act or omission of the mortgagee has impaired the validity or priority of the lien created by the chattel security instruments; (b) the mortgagee has a good right to assign the security instruments; and (c) the chattel security instruments are a first lien on the items covered by the instrument except for such other liens or encumbrances as may be approved by HUD.

Casualty Insurance Requirements

HUD requires the maintenance of specified casualty insurance on the Mortgaged Property. The Authority, as FHA mortgagee, must obtain such coverage in the event the borrower fails to do so. Alternatively, failure to maintain such insurance at the time of a default and at the time of the assignment of the 2020 Mortgage to HUD may result in the loss or curtailment of Mortgage Insurance Benefits.

Under HUD regulations, if a mortgagee receives proceeds from any policy of casualty insurance, it may exercise its option under the mortgage to use such proceeds for repairing, replacing, or rebuilding the mortgaged property, but may not use such proceeds for application to the mortgage indebtedness or make any other disposition of the proceeds without HUD's prior written approval. With respect to any use of insurance proceeds requiring HUD's consent, if HUD fails to give its approval to the use of the insurance proceeds within sixty (60) days after written request by the mortgagee, the mortgagee may use or apply the funds for the purposes specified in the mortgage without prior HUD approval. In the event that such casualty insurance proceeds are applied to prepayment of the 2020 Note, such proceeds shall be deposited in the Redemption Account for application to the Extraordinary Mandatory Redemption of a corresponding principal amount of the Series 2020 Bonds. See "PART 3 - THE SERIES 2020 BONDS – Redemption of the Series 2020 Bonds" herein.

[*Balance of page intentionally left blank*]

PART 6 - CERTAIN PROVISIONS OF THE FHA DOCUMENTS

The 2020 Note

The 2020 Note to be delivered by the Institution to the Authority to evidence the amount of money expected to be advanced by the Authority to the Institution, shall be in the amount not to exceed $141,202.000.00 unless otherwise approved by the Authority, as FHA mortgagee, and HUD. Up to and including thirty (30) days prior to the Commencement of Amortization, the Institution is required to make monthly payments of interest at the Construction Note Rate on amounts disbursed from the Mortgage Account pursuant to the Building Loan Agreement. Thereafter, the 2020 Note provides that interest shall be paid monthly at the Permanent Note Rate on the outstanding balance of such principal, although at Final Endorsement it is expected that the interest rate on the 2020 Note may be further reduced but in no event to a rate that would not be sufficient to pay the principal of and interest on the Series 2020 Bonds as the same shall become due. The first amortization payment shall be due no later than the Commencement of Amortization, and the final maturity of the 2020 Note is 24 years and 11 months following the Commencement of Amortization of principal (i.e., July 1, 2048). Payments on the 2020 Note are due on the first day of each month and will be made by the Institution to the Mortgage Servicer on behalf of the Authority, as FHA mortgagee. Under the Servicing Agreement, the Mortgage Servicer is authorized to deduct the Servicing Fee and any Mortgagee Advances from such payment, and then is required to promptly remit the balance to the Trustee. Prior to Final Endorsement all or a portion of the interest on the 2020 Note will be paid from interest capitalized on the 2020 Note pursuant to HUD's requirements. In all other instances interest on funds advanced under the 2020 Note shall be paid from the Institution's revenues. In the event of a failure by the Institution to make any payment on the 2020 Note when due, the entire amount of the 2020 Note may be declared due and payable by the Authority, as FHA mortgagee. See also "PART 10 – EXISTING FHA-INSURED LOANS OF THE INSTITUTION."

If the Series 2020 Bonds are no longer considered to be Outstanding, the 2020 Note and the 2020 Mortgage may be released and assigned for a new issue of bonds. Additional fees must be paid by the Institution which are related to the costs of the Authority to redeem bonds. Upon prepayment in part, payment of the remaining principal amount will be recast over the remaining term to the maturity of the 2020 Note so as to be payable in approximately equal monthly amounts which, when applied first to interest on the outstanding balance and the remainder to principal, will be sufficient to repay the amounts due on the 2020 Note by its maturity.

The 2020 Mortgage

The 2020 Mortgage (in a form prescribed by HUD) will be executed and delivered by the Institution. The 2020 Mortgage grants a lien on the Mortgaged Property together with all buildings, improvements and fixtures thereon, rents, revenues, issues, and profits thereof, and all building materials, equipment, furnishings, and other property incident to use and occupancy thereof. Until the final payment of the 2020 Note, the Institution agrees not to sell, encumber, or alienate the Mortgaged Property in any way without the consent of the Authority and HUD. The Institution also covenants that it will not voluntarily create or permit to be created any other lien or liens against the Mortgaged Property without the written agreement of HUD or execute or file for record any instrument that imposes a restriction upon the sale or occupancy of the Mortgaged Property on the basis of race, creed, or color.

The 2020 Mortgage constitutes a third mortgage lien on the Mortgaged Property.

In the event the Institution fails to pay any of the sums required to be paid under the 2020 Note, the Authority, as FHA mortgagee, may, at its option, pay such amounts. The 2020 Mortgage provides that all

sums paid by the Authority may be added to the principal amount of the 2020 Note, bear interest at the rate set forth in the 2020 Note and will be due and payable on demand.

The Institution agrees that, in addition to payments for debt service due on the 2020 Note, it will pay monthly amounts to provide for the payment when due of premiums on the Mortgage Insurance, casualty insurance, water rates, and taxes, and assessments. If not so paid by the Institution, the Authority may pay such items and the amounts so paid shall be added to the Institution's indebtedness.

The 2020 Mortgage requires the Institution to keep the property insured against casualties as stipulated by HUD, such insurance to be carried for terms and with companies acceptable to the Authority, as FHA mortgagee. Coverage shall not be less than 100% of the replacement costs of the Mortgaged Property. Policies shall be endorsed with a standard mortgagee clause payable to the Authority and must also name HUD as an additional insured. Any awards or claims for damages arising on account of condemnation are payable or assigned to the Authority, as FHA mortgagee, to the extent of the indebtedness.

Under the 2020 Mortgage, the Institution covenants that it will not commit or permit waste and that it will maintain the Mortgaged Property in good repair and will promptly comply with all applicable laws and regulations affecting the property. If the Institution fails to make any required inspection, repair, care, or attention of any kind to the property, the Authority, in its discretion, may do so. The cost thereof shall also be added to the indebtedness. Under the 2020 Mortgage, the Institution is not permitted to make any structural alterations without the consent of the Authority and HUD.

In the event of a default under the 2020 Note or the 2020 Mortgage, any sums owed by the Institution to the Authority under any of the FHA Documents and the Loan Agreement shall, at the option of the Authority, become immediately due and payable. In the 2020 Mortgage, the Institution expressly agrees that the Authority may invoke the power of sale and any other remedies permitted by applicable law. Notwithstanding such agreement, the Resolutions require the Authority to assign the 2020 Note and the 2020 Mortgage to HUD in the event of default thereunder and does not authorize the Authority to sell the Mortgaged Property.

The 2020 Mortgage also provides that in the event of a default under the 2020 Mortgage all payments made by the Authority to remedy a default by the Institution and the total of any payments due from the Institution to the Authority under the loan documents may be added to the debt secured by the 2020 Mortgage and repaid to the Authority upon demand. In addition, the 2020 Mortgage provides that any such amount shall be secured by the 2020 Mortgage. It is not anticipated that the Authority will advance moneys under the above circumstances.

Upon satisfaction of the 2020 Note, in accordance with its terms and upon execution by the Institution of all agreements and stipulations set forth in the 2020 Mortgage, the FHA mortgagee will execute a corresponding release and cancellation of the 2020 Mortgage.

The Building Loan Agreement

The Building Loan Agreement (in the form prescribed by HUD) (the "**Building Loan Agreement**") will be executed by the Institution in connection with the Project, as borrower, and the Authority, as FHA mortgagee. The Building Loan Agreement provides that: (1) the Project be completed in accordance with the drawings and specifications of the architect; (2) any changes in the specifications be approved by the architect and any changes in construction cost also be approved by HUD; (3) advances for construction be made only for work completed and material and equipment stored on the site, subject to a 10% retainage until completion of the Project (unless a lesser retainage is permitted by HUD); (4) all

advances be subject to prior approval of the Authority, as FHA mortgagee, and HUD; (5) the Institution furnish, prior to the first advance, a title insurance policy or policies for the benefit of the Authority, as FHA mortgagee, and HUD which policy or policies will be endorsed to cover each advance; (6) copies of appropriate liability and casualty insurance policies be delivered to the Mortgage Servicer on behalf of the Authority, as FHA mortgagee; and (7) to assure completion of the Project, the contractor provide performance and payment bonds or other assurance required by HUD.

HUD and the Authority, as FHA mortgagee, may, in their discretion, approve a construction cost increase but not until the Institution deposits with the Authority funds sufficient to cover the increase or concurrently submits a change order that will reduce construction costs by an amount corresponding to the increase. Under the Building Loan Agreement, the Authority is required to continue to make advances to the Institution provided there has been no default by the Institution thereunder.

A failure to complete the Project within the time frame provided for in the Building Loan Agreement would constitute a default under the 2020 Note and the 2020 Mortgage, in which case the Authority would be entitled to exercise its right to assign the 2020 Note and the 2020 Mortgage to HUD and to file a claim for the Mortgage Insurance Benefits in accordance with applicable HUD regulations.

The HUD Regulatory Agreement

The Hospital Regulatory Agreement - Borrower (the "**HUD Regulatory Agreement**") between the Institution and HUD sets forth certain of the Institution's obligations in connection with the management and operation of the Institution and the Project. The HUD Regulatory Agreement is incorporated by reference into the 2020 Mortgage.

The HUD Regulatory Agreement prohibits the use of the Project for any purpose other than the purposes for which it was intended. The HUD Regulatory Agreement also prohibits the conveyance, transfer, or encumbrance of any real or personal property comprising the Project. The HUD Regulatory Agreement also provides that the Institution may use all rents and other receipts from the Project only for expenses of the Institution including reasonable operating expenses and necessary repairs and that the Institution may not, without prior written approval of HUD, remodel, add to, or demolish any part of the Project. The Institution also is required to maintain the Project in good repair.

In the event of a default under the HUD Regulatory Agreement, the HUD Regulatory Agreement provides that HUD may notify the FHA mortgagee of the default and request the FHA mortgagee to declare a default under the 2020 Mortgage and the 2020 Note. The Authority, as FHA mortgagee, is not a party to the HUD Regulatory Agreement and, therefore, may not directly declare the Institution in default thereunder.

Pursuant to the terms of the Resolutions, the FHA Documents may be amended by the parties thereto, provided that no such amendment may have a material adverse effect on the security for the Series 2020 Bonds.

[*Balance of page intentionally left blank*]

PART 7 - ESTIMATED SOURCES AND USES OF FUNDS

Estimated Sources of Funds	
Principal Amount of Series 2020 Bonds	$135,845,000.00
Equity Contribution from Institution[(1)]	14,998,982.00
Original Issue Premium	14,047,728.75
Total Sources of Funds	$164,891,710.75
Estimated Uses of Funds	
Construction and Building Costs	$132,145,522.00
Reserve Account of the Debt Service Reserve Fund	8,690,000.00
HUD Related Fees and Expenses[(2)]	5,233,272.00
Series 2020 Bonds Costs of Issuance[(3)]	3,682,353.75
Capitalized Interest[(4)]	15,140,563.00
Total Uses of Funds	$164,891,710.75

1. Consists of prepaid expenses, if any, and a stand-by letter of credit deposited with the Trustee on the date of delivery of the Series 2020 Bonds.
2. Includes HUD examination and inspection fees, the mortgage banker's fee, mortgage insurance premiums, title and recording fees and certain other fees and expenses during the construction period.
3. Includes the Underwriters' discount, the Authority fee, legal and accounting fees, certain other fees and expenses related to the financing and the rounding amount.
4. Includes the amounts of (a) interest required to be capitalized by the Building Loan Agreement for interest on the 2020 Note during the 35-month construction period at the Construction Note Rate and (b) any additional proceeds of the Series 2020 Bonds expected to be used to pay interest on the Series 2020 Bonds during this period.

PART 8 - THE MORTGAGE SERVICER

Bank of America, N.A. ("**Mortgage Servicer**") will act as mortgage servicer with respect to the 2020 Note. Mortgage Servicer is an affiliate of BofA Securities, Inc., the senior managing underwriter of the Series 2020 Bonds.

Mortgage Servicer will enter into a subservicing agreement with Prudential Huntoon Paige Associates, LLC ("**PHPAL**") to perform its obligations as mortgage servicer for the 2020 Note and the 2020 Mortgage. Until October 1989, when it was sold, PHPAL was known as Merrill Lynch MBS, Inc. and was a wholly-owned subsidiary of Merrill Lynch, Pierce, Fenner & Smith Incorporated, an affiliate of Mortgage Servicer.

PART 9 - THE PROJECT

Proceeds of the Series 2020 Bonds will be utilized to fund a $141,202,000.00 FHA-insured mortgage loan under Section 241 of the National Housing Act, as amended, by the Authority to the Institution to finance the majority of the cost of the Project. The remaining balance of the cost of the Project ($14,998,982.00) will be funded out of Hospital equity.

The "**Project**" consists of: (A) the renovation and construction of the Institution's (i) modernized emergency department, (ii) modernized neonatal intensive care unit, (iii) post-anesthesia care unit, (iv) cardiac catheterization laboratories, and supporting pre- and post-procedure areas, (v) cardiothoracic intensive care unit, and (vi) various infrastructure projects, including electrical, plumbing, mechanical, and

emergency generator support systems; and (B) the acquisition of updated information systems and medical equipment for the Institution. The Project will be located at the Main Campus.

All required certificate of need approvals have been received from the New York State Department of Health ("**NYSDOH**") and all required land use and zoning approvals have been received from The City of New York except for an approval from the New York City Planning Commission ("**NYCPC**") for a modification to the previously approved zoning approval that relates to 6,245 square feet of new community facility development across several enlargements to the Eisenstadt Administration Pavilion on the Main Campus, relating to the relocation of the Pediatric Emergency Room, a subproject of the total modernization project.

The pending zoning approval has been deemed a Type II action by the NYCPC, which is not required to be approved through the NYCPC's Uniform Land Use Review Procedure ("**ULURP**") and is not subject to the State Environmental Quality Review Act ("**SEQRA**") or the New York City Environmental Quality Review ("**CEQR**"), which is the process by which agencies of the City of New York review proposed discretionary actions to identify the effects those actions may have on the environment. Determination of the negative declaration on CEQR and Type II action status is an important statement supporting the very high likelihood of uncomplicated NYCPC review and approval. New York State (i.e. SEQRA) accepts the findings of the New York City (i.e., CEQR) review.

Currently, the NYCPC staff is unable to hold public hearings on zoning matters because of mandatory stay at home orders in effect in the City of New York that relate to the COVID-19 pandemic. See **"**PART 11 – BONDHOLDERS' RISKS –Infectious Disease Outbreak and COVID-19."

If the pending zoning approval is not obtained by the end of 2020 or the beginning of 2021, the Institution does not expect such delay to affect the overall progress of the Project and such delay is not expected to negatively affect the ability of the entire Project to be completed within the project construction period. In the highly unlikely event that the pending zoning request is not approved on a timely basis that will enable the Institution to complete the entire Project within the time frame required by the Building Loan Agreement, the Institution will reconfigure the affected areas within the existing building envelope to enable construction to proceed with the subproject without further zoning approval, expending the approximately $15 million dedicated to this subproject within the budget and time allocated.

PART 10 – EXISTING FHA-INSURED LOANS OF THE INSTITUTION

In 1996, the Authority issued its Maimonides Medical Center FHA-Insured Mortgage Hospital Revenue Bonds, Series 1996 (the "**Series 1996 Bonds**") to finance a mortgage loan to the Institution in the original principal amount of $32,676,000.00, which loan was evidenced by a mortgage note that was insured by HUD pursuant to Section 242 of the NHA (the "**1996 Note**") and was secured by a mortgage encumbering the Mortgaged Property (the "**1996 Mortgage**"). The 1996 Mortgage constitutes a first mortgage lien on the Mortgaged Property.

In 2004, the Authority issued its Maimonides Medical Center FHA-Insured Mortgage Hospital Revenue Bonds, Series 2004 (the "**Series 2004 Bonds**") to finance a supplemental mortgage loan to the Institution in the original principal amount of $107,704,000, which loan was evidenced by a supplemental mortgage note that was insured by HUD pursuant to Section 241 of the NHA (the "**2004 Note**") and was secured by a supplemental mortgage encumbering the Mortgaged Property (the "**2004 Mortgage**"). The 2004 Mortgage constitutes a second mortgage lien on the Mortgaged Property. A default with respect to the 2004 Note or the 2004 Mortgage will not cause a default with respect to the 1996 Note or the 1996 Mortgage. A default with respect to the 2020 Note or the 2020 Mortgage will not cause a default with

respect to the 1996 Note or the 1996 Mortgage or with respect to the 2004 Note or the 2004 Mortgage. However, a default with respect to the 1996 Note or 1996 Mortgage or with respect to the 2004 Note or the 2004 Mortgage shall, at the sole option of HUD, constitute a default with respect to the 2020 Note or the 2020 Mortgage.

In 2013, the Authority assigned the 1996 Note, the 1996 Mortgage, the 2004 Note, and the 2004 Mortgage to Prudential Huntoon Paige Associates, LLC, a Delaware limited liability company. The Series 1996 Bonds and the Series 2004 Bonds were refunded with the proceeds of the Maimonides Medical Center GNMA Collateralized Taxable Revenue Bonds, Series 2013 issued by the Institution (the "**Series 2013 Bonds**").

As of June 15, 2020, the outstanding principal amount outstanding of the 1996 Note and the 1996 Mortgage is approximately $2,701,614, the outstanding principal amount outstanding of the 2004 Note and the 2004 Mortgage is approximately $63,161,880. As of June 15, 2020, the outstanding principal amount outstanding under the Series 2013 Bonds is approximately $67,280,000.

See also "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Discussion of Outstanding Indebtedness."

PART 11 – BONDHOLDERS' RISKS

The following, prepared by the Institution, is a discussion of certain risks that could affect payments to be made by the Institution with respect to the Series 2020 Bonds. Such discussion is not, and is not intended to be, exhaustive and should be read in conjunction with all other parts of this Official Statement, and such discussion should not be considered to be a complete description of all risks that could affect such payments. The operations and financial condition of the Institution may be affected by factors other than those described below. No assurance can be given as to the nature of such factors or the potential effects thereof upon the Institution. Investors should recognize that the discussion below does not cover all such risks, that payment provisions for, and regulations and restrictions on, hospitals change frequently and that additional material limitations and regulations or restrictions may be created, implemented, or expanded while the Series 2020 Bonds are outstanding. Other sections of this Official Statement, as cited herein, should be referred to for a more detailed description of risks described in this section, which descriptions are qualified by reference to any documents discussed herein. Prospective purchasers of the Series 2020 Bonds should carefully analyze the information contained in this Official Statement, including the Appendices hereto, and in the documents summarized herein. Copies of all such documents are on file with the Authority and the Trustee.

General

The Series 2020 Bonds are not a debt or liability of the State of New York or any political subdivision thereof, but are special and limited obligations of the Authority payable from the revenues received by the Authority pursuant to the Loan Agreement and the 2020 Note, the funds and accounts held by the Trustee pursuant to the Resolution (except the Arbitrage Rebate Fund and any amounts on deposit in the Mortgage Payment Fund (A) between January 20 and January 31 of each year, constituting excess mortgage payments made by the Institution during the immediately preceding six (6) month period, and (B) between July 20 and July 31 of each year, constituting excess mortgage payments made by the Institution during the immediately preceding six (6) month period). Such payments will be made from the revenues derived by the Institution from its operations and from other nonoperating revenues received by

the Institution, including income from the investment of funds held on behalf of the Institution. The Authority has no taxing power. No representation or assurance can be made that revenues will be realized from the Institution in amounts sufficient to provide funds for payment of debt service on the Series 2020 Bonds when due and to make other payments necessary to meet the obligations of the Institution. Further, there is no assurance that the revenues of the Institution can be increased sufficiently to match increased costs that may be incurred.

The receipt of future revenues by the Institution is subject to, among other factors, federal and state regulations and policies affecting the health care industry; the policies and practices of managed care providers, private insurers, and other third-party payors; and private purchasers of health care services. The effect on the Institution of future changes in federal, state, and private policies cannot be determined at this time. Loss of established managed care contracts by the Institution could also adversely affect the future revenues of the Institution.

Future revenues and expenses of the Institution may be affected by events and economic conditions, which may include an inability to control expenses in periods of inflation, as well as other conditions such as demand for health care services; the capability of the management of the Institution; the receipt of grants and contributions; referring physicians' and self-referred patients' confidence in the Institution; and increased use of discounted payment schedules through contracts with health maintenance organizations, preferred provider organizations, and other payors. Other factors that may affect revenues and expenses include the ability of the Institution to provide services required by patients; the relationship of the Institution with physicians; the success of the Institution's strategic plans; the degree of cooperation among and competition with other hospitals and physician practices in the Institution's service area; changes in levels of private philanthropy; malpractice claims and other litigation; economic and demographic developments in the United States and in the service areas in which facilities of the Institution is located; changes in interest rates that affect investment results; and changes in rates, costs, third-party payments (including, without limitation, Medicare and Medicaid program reimbursement) and governmental regulations concerning payment. All of the above referred-to factors could affect the Institution's ability to make payments pursuant to the Loan Agreement and the 2020 Note.

The Institution is subject to a wide variety of federal and state regulatory actions and legislative and policy changes by the governmental and private agencies that administer Medicare, Medicaid, and other payors. The Institution is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare and Medicaid Services ("**CMS**") of the U.S. Department of Health and Human Services ("**HHS**"), the Internal Revenue Service ("**IRS**") and other federal, state, and local government agencies. The future financial condition of the Institution could be adversely affected by, among other things, changes in the method and amount of payments to the Institution by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, the costs associated with responding to governmental audits, inquiries and investigations, demand for health care, other forms of care or treatment, changes in the methods by which employers purchase health care for employees, capability of management, changes in the structure of how health care is delivered and paid for (i.e., accountable care organizations and other health care reform payment mechanisms), future changes in the economy, demographic changes, availability of physicians, nurses, and other health care professionals, and malpractice claims and other litigation. These factors and others may adversely affect payment by the Institution on the Series 2020 Bonds. In addition, the tax-exempt status of the Institution could be adversely affected by, among other things, an adverse determination by a governmental entity or non-compliance with governmental regulations or legislative changes that could, in turn, adversely affect the Series 2020 Bonds, including the tax-exempt status of the Series 2020 Bonds. Neither the Underwriters nor the Authority have made any independent investigation of the extent to which any such factors may have an adverse effect on the revenues of the Institution.

Forward Looking Statements

Certain statements in this Official Statement that relate to the Institution, including, but not limited to, statements in "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER" are forward-looking statements that are based on the beliefs of, and assumptions made by, the management of the Institution. Such forward-looking statements involve known and unknown risks, uncertainties, and other factors that may cause the actual results or performance of the Institution to be materially different from any expected future results or performance. Such factors include, but are not limited to, items described in "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER" and this "PART 11 - BONDHIOLDER'S RISKS."

Impact of Market Turmoil

Disruption of the credit and financial markets in the late 2000s and early 2010s resulted in volatility in the securities markets, significant losses in investment portfolios, increased business failures, and consumer business bankruptcies. In response to the prior disruption of the credit and financial markets, federal legislation was enacted. Ongoing or future disruption of credit and financial markets, whatever the cause, could lead to similar consequences again.

