STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

ANNUAL MEETING

AGENDA

February 2, 2012

10:15 a.m.

90 Church Street
4th Floor, Room 4A & 4B
New York City

I. INTRODUCTION OF OBSERVERS

Dr. William Streck, Chairman

II. APPROVAL OF MINUTES

December 8, 2011 **Exhibit #1**

III. ELECTION OF OFFICERS

A. Election of Vice of Chairperson

B. Announce Committee Chairpersons and Vice Chairpersons and Committee Membership

- Committee on Codes, Regulations and Legislation
- Committee on Establishment and Project Review
- Committee on Health Planning
- Committee on Public Health
- Ad Hoc Committee to Lead the State Health Improvement Plan

IV. 2011 ANNUAL REPORT

Public Health and Health Planning Annual Report **Exhibit #2**

V. REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

A. Report of the Department of Health

Nirav R. Shah, M.D., M.P.H., Commissioner of Health

B. Report of the Office of Health Systems Management Activities

Lora Lefebvre, Deputy Director, Office of Health Systems Management

C. Report of the Office of Health Information Technology Transformation Activities

Rachel Block, Deputy Commissioner, Office of Health Information
Technology Transformation

D. Report of the Office of Health Insurance Programs Activities

Jason Helgerson, Deputy Commissioner, Office of Health Insurance Programs

E. Report of the Office of Public Health Activities

Dr. Guthrie Birkead, Deputy Commissioner, Office of Public Health

VI. PUBLIC HEALTH SERVICES

Report on the Activities of the Committee on Public Health

Jo Ivey Boufford, M.D., Chair of the Public Health Committee

VII. HEALTH POLICY

A. Report on the Activities of the Committee on Health Planning

John Rugge, M.D., Chair of the Health Planning Committee

*****Break for Lunch*****

VIII. REGULATION

Report of the Committee on Codes, Regulations and Legislation **Exhibit #3**

Angel Gutiérrrez, M.D., Chair

For Emergency Adoption

11-27 Amendment of Section 401.2 of Part 401 of Title 10 NYCRR
(Amendment to Limitations of Operating Certificates)

For Adoption

11-27 Amendment of Section 401.2 of Part 401 of Title 10 NYCRR
(Amendment to Limitations of Operating Certificates)

For Discussion

11-24 Amendment of Parts 763 and 766 of Title 10 NYCRR (Certified Home Health Agency (CHHA) and Licensed Home Care Services Agency (LHCSA) Requirements)

IX. PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Report of the Committee on Establishment and Project Review

Jeffrey Kraut, Chair

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

Acute Care Services – Construction **Exhibit #4**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112074 C	University Hospital (Suffolk County)	Contingent Approval

Diagnostic and Treatment Center – Construction **Exhibit #5**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112250 C	Smile New York Outreach, LLC d/b/a Smile Program Mobile Dentists (Queens County)	Contingent Approval

Long Term Home Health Care Program – Construction **Exhibit #6**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112116 C	Dominican Sisters Family Health Service, Inc. (Westchester County)	Contingent Approval

Transitional Care Units - Construction **Exhibit #