In recent weeks, the global spread of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) resulting in the coronavirus disease ("**COVID-19**") has resulted in volatility in the U.S. and global financial markets, increased unemployment, strained State and local government budgets that may result in reduced or delayed Medicare and Medicaid reimbursement, and significant realized and unrealized losses in investment portfolios. Our collective national effort to mitigate the COVID-19 pandemic has caused a deep contraction in vast areas of our economy, with many hospitals facing potentially sharp declines in revenue and, in some cases, increased unbudgeted costs. Financial results, generally, and liquidity, in particular, may be materially diminished. In addition, many businesses, and, in some cases, entire industries, have been adversely impacted by disruptions in operations, supply chain delays or cessation, and redeployment of personnel resources, among other challenges, which may lead to business failures and bankruptcies. Such impacts may disrupt supply chains for equipment and supplies necessary of the operation of hospitals across the country, and the Institution in particular. In addition, governmental response measures are uncertain and evolving.

The effect of the COVID-19 outbreak has resulted in the cancellation of elective procedures at hospitals generally, and the Institution in particular. Federal, State, and local government responses to the COVID-19 outbreak may include unexpected and severe restrictions on business operations or new requirements for businesses, such as mandating paid sick leave, that affect the entire U.S. economy. These measures may also include federal relief packages for specific industries, including targeted benefits to the health care industry due to the nature of the outbreak. Access to capital markets may be hindered and increased costs of borrowing may occur as a result. Given the uncertainty regarding the COVID-19 outbreak, the full range of its consequences cannot be predicted at this time. See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Introduction – General."

Infectious Disease Outbreak and COVID-19

The Institution's operations and financial results may be harmed by any international, national, or localized outbreak of a highly contagious or epidemic disease. The current international outbreak of COVID-19 is having numerous and varied medical, economic, and social impacts, any and all of which may adversely affect the Institution's operations and financial results. Health care providers are cancelling or delaying non-urgent appointments and procedures, which is likely to have an adverse effect on their

revenues. A substantial portion of the population is subject to voluntary or involuntary quarantine, including New York State, leading to general and substantial reductions in economic activity. Certain new health and safety rules have been instituted for construction projects such as the Project.

The staff and employees of health care providers, particularly front-line health care workers, such as physicians and nursing personnel, are disproportionately likely to become ill from COVID-19, which may create a shortage of medical staff in areas severely affected by COVID-19. Throughout the United States, health care providers are experiencing, or expect to experience, shortages of pharmaceuticals, protective gear, testing materials, medical equipment, blood, and other necessary supplies. Health care providers and facilities may become understaffed and under-supplied as the number of COVID-19 cases grows, limiting their ability to provide comprehensive care to patients.

National and New York unemployment rates have increased as business remain closed during the various stay-at-home orders in effect across the country. It is uncertain when and how rapidly unemployment rates will decline as States begin to ease stay-at-home orders. It is expected that the COVID-19 pandemic will cause significant declines in State and local tax revenues. These financial challenges may negatively affect hospitals, in general, and the Institution, in particular, in a number of ways, including the elimination or reduction of health care safety net programs (causing a greater number of indigent, uninsured, or underinsured patients) and reductions in Medicaid reimbursement rates. Unemployment frequently leads to a loss of employer-sponsored health insurance, which then results in greater numbers of persons being uninsured, underinsured, or insured by Medicaid, which generally reimburses health care providers at much lower rates than commercial insurance. As a result, health care providers may provide significant amounts of uncompensated care.

National, state, and local governments have taken, and are expected to continue to take, various actions, including the passage of laws and regulations, on a wide array of topics, in an attempt to slow the spread of COVID-19 and to address the health and economic consequences of the outbreak. This has included major U.S. Congressional legislation, such as the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, enacted on March 6, 2020, the Families First Coronavirus Response Act enacted on March 18, 2020, and the Coronavirus Aid, Relief, and Economic Security Act (the "**CARES Act**"), signed into law on March 27, 2020. Many of these government actions are expected to cause substantial changes to the way health care is provided, and how society in general functions. It is not clear how long such measures will remain in place.

In addition to the CARES Act funding, CMS expanded and streamlined the process for its Accelerated and Advance Payment Program, pursuant to which hospital providers can receive advance Medicare disbursements that cover a time period of up to six months. The advance and accelerated payments are a loan that providers much pay back. CMS announced that it will begin to automatically offset the accelerated/advance payments 120 days after distribution. For Medicare Part A providers, including certain hospitals, offsets will be processed for up to one year after the disbursement date, at which time such providers will have to repay the outstanding balance without interest, or to the extent any amounts remain outstanding after one year, interest on the outstanding balances will accrue at the rate of 9.625% per annum. CMS suspended this program as of April 26, 2020, for Medicare Part B providers and announced it was reevaluating amounts to be paid under the program for Medicare Part A providers. See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER –Management's Discussion and Analysis of Recent Financial Performance – Infection Disease Outbreak and COVID-19 (March 1st – Current)."

As these actions are far-reaching and rapidly changing, the Institution cannot yet predict the impacts of the COVID-19 outbreak, financial or otherwise, yet has taken actions to sustain its operations and to prioritize the well-being of its patients and employees.

See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – General."

Adequacy of Revenues

The 2020 Note, the 2020 Mortgage, and the Mortgage Insurance Benefits are the primary security for the Series 2020 Bonds. Reliance has been placed by the Authority, as FHA mortgagee, upon the underwriting criteria utilized by HUD in insuring the 2020 Mortgage and as evidence of the adequacy of the Institution's revenues to maintain the Mortgaged Property and make the payments required under the 2020 Note and the 2020 Mortgage.

The ability of the Institution to make payments under the 2020 Note and the Loan Agreement depends, among other things, on the capabilities of management, economic conditions including the demand for health care services, the ability of the Institution to provide services required by patients and physicians, confidence in the Institution, competition from other health care facilities in the Institution's service area, various third-party reimbursement programs (including Medicare and Medicaid), and other factors. See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER."

Legislative, Regulatory, and Contractual Matters Affecting Revenue

The health care industry is heavily regulated by the federal and state governments. A substantial portion of revenue comes from governmental sources. Governmental revenue sources are subject to legislative and policy changes by the governmental and private agencies that administer Medicare, Medicaid, other third-party payors, and governmental payors and actions by, among others, The Joint Commission, CMS, and other federal, state, and local government agencies. These agencies have broad discretion to alter or eliminate programs that contribute significantly to revenues of the Institution. In the past, there have been frequent and significant changes in the methods and standards used by government agencies to reimburse and regulate the operation of hospitals. See "Health Care Reform - Affordable Care Act" for more information on current and proposed future changes in hospital reimbursement. No assurances can be given that further substantial changes will not occur in the future or that payments made under such programs will remain at levels comparable to the present levels or be sufficient to cover all existing costs. While changes are anticipated, the impact of such changes on the Institution cannot be predicted.

The Institution has established estimates, based on information presently available, of amounts due to or from Medicare and non-Medicare payors for adjustments to current and prior years' payment rates, based on industry-wide and Institution-specific data. The current Medicaid, Medicare, and other third-party payor programs are based upon extremely complex laws and regulations that are subject to interpretation. Medicare cost reports, which serve as the basis for final settlement with government payors, have been settled for all years through and including 2016 except that years 2010 through 2013 is not settled as, like other hospitals, the Institution was the beneficiary of the U.S. Supreme Court's decision in *Azar v. Allina Health Services* (2019) which held that HHS's policy to retroactively reduce Medicare payments was vacated due to HHS's failure to go through notice and comment as part of its administrative process. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount when open years are settled, and additional information is obtained. Additionally, noncompliance with such laws and regulations could result in fines, penalties, and exclusion from such programs. The Institution is not aware of any allegations of noncompliance that could have a material adverse effect on the consolidated financial statements and believes that it is in compliance with all applicable laws and regulations.

Legislation is periodically introduced in Congress and in the New York State Legislature that could result in limitations on the Institution's revenue, third-party payments, and costs or charges, or that could result in increased competition or an increase in the level of indigent care required to be provided by the Institution. From time to time, legislative proposals are made at the federal and state level to engage in broader reform of the health care industry, including proposals to promote competition in the health care industry, to contain health care costs, to provide national health insurance, and to impose additional requirements and restrictions on health care insurers, providers and other health care entities. The effects of future reform efforts on the Institution cannot be predicted.

The Federal Budget and the Federal Debt Limit

Budget Control Act. The Federal Budget Control Act of 2011 (the "**Budget Control Act**") mandates significant reductions in federal spending caps for fiscal years 2012-2021, including annual reductions of two percent on all Medicare payments during this period. The Bipartisan Budget Act of 2018 extended these reductions through 2027 (although the cuts were eliminated by the CARES Act from May 1, 2020 through December 31, 2020). It is possible that Congress could act to extend or increase these across-the-board reductions.

Because Congress may make changes to the budget in the future, it is impossible to predict the impact any spending cuts that are approved may have on the Institution. Further, with no long-term resolution in place for Federal deficit reduction, hospital, and physician reimbursement are likely to continue to be targets for reductions with respect to any interim or long-term Federal deficit reduction efforts. These and any additional reductions in Medicare spending could have a material adverse effect upon the financial condition or operations of the Institution.

Debt Limit Increase. The Federal government has, through legislation, created a debt "ceiling" or limit on the amount of debt that may be issued by the U.S. Treasury. In the past several years, disputes have arisen within the federal government in connection with discussions concerning the authorization for an increase in the federal debt ceiling. Any failure by Congress to increase the Federal debt limit may impact the federal government's ability to incur additional debt, pay its existing debt instruments, and to satisfy its obligations relating to the Medicare and Medicaid programs. Management of the Institution is unable to determine at this time what impact any failure to increase the federal debt limit may have on the operations and financial condition of the Institution, although such impact may be material and adverse. Additionally, the market price or marketability of the Institution's outstanding bonds in the secondary market may be materially adversely impacted by any failure to increase the federal debt limit.

Health Care Reform - Affordable Care Act

The discussion herein describes risks associated with certain existing federal and state laws, regulations, rules, and governmental administrative policies and determinations to which the Institution and the health care industry are subject. While these are regularly subject to change, many of the existing provisions were enacted by or promulgated pursuant to the ACA (defined below), to which opposition has been expressed by President Trump as well as members of the United States Congress, and which has been the subject of several, to date unsuccessful, federal legislative efforts to repeal or substantially amend the same. It is not possible to predict with any certainty whether or when the ACA or any specific provision or implementing measure will be repealed, withdrawn, or modified in any significant respect, but any such measures could have a material adverse effect on the operations, financial condition, and financial performance of the Institution.

The following discussion should be read with the understanding that significant changes could occur in the near future and beyond in many of the statutory and regulatory matters discussed.

As a result of the Patient Protection and Affordable Care Act, enacted in March 2010, as amended by the Health Care and Education Reconciliation Act (together, the "**ACA**"), substantial changes have occurred and further are anticipated in the United States health care system. Some of the provisions of the ACA took effect immediately, while others will take effect at later dates or will be phased in over time. Such legislation has been intended by its supporters to be transformative and includes numerous provisions affecting the delivery of health care services, the financing of health care costs, payment to health care providers, and the legal obligations of health insurers, providers, employers, and consumers. These provisions are slated to take effect at specified times over approximately the next decade and, therefore, the full consequences of the ACA on the health care industry will not be immediately realized. Due to the complexity of the ACA, the ramifications of federal health care reform legislation may also become apparent only following implementation or through later regulatory and judicial interpretations. Portions of the ACA may also be limited or nullified as a result of legal challenges or amendments. In addition, the uncertainties regarding the implementation of the ACA create unpredictability for the strategic and business planning efforts of health care providers, which constitutes a risk.

In June 2012, the U.S. Supreme Court upheld most provisions of the ACA, including a key provision known as the "individual mandate," while limiting the power of the federal government to penalize states for refusing to expand Medicaid. The individual mandate, which took effect in 2014, generally required that individuals either have a certain amount of health insurance coverage or pay a yearly tax penalty. As discussed below, the individual mandate tax penalty was eliminated by recent tax legislation. In June 2015, the U.S. Supreme Court upheld U.S. Treasury Regulations issued under the ACA that allow health insurance exchange purchasers to receive tax-credit subsidies, regardless of whether the purchase is made through a federal or state-operated exchange. However, under the Tax Cuts and Jobs Act (defined below), the penalty for failure to comply with the individual mandate was reduced to zero for tax years 2020 and beyond. (See "Tax Reform" below.)

The changes in the health care industry brought about by the ACA may have both positive and negative effects, directly and indirectly, on the nation's hospitals and other health care providers, including the Institution. For example, the projected increase in the numbers of individuals with health care insurance occurring because of Medicaid expansion, creation of health insurance exchanges, and subsidies for insurance purchase could result in lower levels of bad debt and increased utilization or profitable shifts in utilization patterns for hospitals. However, the extent to which Medicaid expansion, which is now optional on a state by state basis, is either not pursued or results in a shifting of significant numbers of commercially-insured individuals to Medicaid, or health insurance options on exchanges are limited or unaffordable, as well as the cost containment measures and pilot programs that the ACA requires, may offset these benefits.

A negative impact to the hospital industry overall will likely result from scheduled cumulative reductions in Medicare payments; such reductions are substantial. The legislation's cost-cutting provisions to the Medicare program include reduction in Medicare market basket updates to hospital reimbursement rates under the inpatient prospective payment system ("**IPPS**"), additional reductions to or elimination of Medicare reimbursement for certain patient readmissions and hospital-acquired conditions, as well as anticipated reductions in rates paid to Medicare managed care plans that may ultimately be passed on to providers. Industry experts also expect that government cost reduction actions may be followed by private insurers and payors reductions, which could have a material impact on the Institution and could offset any positive effects of the ACA. See also "Medicare and Medicaid Programs; General" below.

The ACA likely will affect some health care organizations differently than others, depending, in part, on how each organization adapts to the legislation's emphasis on directing more federal health care

dollars to integrated provider organizations and providers with demonstrable achievements in quality care. The ACA proposes a value-based purchasing system for hospitals under which a percentage of payments will be contingent on satisfaction of specified performance measures related to common and high-cost medical conditions, such as cardiac, surgical, and pneumonia care. The legislation also funds various demonstration programs and pilot projects and other voluntary programs to evaluate and encourage new provider delivery models and payment structures, including "accountable care organizations" and bundled provider payments. The outcomes of these projects and programs, including the likelihood of their being made permanent or expanded, or their effect on health care organizations' revenues or financial performance cannot be predicted.

The ACA contains amendments to existing criminal, civil, and administrative anti-fraud statutes and increases funding for enforcement and efforts to recoup prior federal health care payments to providers. Under the ACA, a broad range of providers, suppliers, and physicians are required to adopt compliance and ethics programs. While the government has already increased its enforcement efforts, failure to implement certain core compliance program features provide new opportunities for regulatory and enforcement scrutiny, as well as potential liability if an organization fails to prevent or identify improper federal health care program claims and payments.

Some of the specific provisions of the ACA that may affect the Institution's operations, financial performance, or financial condition are described below. **This listing is not intended to be, nor should be considered by the reader as, comprehensive. The ACA is complex and comprehensive, and it includes myriad programs and initiatives and changes to existing programs, policies, practices, and laws. The reader is encouraged to review the ACA, itself and/or more comprehensive summaries and analyses of the ACA available in the public media.**

Market Basket Reductions. Commencing upon enactment of the ACA, the annual Medicare market basket updates for hospitals have been reduced. The market basket adjustments for inpatient hospital care have averaged approximately 2% to 4% annually in recent years. For fiscal year 2020, CMS finalized ACA-required market basket reductions of 0.4% (for productivity) and 0.75% (pre-determined). The reductions in market basket updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are more dependent upon Medicare than other providers. These reductions and the productivity adjustments have had, and will continue to have, a disproportionately negative effect upon those providers (such as the Institution) that are relatively more dependent upon Medicare than other providers. In addition, the reductions in market basket updates were effective prior to the periods during which insurance coverage and the insured consumer base began to expand, which may have an interim negative effect on revenues. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may result in reductions in Medicare payment per discharge on a year-to-year basis.

Hospital Acquired Conditions Penalty. Beginning in federal fiscal year 2015, Medicare inpatient payments to hospitals that are in the top quartile nationally for frequency of certain "hospital-acquired conditions" will be reduced by 1% for all discharges for the applicable federal fiscal year. In addition, the ACA provides that, as of July 1, 2011, CMS shall no longer provide federal funding to states for any amounts expended by providers in treating so-called provider-preventable conditions. CMS has also directed states to submit amendments to their Medicaid state plans to require payment denials for the cost of treating such conditions, consistent with the prohibition on federal reimbursement. The NYSDOH issued an emergency regulation, effective December 6, 2011, that denied payment for several "potentially preventable negative outcomes," retroactive to Medicaid discharges from July 1, 2011. The conditions included under this emergency regulation are far more extensive than those included in the Medicare "hospital-acquired conditions," although New York State estimates that they are limited to less than 0.1% of Medicaid discharges.

Fraud and Abuse. ACA included significant changes to health care fraud and abuse laws that will intensify the risks and consequences of enforcement actions. These changes include: expansion of the Federal False Claims Act; lessening of the intent requirements under the federal Anti-Kickback Statute; requiring the reporting and return of Medicare and Medicaid overpayments; and new funding and expanded powers to investigate fraud, including through expansion of the RAC program and the requirement that states create a Medicaid RAC program. New York's State Plan Amendment for the Medicaid RAC program was approved in March 2011 and designated HMS as its RAC contractor in April 2011. ACA also creates enhanced penalties for noncompliance, including increased criminal penalties and expansion of administrative penalties under Medicare and Medicaid. In addition to these potential noncompliance penalty costs, all hospitals will eventually be required to establish and maintain compliance and ethics programs that satisfy certain federal requirements as a condition of enrollment in Medicare, Medicaid, and the Children's Health Insurance Program. See "Regulatory Environment."

Readmission Rate Penalty. Beginning in federal fiscal year 2013, Medicare inpatient payments to those hospitals with excess readmissions compared to the national average for three patient conditions (acute myocardial infarction, pneumonia and heart failure) are reduced based on a risk-adjusted measure of the hospital's readmissions performance. The maximum penalty was 1% in fiscal year 2013, which increased to 3% in fiscal year 2015. In fiscal year 2015, the patient conditions assessed for this penalty was expanded to include acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty. Effective fiscal year 2017, CMS expanded the program to include patients admitted for coronary artery bypass graft surgery. In 2018, CMS ceased evaluating readmission rates in relation to all hospital, and now instead assigns hospitals to peer groups with similar proportions of low-income patients. It is expected that hospitals serving a greater proportion of low-income patients will see a reduction in readmission rate penalties.

Medicare Disproportionate Share Payments. Beginning in federal fiscal year 2014, the ACA mandated that hospitals receiving supplemental Disproportionate Share ("**DSH**") payments from Medicare (i.e., those hospitals that care for a disproportionate share of low-income Medicare beneficiaries) have their DSH payments reduced by 75%. This reduction was potentially adjusted by adding back payments based on the volume of uncompensated care provided by a DSH hospital, and was anticipated to be offset by a higher proportion of covered patients as other provisions of the ACA went into effect. The ACA also mandated cuts to Medicaid DSH payments to account for anticipated reductions in uninsured individuals and uncompensated care. The Medicaid DSH payment reduction schedule has been delayed by various pieces of legislation. Pursuant to the budget bill passed in February 2018, the Medicare DSH payment reductions were scheduled to begin in fiscal year 2020, with a reduction of $4 billion per year in fiscal year 2020, but those cuts were eliminated under the CARES Act. Medicaid DSH cuts are now set to be reduced by $4 billion in fiscal year 2021 (delayed until December 1, 2020), with a reduction of $8 billion per year for fiscal years 2022 through 2025. The Institution has qualified for DSH payments in the past, but there can be no assurance that it will qualify for DSH status in the future. Loss or reduction of funding for the Medicaid DSH program could adversely affect the Institution. In fiscal year ended December 31, 2019, the Institution received approximately $40.3 million in DSH payments from Medicare including Medicare HMO.

Payments to Medicare Advantage Plans. Hospitals also receive payments from health plans under the Medicare Advantage program. The ACA includes significant changes to federal payments to Medicare Advantage plans. Payments to plans were frozen for fiscal year 2011. Beginning in fiscal year 2012, federal payments to Medicare Advantage plans have been tied to the level of fee-for-service spending in the applicable county, resulting in a reduction below the fiscal year 2011 level for certain Medicare Advantage plans. These reduced federal payments could in turn affect the scope of coverage of these plans or cause plan sponsors to negotiate lower payments to providers.

The ACA addresses almost all aspects of hospital and provider operations and health care delivery, and the ACA has changed and is changing how health care services are covered, delivered, and reimbursed. These changes will result in new payment models with the risk of lower health care provider reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for health care providers to assess, and potentially alter, their business strategy and practices, among other consequences. While most providers will receive reduced payments for care, millions of previously uninsured Americans may gain insurance coverage. "Health insurance exchanges" could fundamentally alter the health insurance market and negatively impact health care providers, enabling insurers to aggressively negotiate rates.

The ACA and its implementation have been, and remain, politically controversial. The ACA has continually faced legal and legislative challenges, including repeal efforts, since its enactment. President Trump and Republican leaders of Congress have repeatedly cited health care reform, and particularly repeal and replacement of the ACA, as a key goal. To that end, Congressional leaders have introduced various ACA repeal bills. While no bills wholly repealing the ACA have passed both chambers of Congress, the Tax Cuts and Jobs Act passed in late 2017 (defined and discussed below) eliminated the ACA's individual mandate tax penalty associated with failing to maintain health coverage, effective 2019. Further, there is currently a case before the U.S. Supreme Court brought by several states seeking to overturn the entire ACA. Management cannot predict the effect of the elimination of the individual mandate tax penalty, the likelihood of any future ACA repeal bills or other health care reform bills becoming law, or the subsequent effects of any such laws, though such effects could materially impact the Institution's business or financial condition. However, any legal, legislative, or executive action that (1) reduces federal health care program spending, (2) increases the number of individuals without health insurance, (3) reduces the number of people seeking health care, or (4) otherwise significantly alters the health care delivery system or insurance markets could have a material adverse effect on the Institution's business or financial condition.

In addition to actual and possible legislative changes, the ACA implementation and the ACA insurance exchange markets may be impacted by executive branch actions. President Trump has issued two broad executive orders aimed at de-regulation: (1) one requiring federal agencies to remove two previously implemented regulations for every new regulation added, and (2) one directing each federal agency to set up a "regulatory reform task force" to review existing regulations and eliminate those that are costly or unnecessary. Additionally, President Trump has issued executive actions directly aimed at the ACA: (1) one requiring federal agencies with authorities and responsibilities under the ACA to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay" parts of the law that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers, (2) a second instructing federal agencies to make new rules allowing the proliferation of "association health plans" and short-term health insurance, which plans have fewer benefit requirements than those sold through ACA insurance exchanges, and (3) a third ordering the federal government to withhold ACA cost-sharing subsidies currently paid to insurance companies in order to reduce deductibles and co-pays for many low-income people. These executive actions have the potential to significantly impact the insurance exchange market by causing a reduction in the number of healthy individuals in the ACA health insurance exchanges, a reduction in the number of plans available on the health insurance exchanges, and/or an increase in insurance premiums. The Institution cannot predict the likelihood of similar future executive actions or effect of any such executive actions on the financial conditions or results of operations of the Institution, though such effects could be material. Further, because of executive actions taken by President Trump with respect to the ACA, potential challenges by states to such executive actions and continuing efforts by Congress to modify the ACA, there is significant uncertainty as to whether the ACA will continue to be implemented, funded, and enforced as originally enacted.

Tax Reform

On December 22, 2017, President Trump signed into law "H.R. 1 – An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018," (the "**Tax Cuts and Jobs Act**"). The Tax Cuts and Jobs Act lowered corporate and individual tax rates and eliminated certain tax preferences and other tax expenditures. As discussed above, the Tax Cuts and Jobs Act also eliminated, effective 2019, the tax penalties associated with failure to comply with the ACA's individual mandate. The Commonwealth Fund ACA Tracking Survey, released in May 2018, notes that the number of uninsured Americans has increased since 2016, reversing years of decline since the ACA was passed in 2010. According to the report, the number of uninsured adults between the ages of 19 and 64 rose to 15.5% in March 2018, up from 12.7% in 2016, and an estimated 4 million people lost individual coverage during that period. The elimination of the individual mandate may result in a higher uninsured rate, which may adversely affect the financial condition of the Institution. Additionally, due to the significant job losses due to COVID-19, it is possible that rate of uninsured persons could rise higher in 2020 and beyond due to the loss of employer-sponsored health care.

The Tax Cuts and Jobs Act also eliminates the issuance of tax-exempt bonds to advance refund outstanding tax-exempt bonds; imposes an excise tax on exempt entities' executive compensation in excess of $1,000,000 per year; requires that the tax on an exempt organization's unrelated business income be computed separately for each line of business; requires the inclusion of certain fringe benefits in the calculation of unrelated business income tax; and limits the use of net operating losses in computing unrelated business income tax, each of which may, collectively or individually, adversely affect the financial condition or operations of the Institution.

General Economic Conditions, Bad Debt, Indigent Care and Investment Performance

Health care providers are economically influenced by the environment in which they operate. Any national economic difficulties may constrain corporate and personal spending, limit the availability of credit and increase the national debt and federal and certain state government deficits. To the extent that unemployment rates are high, employers reduce their workforces and their budgets for employee health care coverage or private and public insurers seek to reduce payments to health care providers or curb utilization of health care services, health care providers may experience decreases in insured patient volume and reductions in payments for services. In addition, to the extent that state, county or city governments are unable to provide a safety net of medical services, pressure is applied to local health care providers to increase free care. Economic downturns and lower funding of federal Medicare and state Medicaid and other state health care programs may increase the number of patients who are unable to pay for some or all of their medical and hospital services. These conditions may give rise to increases in health care providers' uncollectible accounts, or "bad debt," uninsured discount and charity care and, consequently, to reductions in operating income. Declines in investment portfolio values may reduce or eliminate non-operating revenues. Investment losses (even if unrealized) may trigger debt covenant violations and may jeopardize hospitals' economic security. Losses in pension and other post-retirement benefit funds may result in increased funding requirements for hospitals and health systems. Potential failure of lenders, insurers or vendors may negatively impact the results of operations and the overall financial condition of health care providers. Philanthropic support may also decrease or be delayed, which may cause health care providers to use more of their unrestricted funds for capital planning.

Patient Service Revenues

General

A substantial portion of the net patient service revenue of the Institution is derived from third-party payors that reimburse or pay for the services and items provided to patients covered by such third parties. These third-party payors include the federal Medicare program, state Medicaid programs and private health plans and insurers, including health maintenance organizations ("**HMOs**") and preferred provider organizations ("**PPOs**"). Many of these payors make payments to the Institution in amounts that may not reflect the direct and indirect costs of the Institution providing services to patients. Accordingly, there can be no assurance that payments made under these programs will be adequate to cover the Institution's actual costs of furnishing health care services and items. In addition, the financial performance of the Institution could be adversely affected by the financial position or the insolvency or bankruptcy of or other delay in receipt of payments from third-party payors that provide coverage for services to their patients.

Medicare and Medicaid Programs; General

Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program and Medicaid is jointly funded by federal and state governments and governed by federal and state laws. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, blind, disabled, or qualify for the End Stage Renal Disease Program. Medicaid is designed to pay providers for care given to low-income persons, is funded by federal and state appropriations, and is administered by the individual states. Benefits are available under each participating state's Medicaid program, within prescribed limits, to persons meeting certain income or other eligibility requirements including children, the aged, the blind and/or disabled. Health care providers have been and will be affected significantly by changes in the last several years in federal and state health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs.

Medicare

Medicare is a federal governmental health insurance system under which physicians, hospitals and other health care providers are reimbursed or paid directly for services provided to eligible elderly, disabled persons, and persons with End Stage Renal Disease. Medicare is administered by CMS. In order to achieve and maintain Medicare certification and billing privileges, a health care provider must meet CMS's "Conditions of Participation" on an ongoing basis. A provider will be deemed to meet the Conditions of Participation if it is accredited by a CMS-approved accrediting organization such as The Joint Commission, the Healthcare Facilities Accreditation Program or DNV-GL Healthcare, Inc. However, despite accreditation, a provider may be surveyed for compliance with the Conditions of Participation by a state agency survey team acting on behalf of CMS. In the event that noncompliance is found, a notice of termination of participation may be issued and a provider may be required to develop and implement a potentially burdensome corrective action plan. If the corrective action plan is not accepted by CMS, or if the corrective action plan is not successfully implemented, the provider's Medicare provider agreement could be terminated. Other sanctions could potentially be imposed, including, in limited circumstances, monetary penalties. Failure of a hospital or other health care provider to comply with the Conditions of Participation could result in loss of its eligibility to participate in the Medicare and Medicaid programs, which would have a material negative effect on the financial conditions and results of operations of such hospital or health care provider.

CMS requires all Medicare-certified providers, including hospitals, to revalidate their Medicare enrollment records in order for CMS to implement new screening criteria mandated by the ACA. Under this initiative, Medicare contractors send mandatory revalidation requests to providers, who will have a limited time to respond to the requests. Failure to timely revalidate Medicare enrollment records for any hospital facility could result in deactivation or termination of a hospital's provider agreement, which could adversely affect the hospital's patient services revenues and financial performance.

For the fiscal year ended December 31, 2019, Medicare/Medicare HMO represented approximately 40.8% of the Institution's net patient service revenue. As a consequence, changes in the Medicare program may have a material adverse effect on the Institution. The aggregate costs to a provider of providing care to Medicare beneficiaries may exceed aggregate Medicare payments received during the relevant fiscal year period. CMS was able to use authority provided by the ACA to produce average premium declines for the Medicare Advantage program. Reductions in Medicare reimbursement, increases in Medicare reimbursement in amounts less than increases in the costs of providing care, or premium declines may have a material adverse financial effect on the Institution.

A substantial portion of the Medicare revenues of the Institution is derived from payments made for services rendered to Medicare beneficiaries under a prospective payment system ("**PPS**"). Under a PPS, the amount paid to the provider for an episode of care is established by federal regulation and is not related to the provider's charges or costs of providing that care. Presently, hospital inpatient and outpatient services, and home health care are paid on the basis of a PPS. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned Diagnosis Related Group ("**DRG**"). DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. All services paid under the PPS for hospital outpatient services are classified into groups called ambulatory payment classifications ("**APCs**"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Hospital capital costs apportioned to Medicare patient use (including depreciation and interest) are paid by Medicare on the basis of a standard federal rate (based upon average national costs of capital), subject to limited adjustments specific to the hospital. There can be no assurance that future payments will be sufficient to cover the actual capital-related costs of facilities applicable to Medicare patient stays or will provide flexibility for hospitals to meet changing capital needs.

The ACA established a value-based purchasing program that rewards hospitals with incentive payments for the quality of care they provide to Medicare patients. The quality performance standards take into account a broad range of factors designed to measure quality of care, how closely best clinical practices are followed and the overall experience of the patients. Because the ACA provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards will receive greater reimbursement under the value-based purchasing program than they would have otherwise. Hospitals that do not achieve the necessary quality performance will receive reduced Medicare inpatient hospital payment. The Institution is unable to predict how value-based purchasing will affect its results of operations; however, the program could negatively impact the revenues of the Institution.

The Secretary of HHS is required to review annually the DRG categories to take into account any new procedures, reclassify DRGs and recalibrate the DRG relative weights that reflect the relative resources used by hospitals with respect to discharges classified within a given DRG category. There is no assurance that the Institution will be paid amounts that will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients. CMS may only adjust DRG weights on a budget neutral basis.

PPS-exempt hospitals and units (inpatient psychiatric, rehabilitation and long-term hospital services) are currently reimbursed under prospective payment systems separate from the PPS/DRG system

used for general acute care hospitals and units. However, these exempt hospital/unit PPS payment methodologies are similar in that they utilize nationally determined payment rates (per discharge for rehabilitation and long-term care, per diem for psychiatric). These national rates are then generally subject to patient and/or facility specific adjustments for such factors as: case mix, regional wage or cost differences, medical education, disproportionate share, and outliers. The types of adjustments vary for each of the exempt PPS programs.

From time to time and as part of the ACA, the factors used in calculating the prospective payments for units of service are modified by CMS, which may reduce revenues for particular services. Additionally, as part of the federal budgetary process, Congress has regularly amended the Medicare law to reduce increases in payments that are otherwise scheduled to occur, or to provide for reductions in payments for particular services. Similarly, federal legislation is regularly passed that affects payments made under the PPS. For example, such legislation may add or eliminate categories of funding. These actions could adversely affect the revenues of the Institution.

Various additional payments may be made to individual providers. Hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive supplemental Social Security income) currently receive additional payments in the form of disproportionate share payments. Additional payments are made to hospitals that treat patients who are costlier to treat than the average patient; these additional payments are referred to as "outlier payments." Eligible hospitals are paid for a portion of their direct and indirect medical education costs. Providers may also apply for certain additional payments relating to new technology. Any and all additional payments described herein are subject to reductions and modifications or other changes.

Medicare Audits. All hospitals participating in the Medicare and Medicaid programs must meet specific financial reporting requirements, which involve submission of annual cost reports to identify expenses associated with the services provided to Medicare and Medicaid beneficiaries. These cost reports are subject to routine audits and retroactive audit adjustments, which may result in adjustments to the amounts ultimately determined to be due in reimbursement. The Institution receives payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the amounts that may be payable or receivable from Medicare for the settlement of the annual cost reports are reflected as amounts due to/from third-party payors in the Institution financing statements and represent several years of open cost reports due to time delays in the fiscal intermediaries' audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the Federal False Claims Act or other federal statutes, subjecting a hospital to civil or criminal sanctions. Management is not aware of any situation whereby a material Medicare payment is being withheld from the Institution.

The ACA amended certain provisions of the federal False Claims Act (described below under "Regulatory Environment") and added provisions regarding the timing of the obligation to reimburse overpayments. The effect of these changes on existing programs of the Institution cannot be predicted, although Management does not believe that the effects will be materially adverse.

Off-Campus Provider-Based Departments. Some health care providers bill for services as "provider-based entities" and, as such, are subject to CMS' provider-based regulations. A hospital outpatient department is considered to be "off-campus" if it is located more than 250 yards from a main provider hospital or a remote location of a hospital. As of January 1, 2017, off-campus hospital outpatient

departments established on or after November 2, 2015, were no longer eligible for payment under the Outpatient PPS for non-emergency services. Instead, starting in 2017, CMS commenced paying for non-emergency services performed at these facilities under the Medicare physician fee schedule ("**MPFS**"), which offers lower rates of payment than the Outpatient PPS for the same services. CMS has continued to pay non-exempt off-campus hospital outpatient departments under MPFS, subject to a "relativity adjustment" in 2018. CMS has recently opposed additional rule changes related to off-campus hospital departments that, if finalized, may further reduce payments to hospitals for outpatient services. In particular, CMS promulgated rules to pay off-campus hospital departments that were in operation before November 2, 2015, and otherwise exempt from the reduced payments, under the MPFS schedule for certain categories of services. However, CMS's rulemaking setting forth the reductions was vacated by a federal district court in 2019 after industry challenged the cuts; the case is currently being appealed by the agency. CMS proposed similar payment cuts for fiscal year 2020, which is also being challenged by providers subject to the reductions. The reduction in payment rates for services rendered in off-campus provider-based departments arguably place a greater burden on providers to consider the potential adverse reimbursement implications of moving or expanding existing provider-based departments.

Medical Education Costs. Medicare pays for certain costs associated with both direct and indirect medical education (including portions of the salaries of residents and faculty and other overhead costs directly attributable to medical education programs for training residents, nurses and allied health professionals) under Section 1886(h) of the Social Security Act. Payment for direct graduate medical education ("**DGME**") reimburses hospitals for the direct costs of their medical education programs, including faculty and resident salaries and other costs incurred directly and in support of the teaching programs. The payment amount for DGME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year, multiplied by the hospital's Medicare "patient load." Payment for the operating costs of indirect medical education is made as an adjustment to a hospital's MS-DRG payment (defined below) and based on a statutory formula determined in part by the ratio of a hospital's number of full-time equivalent residents to its average number of staffed beds. There can be no assurance that payments to the Institution for providing medical education will be adequate to cover the costs attributable to medical education programs for training residents, nurses and allied health professionals.

Capital Costs. Hospitals are paid on a fully prospective basis for capital costs (including depreciation and interest) related to the provision of inpatient services to Medicare beneficiaries. Thus, capital costs are paid exclusively on the basis of a standard federal rate (based on average national costs), subject to certain adjustments (such as for disproportionate share, indirect medical education and outlier cases) specific to the Institution. There can be no assurance that the prospective payments for capital costs will be sufficient to cover the actual capital-related costs of the Institution allocable to Medicare patient stays or to provide adequate flexibility in meeting the Institution's future capital needs.

Physician Payments. On April 16, 2015, former President Obama signed into law Medicare Access and CHIP Reauthorization Act ("**MACRA**"), legislation that substantially alters how physicians and other practitioners are paid by Medicare for services furnished to program beneficiaries. CMS previously relied on a formula known as the Sustainable Growth Rate ("**SGR**"), which imposed an indirect limit on the growth of Medicare payments for physician services based on an estimate of changes in each of four factors, including the estimated change to the U.S. Gross Domestic Product over a ten-year period. MACRA permanently replaced the SGR formula with statutorily prescribed physician payment updates and incentives based upon performance measures that began in January 2017. This legislation increases Medicare physician reimbursement by 0.5% annually until 2019 and then provides for no additional increases to base physician reimbursement through 2025.

MACRA moved Medicare physician reimbursement from a fee-for-service to a pay-for-performance model that will continue to control the growth of physician payments based on clinical outcomes and quality reporting. In addition to the base payment methodology, physicians can earn merit-based payments based on factors including compliance with meaningful use of certified electronic health records technology ("**CEHRT**") and demonstration of quality-based medicine.

Beginning January 1, 2019, and carrying through 2025, physician payment adjustments will occur through the Quality Payment Program's two reimbursement tracks - the Merit-based Incentive Payment System ("**MIPS**") or an Advanced Alternative Payment Model ("**APM**"). In calculating physician payment adjustments, MIPS streamlines existing quality and value programs, accounting for physician performance under the meaningful use of electronic health records incentive program, the value-based modifier, and physician quality reporting system. Payments to physicians participating in APMs similarly accounts for performance under such programs. Beginning January 1, 2026, and effective January 1 of each subsequent calendar year, physician payments will be increased 0.75% for physicians who adequately participate in APMs, and 0.25% for those in MIPS. Notably, CMS has designated calendar year 2017 as the "transition year" during which physician reporting obligations for participation in these programs are substantially reduced. The outcomes of these programs, including the likelihood of being revised or expanded or their effect on health care organizations revenues or financial performance cannot be predicted, and it remains unclear what effect this legislation will have on the Institution. For example, these programs may encourage more physicians to retire, not accept Medicare (or only accept Medicare Advantage). Alternatively, or in addition to other externalities of the implementation of these programs, increased focus and performance scoring on resource use may impact utilization of health care resources by the Institution. Furthermore, implementation of a quality payment system will likely require regular reporting to CMS and greater internal resources to monitor performance and prevent payment reductions.

Medicaid

Medicaid is a health insurance program for certain low-income individuals that is jointly funded by the federal government and the states. Pursuant to broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the payment rates for services; and administers its own programs. For the fiscal year ended December 31, 2019, Medicaid/Medicaid HMO represented approximately 30.9% of the Institution's net patient service revenues. As a consequence, changes in the Medicaid program may have a material adverse effect on the Institution.

Under the Medicaid program, the federal government supplements funds provided by the various states for qualifying medical assistance services. Payment for such medical and health services is made to providers in amounts determined in accordance with procedures and standards established by state law under federal guidelines. Fiscal considerations of both federal and state governments in establishing their budgets will directly affect the funds available to the providers for payment of services rendered to Medicaid beneficiaries.

Payment for Medicaid patients is subject to appropriation by the respective state legislatures of sufficient funds to pay the incurred patient obligations. Many states have experienced significant budget shortfalls in recent years. There can be no assurance that the states from which the Institution receives Medicaid reimbursement will not experience budget short falls in the future, including with respect to their Medicaid programs, or that claims-processing or cost-report settlements will not arise under the programs. As part of their efforts to comply with their balanced budget laws, states have in the past reduced Medicaid reimbursement rates, and there can be no assurance that additional reductions will not be implemented in the future.

The federal government continues to explore options for a long-term solution to the funding difficulties with Medicaid. Certain additional proposals being examined may ultimately result in reduced federal Medicaid funding to the states, which could adversely impact the amount of revenue received by the Institution. Further changes to the ACA or lawsuits seeking to strike down the ACA could result in additional pressure on Medicaid funding, reducing the number of individuals qualifying for treatment as Medicaid patients and resulting in a greater number of uninsured individuals. Management of the Institution cannot predict the effect of these changes to the Medicaid program on the financial condition of the Institution.

As described under the caption "PART 11 – BONDHOLDERS' RISKS – Health Care Reform - Affordable Care Act" above, one component of the ACA is designed to incentivize states to expand their Medicaid programs to individuals earning up to 138% of the federal poverty level by offering additional Medicaid funding to participating states. The State of New York expanded Medicaid programs to cover such individuals.

Medicaid Partnership Plan 1115 Waiver. New York State's program for mandatory Medicaid managed care enrollment, The Partnership Plan (also known as the 1115 Waiver), was approved by CMS in July 1997, allowing the State to begin enrolling most Medicaid recipients in managed care plans. Mandatory Medicaid managed care enrollment programs were instituted throughout New York City, and a significant portion of the Medicaid eligible population has been enrolled in managed care plans. Prior amendments to the Partnership Plan 1115 Waiver further extended the groups eligible and required to enroll in Medicaid managed care, which resulted in an increase in Medicaid managed care admissions. Additionally, following a July 2015 approval of the State's value-based purchasing "roadmap" under the 1115 Waiver's new value-based purchasing requirements, managed care plan incentives for meeting value-based purchasing goals were added in order to encourage the development of integrated delivery systems within the State. Specific expected improvements include: (i) reducing avoidable readmissions; (ii) improving community health by expanding access to preventive and disease management programs; (iii) implementing programs aimed at improving access to preventive services; and (iv) encouraging community involvement to encourage health and wellness. Since 1997, the Partnership Plan 1115 Waiver has been renamed as the Medicaid Redesign Team Waiver, and extended several times, most recently on December 6, 2016, effective through March 31, 2021. NYSDOH has requested a 12-month extension of the current 1115 Waiver. Goals for the 1115 Waiver include (i) improving access to health care for the Medicaid population, (ii) improving the quality of health services delivered and (iii) expanding coverage to additional low income New York State residents with resources generated through Medicaid efficiencies.

New York State Medicaid Redesign. In January 2011, Governor Andrew M. Cuomo issued Executive Order No. 5 creating the Medicaid Redesign Team ("**MRT**") and setting in motion a process of substantial reform of New York's Medicaid program. The MRT, comprised of health care professionals, stakeholders in the industry, and legislators, was charged with reducing Medicaid costs and improving patient care. On February 24, 2011, the MRT issued a report containing findings and recommendations for cost reductions of over $2.3 billion to the Governor for consideration in the budget negotiation process. On February 4, 2020, Governor Cuomo formed the Medicaid Redesign Team II ("**MRT II**"). MRT II was charged with restoring financial sustainability to the Medicaid program and advancing core healthcare strategies with a goal of reducing Medicaid spending by $2.5 billion for New York State's Fiscal Year 2021. On March 19, 2020, MRT II issued a report with proposals to meet those goals. The New York State Enacted Budget for Fiscal Year 2021 included $2.2 billion of the MRT II recommendations.

All New York State Enacted Budgets since 2011-2012 had assumed a targeted growth rate for Medicaid equal to the ten-year average change in the medical component of the Consumer Price Index. If spending in any fiscal year was projected to exceed this budget cap, the NYSDOH and the New York State Division of the Budget were authorized to develop and implement a plan of action to bring spending in line

with the cap, which included modifying or reducing reimbursement methods or program benefits. In Fiscal Year 2019, the NYSDOH deferred more than $1.7 billion of Medicaid payments into Fiscal Year 2020 to avoid exceeding the budget cap, and there was a recognition at that time that additional cost savings measures would be required to control costs. MRT II's recommendations put forth savings for Fiscal Year 2020 and beyond.

The effect of the MRT II recommendations on the Institution depends significantly on the ability to collaborate with different types of providers and relationships with Medicaid managed care plan. The recent New York State Enacted Budget maintained the prior 1% across-the-board ("**ATB**") reductions and added an additional ATB reduction of 0.5% in Fiscal Year 2021 and Fiscal Year 2022. Further, the $2.5 billion MRT II target was established before the recent outbreak of the COVID-19 public health emergency, which will have a significant impact on the New York State health care system. Even with the enacted savings, there can be no assurance that the anticipated Medicaid savings will be achieved or that the rate of annual growth in NYSDOH State Funds Medicaid spending will be limited. In addition, many of the cost-saving initiatives are dependent upon timely federal approvals, appropriate amendments to the existing systems and processes and a collaborative working relationship with health care industry stakeholders.

Inpatient Operating Costs

Under IPPS, acute care hospitals are paid a specified amount towards their operating costs based on the Medicare Severity Diagnosis Related Group ("**MS-DRG**") to which each Medicare inpatient service is assigned, which is determined by the diagnoses, procedures, and other factors for each particular inpatient stay. The amount paid for each MS-DRG is established prospectively by CMS as a part of Institution's PPS, and such amount is not related to a hospital's actual costs. For each MS-DRG, CMS assigns a weighting factor that reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups. Each MS-DRG weight represents the average resources required to care for cases in that particular MS-DRG, relative to average resources to treat cases in all DRGs. CMS is required to adjust, or recalibrate, on a budget-neutral basis, the MS-DRG weights annually to reflect changes in treatment patterns, new technologies and other factors affecting the use of hospital resources.

To calculate the payment for a particular discharge, the MS-DRG weight is multiplied by a "standardized amount" that reflects the operating and labor costs particular to the geographic region where the Institution is located. The standardized amounts are adjusted annually based upon an annual update factor. The annual update factor is based on a hospital "market basket" index, or the percentage by which the cost of the mix of goods and services for the cost reporting period at issue will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period. Congress can apply (and has done so) a statutory adjustment to the market basket index for any given year. For every year since 1983, Congress has modified the increases and given substantially less than the increase in the market basket index.

The ACA provides for additional reductions to the market basket update, as well as other payment adjustments, in future years. See "Health Care Reform- Affordable Care Act - Market Basket Reductions." There is, therefore, no assurance that future updates in MS-DRG payments will keep pace with the increases in providing inpatient hospital services. Additional payments are available, where applicable, for the direct and indirect costs of medical education, for hospitals serving a disproportionate share of patients subsidized by federal funds and for certain atypical or "outlier" cases. With the exception of outlier cases, PPS payments are not adjusted for actual costs or variations in service or length of stay. The PPS amount and adjustments described above are calculated using formulae established by CMS that are revised periodically pursuant to federal budgetary policy. There is no assurance that the Institution will be paid amounts that

adequately reflect the actual cost of providing health care or the cost of the health care technologies available to patients.

Effective October 1, 2013, CMS adopted a policy known as the Inpatient Hospital Prepayment Review "Probe & Educate" review process or the "Two-Midnight" rule. The "Two-Midnight" rule specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. With some exceptions, stays not expected to extend past two midnights should not be admitted and instead should be billed as outpatient. Enforcement of the "Two-Midnight" rule was ultimately delayed until the end of 2015. Effective October 1, 2015, responsibility for initial review of inpatient admissions shifted from Medicare Administrative Contractors to quality improvement organizations ("**QIO**"), and recovery audit contractors will only conduct reviews for providers that have been referred by the related QIO. The Outpatient PPS Final Rule, issued in November 2015 and effective January 1, 2016, revised the Two-Midnight Rule to allow an exception for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark if documentation in the medical records supports that the patient required inpatient care. CMS has announced that it will not continue to impose an inpatient payment cut to hospitals under the "Two-Midnight" rule starting in 2017 following ongoing industry criticism and a legal challenge. In the 2017 Medicare IPPS final rule released on August 2, 2016, CMS permanently removed the inpatient payment cuts under the "Two-Midnight" rule for fiscal year 2017 and onward and provided a temporary increase of approximately 0.8% payment in fiscal year 2017 to help offset the fiscal year 2014-2016 cuts under the "Two-Midnight" rule.

Outpatient Services

Under Section 1833(t) of the Social Security Act, hospital outpatient services, including hospital operating and capital costs, are paid on a prospective basis under a methodology known as the outpatient prospective payment system ("**OPPS**"). Certain hospital supplier services, however, including certain physician and non-physician practitioner services, ambulance, physical and occupational therapy, and speech pathology services are reimbursed pursuant to fee schedules rather than pursuant to the hospital OPPS. Under hospital OPPS, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. CMS classifies outpatient services and procedures, which are comparable clinically and in terms of resource use, into ambulatory payment classification ("**APC**") groups. Using hospital outpatient claims data from the most recent available hospital cost reports, CMS determines the geometric mean cost of services and procedures in each APC group. Payment is made on the basis of the APC group rather than on the cost of the individual service. The actual cost of care, including capital costs, may be more or less than the reimbursements. Generally, Medicare payment rates to hospitals for outpatient hospital services are adjusted annually based on estimated cost increases and other factors, including productivity and budget neutrality adjustments. These adjustments are typically positive, and often range from 0.5% to 2.5%. However, occasionally, because of statutory formulas and other legislative and administrative actions, these adjustments can be negative, and Medicare payments to hospitals can be reduced as a result. Moreover, Congress often takes action to specify payment update reductions, which can have the effect of constraining or reducing hospital payments. There is no guarantee that APC rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

There can be no assurance that the hospital OPPS rate will be sufficient to cover the actual costs of the Institution allocable to Medicare patient care. In addition to the APC rate, there is a predetermined beneficiary coinsurance amount for each APC group; with the exception of Medicare-covered preventive services. There can be no assurance that the beneficiary will pay this amount.

State Children's Health Insurance Program

The State Children's Health Insurance Program ("**SCHIP**") provides federal matching funds to states that cover 65% to 84% of the costs of health care coverage, primarily for low-income children. CMS administers SCHIP, but each state creates its own program based on minimum federal guidelines, or the state may apply for a waiver, which allows the state to create its own program using the federal funds, but often with different criteria for eligibility. New York's SCHIP program, known by its marketing name Child Health Plus, was created by the New York Legislature in 1990.

While generally considered to be beneficial for both patients and providers because it reduces the number of uninsured children, it is difficult to assess the fiscal impact of SCHIP payments on the Institution. Moreover, each state must periodically submit its SCHIP plan to CMS for review to determine if it meets the federal requirements. If a state does not meet the federal requirements, it may lose its federal funding for its program. From time to time Congress and/or the President seek to expand or contract SCHIP. Federal funding for SCHIP expired on September 30, 2017, and SCHIP was reauthorized in 2018 for another six years after much debate. The loss of federal approval for a state's SCHIP program or a reduction in the amounts available under SCHIP could have an adverse impact on the financial condition of the Institution.

Third-Party Payors

Many commercial insurance plans, including private health plans, private insurers, HMOs, PPOs and other managed care payors reimburse their customers or make direct payments to the Institution for charges at established rates. Certain of these third-party payors make payments that may be less than the direct charges of the Institution or the actual costs incurred in providing services. The Institution's financial performance, to some extent, is dependent on its ability to enter into new, and maintain existing, third-party payor agreements on advantageous terms. If payments by this or other third-party payors are inadequate to cover the Institution's actual costs for service, are delayed or affected by the financial health of the third-party payors or if the Institution is unable to obtain or retain these or other contracts on advantageous terms, the finances of the Institution could be adversely affected.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. The hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the hospital's actual cost of care, or if utilization by such enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly. In addition to this standard managed care risk sharing approach, private health insurance companies are increasingly adopting various additional risk sharing/cost containing measures, sometimes similar to those introduced by government payors. Providers may expect health care cost containment and its associated risk sharing to continue to increase in the coming years amongst all payors.

Often, HMO contracts are enforceable for a stated term, regardless of losses by the health care organization, and may require health care organizations to care for enrollees for a certain time period, regardless of whether the HMO is able to pay the health care organization. As with other large health care systems, the Institution from time to time has disputes with HMOs, PPOs and other managed care payors concerning payment and contract interpretation issues. Such disputes may result in mediation, arbitration or litigation, which could adversely affect the financial condition of the Institution.

Failure to maintain contracts could have the effect of reducing a health care organization's market share and net patient service revenues. Conversely, participation may result in lower net income if participating organizations are unable to adequately contain their costs. In part to reduce costs, health plans

are increasingly implementing, and offering to purchasing employers, tiered provider networks, which involve classification of a plan's network providers into different tiers based on care quality and cost. With tiered benefit designs, plan enrollees are generally encouraged, through incentives or reductions in copayments or deductibles, to seek care from providers in the top tier. Classification of a provider in a non-preferred or lower tier by a significant payor may result in a material loss of volume. The new demands of dominant health plans and other shifts in the managed care industry may also reduce patient volume and revenue. Thus, managed care poses a significant business risk for the Institution.

The ACA imposes over time increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the ACA imposes many new obligations on states related to health care insurance. Additionally, states are also increasingly seeking to regulate the delivery of health care services, including in the managed care industry. The effects of these changes could have a negative effect on the financial condition of any third-party payor that offers health care insurance, which could, in turn, lead to reduced rates paid by third-party payors to providers such as the Institution.

Managed Care and Other Private Initiatives

Currently, the term "managed care" refers to all commercial relationships between payors and providers. The term covers the negotiated arrangement for prices and payment terms that a health care provider will accept from a payor on behalf of a covered individual. All prices and terms are carefully articulated in contracts between providers and payors. Prices and terms differ for each hospital and for each payor and, usually, for each product sold by each payor. For example, a payor may sell HMO, PPO, Medicare, and Medicaid products to various populations. That payor will then have a unique price established with each individual hospital for every covered service offered for each product sold.

Typical payment methodologies that have been established include severity-adjusted case neutral rates; per diem rates for stays in a Medical/Surgical Unit, Intensive Care Unit, and Cardiac Care Unit; case rates for obstetric deliveries, open heart surgeries and other tertiary level services; discounts from full charges; and set fees for outpatient services. Management believes the Institution, on a yearly contracting basis, has developed equitable pricing arrangements with most of the payors with which it contracts. As part of these negotiated contracts, the Institution has developed payment terms limiting the extent to which a payor may retroactively deny payments for services, which has been a common practice among managed care companies. The contracts also define requirements for insurers/managed care payors to conduct concurrent and prospective reviews However, these contracts have finite terms and are subject to renegotiation, and managed care payors are expected to continue to seek ways to reduce the utilization and costs of health care services. Payment methodologies include per diem rates, per discharge rates, discounts from established charges, fee schedules and capitation payments. Enrollment in managed care programs has increased, and managed care programs are expected to have a greater influence on the manner in which health care services are delivered and paid for in the future. In addition, some managed care organizations have been delaying reimbursements to hospitals, thereby affecting cash flows. The Institution's financial condition may be adversely affected by these trends.

Competition

Payments to the health care industry have undergone rapid and fundamental change, triggered in part by the deregulation of the acute care hospital reimbursement system and the requirement to negotiate all nongovernment contracts and prices. This may further increase competitive pressures on acute care hospitals and other health care providers, including the Institution. The Institution faces and will continue

to face competition from other hospitals, integrated delivery systems and ambulatory care providers that offer similar health care services.

There are many limitations on the ability of a hospital to increase volume and control costs, and there can be no assurance that volume increases, or expense reductions, needed to maintain the financial stability of the Institution will occur.

Management believes that insurers will encourage competition among health care providers on the basis of price, payment terms and quality. Payors have used the threat of patient steerage, restrictive physician contracting, carve outs, and network exclusion to drive provider prices lower. This may lead to increased competition among health care providers based on price where insurance companies attempt to steer patients to the providers that have the most favorable contracts.

Workforce Shortages

Workforce shortages are affecting health care organizations at the local, regional, and national level. There can be no assurance that such workforce shortages will not continue or increase over time and adversely affect the Institution's ability to control costs and its financial performance.

In order to recruit and retain professional and nursing staff to strengthen clinical services, the Institution has offered, and in the future intends to offer, competitive salaries to both newly recruited individuals and existing staff. In some years such salaries have increased, and in the future may continue to increase, more than the rate of inflation. Such increases in the future may exceed increases in the Institution's rates of payment.

Labor Relations and Collective Bargaining

Hospitals and other health care providers often are large employers with a wide diversity of employees. Increasingly, employees of hospitals and other providers are becoming unionized, and many hospitals and other providers have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to the Institution. See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Collective Bargaining Agreements/Employee Relations."

In addition, employee strikes, or other adverse labor actions, may have an adverse impact on the Institution.

Multiemployer Pension Plans

Certain Institution employees are covered by defined benefit multiemployer pension plans (each, a "**Plan**") to which the Institution makes contributions pursuant to collective bargaining agreements. Each Plan covers employees of multiple unrelated employers, and employers do not typically have access to complete and current information concerning the funding status of a Plan. Plans carry with them the risk that benefit liabilities associated with one participating employer may, over time, be shouldered by other participating employers through increased contributions payable by them, for example where a participating employer is unable to make its required contributions (e.g., due to bankruptcy). Further, under pension regulations, all members of a "controlled group," including such a participating employer, determined under Internal Revenue Service rules, generally are jointly and severally liable together with such participating employer to make contributions to the Plan.

Entities that participate in a Plan, including the Institution, are subject to various risks, including but not limited to lack of transparency concerning the full extent of the funding status of the Plan; lack of transparency concerning creditworthiness of other employers participating in the Plan (and attendant risk liability for shortfalls in funding by such other employers); unpredictable spikes in pension cost upon renewal of collective bargaining agreements due to underfunding of the Plan resulting from failure by other employers to contribute to the Plan as required or other causes such as adverse investment results with respect to Plan assets or increases in Plan liabilities due to benefit increases or changes in actuarial assumptions; withdrawal liabilities as described above; and other factors which may be outside the knowledge or control of the Institution.

Under current generally accepted accounting principles, the extent of any funding shortfall in a Plan is not recorded as a liability of a participating employer on its financial statements, although the amount of such funding shortfall which may be allocated to such participating employer may be material.

Changes in generally accepted accounting principles that took effect for the Institution's fiscal year ended December 31, 2011, require that an employer's financial statements reflect certain additional information concerning the extent of its participation in a Plan, the most recent certified funding "zone" status of the Plan, and certain other information, not including the dollar amount of any current underfunding of such Plan (which, as noted above, is not generally known by the employers on a current basis). See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER– Pension Plans and Post-Retirement Health Care Benefits"

Risks Related to Construction of the Project

The Project is subject to the risk of delays due to a variety of factors including, among others, mandatory stay-at-home orders issued in relation to a pandemic or other natural or man-made emergency, delays in obtaining the necessary permits, licenses and other governmental approvals, site difficulties, labor disputes, delays in delivery and shortage of materials, weather conditions, fire and other casualties and default by the Institution, contractors or subcontractors. If completion of the Project is delayed beyond the estimated construction period, receipt of revenues projected from the operations of the Project will be delayed and the ability of the Institution to make required payments may be adversely affected. Such a delay could adversely affect the ability of the Institution to meet the debt service payments on the Series 2020 Bonds and the operating expenses of the Institution.

Management of the Institution believes that the proceeds of the Series 2020 Bonds, together with other funds of the Institution, will be sufficient to finance the costs of the Project. The cost of the Project may be increased, however, if there are change orders. Further, the cost of construction of the Project may be affected by other factors beyond the control of the Institution, including, but not limited to, labor disputes, delays in delivery and shortage of materials, site difficulties, adverse weather conditions, contractor defaults, fire and casualty and unknown contingencies.

See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Introduction – General" with respect to the impact of the COVID-19 crisis on the Institution."

Regulatory Environment

"Fraud" and "False Claims"

Health care "fraud and abuse" laws have been enacted at the federal and state levels to broadly regulate the provision of services to government program beneficiaries and the methods and requirements

for submitting claims for services rendered to the beneficiaries. Under these laws, hospitals and others can be penalized for a wide variety of conduct, including submitting claims for services that are not provided, billing in a manner that does not comply with government requirements or including inaccurate or misleading billing information, billing for services deemed to be medically unnecessary, or billings accompanied by an illegal inducement to utilize or refrain from utilizing a service or product.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud, including the exclusion of a hospital from participation in the Medicare/Medicaid programs, civil monetary penalties, and suspension of Medicare/Medicaid payments. Fraud and abuse cases may be prosecuted by one or more government entities and/or private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation. The ACA also significantly increased funding for enforcement efforts under fraud and abuse laws.

Laws governing fraud and abuse may apply to a hospital and to nearly all individuals and entities with which a hospital does business. Fraud investigations, settlements, prosecutions, and related publicity can have a catastrophic effect on hospitals. See "Enforcement Activity," below. Major elements of these often highly technical laws and regulations are generally summarized below. Violations and alleged violations may be deliberate, but also can occur in circumstances where management is unaware of the conduct in question, as a result of mistake, or where the individual participants do not know that their conduct is in violation of law. Violations may occur and be prosecuted in circumstances that do not have the traditional elements of fraud, and enforcement actions may extend to conduct that occurred in the past. The government periodically conducts widespread investigations covering categories of services or certain accounting or billing practices.

Federal and New York State Anti-kickback Laws

The Federal Anti-kickback Statute (the "**Federal AKS**") is a criminal statute that prohibits the knowing and willful offering, paying, soliciting or receiving of any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind, in return for or to induce business that may be paid for, in whole or in part, by a Federal health care program.

For purposes of the Federal AKS, a "Federal health care program" is generally defined to include any plan or program that provides health benefits (whether directly, through insurance or otherwise), which is funded directly, in whole or in part, by the United States Government. The definition also includes certain State health care programs. Examples of "Federal health care programs" include, but are not limited to, Medicare, Medicaid, Veterans' programs and State Children's Health Insurance programs.

Violation of the Federal AKS is a felony criminal offense subject to imprisonment for up to ten years and/or a fine of up to $100,000. In addition, under its civil monetary penalties authorities (see below, "Federal Civil Monetary Penalties Law"), the Office of Inspector General of the United States Department of Health and Human Services (the "**OIG**") may impose a civil monetary penalty of up to $100,000, an assessment of up to three times the total remuneration offered, paid, solicited or received and exclusion from participation in Federal health care programs for conduct that it determines has violated the Federal AKS. Claims submitted to a Federal health care program that include items or services resulting from a violation of the Federal AKS may also be considered to be false or fraudulent claims for purposes of the false claims act laws (see below, "Federal and New York State False Claims Acts").

The scope of the Federal AKS is broad and includes many economic arrangements and payment practices in which hospitals, physicians and other health care providers may be involved, including but not limited to, joint ventures, certain investment interests, space and equipment rentals, personal services and

management contracts, sales of a practice, employment relationships and others. Given the expansive nature of the Federal AKS, the law includes certain exceptions. In addition, the OIG has promulgated a series of regulations, known as "safe harbors," that set out certain payment practices that are deemed to not be violations of the Federal AKS. To qualify for "safe harbor" protection, however, an arrangement must squarely meet all of the conditions of the applicable safe harbor(s). If an arrangement does not fit within a safe harbor, however, it does not mean that the arrangement is illegal *per se* violating the Federal AKS.

The Federal AKS has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals, even if there are other, wholly legitimate, business purposes for the arrangement. In assessing a potential Federal AKS violation, government agencies may also consider other facts and circumstances, including but not limited to, whether the proposed transaction would result in: (a) a distortion in medical decision-making; (b) overutilization of Federal health care program items or services; (c) increased Federal health care program costs; and/or (d) unfair competition.

New York State also makes it a crime for a Medicaid provider to offer, agree to give or give, or to solicit, receive, accept or agree to receive or accept, any payment or other consideration in any form to or from another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under the Medicaid program, or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid program. Those who violate this State law may be found guilty of a misdemeanor crime punishable by a fine of up to $10,000 (or up to double the amount of the violator's gain) and/or imprisonment for up to one year. If, however, the violation results in the Medicaid provider obtaining money or property having a value in excess of $7,500, the crime rises to a class E felony, meaning that the duration of the potential imprisonment increases. Other consequences may also result from a violation of the State law (see below, "Federal and New York State False Claims Acts," "Federal Civil Monetary Penalties Law" and "Exclusions from Federal Health Care Program Participation"). However, if an activity meets a Federal exception or "safe harbor" under the Federal AKS, the activity will also be deemed to have not violated the New York State law.

The outcome of any government effort to enforce the Federal and/or New York State anti-kickback laws is difficult to predict due, in part, to government discretion in pursuing enforcement. An anti-kickback law investigation, action or proceeding may have a material adverse impact on a provider's financial condition.

Federal and State False Claims Acts

The Federal criminal False Claims Act makes it illegal to knowingly make or present a false, fictitious or fraudulent claim to the United States, including any of its departments or agencies. Violation of the Federal criminal FCA may result in fines and imprisonment of up to five years.

The Federal civil False Claims Act (the "**Federal Civil FCA**") is often used by the government to combat health care fraud and abuse. In general terms, it is aimed at protecting the United States Government from being defrauded. To that end, the Federal Civil FCA covers a wide variety of conduct, including conduct involving Medicare, Medicaid, and other Federal program funds. For example, the Federal FCA may be violated by any person who: (i) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (ii) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (iii) conspires to commit the above (or other specified) violations; or (iv) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the United States Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the United States Government.

Under the Federal Civil FCA statute, a person found to have violated the law may be held liable for a per claim civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the United States Government. These statutory penalties are subject to periodic adjustments for inflation and recently have been increased, respectively, to not less than $11,665 and not more than $23,331 effective January 13, 2020. In addition, a civil monetary penalty, assessment and exclusion from participation in Federal health care programs are also possible under the OIG's civil monetary penalties authorities, if the OIG has determined that certain violations have occurred (see below, "Federal Civil Monetary Penalties Law").

The State also has a false claims act (the "**New York State FCA**"). The New York State FCA is very similar to the Federal Civil FCA. Generally, it is aimed at protecting the State and local governments from being defrauded (including, but not limited to, as to Medicaid funds). Among other things, the New York State FCA imposes penalties and damages on individuals and entities that: (i) knowingly present, or cause to be presented, false or fraudulent claims for payment or approval; (ii) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim, (iii) conspire to commit the above (or other specified) violations; or (iv) knowingly conceal or knowingly and improperly avoid or decrease and obligation to pay or transmit money or property to the state or a local government, or conspire to do the same. Similar to the Federal Civil FCA, violations of the New York State FCA are subject to three times the amount of all damages that the state or local government sustains, plus per claim penalties that are equal in amount to the penalties under the Federal Civil FCA, as adjusted for inflation.

Both the Federal Civil FCA and New York State FCA permit individuals to initiate civil actions on behalf of the government in lawsuits known as "*qui tam*" actions. *Qui tam* plaintiffs, also known as "relators" or "whistleblowers," may share in the damages recovered by the government or that are recovered independently, if the government does not participate, or "intervene," in the case.

Among other things, health care providers may be liable under the Federal Civil FCA and the New York State FCA if they engage in any of the conduct described above. This includes, for example, instances where a provider fails to report and return an overpayment within the time period allowed under applicable law for doing so. Federal Civil FCA and New York State FCA violations also have been alleged based on the existence of purportedly impermissible kickback or self-referral arrangements or on a theory that providers are liable for the submission of false claims when they are not in full compliance with applicable legal and regulatory standards.

Federal Civil FCA and/or New York State FCA violations, investigations, actions or proceedings may lead to settlements (including the possible imposition of a corporate integrity agreement), assessments of significant damages, fines and penalties, exclusion from participation in Federal health care programs and/or reputational damage that, individually or collectively, may have a material adverse impact on the provider and, potentially, its affiliates.

Limitations on Certain Arrangements Imposed by Federal and State Physician Self-Referral Laws

The Federal Physician Self-Referral Law, commonly known as the "Stark" law, prohibits a physician from referring patients to receive certain designated health services ("**DHS**") that are payable by Medicare (and possibly Medicaid) to an entity with which the physician (or an immediate family member of the physician) has a direct or indirect financial relationship, unless a specific exception to the law is met. The Stark law also prohibits the entity receiving the referral for DHS from presenting or causing to be presented a claim or bill to Medicare (or from billing another individual, entity or third-party payor) for DHS that are furnished pursuant to a prohibited referral.

Under the Stark law, financial relationships include a direct or indirect ownership or investment interest (whether by equity, debt or other means) and direct or indirect compensation arrangements.

The DHS subject to the Stark law are: clinical laboratory services; physical therapy services; occupational therapy services; outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Under the Stark law, "immediate family member" is defined to include a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

The Stark law contains several statutory and regulatory exceptions that are similar, but not identical, to the "safe harbor" regulations under the Federal AKS. Unlike the Federal AKS, however, if a financial relationship between a physician (or immediate family member) and the entity receiving DHS referrals does not meet all the requirements of the applicable exception(s), the Stark law will have been violated, regardless of the intent of the parties. In other words, unlike the Federal AKS, the Stark law is a "strict liability" law.

Under the Stark statute, a violation of the Stark law will result in denial of payments for DHS provided in violation of the law, and the obligation to timely refund any amounts collected for such DHS. In addition, violations of the Stark law may result in civil monetary penalties for each service billed. Under the OIG's civil monetary penalties authorities (see below, "Federal Civil Monetary Penalties Law"). In January 2020, HHS updated the penalties assessed for violations of the Stark statute to be up to $25,372 for each claim that is submitted or caused to be submitted in violation of the Stark law. If a physician or other entity enters into an arrangement or scheme (such as a cross-referral scheme) to circumvent the Stark law – that is, if the physician or entity knows or should know the arrangement or scheme has the principal purpose of assuring physician referrals to a particular entity which if the physician made directly would violate the Stark law – a civil monetary penalty of up to $169,153 for each such arrangement or scheme may be imposed. Further, a Stark law violation may lead to exclusion from Federal health care programs.

New York State has its own statute and regulations that prohibit certain self-referrals. Under the "New York Health Care Practitioner Referrals" law (the "**State Stark**" law), a practitioner (i.e., a licensed or registered physician, dentist, podiatrist, chiropractor, nurse, midwife, physician assistant or specialist assistant, physical therapist or optometrist) may not make a referral to a health care provider (as defined under the law) for clinical laboratory services, pharmacy services, radiation therapy services, x-ray or imaging services or physical therapy services if the practitioner or an immediate family member has a financial relationship (including an ownership interest, an investment interest or a compensation arrangement) with that provider, unless a statutory or regulatory exception is met (and again, there are a number of varied exceptions that exist). "Immediate family member" under the State Stark law includes a spouse; birth and adoptive parents, children and siblings; stepparents, stepchildren and stepsiblings; fathers-in-law, mothers-in-law, brothers-in-law, sisters-in-law, sons-in-law and daughters-in-law; and grandparents and grandchildren.

As with the Federal Stark Law, if the State Stark law is implicated, all applicable exception(s) must be met, or the law will have been violated. In other words, as with the Federal Stark law, the intent of the parties is irrelevant under the State Stark law. Unlike its Federal counterpart, the State Stark law covers all payors. If the referral is prohibited, so too is any demand for payment. The State Stark law also prohibits

any cross-referral scheme designed to make referrals indirectly that could not be made directly. A provider or practitioner that collects any amount under a prohibited referral is jointly and severally liable to the payor. In addition, disciplinary action (including license revocation) by the appropriate State licensing authority may also result from a violation of the law. There is no express penalty stated in the State Stark law statute or regulations. However, New York's Public Health Law Section 12-b authorizes penalties of imprisonment up to one year and/or fines up to $10,000 for willful violations of any provision of the Public Health Law or any lawful regulation thereunder for which there is no otherwise prescribed penalty.

Notably, there are differences between the scope and breadth of the Federal Stark law and the State Stark law, and their respective exceptions. Compliance with one of these laws does not necessarily mean that the arrangement is in compliance with the other.

Enforcement actions or proceedings for violations of the Federal Stark law or the State Stark law could have a material adverse impact on the financial condition of a health care provider, including the Institution.

Health Insurance Portability and Accountability Act

The Federal Health Insurance Portability and Accountability Act of 1996, as amended by Title XIII of the American Recovery & Reinvestment Act of 2009, known as the Health Information Technology and Economic and Clinical Health Act (collectively, "**HIPAA**"), provides data privacy and security protections for individually identifiable health information held by covered entities (health plans, health care clearinghouses and health care providers who conduct the standard health care transactions electronically) and their business associates. Moreover, HIPAA adds additional criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds, or other assets of a health care benefit program. A health care provider convicted of health care fraud could be subject to mandatory exclusion from Medicare.

HIPAA also established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health record technology ("**CEHRT**") by physicians and health care providers. Incentives are paid out according to a schedule set forth in HIPAA, and a particular health care provider's or physician's incentive payments will be determined primarily upon the date such health care provider or physician becomes a "meaningful user" of CEHRT. Health care providers and physicians that fail to become meaningful users of CEHRT systems in accordance with HIPAA's schedule will be subject to a reduction in Medicare payments.

Failure to comply with HIPAA can result in both criminal and civil fines and penalties. Mandatory breach notification and reporting requirements increase the risk of government enforcement as well as class action lawsuits, especially if large numbers of individuals are affected by a breach. Additionally, states may have privacy or consumer protection laws that are broader than HIPAA and, unlike HIPAA, authorize a private right of action. Any sanctions imposed as a result of a HIPAA or state privacy law violation could have a material adverse effect on the Institution's business or financial condition.

HITECH Act

The Health Information Technology for Economic and Clinical Health Act ("**HITECH Act**") increases the maximum civil monetary penalties for violation of HIPAA and grants broad enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable health information and (iv) restricts covered

entities' marketing communications. HHS is also required to establish procedures for individuals harmed by a breach of these privacy provisions to recover a percentage of the monetary penalties or settlement paid by violators (although those rules have yet to be promulgated or go into effect).

The HITECH Act also provides for almost $20 billion in federal incentives for health care providers to adopt electronic health records and health information technology ("**EHR/HIT**") with the goal of improving patient outcomes and efficiency of delivery of medical care. The HITECH Act encourages adoption of EHR/HIT through federal loans and grants to providers to implement adopt "meaningful use" of this technology. Adoption of the software, hardware and infrastructure necessary to comply with these "meaningful use" criteria could represent a significant additional capital expense for health care providers. While the incentive to adopt EHR/HIT is initially provided through additional reimbursement under Medicare and matching funds under Medicaid for qualified entities that comply with the "meaningful use" adoption criterion, beginning in 2015 Medicare payments are set to begin to be reduced for entities and individuals that fail to adopt these systems.

The HITECH Act revises the civil monetary penalties associated with violations of HIPAA as well as provides state attorneys general with authority to enforce the HIPAA privacy and security regulations in some cases through a damage's assessment of $100 per violation or an injunction against the violator. The revised civil monetary penalty provisions establish a tiered system, ranging from a minimum of $100 per violation for an unknowing violation to $1,000 per violation for a violation due to reasonable cause, but not willful neglect. For a violation due to willful neglect, the penalty is a minimum of $10,000 or $50,000 per violation, depending on whether the violation was corrected within 30 days of the date the violator knew or should have known of the violation. Maximum penalties may reach $1,500,000 for identical violations. The penalty amounts are adjusted upwards for inflation.

Criminal penalties will be enforced against persons who knowingly obtain or disclose personal health information in violation of HIPAA. The Office for Civil Rights ("**OCR**"), the administrative office that is tasked with enforcing HIPAA, performs periodic audits of health care providers, group health plans, and their business associates to ensure that required policies under HIPAA (as amended by the HITECH Act) are in place. Finally, as noted above, OCR is working to establish a methodology under which an individual who is harmed by an offense punishable under HIPAA may be able to recover a percentage of the civil monetary penalty or monetary settlement collected with respect to the offense. These enforcement actions may significantly increase the number of HIPAA-related complaints from individuals, as well as increase penalty and settlement amounts.

OCR has stated that it has now moved from education to enforcement in its implementation of the law. Recent settlements of HIPAA violations for breaches involving lost data have reached the millions of dollars. Any breach of HIPAA, regardless of intent or scope, may result in costs, penalties, or settlement amounts that are material to a covered health care provider or health plan.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments to certain eligible hospitals and health care professionals ("**Eligible Providers**") that demonstrate the "meaningful use" of CEHRT. Eligible Providers demonstrate meaningful use of CEHRT by meeting and attesting to meaningful use objectives and associated measures specified by CMS for using CEHRT and by reporting on certain quality measures. Incentive payments under the Medicare program ended in 2016. Pursuant to the HITECH Act, and commencing in 2015, Eligible Providers who have not satisfied the performance and reporting criteria for demonstrating meaningful use in the applicable meaningful use reporting year will have their Medicare payments reduced. The payment reduction starts at 1% and increases each year that an eligible hospital or professional does not demonstrate meaningful use, up to a maximum 5% reduction. CMS has engaged a contractor that conducts pre-payment and post-payment audits of certain selected Eligible Providers that have submitted meaningful use attestations. An Eligible

Provider that fails the audit will have an opportunity to appeal. Ultimately, Eligible Providers that elect not to appeal or fail on appeal will have to repay any incentive payments that they received through these programs or refund Medicare reimbursement that would have been reduced as part of the payment reductions.

Moreover, MACRA ended the payment reductions for physicians who fail to demonstrate meaningful use after 2018. However, beginning in 2019, use of CEHRT has become a performance category under MACRA's MIPS for certain physicians and other health care professionals who do not meet MACRA's thresholds for participation in certain alternative payment models designated by Medicare. A physician's failure to use CEHRT consistent with MIPS' requirements lowers the physician's performance score under MIPS and could result in reduced Medicare reimbursement for professional services performed by the physician. CMS has issued a final rule to implement MIPS with numerous, complex requirements. The need to implement technology, operational and other changes to address MIPS requirements for use of CEHRT may have a material adverse impact on the Institution. Generally, MACRA did not change hospital participation in the Medicare EHR Incentive Program or participation for physicians in the Medicaid EHR incentive program.

State and local authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a health care provider's reputation and materially adversely affect business operations.

An EHR/HIT is a digital version of a paper chart that contains all of a patient's medical history from a single practice. While EHR/HIT systems are designed to provide a variety of benefits such as the ability to easily track data over time, identify patients who are due for preventive visits and screenings and improve the overall quality of care delivered by health professionals, the use of EHR/HIT systems has given rise to a number of risk management and patient safety issues including, but not limited to, inappropriate access, ransomware attacks, record tampering, inaccurate patient information, loss due to natural catastrophes, unavailability of data due to technical problems, and potential malpractice liability. Providers implementing EHR/HIT systems have experienced adverse financial results during the conversion and implementation process due to additional operating expenses, staff time committed to the process, and delays in billings. These aforementioned risks related to EHR/HIT systems may adversely affect the operations of the Institution in an amount and for a period of time that cannot be determined at this time.

Regulation of Patient Transfers

Federal and New York laws require hospitals to provide emergency treatment to all persons presenting themselves with emergency medical conditions. Congress enacted the Emergency Medical Treatment and Active Labor Act ("**EMTALA**") in response to concerns regarding inappropriate hospital transfers of emergency patients based on the patient's inability to pay for the services provided. EMTALA requires hospitals with emergency rooms, including the Institution, to treat or conduct an appropriate and uniform medical screening for emergency conditions (including active labor) on all patients and to stabilize

a patient's emergency medical condition before releasing, discharging or transferring the patient to another hospital.

Failure to comply with EMTALA can result in exclusion from the Medicare and/or Medicaid programs as well as civil penalties that may exceed $100,000 per violation. In addition, the hospital is liable for any claim by an individual who has suffered harm as a result of such violation.

Federal Civil Monetary Penalties Law

The Federal Civil Monetary Penalty Law (the "**CMPL**") is another "fraud and abuse" law that addresses a broad range of health care related conduct with which health care providers must be concerned. Violation of the CMPL may lead to the imposition of substantial civil monetary penalties, assessments or damages and/or exclusion from Federal health care programs.

Among other things, the CMPL prohibits any person (including an entity) from knowingly presenting or causing to be presented to the United States (or any of its departments or agencies) a claim: (i) for a medical or other item or service that the person knows or should know was not provided as claimed, including engaging in a pattern or practice of submitting "upcoded" claims (i.e., using codes that will result in a higher payment than the code that is applicable to the item or service actually provided); (ii) for medical or other items or services when the person knows or should know the claim is false or fraudulent; (iii) for a medical or other item or service furnished during a period when the person was excluded from participating in the Federal health care program under which the claim was made; (iv) for a physician's service (or services incident to a physician's service) when the person presenting the claim knows or should know that the individual who furnished (or supervised the furnishing of) the service was not licensed as a physician; and (v) for a pattern of medical or other items or services that the person knows or should know are not medically necessary.

Other examples of conduct proscribed by the CMPL include, but are not limited to, prohibitions against any person (including an entity): (i) offering or transferring remuneration to an individual who is eligible for Medicare or certain defined State health care program benefits under circumstances where the person knows or should know that to do so is likely to influence the individual to order or receive items or services from a particular provider, practitioner or supplier that are payable under Medicare or a State health care program (i.e., "beneficiary inducements"); (ii) arranging or contracting (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program; (iii) engaging in kickbacks in violation of the Federal AKS; (iv) knowingly making or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program; and (v) knowing of an overpayment and failing to report and return it in accordance with applicable law.

The imposition of civil money penalties, assessments or damages on a health care provider for violation of the CMPL will vary depending on, among other things, the nature of the conduct, may be substantial and could have a material adverse impact on the provider's financial condition.

Exclusions from Federal Health Care Program Participation

The OIG has authority to exclude individuals and entities from Federal health care programs, including but not limited to, Medicare and Medicaid. Some exclusions are mandatory, and some are permissive. Mandatory exclusion is required for: (i) convictions relating to the delivery of an item or service under Medicare or a State health care program (as defined in applicable law); (ii) convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; (iii) felony

convictions relating to other health care-related fraud, theft, or other financial misconduct; and (iv) felony convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

The OIG's permissive exclusion authority is broad and includes, but is not limited to, the discretion to impose an exclusion based on: (i) misdemeanor convictions relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with either the delivery of a health care item or service, or with respect to any act or omission in a health care program (other than Medicare or a State health care program) that is operated by or financed in whole or in part by any Federal, State, or local government agency; (ii) convictions for criminal offenses relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with any act or omission in any program (other than a health care program) that is operated by or financed in whole or in part by any Federal, State, or local government agency; (iii) certain convictions relating to obstruction of an investigation or audit; (iv) misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (v) submitting claims for excessive charges or unnecessary services; (vi) suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; (vii) provision of unnecessary services; (viii) submission of false or fraudulent claims to a Federal health care program; and (ix) engaging in unlawful kickback arrangements.

The New York State Office of the Medicaid Inspector General (the "**OMIG**") also has the authority to exclude individuals and entities from participation in the Medicaid program upon determining that the individual or entity engaged in an "unacceptable practice." Unacceptable practices under the Medicaid program include a wide variety of conduct, including but not limited to, conduct relating to fraud and abuse (e.g., false claims, false statements, kickbacks, etc.), unacceptable recordkeeping, employing persons who are suspended, disqualified or otherwise terminated from participation in the Medicaid program, failure to meet professionally recognized standards of care, and other conduct.

Exclusion from Medicare, Medicaid, or other Federal health care programs may have a material adverse effect on the financial condition of a provider.

Enforcement Activity

Enforcement activity against health care providers has increased in recent years, and enforcement authorities are adopting more aggressive approaches, including conducting data-driven investigations. In the current regulatory climate, it is anticipated that many hospitals and providers will be subject to investigations, audits and/or other inquiries. Such investigations, audits and/or inquiries may address areas such as billing and documentation practices, false claims, referral relationships, compliance obligations and/or adherence to Federal or State health care program standards and requirements.

Due to the complexity of the applicable laws and regulations, the instances in which an alleged violation may arise to trigger such investigations, audits or inquiries are increasing and could result in one or more actions or proceedings against the Institution. Any such actions or proceedings may have a materially adverse effect on the financial condition of the Institution.

Moreover, enforcement authorities are often in a position to compel settlements by providers charged with, or being audited or investigated for, misconduct by withholding or threatening to withhold Federal health care program payments or by threatening the possibility of a civil, administrative or criminal action or proceeding. In addition, the cost of defending any such audit, investigation, action or proceeding, the time and management attention consumed thereby and the facts of a particular case may dictate pursuing a settlement. Regardless of the merits of a particular case or cases, the Institution could experience

materially adverse settlement costs relating to such matters, as well as materially adverse costs associated with the implementation of any related settlement agreement and/or corporate integrity agreement. Further, prolonged and/or publicized audits, investigations, actions or proceedings could be damaging to the reputation, business and credit of the Institution, regardless of the outcome, and could have material adverse consequences on the financial condition of the Institution.

Licensure and Accreditation

The Institution's medical facilities are subject to periodic review by licensing and/or accrediting agencies to determine compliance with various federal, state, and local requirements relating to issues such as personnel, operating policies and procedures, fire prevention, rate-setting, the adequacy of medical care, and compliance with building codes and environmental protection laws. In addition to facility-specific licensure, various licenses and permits also are required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Renewal and continuance of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require or include affirmative action or response by the Institution. Loss of accreditation or licensure could impair the ability of the Institution to operate all or a portion of its health care facilities and have a material adverse impact on the Institution's business or financial condition.

Increased Enforcement Affecting Academic Research

In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also increased enforcement of laws and regulations governing the conduct of clinical trials at hospitals. DIMS elevated and strengthened its Office of Human Research Protection, one of the agencies with responsibility for monitoring federally funded research. In addition, the National Institute of Health ("**NIH**") significantly increased the number of facility inspections that these agencies perform. The United States Food and Drug Administration ("**FDA**") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. Moreover, the OIG, in past "Work Plans" has included several enforcement initiatives related to reimbursement for experimental drugs and devices (including kickback concerns) and has issued compliance program guidance directed at recipients of extramural research awards from the NIH and other agencies of the U.S. Public Health Service. The Institution receives payments for health care items and services under many of these grants and is subject to complex and ambiguous coverage principles and rules governing billing for items or services it provides to patients participating in clinical trials funded by governmental agencies and private sponsors. These agencies' enforcement powers range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs, and errors in the billing of Medicare for care provided to patients enrolled in clinical trials that are not eligible for Medicare reimbursement can subject the Institution to sanctions as well as repayment obligations.

Department of Health Regulations

The Institution is subject to regulations of NYSDOH. Compliance with such regulations may require substantial expenditures for administrative or other costs. The Institution's ability to add services or beds and to modify existing services materially is also subject to NYSDOH review and approval. Approvals can be highly discretionary, may involve substantial delay, and may require substantial changes in the proposed request. Accordingly, the Institution's ability to make changes to its service offerings and respond to changes in the environment may be limited.

New York State Executive Order 38

On January 18, 2012, Governor Andrew Cuomo signed Executive Order 38 (the "**EO 38**") limiting spending by covered providers, such as hospitals, for administrative costs and executive compensation from state funds and state-authorized payments, such as Medicaid payments, (collectively, "**State Funds**") and placed additional limitations on the use of any other sources of funds ("**non-State Funds**") for executive compensation. State agencies, including the NYSDOH, promulgated final regulations implementing EO 38. The final regulations limit the use of State Funds for executive compensation up to $199,000 annually for covered executives and places additional limits on the use of non-State Funds for executive compensation in excess of $199,000 annually for such covered executives. In addition, the final regulations require that at least 85% of State Funds be used for direct care or services, rather than administrative costs. The final regulations became effective July 1, 2013. There have been a number of legal challenges to the validity of the final regulations which provided additional uncertainty. However, on October 18, 2018, the New York Court of Appeals, in *Matter of Leading Age New York, Inc. et al v. Shah*, 2018 WL 5046104 (NY, 2018), affirmed an Appellate Division decision, and upheld the validity of the final regulations in connection with executive compensation which limited the use of State Funds and invalidated the final regulations regarding the use of non-State Funds**.**

Other Governmental Regulation

The Institution is subject to regulatory actions and policy changes by those governmental and private agencies that administer the Medicare and Medicaid programs and actions by, among others, the National Labor Relations Board, professional and industrial associations of staff and employees, applicable professional review organizations, The Joint Commission, the Environmental Protection Agency, the Internal Revenue Service ("**IRS**") and other federal, state, and local governmental agencies, and by the various federal, state, and local agencies created by the National Health Planning and Resources Development Act and the Occupational Safety Health Act.

Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require or include affirmative activity or response by the Institution. These activities generally are conducted in the normal course of business of health facilities. Nevertheless, an adverse result could cause a loss or reduction in the Institution's scope of licensure, certification or accreditation, could reduce the payment received or could require repayment of amounts previously remitted to the provider.

OIG and OMIG Compliance Guidelines

On February 23, 1998, OIG published Compliance Program Guidance ("**CPG**") for the hospital industry. In recognition of the significant changes in the delivery and reimbursement for hospital services that have occurred since the CPG's publication, OIG published Supplemental Compliance Program Guidance on January 31, 2005. These issuances (collectively, the "**Guidance**") provide recommendations to hospitals for adopting and implementing effective programs to promote compliance with applicable federal and state law and the program requirements of federal, state, and private health plans, and they include a discussion of significant risk areas for hospitals. Compliance with the Guidance is currently voluntary, but as discussed in "Health Care Reform" above, every hospital is required to establish and maintain a compliance program that meets the Guidance. Regardless, compliance with the Guidance is an important factor in controlling risk because OIG will consider the existence of an effective compliance program that pre-dated any governmental investigation when addressing the appropriateness of administrative penalties. The Institution maintains a corporate compliance program that is designed to assist the Board and staff to meet or exceed applicable standards established by federal and state laws and regulations. However, the existence of a compliance program or compliance therewith does not guarantee

that health care providers, such as the Institution, will not be investigated by one or more federal or state agencies that enforce health care fraud and abuse laws or that they will not be required to make repayments to various health care insurers (including the Medicare and/or Medicaid programs).

Since October 2009, hospitals in New York have been required by statute and regulation to have an effective compliance program that meets applicable statutory regulatory Medicaid program requirements. The compliance program must include, among other things, a chief compliance officer, written policies and the conduct of audits after the identification of risk areas. OMIG may conduct audits of compliance programs and assess their effectiveness. Under New York law, each year the Institution must certify that it has a compliance program in place and that it has been effective, and management of the Institution has advised that it will so certify this year.

Not-for-Profit Status

As a non-profit tax-exempt organization, the Institution is subject to federal, state, and local laws, regulations, rulings and court decisions relating to its organization and operation, including its operation for charitable purposes. At the same time, the Institution conducts large-scale complex business transactions and is a significant employer in its geographic areas. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex health care organization.

Recently, an increasing number of the operations or practices of health care providers have been challenged or questioned to determine if they are consistent with the regulatory requirements for nonprofit tax-exempt organizations. These challenges, in some cases, are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead, in many cases are examinations of core business practices of the health care organizations. Areas that have come under examination have included pricing practices, billing and collection practices, charitable care, executive compensation, exemption of property from real property taxation and others. For example, in August of 2011, the real estate tax exemption of three Illinois-based hospitals was revoked for failing to provide sufficient charity care. These challenges and questions have come from a variety of sources, including state attorneys general, the IRS, labor unions, Congress, state legislatures and patients, and in a variety of forums, including hearings, audits, and litigation.

Tax-Exempt Status of the Series 2020 Bonds

The failure of the Institution to maintain its existence as an organization described in Section 501(c)(3) of the Code or to comply with certain provisions of the Code and the regulations thereunder may cause interest paid or payable on the Series 2020 Bonds to become subject to inclusion in gross income for federal income tax purposes retroactive to the date of issuance of the Series 2020 Bonds, regardless of the date on which such noncompliance or misrepresentation is ascertained. In the event that the interest on the Series 2020 Bonds should become subject to inclusion in gross income for federal income tax purposes, the Resolution does not provide for payment of additional interest on the Series 2020 Bonds, the redemption of the Series 2020 Bonds, or the acceleration of the payment of the principal of the Series 2020 Bonds.

For additional information, see "PART 15 – TAX MATTERS."

Internal Revenue Service Examination of Compensation Practices and Community Benefit

The IRS has been historically concerned about executive compensation practices of tax-exempt hospitals. In 2004, the IRS began a compliance program to measure compliance by tax-exempt organizations with requirements that they not pay excessive compensation and benefits to their officers and

other insiders. In February 2009, the IRS issued its Hospital Compliance Project Final Report (the "**IRS Final Report**") that examined tax-exempt organizations' practices and procedures with regard to compensation and benefits paid to their officers and other defined "insiders." The IRS Final Report indicated that the IRS will continue to heavily scrutinize executive compensation arrangements, practices and procedures of tax-exempt hospitals and other tax-exempt organizations and, in certain circumstances, may conduct further investigations or impose fines on tax-exempt organizations.

The IRS has also undertaken a community benefit initiative directed at hospitals. The IRS Final Report determined that the reporting of community benefit by nonprofit hospitals varied widely, both as to types of programs and expenditures classified as community benefit and the measurement of community benefits. As a result, the Form 990 requires detailed disclosure of compensation practices, corporate governance, loans to management and others, joint ventures and other types of transactions, political campaign activities, and other areas the IRS deems to be a compliance risk. The Form 990 also requires the disclosure of information on community benefit as well as reporting of information related to tax-exempt bonds, including compliance with the arbitrage rules and rules limiting private-use of bond-financed facilities, including compliance with the safe harbor guidance in connection with management contracts and research contracts. The Form 990 is intended to provide enhanced transparency as to the operations of exempt organizations. It is likely that the IRS will use detailed information to assist in its enhanced enforcement efforts.

The ACA also contains new requirements for tax-exempt hospitals. Under the ACA, each tax-exempt hospital facility is required to (i) conduct a community health needs assessment at least every three years and adopt an implementation strategy to meet the identified community needs, (ii) adopt, implement and widely publicize a written financial assistance policy and a policy to provide emergency medical treatment without discrimination, (iii) limit charges to individuals who qualify for financial assistance under such tax-exempt hospital's financial assistance policy to no more than the amounts generally billed to individuals who have insurance covering such care and refrain from using "gross charges" when billing such individuals, and (iv) refrain from taking extraordinary collection actions without first making reasonable efforts to determine whether the individual is eligible for assistance under such tax-exempt hospital's financial assistance policy. In addition, the Treasury Department is required to review information about each tax-exempt hospital's community benefit activities at least once every three years, as well as to submit an annual report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, and costs incurred by tax-exempt hospitals for community benefit activities. The periodic reviews and reports to Congress regarding the community benefits provided by 501(c)(3) hospitals may increase the likelihood that Congress will require such hospitals to provide a minimum level of charity care in order to retain tax-exempt status and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

Internal Revenue Code Limitations

Private Benefit and Excess Benefit Transactions. The Code contains restrictions on the issuance of tax-exempt bonds for the purpose of financing and refinancing different types of health care facilities for not-for-profit organizations, including facilities generating taxable income. Consequently, the Code could adversely affect the Institution's ability to finance its future capital needs and could have other adverse effects on the Institution that cannot be predicted at this time. The Code continues to subject unrelated business income of nonprofit organizations to taxation.

As a tax-exempt organization, the Institution is limited with respect to the use of practice income guarantees, reduced rent on medical office space, below market rate interest loans, joint venture programs, and other means of recruiting and retaining physicians. The IRS has recently intensified its scrutiny of a broad variety of contractual relationships commonly entered into by hospitals and affiliated entities,

including the Institution, and has issued detailed hospital audit guidelines suggesting that field agents scrutinize numerous activities of hospitals in an effort to determine whether any action should be taken with respect to limitations on, or revocation of, their tax-exempt status or assessment of additional tax. The IRS has also commenced intensive audits of select health care providers to determine whether the activities of these providers are consistent with their continued tax-exempt status. The IRS has indicated that, in certain circumstances, violation of the fraud and abuse statutes could constitute grounds for revocation of a hospital's tax-exempt status.

Any suspension, limitation, or revocation of the tax-exempt status of the Institution or assessment of significant tax liability could have a material adverse effect on the Institution and might lead to loss of tax exemption of interest on the Series 2020 Bonds.

Revocation of the tax-exempt status of the Institution under Section 501(c)(3) of the Code could subject the interest paid to Bondholders to federal income tax retroactively to the date of the issuance of the Series 2020 Bonds. Section 501(c)(3) of the Code specifically conditions the continued exemption of all Section 501(c)(3) organizations upon the requirement, among others, that no part of the net earnings of the organization inure to the benefit of any private individual. Any violation of the prohibition against private benefit may cause the organization to lose its tax-exempt status under Section 501(c)(3) of the Code. The IRS has issued guidance in informal private letter rulings and general counsel memoranda on some situations that give rise to private benefit, but there is no definitive body of law and no regulations or public advisory rulings that address many common arrangements between exempt health care providers and nonexempt individuals or entities. There can be no assurance concerning the outcome of an audit or other investigation given the lack of clear authority interpreting the range of activities undertaken by the Institution.

Intermediate sanctions legislation enacted in 1996 imposes penalty excise taxes in cases where an exempt organization is found to have engaged in an "excess benefit transaction" with a "disqualified person." Such penalty excise taxes may be imposed in lieu of revocation of exemption or in addition to such revocation in cases where the magnitude or nature of the excess benefit calls into question whether the organization functions as a public charity. The tax is imposed both on the disqualified person receiving such excess benefit, and on any officer, director, trustee or other person having similar powers or responsibilities who participated in the transaction willfully or without reasonable cause, knowing it will involve "excess benefit." "Excess benefit transactions" include transactions in which a disqualified person receives unreasonable compensation for services or receives other economic benefit from the organization that either exceeds fair market value or, to the extent provided in regulations yet to be promulgated, is determined in whole or in part by the revenues of one or more activities of such organization. "Disqualified persons" include "insiders" such as board members and officers, senior management, and members of the medical staff, who in each case are in a position to substantially influence the affairs of the organization; their family members; and entities which are more than 35% controlled by a disqualified person.

Although the Institution believes that the sanction of revocation of tax-exempt status is likely to be imposed only in cases of pervasive excess benefit, the imposition of penalty excise tax in lieu of revocation, based upon a finding that the Institution engaged in an excess benefit transaction, is likely to result in negative publicity and other consequences that could have a materially adverse effect on the operations, property or assets of the Institution.

Charity Care. Hospitals are permitted to have tax-exempt status under the Code because the provision of health care historically has been treated as a "charitable" enterprise. This treatment arose before most Americans had health insurance, and when charitable donations were required to fund the health care provided to the sick and disabled. Some have posited that, with the onset of employer health insurance and government reimbursement programs, there is no longer any justification for special tax

treatment for the not-for-profit health care sector, and the availability of tax-exempt status should be eliminated. Management of the Institution cannot predict the likelihood for such a dramatic change in the law. Federal and state tax authorities are beginning to demand that tax-exempt hospitals justify their tax-exempt status by documenting their charitable care and other community benefits.

Tax Audits

Taxing authorities historically have conducted tax audits of non-profit organizations to confirm that such organizations are in compliance with applicable tax rules and in some instances have collected significant payments as part of the settlement process. The Institution is currently not under audit.

Antitrust

Enforcement of the antitrust laws against health care providers is becoming more common Antitrust liability may arise in a wide variety of circumstances including medical staff privilege disputes, payor contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, and certain pricing and salary setting activities. Actions can be brought by federal and state enforcement agencies seeking criminal and civil penalties and, in some instances, by private litigants seeking damages for harm arising out of allegedly anti-competitive behavior. Common areas of potential liability include joint action among providers with respect to payor contracting, medical staff credentialing, and issues relating to market share. Liability in any of these or other trade regulation areas may be substantial, depending on the facts and circumstances of each case. With respect to payor contracting, the Institution, from time to time, may be involved in joint contracting activity with hospitals or other providers. The degree to which these or similar joint contracting activities may expose a participant to antitrust risk from governmental or private sources is dependent on a myriad of factors that may change from time to time. If any provider with whom the Institution is or becomes affiliated is determined to have violated the antitrust laws, the Institution may be subject to liability as a joint actor.

Some judicial decisions have permitted physicians who are subject to disciplinary or other adverse actions by a hospital at which they practice, including denial or revocation of medical staff privileges, to seek treble damages from the hospital under the federal antitrust laws. The Federal Health Care Quality Improvement Act of 1986 provides immunity from liability for discipline of physicians by hospitals under certain circumstances, but courts have differed over the nature and scope of this immunity. In addition, hospitals occasionally indemnify medical staff members who incur costs as defendants in lawsuits involving medical staff privilege decisions. Some court decisions have also permitted recovery by competitors claiming harm from a hospital's use of its market power to obtain unfair competitive advantage in expanding into ancillary health care businesses. Antitrust liability in any of these contexts can be substantial, depending upon the facts and circumstances involved. There can be no assurance that a third party reviewing the activities of the Institution would find such activities to be in full compliance with the antitrust laws.

Acceleration

Upon the occurrence of certain events of default under the Resolution or the Loan Agreement, the Series 2020 Bonds may become subject to acceleration. If Bonds are accelerated prior to their stated maturity, the owners of such Bonds will no longer continue to receive interest.

Environmental Matters

Health care providers are subject to a wide variety of federal, state, and local environmental and occupational health and safety laws and regulations. These requirements govern medical and toxic or

hazardous waste management, air and water quality control, notices to employees and the public and training requirements for employees. As owners and operators of properties and facilities, the Institution may be subject to potentially material liability for costs of investigating and remedying the release of any such substances either on, or that have migrated off the property. Typical health care provider operations include, but are not limited to, in various combinations, the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants or contaminants. As such, health care provider operations are particularly susceptible to the practical, financial and legal risks associated with the obligations imposed by applicable environmental laws and regulations. Such risks may result in damage to individuals, property, or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance. There can be no assurance that the Institution will not encounter such risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of the Institution.

Affiliation, Merger, Acquisition, and Divestiture

As part of its ongoing planning and property management functions, the Institution reviews the use, compatibility, and financial viability of many of its operations, and from time to time, may pursue changes in the use, or disposition, of their facilities. Likewise, the Institution may receive offers from, or conduct discussions with, third parties about the potential acquisition of operations or properties that may become part of the Institution in the future, or about the potential sale of some of the operations and properties of the Institution. Discussions with respect to affiliation, merger, acquisition, disposition, or change of use, including those that may affect the Institution, are held on an intermittent, and usually confidential, basis. As a result, it is possible that the assets currently owned by the Institution may change from time to time, subject to the provisions in the financing documents that apply to merger, sale, disposition or purchase of assets. See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Introduction – Major Affiliations."

Insurance

The dollar amounts of patient damage recoveries remain potentially significant. A number of insurance carriers have withdrawn from this segment of the insurance market citing underwriting losses, and premiums have increased sharply in the last several years. The effect of these developments has been to significantly increase the operating costs of hospitals, including the Institution.

The Institution currently carries malpractice, directors', and officers' liability, and general liability insurance, which management of the Institution considers adequate, but no assurance can be given that the Institution will maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover all malpractice judgments rendered against the Institution or settlements of any such claims or that such coverage will be available at a reasonable cost in the future. For a discussion of the insurance coverage of the Institution, see "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Insurance."

Litigation and Claims

The Institution is involved in litigation and claims that are not considered unusual to their business. While the ultimate outcome of these lawsuits cannot be determined at this time, it is the opinion of management that the ultimate resolution of these claims will not have a material adverse effect on the Institution. The Institution, like most other employers in the current economic climate, has experienced a recent increase in the number of employment-related actions. See "APPENDIX A – CERTAIN

INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Compliance – Current Material Pending Audits" and "– Litigation" herein.

Certain Accreditations

The Institution is subject to periodic review by The Joint Commission. The Institution has received accreditation from The Joint Commission. No assurance can be given as to the effect on future operations of existing, or subsequently amended, laws, regulations and standards for certification or accreditation.

In addition, the Institution sponsors programs of graduate medical education ("**GME Programs**"), training residents and fellows, which programs are accredited by the Accreditation Council for Graduate Medical Education ("**ACGME**") (for medical programs) and by the American Dental Association ("**ADA**") (for dental programs). All GME Programs are subject to periodic review by the applicable specialty Residency Review Committee of the ACGME, or by the ADA, as appropriate. No assurance can be given as to (i) the outcome of future reviews of these GME Programs, (ii) such programs' continued accreditation, or (iii) the continuing eligibility of the costs associated therewith for graduate medical education reimbursement. See "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Educational Programs – Medical."

Increased Costs and State-Regulated Reimbursement

In recent years, substantial cutbacks in personnel and other cost-cutting measures have been instituted at hospitals throughout the State. Generally, these cutbacks have been instituted to address the disparity between rising medical costs and State-regulated reimbursement formulas, including those for Medicaid, Blue Cross and Blue Shield, and other third-party payors. Rising health care costs resulted from, among other factors, health care costs exceeding inflation, staff shortages, pharmaceutical costs and the highly technical nature of the industry. The Institution has been affected by the impact of such rising costs.

Secondary Market

There can be no assurance that there will be a secondary market for the purchase or sale of the Series 2020 Bonds. From time to time there may be no market for them depending upon prevailing market conditions, including the financial condition or market position of firms who may make the secondary market, the evaluation of the Institution's capabilities and the financial conditions and results of operations of the Institution.

Enforceability of Lien on Gross Revenues

The Loan Agreement provides that the Institution shall make payments to the Trustee sufficient to pay the Series 2020 Bonds and the interest thereon as the same become due. The obligation of the Institution to make such payments is evidenced by the 2020 Note and secured by the 2020 Mortgage and secured by, among other things, a security interest in the revenues of the Institution. See "PART 3 - The SERIES 2020 BONDS - Security for the Series 2020 Bonds." Revenues paid by the Institution to other parties in the ordinary course might no longer be subject to the lien on the Resolution and might therefore be unavailable to the Authority, as FHA mortgagee.

To the extent that revenues are derived from payments by the federal or state government under the Medicare or Medicaid program, any right of the Authority, as FHA mortgagee, to receive such payments directly may be unenforceable. The Social Security Act and state regulations prohibit anyone other than the individual receiving care or the Institution providing service from collecting Medicare and Medicaid payments directly from the federal or state government. In addition, Medicare and Medicaid receivables

may be subject to provisions of the Assignment of Claims Act of 1940, which restricts the ability of a secured party to collect accounts directly from government agencies. With respect to receivables and revenues not subject to the lien of the 2020 Mortgage, the Authority, as FHA mortgagee, would occupy the position of an unsecured creditor. Counsel to the Institution has not provided an opinion with regard to the enforceability of the lien on revenues of the Institution, where such revenues are derived from the Medicare and Medicaid programs. The Authority, as FHA mortgagee, and HUD will require that revenues derived from Medicare and Medicaid programs be deposited into an account or accounts subject to a sweep instruction that will cause a daily sweep of the funds into an account subject to a control agreement in favor of the Authority, as FHA mortgagee. All other revenues of the Institution required by HUD to be encumbered by the 2020 Mortgage will be subject to a control agreement in favor of the Authority, as FHA mortgagee.

Pursuant to the New York Uniform Commercial Code, a security interest in the proceeds of revenues may not continue to be perfected if such proceeds are not paid over to the Authority, as FHA mortgagee, by the Institution under certain circumstances. If any required payment is not made when due, the Institution must transfer or pay over immediately to the Trustee any revenues with respect to which the security interest remains perfected pursuant to law. Any revenues thereafter received shall upon receipt by the Institution be transferred to the Authority, as FHA mortgagee, without such revenues being commingled with other funds, in the form received (with necessary endorsements) up to an amount equal to the amount of the missed payment. The value of the security interest in the revenues could be diluted by the incurrence of Additional Indebtedness secured equally and ratably with the Series 2020 Bonds as to the security interest in the revenues of the Institution or by the issuance of debt secured on a basis senior to the Series 2020 Bonds. See "PART 3 - The Series 2020 Bonds - Security for the Series 2020 Bonds."

In the event of bankruptcy of the Institution, transfers of property by the bankrupt entity, including the payment of debt or the transfer of any collateral, including receivables and revenues of the Institution on or after the date which is 90 days (or, in some circumstances, one year) prior to the commencement of the case in bankruptcy court, may be subject to avoidance or recoupment as preferential transfers. Under certain circumstances a court may have the power to direct the use of revenues to meet expenses of the Institution before paying debt service on the Series 2020 Bonds.

Matters Affecting the Value of the Mortgaged Property

Certain of the Mortgaged Property does not comprise general purpose buildings and would require renovations in order to be generally suitable for industrial or commercial use. Consequently, it could be difficult to find a buyer or lessee for the Mortgaged Property if it were necessary to foreclose on the Mortgaged Property. Thus, upon default, it may not be possible to realize proceeds at least equal to the amount of the Outstanding Bonds then outstanding, if any, from a sale or lease of the Mortgaged Property due to its purpose-built improvements or the real estate market generally.

Bondholders also should note that, under applicable federal and State environmental statutes, in the event of any past or future releases of pollutants or contaminants on or near the Mortgaged Property, a lien superior to the Trustee's lien on behalf of the Bondholders could attach to the Mortgaged Property and Gross Revenues to secure the costs of removing or otherwise treating such pollutants or contaminants. Such a lien would adversely affect the Trustee's ability to realize value from disposition of the Mortgaged Property upon foreclosure. Furthermore, in determining whether to exercise any foreclosure rights with respect to the Mortgaged Property, the Trustee would need to take into account the potential liability of any owner of the Mortgaged Property, including an owner by foreclosure, for clean-up costs with respect to such pollutants and contaminants.

The value of the lien on the Mortgaged Property could be diluted by the issuance of Additional Indebtedness secured equally and ratably with the obligations under the Loan Agreement as to the lien on the Mortgaged Property. See "PART 3 - The SERIES 2020 BONDS - Security for the Series 2020 Bonds" herein and "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION."

Bankruptcy

The Series 2020 Bonds are payable from the sources and are secured as described in this Preliminary Offering Statement. The practical realization of value from the collateral for the Series 2020 Bonds described herein upon any default will depend upon the exercise of various remedies specified by the Loan Agreement and the Resolution. These and other remedies may, in many respects, require judicial actions which are often subject to discretion and delay.

Under existing law, the remedies specified by the Loan Agreement and the Resolution may not be readily available or may be limited. A court may decide not to order the performance of the covenants contained in those documents. The legal opinions to be delivered concurrently with the delivery of the Series 2020 Bonds will be qualified as to the enforceability of the various agreements and other instruments by limitations imposed by State and federal laws, rulings and decisions affecting remedies and by bankruptcy, reorganization or other laws affecting the enforcement of creditors' rights generally.

The rights and remedies of the holders of the Series 2020 Bonds are subject to various provisions of Title 11 of the United States Code (the "**Bankruptcy Code**"), including the limitation that only a not-for-profit corporation such as the Institution, and not creditors such as the holders of the Series 2020 Bonds, can institute a filing for bankruptcy under the Bankruptcy Code. If the Institution were to file a petition for relief under the Bankruptcy Code, the filing would automatically stay among other things, the commencement or continuation of any judicial or other proceedings against the Institution, any action to enforce a lien against and any action to enforce any judgments or obtain possession of control over the Institution's property its property. The Institution would not be permitted or required to make payments of principal or interest under the Loan Agreement and the 2020 Note unless an order of the United States Bankruptcy Court were issued for such purpose. In addition, without an order of the United States Bankruptcy Court, the automatic stay may serve to prevent the Trustee from applying amounts on deposit in certain funds and accounts held under the Resolution from being applied in accordance with the provisions of the Resolution, and the application of such amounts to the payment of principal and Sinking Fund Installments of, and interest on, the Series 2020 Bonds. Moreover, any motion for an order modifying or terminating the automatic stay and permitting such funds and accounts to be applied in accordance with the provisions of the Resolution would be subject to prevailing legal limitations and the discretion of the United States Bankruptcy Court, and would be subject to objection and/or comment by other creditors of the Institution, which could affect the likelihood or timing of obtaining such relief. The automatic stay may also extinguish the Trustee's continuing security interest in the Institution's Gross Revenues arising subsequent to the filing of the bankruptcy petition, adversely affect the ability of the Trustee to exercise remedies upon default, including the acceleration of all amounts payable by the Institution, the Resolution, and the Loan Agreement, and may adversely affect the Trustee's or the Trustee's ability to take all steps necessary to file a claim under the applicable documents on a timely basis.

The Institution could file a plan for the restructuring of its debts in a proceeding under the Bankruptcy Code, which plan could include provisions modifying or altering the rights of creditors generally, or any class of them, whether secured or unsecured. The plan, if and when confirmed by the United States Bankruptcy Court, would bind all creditors who have notice or knowledge of the bankruptcy case whether or not they notice to approve the Plan and could discharge all claims against the Institution provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are

that the plan is in the best interests of creditors, is feasible and has been accepted by each class of claims impaired thereunder. Each class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the allowed claims of the class that are voted with respect to the plan are cast in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired there under and does not discriminate unfairly.

Reduction or Loss of Mortgage Insurance

As more fully discussed above under "PART 5 – MORTGAGE INSURANCE," the failure of the Institution to maintain adequate casualty insurance on the Project and Mortgaged Property, and the Authority, as FHA mortgagee's failure to obtain such insurance in lieu thereof, may result in the loss or curtailment of Mortgage Insurance Benefits. Mortgage Insurance Benefits may also be lost or curtailed for failure to pay required Mortgage Insurance premiums to HUD and failure to provide HUD with required notices or otherwise to comply with HUD rules and regulations governing insurance claims. The Servicing Agreement requires that the Mortgage Servicer supervise the Institution with regard to the payment of casualty and Mortgage Insurance premiums, and that the Mortgage Servicer provide HUD with required notices, in some cases at the direction of the Authority, as FHA mortgagee. To the extent offsets are made in the payment of the Mortgage Insurance Benefits, depending upon the amount of such offsets, the total amount of the Mortgage Insurance Benefits may not be adequate to provide for the timely payment of the principal amount of and interest on the Series 2020 Bonds.

A default under the FHA Documents is the only basis upon which the Authority, as FHA mortgagee, may present a claim for Mortgage Insurance Benefits. A default under the Loan Agreement, the Resolution, or any other document to which the Institution is a party, which is not also a default under the 2020 Note or the 2020 Mortgage, will not entitle the Authority, as FHA mortgagee, to present a claim for Mortgage Insurance Benefits. A default with respect to any of the Institution's outstanding Section 242 HUD Mortgages or related note obligations may at the option of HUD constitute a default on the 2020 Note and result in an assignment of the 2020 Note to HUD for payment of Mortgage Insurance Benefits.

Early Redemption and Loss of Premium

Purchasers of the Series 2020 Bonds, including those who purchase Series 2020 Bonds at a price in excess of their principal amount or who hold such a Bond trading at a price in excess of par, should consider the fact that the Series 2020 Bonds are subject to redemption at a redemption price equal to their principal amount plus accrued interest in the event such Bonds are redeemed prior to maturity. This could occur, for example, in the event that the 2020 Note is prepaid as a result of a casualty or condemnation award payments affecting the Project or there is a default under the Mortgage. See "PART 3 - THE SERIES 2020 BONDS – Extraordinary Mandatory Redemption."

Adequacy of the Debt Service Reserve Fund

As described in "PART 2 — PLAN OF FINANCING — Payment of Mortgage Insurance Benefits" and "PART 3 - The SERIES 2020 BONDS - Security for the Series 2020 Bonds," the Debt Service Reserve Fund has been established to provide additional funds for payment of the maturing principal of and interest on the Series 2020 Bonds in the event of a default under the 2020 Note and the 2020 Mortgage and the assignment of the 2020 Note and the 2020 Mortgage to HUD because the Mortgage Insurance Benefits will not be paid immediately. HUD regulations, however, do not permit the Authority, as FHA mortgagee, to give notice of assignment to HUD following a payment default on the 2020 Note and the 2020 Mortgage until after the expiration of a 30-day grace period. It is expected that the Mortgage Insurance Benefits and

certain other moneys held by the Authority, as FHA mortgagee, should be sufficient to provide for the payment of all of the Series 2020 Bonds Outstanding prior to their maturity, together with interest thereon when due, in the event of a default under the 2020 Note and the 2020 Mortgage and the assignment thereof to HUD. In addition, certain funds deposited in the Debt Service Reserve Fund should be sufficient, together with certain other moneys held by the Authority, as FHA mortgagee, for such purpose, to pay interest on and maturing principal of the Series 2020 Bonds, pending receipt of full payment of the Mortgage Insurance Benefits, for a period of twelve months. However, no assurance can be given that the Mortgage Insurance Benefits and the amounts available in the Debt Service Reserve Fund will be sufficient to pay in full or when due the maturing principal of and interest on the Series 2020 Bonds in the event of a default under the 2020 Note and the 2020 Mortgage and the assignment thereof to HUD if the final payment of the Mortgage Insurance Benefits is not made prior to the third Interest Payment Date from the date of default under the 2020 Note and the 2020 Mortgage.

Payment of Mortgage Insurance Benefits may be delayed, for example, due to a delay in the assignment of the 2020 Note and the 2020 Mortgage to HUD, or if disputes arise with HUD as to the amount of the claim or the payment thereof. Further, delays could occur if a bankruptcy proceeding is commenced by or against the Institution following a default under the 2020 Note and the 2020 Mortgage, and if a temporary restraining order is issued by a bankruptcy court against assignment of the 2020 Note and the 2020 Mortgage to HUD. In the event of a default under the 2020 Note and the 2020 Mortgage, the Authority, as FHA mortgagee, is required by the terms of the Resolution to take all actions necessary to assign the 2020 Note and the 2020 Mortgage to HUD and recover the Mortgage Insurance Benefits pursuant to the schedule described in "PART 5 – MORTGAGE INSURANCE— Default and Payment of Mortgage Insurance Benefits."

Considerations Relating to Additional Debt

Subject to the terms set forth therein, the Loan Agreement and the Resolution permit the Institution to incur additional indebtedness, including Additional Bonds. Such indebtedness would increase the Institution's debt service and repayment requirements and may adversely affect debt service coverage on the Series 2020 Bonds.

Limitation of Rights of Individual Bondholders

No Holder of any of the Series 2020 Bonds shall have any right to institute any suit, action or proceeding in equity or at law for the execution of any trust hereunder or under the Series Resolution, or for any other remedy hereunder unless such Holder previously shall have given to the Trustee written notice of the event of default on account of which such suit, action or proceeding is to be instituted, and unless also Holders of not less than twenty-five per centum (25%) in principal amount of the Outstanding Series 2020 Bonds, or, in the case of an event of default specified in the General Resolution, the Holders of not less than a majority in principal amount of the Outstanding Series 2020 Bonds, shall have made written request to the Trustee after the right to exercise such powers or right of action, as the case may be, shall have accrued, and shall have afforded the Trustee a reasonable opportunity either to proceed to exercise the powers granted hereby or to institute such action, suit or proceeding in its or their name, and unless, also there shall have been offered to the Trustee reasonable security and indemnity against the costs, expenses, and liabilities to be incurred therein or thereby, and the Trustee shall have refused or neglected to comply with such request within a reasonable time. Such notification, request and offer of indemnity are hereby declared in every such case, at the option of the Trustee, to be conditions precedent to the execution of the powers and trusts hereof or for any other remedy hereunder and thereunder. It is understood and intended that no one or more Holders of the Series 2020 Bonds secured hereby and by the Series Resolution shall have any right in any manner whatever by his or their action to affect, disturb or prejudice the security hereof or to enforce any right hereunder except in the manner herein provided, and that all proceedings at

law or in equity shall be instituted and maintained for the benefit of all Holders of the Outstanding Bonds of such Series. Notwithstanding any other provision hereof, the Holder of any Series 2020 Bonds shall have the right which is absolute and unconditional to receive payment of the principal of (or Redemption Price, if any) and interest on the Series 2020 Bonds on the stated maturity expressed in the Series 2020 Bonds (or, in the case of redemption, on the redemption date) and to institute suit for the enforcement of any such payment, and such right shall not be impaired without the consent of such Holder.

Other Risk Factors

In the future, the following factors, among others, may adversely affect the operations of health care providers, including the Institution, or the market value of the Series 2020 Bonds, to an extent that cannot be determined at this time:

- Adoption of legislation that would establish a national or statewide single-payor health program or that would establish national, statewide, or otherwise regulated rates.

- Increased unemployment or other economic conditions in the service area of the Institution, which could increase the proportion of patients who are unable to pay fully for the cost of their care.

- Efforts by insurers and governmental agencies to limit the cost of hospital and physician services, to reduce the number of beds and to reduce the utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety and outpatient care, or comparable regulations or attempts by third-party payors to control or restrict the operations of certain health care facilities.

- Adoption of proposed legislation in New York State that would set nurse-to-patient ratios by unit.

- Reduced demand for the services of hospitals that might result from decreases in population or loss of market share to competitors.

- Bankruptcy or business failures of an indemnity/commercial insurer, managed care plan or other payor could have a material adverse impact on contracted hospitals and other health care providers in the form of payment shortfalls or delay, and/or continuing obligations to care for managed care patients without receiving payment.

- The occurrence of a natural or man-made disaster, including but not limited to acts of terrorists, that could damage the facilities of the Institution, interrupt utility service to the facilities, result in an abnormally high demand for health care services or otherwise impair the operations and the generation of revenues from the Institution's facilities.

- Adoption of a so-called "flat tax" federal income tax, a reduction in the marginal rates of federal income taxation or replacement of the federal income tax with another form of taxation, any of which might adversely affect the market value of the Series 2020 Bonds and the level of charitable donations to the Institution.

- New clinical techniques and technology, as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in ways that are currently unanticipated, and that may dramatically change medical and hospital care.

These could result in higher health care costs, reductions in patient populations, lower utilization of hospital service and/or new sources of competition for hospitals.

- Cost and availability of any insurance, such as professional liability, fire, flood, automobile and general comprehensive liability coverages, which health care facilities of a similar size and type generally carry.

- Fluctuations in global capital markets that could affect the Institution's access to capital, the value of its investment assets and pension funds.

- The treatment of a highly contagious disease at the Institution's facilities may result in a temporary shutdown or diversion of patients or cause unaffected individuals to decide to defer elective procedures or otherwise avoid medical treatment, resulting in reduced patient volumes and operating revenues. (See APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Introduction – General."

- Limitations on the availability of, and increased compensation necessary to secure and retain, nursing, technical and other professional personnel.

- The Institution has a number of facilities under which interest/swap payments are calculated by reference to LIBOR (see "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER – Discussion of Outstanding Indebtedness"). Most of these facilities are scheduled to mature subsequent to the expected date of when governmental regulators will no longer be requiring LIBOR panel banks to provide LIBOR rates (December 2021). Although the transition from LIBOR has been widely discussed, there are still numerous credit and legal issues to be resolved in the marketplace. As a result, the Institution is not expected to transition these LIBOR-based facilities until such concerns are generally adequately addressed in the marketplace and are specifically satisfactorily addressed through the Institution's negotiations with its bank counterparties.

PART 12 – THE AUTHORITY

Background, Purposes and Powers

The Authority is a body corporate and politic constituting a public benefit corporation. The Authority was created in 1944 to finance and build dormitories at State teachers' colleges to provide housing for the large influx of students returning to college on the G.I. Bill following World War II. Over the years, the State Legislature has expanded the Authority's scope of responsibilities. Today, pursuant to the Dormitory Authority Act (being Chapter 524 of the Laws of 1944 of the State, as amended, and constituting Titles 4 and 4B of Article 8 of the Public Authorities Law of the State, as amended), the Authority is authorized to finance, design, construct, or rehabilitate facilities for use by a variety of public and private not-for-profit entities.

The Authority provides financing services to its clients in three major areas: public facilities; not-for-profit healthcare; and independent higher education and other not-for-profit institutions. The Authority issues State-supported debt, including State Personal Income Tax Revenue Bonds and State Sales Tax Revenue Bonds, on behalf of public clients such as The State University of New York, The City University of New York, the Departments of Health and Education of the State, the Office of Mental Health, the Office of People with Developmental Disabilities, the Office of Addiction Services and Supports, the Office of

General Services, and the Office of General Services of the State on behalf of the Department of Audit and Control. Other public clients for whom the Authority issues debt include Boards of Cooperative Educational Services ("**BOCES**"), State University of New York, the Workers' Compensation Board, school districts across the State and certain cities and counties that have accessed the Authority for the purpose of providing court facilities. The Authority's private clients include independent colleges and universities, private hospitals, certain private secondary schools, special education schools, facilities for the aged, primary care facilities, libraries, museums, research centers and government-supported voluntary agencies, among others.

To carry out its programs, the Authority is authorized to issue and sell negotiable bonds and notes to finance the construction of facilities for such institutions, to issue bonds or notes to refund outstanding bonds or notes and to lend funds to such institutions. At June 30, 2020, the Authority had approximately $62.7 billion aggregate principal amount of bonds and notes outstanding. The Authority also is authorized to make tax-exempt leases, with its Tax-Exempt Leasing Program (TELP). As part of its operating activities, the Authority also administers a wide variety of grants authorized by the State for economic development, education and community improvement and payable to both public and private grantees from proceeds of State Personal Income Tax Revenue Bonds issued by the Authority.

The Authority is a conduit debt issuer. Under existing law, and assuming continuing compliance with tax law, interest on most bonds and notes issued by the Authority has been determined to be excludable from gross income for federal tax purposes under Section 103 of the Code, as amended. All of the Authority's outstanding bonds and notes, both fixed and variable rate, are special obligations of the Authority payable solely from payments required to be made by or for the account of the client institution for which the particular special obligations were issued. The Authority has no obligation to pay its special obligations other than from such payments. The Authority has always paid the principal of and interest on all of its obligations on time and in full; however, as a conduit debt issuer, payments on the Authority's special obligations are solely dependent upon payments made by the Authority's client for which the particular special obligations were issued and the security provisions relating thereto.

The Authority also offers a variety of construction services to certain educational, governmental and not-for-profit institutions in the areas of project planning, design and construction, monitoring project construction, purchasing of furnishings and equipment for projects, interior design of projects and designing and managing projects to rehabilitate older facilities.

In connection with the powers described above, the Authority has the general power to acquire real and personal property, give mortgages, make contracts, operate certain facilities and fix and collect rentals or other charges for their use, contract with the holders of its bonds and notes as to such rentals and charges, borrow money and adopt a program of self-insurance.

The Authority has a staff of approximately 536 employees located in three main offices (Albany, New York City, and Buffalo) and at approximately 47 field sites across the State.

Governance

The Authority is governed by an eleven-member board. Board members include the Commissioner of Education of the State, the Commissioner of Health of the State, the State Comptroller or one member appointed by him or her who serves until his or her successor is appointed, the Director of the Budget of the State, one member appointed by the Temporary President of the State Senate, one member appointed by the Speaker of the State Assembly and five members appointed by the Governor, with the advice and consent of the Senate, for terms of three years. The Commissioner of Education of the State, the Commissioner of Health of the State, and the Director of the Budget of the State each may appoint a

representative to attend and vote at Authority meetings. The members of the Authority serve without compensation, but said members are entitled to reimbursement of expenses incurred in the performance of their duties.

The Governor of the State appoints a Chair from the members appointed by him or her and the members of the Authority annually choose the following officers, of which the first two must be members of the Authority: Vice-Chair, Secretary, Treasurer, Assistant Secretaries and Assistant Treasurers.

The current members of the Authority are as follows:

ALFONSO L. CARNEY, JR., *Chair*, New York.

Alfonso L. Carney, Jr. was reappointed as a Member of the Authority by the Governor on July 17, 2013. Mr. Carney is a principal of Rockwood Partners, LLC, which provides medical consulting services in New York City. He has served as Acting Chief Operating Officer and Corporate Secretary for the Goldman Sachs Foundation in New York where, working with the President of the Foundation, he managed the staff of the Foundation, provided strategic oversight of the administration, communications and legal affairs teams, and developed selected Foundation program initiatives. Mr. Carney has held senior level legal positions with Altria Group Inc., Philip Morris Companies Inc., Philip Morris Management Corporation, Kraft Foods, Inc. and General Foods Corporation. Mr. Carney holds a Bachelor's degree in philosophy from Trinity College and a Juris Doctor degree from the University of Virginia School of Law. His term expired on March 31, 2016 and by law he continues to serve until a successor shall be chosen and qualified.

JOHN B. JOHNSON, JR., *Vice-Chair*, Watertown.

John B. Johnson, Jr. was reappointed as a Member of the Authority by the Governor on July 17, 2013. Mr. Johnson is Chairman of the Board of the Johnson Newspaper Corporation, which publishes the Watertown Daily Times, Batavia Daily News, Malone Telegram, Catskill Daily Mail, Hudson Register Star, Ogdensburg Journal, Massena-Potsdam Courier Observer, seven weekly newspapers and three shopping newspapers. He holds a Bachelor's degree from Vanderbilt University, and Master's degrees in Journalism and Business Administration from the Columbia University Graduate School of Journalism and Business. Mr. Johnson was awarded an Honorary Doctor of Science degree from Clarkson University. Mr. Johnson's term expired on March 31, 2016 and by law he continues to serve until a successor shall be chosen and qualified.

BERYL L. SNYDER, J.D., *Secretary*, New York.

Beryl L. Snyder was reappointed as a member of the Authority by the Governor on June 19, 2013. Ms. Snyder is a principal in HBJ Investments, LLC, an investment company where her duties include evaluation and analysis of a wide variety of investments in, among other areas: fixed income, equities, alternative investments and early stage companies. She holds a Bachelor of Arts degree in History from Vassar College and a Juris Doctor degree from Rutgers University. Her current term expired on August 31, 2016 and by law she continues to serve until a successor shall be chosen and qualified.

JONATHAN H. GARDNER, ESQ., Buffalo.

Jonathan H. Gardner was appointed as a Member of the Authority by the Governor on June 17, 2014. Mr. Gardner is a partner of the law firm Kavinoky Cook, LLP in Buffalo, New York. His practice areas include corporate and securities law, commercial transactions, private placements, venture capital financing and business combinations representing private and public companies. Mr. Gardner is also an

adjunct professor at the University of Buffalo Law School. He holds a Bachelor of Arts degree from Brown University and a Juris Doctor degree from the University of Chicago Law School. Mr. Gardner's term expired on March 31, 2015 and by law he continues to serve until a successor shall be chosen and qualified.

WELLINGTON Z. CHEN, Queens.

Wellington Z. Chen was appointed as a Member of the Authority by the Governor on June 20, 2018. Mr. Chen is the Executive Director of the Chinatown Partnership Development Corporation. In this capacity, he leads the Chinatown Partnership in implementing initiatives in infrastructure, post 9/11 rebuilding and public space improvements in a comprehensive effort to improve the environmental and the business conditions. He is a graduate of the School of Architecture and Environmental Studies at The City College of New York. Mr. Chen's term expired on March 31, 2020, and by law he continues to serve until a successor shall be chosen and qualified.

JOAN M. SULLIVAN, Slingerlands.

Joan M. Sullivan was appointed as a Member of the Authority by the New York State Comptroller on March 26, 2019. Ms. Sullivan is President of On Wavelength Consulting LLC, a firm that assists governmental entities with development of public procurements and private companies with the preparation of effective responses to government solicitations. She possesses over 40 years of experience working in and for the government of New York State, including an expansive career at the NYS Office of State Comptroller where she last served as Executive Deputy Comptroller before accepting an appointment as Executive Director of The NYS Forum, Inc. Ms. Sullivan holds a Bachelor of Arts degree in Business Administration (Accounting) from Siena College.

GERARD ROMSKI, ESQ., Mount Kisco.

Gerard Romski was reappointed as a Member of the Authority by the Temporary President of the State Senate on May 9, 2016. He is Counsel and Project Executive for "Arverne by the Sea," where he is responsible for advancing and overseeing all facets of "Arverne by the Sea," one of New York City's largest mixed-use developments located in Queens, New York. Mr. Romski is also of counsel to the New York City law firm of Rich, Intelisano & Katz, LLP. Mr. Romski holds a Bachelor of Arts degree from the New York Institute of Technology and a Juris Doctor degree from Brooklyn Law School.

JANICE McKINNIE, Buffalo.

Janice McKinnie was appointed as a Member of DASNY by the Speaker of the Assembly on June 12, 2020. Ms. McKinnie is the Executive Director of True Community Development Corporation where she has led various housing rehabilitation and development projects and has formed strategic alliances with local and regional community groups to promote affordable housing and economic growth within the area of Buffalo. She is also the owner of Developments By JEM, LLC, a construction and project development consulting firm and a NYS certified M/WBE business. Ms. McKinnie is a graduate of the State University College of Buffalo and holds a Master's degree in organizational leadership from Medaille College.

SHANNON TAHOE, *Acting Commissioner of Education of the State of New York*, Cohoes; ex-officio.

Shannon Tahoe assumed the role of Acting Commissioner of Education and Acting President of the University of the State of New York effective November 16, 2019. Since September 2006, Ms. Tahoe has served in various capacities within the Department, including Deputy Counsel and Assistant Counsel for Legislation. In October 2019, she was appointed Acting Counsel and Deputy Commissioner for Legal

Affairs. This appointment will continue to remain in effect along with her appointment as Acting Commissioner of Education and Acting President of the University of the State of New York. Ms. Tahoe has provided legal advice and counsel on critical policy matters and key initiatives. She is familiar with all aspects of the work of the Department, having managed the day-to-day operations of the Office of Counsel as Deputy Counsel and now Acting Counsel. During her tenure, Ms. Tahoe has also assisted with the successful management of a broad array of critical Departmental functions and responsibilities. She holds a Juris Doctorate degree from Syracuse University and Bachelor of Science degree from the University of Rochester.

ROBERT F. MUJICA, JR., *Budget Director of the State of New York*, Albany; *ex-officio*.

Robert F. Mujica Jr. was appointed Director of the Budget by the Governor and began serving on January 14, 2016. He is responsible for the overall development and management of the State's fiscal policy, including overseeing the preparation of budget recommendations for all State agencies and programs, economic and revenue forecasting, tax policy, fiscal planning, capital financing and management of the State's debt portfolio. Prior to his appointment, Mr. Mujica was Chief of Staff to the Temporary President and Majority Leader of the Senate and concurrently served as the Secretary to the Senate Finance Committee. For two decades, he advised various elected and other government officials in New York on State budget, fiscal and policy issues. Mr. Mujica received his Bachelor of Arts degree in Sociology from Brooklyn College at the City University of New York. He received his Master's degree in Government Administration from the University of Pennsylvania and holds a Juris Doctor degree from Albany Law School.

HOWARD A. ZUCKER, M.D., J.D., *Commissioner of Health of the State of New York*, Albany; *ex-officio*.

Howard A. Zucker, M.D., J.D., was appointed Commissioner of Health on May 5, 2015 after serving as Acting Commissioner of Health since May 5, 2014. Prior to that, he served as First Deputy Commissioner leading the NYSDOH's preparedness and response initiatives in natural disasters and emergencies. Before joining the NYSDOH, Dr. Zucker was professor of Clinical Anesthesiology at Albert Einstein College of Medicine of Yeshiva University and a pediatric cardiac anesthesiologist at Montefiore Medical Center. He was also an adjunct professor at Georgetown University Law School where he taught biosecurity law. Dr. Zucker earned his medical degree from George Washington University School of Medicine. He also holds a Juris Doctor degree from Fordham University School of Law and a Master of Laws degree from Columbia Law School.

The principal staff of the Authority is as follows:

REUBEN R. McDANIEL, III is the President and chief executive officer of the Authority, responsible for the overall management of the Authority's administration and operations. Mr. McDaniel possesses more than 30 years of experience in financial services, including public finance, personal wealth management, corporate finance and private equity. During his career in public finance, he participated in more than $75 billion in tax-exempt bond issuances throughout the country. He has also managed investment portfolios and business assets for a variety of professionals. He previously served as Chair of the Atlanta Board of Education for Public Schools. Mr. McDaniel holds an undergraduate degree in Economics and Mathematics from the University of North Carolina at Charlotte and a Master of Business Administration from the University of Texas at Austin.

PAUL G. KOOPMAN is the Vice President of the Authority and assists the President in the administration and operation of the Authority. Mr. Koopman joined the Authority in 1995 managing the Accounts Payable and Banking and Investment Units followed by management positions in the

Construction Division including Managing Senior Director of Construction where he was the primary relationship manager for some of the Authority's largest clients and provided oversight of the Authority's construction administration functions. Most recently, Mr. Koopman served as Managing Director of Executive Initiatives of the Authority where he worked closely with executive staff on policy development, enterprise risk management, and strategic planning. His career in public service began in 1985 with the NYS Division of the Budget, and then continued as Chief Budget Analyst for the New York State Facilities Development Corporation. A graduate of the Rockefeller College of Public Affairs, he holds a Master of Arts degree in Public Administration with a Public Finance concentration, and a Bachelor of Arts degree in Political Science from the State University of New York, University at Albany.

KIMBERLY J. NADEAU is the Chief Financial Officer and Treasurer of the Authority. As Chief Financial Officer and Treasurer, Ms. Nadeau is responsible for supervising the Authority's investment program, general accounting, accounts payable, accounts receivable, financial reporting functions, budget, payroll, insurance and information services, as well as the development and implementation of financial policies, financial management systems and internal controls for financial reporting. She previously was Vice President-Accounting and Controller for US Light Energy. Prior to that she was Vice President-Accounting and Controller for CH Energy Group, Inc. and held various positions culminating in a director level position at Northeast Utilities. Ms. Nadeau also held various positions with increasing responsibility at Coopers & Lybrand LLP. She holds a Bachelor of Science degree in Accounting, a Master of Business Administration with a concentration in Management and a Juris Doctor degree from the University of Connecticut. She is licensed to practice law in New York and Connecticut.

MICHAEL E. CUSACK is General Counsel to the Authority. Mr. Cusack is responsible for all legal services including legislation, litigation, contract matters, and the legal aspects of all the Authority financings. In addition, he is responsible for the supervision of the Authority's environmental affairs unit. He is licensed to practice law in the State of New York and the Commonwealth of Massachusetts, as well as the United States District Court for the Northern District of New York. Mr. Cusack has over twenty years of combined legal experience, including management of an in-house legal department and external counsel teams (and budgets) across a five-state region. He most recently served as of counsel to the Albany, New York law firm of Young/Sommer, LLC, where his practice included representation of upstate New York municipalities, telecommunications service providers in the siting of public utility/personal wireless service facilities and other private sector clients. He holds a Bachelor of Science degree from Siena College and a Juris Doctor degree from Albany Law School of Union University.

PORTIA LEE is the Managing Director of Public Finance and Portfolio Monitoring. She is responsible for supervising and directing the Authority bond issuance in the capital markets, implementing and overseeing financing programs, overseeing the Authority's compliance with continuing disclosure requirements and monitoring the financial condition of existing Authority clients. Ms. Lee previously served as Senior Investment Officer at the New York State Comptroller's Office where she was responsible for assisting in the administration of the long-term fixed income portfolio of the New York State Common Retirement Fund, as well as the short-term portfolio, and the Securities Lending Program. From 1995 to 2005, Ms. Lee worked at Moody's Investors Service where she most recently served as Vice President and Senior Credit Officer in the Public Finance Housing Group. She holds a Bachelor of Arts degree from the State University of New York at Albany.

STEPHEN D. CURRO is the Managing Director of Construction. Mr. Curro is responsible for the Authority's construction groups, including design, project management, resource acquisition, contract administration, interior design, real property, sustainability and engineering, as well as other technical services. Mr. Curro joined the Authority in 2001 as Director of Technical Services, and most recently served as Director of Construction Support Services. He is a registered Professional Engineer in New York and has worked in the construction industry for more than 30 years. He holds a Bachelor of Science in

Civil Engineering from the University of Rhode Island, a Master of Engineering in Structural Engineering from Rensselaer Polytechnic Institute and a Master of Business Administration from Rensselaer Polytechnic Institute's Lally School of Management.

CAROLINE V. GRIFFIN is the Chief of Staff of the Authority. She is responsible for overseeing intergovernmental relations and managing the Communications & Marketing Department, as well as coordinating policy and operations across the Authority's multiple business lines. Ms. Griffin most recently served as the Director of Intergovernmental Affairs for Governor Andrew M. Cuomo where she worked as the Governor's liaison with federal, state and local elected officials and managed staff serving in various capacities in the Governor's Office. Prior to that she served as the Assistant Executive Deputy Secretary for Governor Andrew M. Cuomo overseeing the operations staff and Assistant Secretary for Intergovernmental Affairs for both Governor David A. Paterson and Governor Eliot Spitzer. She holds a Bachelor of Arts degree in Communications from Boston College.

Claims and Litigation

Although certain claims and litigation have been asserted or commenced against the Authority, the Authority believes that such claims and litigation either are covered by insurance or by bonds filed with the Authority, or that the Authority has sufficient funds available or the legal power and ability to seek sufficient funds to meet any such claims or judgments resulting from such matters.

There is not now pending any litigation against the Authority (i) restraining or enjoining the issuance or delivery of the Series 2020 Bonds or (ii) challenging the validity of the Series 2020 Bonds or the proceedings and authority under which the Authority will issue the Series 2020 Bonds.

Other Matters

New York State Public Authorities Control Board

The New York State Public Authorities Control Board (the "**PACB**") has authority to approve the financing and construction of any new or reactivated projects proposed by the Authority and certain other public authorities of the State. The PACB approves the proposed new projects only upon its determination that there are commitments of funds sufficient to finance the acquisition and construction of the Projects. The Authority obtains the approval of the PACB for the issuance of all of its bonds and notes.

Legislation

From time to time, bills are introduced into the State Legislature which, if enacted into law, would affect the Authority and its operations. The Authority is not able to represent whether such bills will be introduced or become law in the future. In addition, the State undertakes periodic studies of public authorities in the State (including the Authority) and their financing programs. Any of such periodic studies could result in proposed legislation which, if adopted, would affect the Authority and its operations.

Environmental Quality Review

The Authority complies with the New York State Environmental Quality Review Act and with the New York State Historic Preservation Act of 1980, and the respective regulations promulgated thereunder to the extent such acts and regulations are applicable.

Independent Auditors

The accounting firm of KPMG LLP audited the financial statements of the Authority for the fiscal year ended March 31, 2020. Copies of the most recent audited financial statements are available upon request at the offices of the Authority.

PART 13 – LEGALITY OF THE SERIES 2020 BONDS FOR INVESTMENT AND DEPOSIT

Under New York State law, the Series 2020 Bonds are securities in which all public officers and bodies of the State and all municipalities and municipal subdivisions, all insurance companies and associations, all savings banks and savings institutions, including savings and loan associations, administrators, guardians, executors, trustees, committees, conservators and other fiduciaries in the State may properly and legally invest funds in their control. However, enabling legislation or bond resolutions of individual authorities and public benefit corporations of the State may limit the investment of funds of such authorities and corporations in the Series 2020 Bonds.

PART 14 – NEGOTIABLE INSTRUMENTS

The Series 2020 Bonds shall be negotiable instruments as provided in the Act, subject to the provisions for registration and transfer contained in the General Resolution and in the Series 2020 Bonds.

PART 15 – TAX MATTERS

Federal Income Tax

In the opinion of Harris Beach PLLC, as Co-Bond Counsel to the Authority, and subject to the limitations set forth below, under existing statutes, regulations, administrative rulings and court decisions as of the date of such opinions, interest on the Series 2020 Bonds is excluded from gross income for federal income tax purposes, pursuant to Section 103 of the Code. Furthermore, Harris Beach PLLC is of the opinion that interest on the Series 2020 Bonds is not an "item of tax preference" for purposes of computing the federal alternative minimum tax imposed on individuals.

The Series 2020 Bonds have been offered and sold to the public at a prices in excess of their respective stated redemption price (the principal amount) at maturity. That excess constitutes bond premium. For federal income tax purposes, bond premium is amortized over the period to maturity of a Series 2020 Bond, based on the yield to maturity of that Series 2020 Bond (or, in the case of a Series 2020 Bond callable prior to its stated maturity, the amortization period and yield may be required to be determined on the basis of an earlier call date that results in the lowest yield on that Series Bond), compounded semiannually. No portion of that bond premium is deductible by the owner of a Series 2020 Bond. For purposes of determining the owner's gain or loss on the sale, redemption (including redemption at maturity) or other disposition of a Series 2020 Bond, the owner's tax basis in such Series 2020 Bond is reduced by the amount of bond premium that is amortized during the period of ownership. As a result, an owner may realize taxable gain for federal income tax purposes from the sale or other disposition of a Series 2020 Bond for an amount equal to or less than the amount paid by the owner for that Series 2020 Bond.

Owners of the Series 2020 Bonds should consult their own tax advisers as to the determination for federal income tax purposes of the existence of bond premium, the determination for federal income tax purposes of the amount of bond premium properly accruable or amortizable in any period with respect to Series 2020 Bonds, other federal tax consequences in respect of bond premium, and the treatment of bond premium for purposes of state and local taxes on, or based on, income.

The Code establishes certain requirements which must be met at the time of, and subsequent to, the issuance and delivery of the Series 2020 Bonds in order that interest on the Series 2020 Bonds be and remain excluded from gross income for federal income tax purposes, pursuant to Section 103 of the Code. Included among these continuing requirements are certain restrictions and prohibitions on the use of the proceeds of the Series 2020 Bonds, restrictions on the investment of bond proceeds and other moneys or properties, required ownership of the facilities financed by the Series 2020 Bonds by an organization described in Section 501(c)(3) of the Code or a governmental unit, and the rebate to the United States of certain earnings in respect of investments. Noncompliance with such continuing requirements may cause the interest on the Series 2020 Bonds to be included in gross income for federal income tax purposes retroactive to the date of issuance of the Series 2020 Bonds, irrespective of the date on which such noncompliance occurs. In the Resolution, the Loan Agreement, and the Tax and Arbitrage Certificate to be executed by the Authority and the Institution in connection with the issuance of the Series 2020 Bonds (the "**Tax Certificate**") the Authority and the Institution have made certain representations and certifications, and have covenanted to comply with certain procedures, designed to assure compliance with the requirements of the Code. The opinion of Harris Beach PLLC described above is made in reliance upon, and assumes continuing compliance with, such covenants and procedures and the continuing accuracy, in all material respects, of such representations and certifications. No opinion is expressed by Harris Beach PLLC, as Co-Bond Counsel to the Authority with respect to the excludability of interest on the Series 2020 Bonds from gross income for federal income tax purposes in the event of noncompliance with such provisions.

Harris Beach PLLC expresses no opinion regarding any other federal tax consequences related to the ownership or disposition of, or the receipt or accrual of interest on, the Series 2020 Bonds. The proposed forms of approving opinion of Co-Bond Counsel are attached to this Official Statement as "APPENDIX G - FORMS OF APPROVING OPINION OF CO-BOND COUNSEL."

In addition to the matters referred to in the preceding paragraphs, prospective purchasers of the Series 2020 Bonds should be aware that the accrual or receipt of tax-exempt interest on the Series 2020 Bonds may otherwise affect the federal income tax liability of the recipient. The extent of these other tax consequences may depend upon the recipient's particular tax status or other items of income or deduction. Harris Beach PLLC expresses no opinion regarding any such consequences. Examples of such other federal income tax consequences of acquiring or holding the Series 2020 Bonds include, without limitation, that (i) with respect to certain insurance companies, the Code reduces the deduction for loss reserves by a portion of the sum of certain items, including interest on the Series 2020 Bonds, (ii) interest on the Series 2020 Bonds earned by certain foreign corporations doing business in the United States may be subject to a branch profits tax imposed by the Code, (iii) passive investment income, including interest on the Series 2020 Bonds, may be subject to federal income taxation under the Code for certain S corporations that have certain earnings and profits, and (iv) the Code requires recipients of certain Social Security and certain other federal retirement benefits to take into account, in determining gross income, receipts or accruals of interest on the Series 2020 Bonds. In addition, the Code denies the interest deduction for indebtedness incurred or continued by a taxpayer, including without limitation, banks, thrift institutions, and certain other financial institutions to purchase or carry tax-exempt obligations, such as the Series 2020 Bonds. The foregoing is not intended as an exhaustive list of potential tax consequences. Prospective purchasers should consult their tax advisors regarding any possible collateral consequences with respect to the Series 2020 Bonds.

Certain requirements and procedures contained or referred to in the Resolution and other relevant documents may be changed, and certain actions may be taken or omitted under the circumstances and subject to the terms and conditions set forth in such documents, upon the advice of, or with the approving opinion of, a nationally recognized bond counsel. Harris Beach PLLC expresses no opinion as to any tax consequences with respect to the Series 2020 Bonds, or the interest thereon, if any such change occurs or actions are taken upon the advice or approval of other bond counsel.

State and Local Income Taxes

Co-Bond Counsel are of the opinion that, under existing statutes, including the Act, interest on the Series 2020 Bonds is exempt from personal income taxes imposed by the State of New York and any political subdivision thereof.

Any noncompliance with the federal income tax requirements set forth above would not affect the exemption of interest on the Series 2020 Bonds from personal income taxes imposed by New York State or any political subdivision thereof.

Co-Bond Counsel express no opinion regarding any other state or local tax consequences related to the ownership or disposition of, or the receipt or accrual of interest on, the Series 2020 Bonds.

Interest on the Series 2020 Bonds may or may not be subject to state or local income taxes in jurisdictions other than the State of New York under applicable state or local tax laws. Co-Bond Counsel express no opinion as to the tax treatment of the Series 2020 Bonds under other state or local jurisdictions. Each purchaser of Series 2020 Bonds should consult his or her own tax advisor regarding the taxable status of the Series 2020 Bonds in a particular state or local jurisdiction other than the State of New York.

Other Considerations

Co-Bond Counsel have not undertaken to determine (or to inform any person) whether any actions taken (or not taken) or events occurring (or not occurring) after the date of issuance of the Series 2020 Bonds may adversely affect the value of, or the tax status of interest on, the Series 2020 Bonds.

No assurance can be given that any future legislation or governmental actions, including amendments to the Code or State income tax laws, regulations, administrative rulings, or court decisions, will not, directly or indirectly, cause interest on the Series 2020 Bonds to be subject to federal, State or local income taxation, or otherwise prevent Bondholders from realizing the full current benefit of the tax status of such interest. Further, no assurance can be given that the introduction or enactment of any such future legislation, or any judicial decision or action of the Internal Revenue Service or any State taxing authority, including, but not limited to, the promulgation of a regulation or ruling, or the selection of the Series 2020 Bonds for audit examination or the course or result of an audit examination of the Series 2020 Bonds or of obligations which present similar tax issues, will not affect the market price, value, or marketability of the Series 2020 Bonds. Prospective purchasers of the Series 2020 Bonds should consult their own tax advisors regarding the foregoing matters.

From time to time the United States Congress has considered and can be expected in the future to consider tax reform and other legislative proposals, including some that carry retroactive effective dates, which, if enacted, could alter or amend the federal tax-exempt status, or adversely affect the market value, of the Series 2020 Bonds. It cannot be predicted whether or in what form any such proposal might be enacted or whether, if enacted, it would apply to bonds issued prior to enactment. Prospective purchasers of the Series 2020 Bonds should consult their own tax advisors regarding any pending or proposed federal tax legislation. Harris Beach PLLC, as Co-Bond Counsel to the Authority, expresses no opinion regarding

any pending or proposed federal tax legislation. In the event any such legislation which amends the federal tax-exempt status or adversely affects the market value of the Series 2020 Bonds become law, the Resolution does not provide for the increase in interest rate on the Series 2020 Bonds or the mandatory redemption of the Series 2020 Bonds. Also, Bondholders of the Series 2020 Bonds are not indemnified for any costs or losses (e.g., tax deficiencies, interest and penalties, loss of market value) that may be incurred as a result of a change in law.

All quotations from and summaries and explanations of provisions of law do not purport to be complete, and reference is made to such laws for full and complete statements of their provisions.

ALL PROSPECTIVE PURCHASERS OF THE SERIES 2020 BONDS SHOULD CONSULT WITH THEIR TAX ADVISORS IN ORDER TO UNDERSTAND THE IMPLICATIONS OF THE CODE AS TO THESE AND OTHER FEDERAL AND STATE TAX CONSEQUENCES, AS WELL AS ANY LOCAL TAX CONSEQUENCES, OF PURCHASING OR HOLDING THE SERIES 2020 BONDS.

PART 16 – STATE AND HUD NOT LIABLE ON THE SERIES 2020 BONDS

The Act provides that notes and bonds of the Authority shall not be a debt of the State nor shall the State be liable thereon, nor shall such notes or bonds be payable out of any funds other than those of the Authority. The General Resolution specifically provides that the Series 2020 Bonds are not a debt of the State nor shall the State be liable thereon.

The Series 2020 Bonds do not constitute an obligation or indebtedness of, and the payment of the Series 2020 Bonds is not insured or guaranteed by, the United States of America or any agency or instrumentality thereof, including HUD.

PART 17 – COVENANT BY THE STATE

The Act provides that the State pledges and agrees with the holders of the Authority's notes and bonds that the State will not limit or alter the rights vested in the Authority to provide projects, to establish and collect rentals therefrom and to fulfill agreements with the holders of the Authority's notes and bonds or in any way impair the rights and remedies of the holders of such notes or bonds until such notes or bonds and interest thereon and all costs and expenses in connection with any action or proceeding by or on behalf of the holders of such notes or bonds are fully met and discharged. Notwithstanding the State's pledges and agreements contained in the Act, the State may in the exercise of its sovereign power enact or amend its laws which, if determined to be both reasonable and necessary to serve an important public purpose, could have the effect of impairing these pledges and agreements with the Authority and with the holders of the Authority's notes and bonds.

PART 18 - LEGAL MATTERS

Certain legal matters incidental to the authorization and issuance of the Series 2020 Bonds by the Authority are subject to the approval of Harris Beach PLLC, New York, New York, and Lewis & Munday, A Professional Corporation, New York, New York, Co-Bond Counsel to the Authority, whose approving opinions will be rendered concurrently with the delivery of the Series 2020 Bonds. The proposed forms of Co-Bond Counsel's opinion is set forth in "APPENDIX G - FORMS OF APPROVING OPINION OF CO-BOND COUNSEL" hereto.

Certain legal matters will be passed upon for the Institution by its counsel, Arent Fox LLP, New York, New York, for the Underwriters by their counsel, Tiber Hudson LLC, Washington, D.C., and for the Mortgage Servicer by its counsel, Krooth & Altman LLP, Washington, D.C.

PART 19 – RATING

The Series 2020 Bonds have been assigned a rating of "AA+" by S&P Global Ratings and "Aa1" by Moody's Investors Services, Inc. based on the 2020 Note and the 2020 Mortgage being insured by HUD on the date of delivery of the Series 2020 Bonds. Each credit rating reflects only the view of the credit rating agency that has issued the credit rating, and an explanation of the significance of such credit rating may be obtained from the rating agency furnishing the same. There is no assurance that either credit rating, or both, will continue for any given period of time or that either credit rating or both credit ratings will not be revised or withdrawn entirely by the applicable credit rating agency, if, in the judgment of the applicable credit rating agency, circumstances so warrant. Any downward revision or withdrawal of a credit rating may have an adverse effect on the market price of the Series 2020 Bonds.

PART 20 – UNDERWRITING

Pursuant to a Bond Purchase Agreement related to the Series 2020 Bonds (the "**Purchase Contract**") among the Authority, the Institution, and **BofA Securities, Inc.**, as representative of the Underwriters (the "**Underwriters**"), the Underwriters have agreed, subject to certain conditions, to purchase (i) the Series 2020 Bonds from the Authority at a purchase price of $149,240,940.75 (reflecting an underwriters' discount of $651,788 and an original issue premium of $14,047,728.75) and to make a public offering of the Series 2020 Bonds at prices that are not in excess of the public offering prices or yields indicated on the inside cover of this Official Statement. The obligations of the Underwriters are subject to certain terms and conditions contained in the Purchase Contract. The Underwriters will be obligated to purchase all of the Series 2020 Bonds if any of the Series 2020 Bonds are so purchased. The Institution has agreed to indemnify the Underwriters against certain liabilities, including certain liabilities arising under federal and state securities laws. The initial offering price of the Series 2020 Bonds may be changed by the Underwriters.

BofA Securities, Inc. has entered into a distribution agreement with its affiliate Merrill Lynch, Pierce, Fenner & Smith Incorporated ("**MLPF&S**"). As part of this arrangement, BofA Securities, Inc. may distribute securities to MLPF&S, which may in turn distribute such securities to investors through the financial advisor network of MLPF&S. As part of this arrangement, BofA Securities, Inc. may compensate MLPF&S as a dealer for their selling efforts with respect to the Series 2020 Bonds.

Citigroup, an underwriter of the Series 2020 Bonds, has entered into a retail distribution agreement with Fidelity Capital markets, a division of National Financial Services LLC (together with its affiliates, "**Fidelity**"). Under this distribution agreement, Citigroup may distribute municipal securities to retail investors at the original issue price through Fidelity. As part of this arrangement, Citigroup will compensate Fidelity for its selling efforts.

The Underwriters and their affiliates are full service financial institutions engaged in various activities, which may include sales and trading, commercial and investment banking, advisory, investment management, investment research, principal investment, hedging, market making, brokerage, and other financial and non-financial activities and services. The Underwriters and certain of their affiliates have, from time to time, performed, and may in the future perform, various investment banking services for the Institution for which it has received or will receive customary fees and expenses.

In the ordinary course of its business activities, the Underwriters and their respective affiliates, officers, directors, and employees may purchase, sell, or hold a broad array of investments and actively traded securities, derivatives, loans, commodities, currencies, credit default swaps, and other financial instruments for their own account and for the accounts of their customers, and such investment and trading activities may involve or relate to assets, securities, and/or instruments of the Institution (directly, as collateral securing other obligations or otherwise) and/or persons and entities with relationships with the Institution. The Underwriters and their affiliates may also communicate independent investment recommendations, market color, or trading ideas and/or publish or express independent research views in respect of such assets, securities, or instruments and may at any time hold, or recommend to clients that they should acquire, long and/or short positions in such assets, securities, and instruments of the Institution.

The Series 2020 Bonds may be offered and sold to certain dealers (including the Underwriters) at prices lower than such public offering prices, and such public offering prices may be changed, from time to time, by the Underwriters.

PART 21 – CONTINUING DISCLOSURE

In order to assist the Underwriters in complying with Rule 15c2-12 promulgated by the Securities and Exchange Commission ("**Rule l5c2-12**"), the Institution has undertaken in a written agreement (the "**Continuing Disclosure Agreement**") for the benefit of the Series 2020 Bondholders to provide to Digital Assurance Certification LLC ("**DAC**"), and for DAC to electronically file with the Municipal Securities Rulemaking Board ("**MSRB**") and its EMMA system, as the sole repository for the central filing of electronic disclosure pursuant to Rules 15c2-12, (i) timely notice of the occurrence of certain events with respect to the Institution and the Series 2020 Bonds, and (ii) on an annual basis, operating data and financial information of the type hereinafter described which is included in "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER" of this Official Statement (the "**Annual Information**"), together with the Institution's annual financial statements prepared in accordance with accounting principles generally accepted in the United States of America and audited by an independent firm of certified public accountants in accordance with auditing standards generally accepted in the United States of America; provided, however, that if the audited financial statements are not then available, unaudited financial statements shall be delivered to DAC for electronic filing with the MSRB. See "APPENDIX H - FORM OF CONTINUING DISCLOSURE AGREEMENT."

In connection with the Series 2013 Bonds, the Institution has undertaken in a written agreement for the benefit of the holders of the Series 2013 Bond to provide to DAC, as the Institution's disclosure agent for the Series 2013 Bonds, certain financial information, including quarterly reports that contain information regarding aggregate inpatient discharges, patient days, average length of stay, emergency room visits, outpatient visits and outpatient procedures; and discharges by major payor source for the fiscal quarter. During the past five years, the Institution has complied with those requirements with its year end reports, but on its quarterly reports, the Institution has not included information about discharges by major payor source for the fiscal quarter. Going forward, the Institution will submit the missing data.

PART 22 – MISCELLANEOUS

References in this Official Statement to the Act, the General Resolution, the Series Resolution, the Loan Agreement, the Servicing Agreement, and the FHA Documents do not purport to be complete. Refer to the Act, the General Resolution, the Series Resolution, the Loan Agreement, the Servicing Agreement, and the FHA Documents for full and complete details of their provisions. Copies of the General Resolution,

the Series Resolution, the Loan Agreement, the Servicing Agreement, and the FHA Documents are on file with the Authority and the Trustee. The agreements of the Authority with Holders of the Series 2020 Bonds are fully set forth in the General Resolution. Neither any advertisement of the Series 2020 Bonds nor this Official Statement is to be construed as a contract with purchasers of the Series 2020 Bonds.

Any statement in this Official Statement involving matters of opinion, whether or not expressly so described, are intended merely as expressions of opinion and not as representations of fact.

The information set forth in PART 12 – THE AUTHORITY regarding the Authority was supplied by the Authority. All other information herein has been obtained by the Underwriters from the Institution and other sources deemed to be reliable by the Underwriters, and it is not to be construed as a representation by the Authority or the Underwriters. In addition, the Authority does not warrant the accuracy of the statements herein relating to the Institution not does it directly or indirectly guarantee, endorse, or warrant (i) the creditworthiness or credit standing of the Institution, (ii) the sufficiency of the security for the Series 2020 Bonds, or (iii) the value or investment quality of the Series 2020 Bonds.

The information regarding the Mortgage Servicer was supplied by the Mortgage Servicer. The Authority believes that this information is reliable, but the Authority and the Underwriters make no representations or warranties as to the accuracy or completeness of this information.

The information regarding DTC and DTC's book-entry only system has been furnished by DTC. The Authority believes that this information is reliable, but the Authority makes no representations or warranties whatsoever to the accuracy or completeness of this information.

"APPENDIX D – DEFINITIONS OF CERTAIN TERMS," "APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION," "APPENDIX F - SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT," and "APPENDIX G - FORMS OF APPROVING OPINION OF CO-BOND COUNSEL" have been prepared by Harris Beach PLLC and Lewis & Munday, A Professional Corporation, Co-Bond Counsel to the Authority.

The Institution has prepared "PART 2 - PLAN OF FINANCING (except for (i) the two undesignated paragraphs immediately preceding "Construction Fund Disbursements," and (ii) "Payment of Mortgage Insurance Benefits" and "Prepayment of Note from Hazard Insurance or Condemnation Proceeds"), "PART 11 – BONDHOLDERS' RISKS" and "APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER" and has reviewed other sections of this Official Statement relating to the Institution. The Institution shall certify as of the dates of sale and delivery of the Series 2020 Bonds that such parts do not contain any untrue statement of material fact and do not omit any material fact necessary to make the statements made therein, in light of the circumstances under which the statements are made, not misleading.

The Institution has agreed to indemnify the Authority and the Underwriters and certain others against losses, claims, damages and liabilities arising out of any untrue statements or omissions of statements of any material fact as described in the preceding paragraph.

[*remainder of page intentionally left blank*]

The execution and delivery of this Official Statement have been duly authorized by the Institution and an Authorized Officer of the Authority.

DORMITORY AUTHORITY OF
THE STATE OF NEW YORK

By: /s/ Reuben R. McDaniel
Authorized Officer

[DOCUMENT EXECUTION CONTINUES ON THE FOLLOWING PAGE]

[INSTITUTION EXECUTION PAGE TO THE OFFICIAL STATEMENT]

MAIMONIDES MEDICAL CENTER
a New York not-for-profit corporation

By: /s/ Kenneth D. Gibbs
Authorized Officer

APPENDIX A – CERTAIN INFORMATION CONCERNING MAIMONIDES MEDICAL CENTER

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX B - CONSOLIDATED FINANCIAL STATEMENTS OF MAIMONIDES MEDICAL CENTER AS OF DECEMBER 31, 2019 AND 2018 AND FOR THE YEARS THEN ENDED, WITH INDEPENDENT AUDITOR'S REPORT

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX C - UNAUDITED INTERIM CONSOLIDATED FINANCIAL STATEMENTS OF MAIMONIDES MEDICAL CENTER AS OF APRIL 30, 2020 AND FOR THE FOUR-MONTH PERIODS ENDED APRIL 30, 2020 AND APRIL 30, 2019

[THIS PAGE INTENTIONALLY LEFT BLANK]

APPENDIX D – DEFINITIONS OF CERTAIN TERMS

APPENDIX E – SUMMARY OF CERTAIN PROVISIONS OF THE GENERAL RESOLUTION

APPENDIX F - SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

APPENDIX G - FORMS OF APPROVING OPINION OF CO-BOND COUNSEL

APPENDIX H - FORM OF CONTINUING DISCLOSURE AGREEMENT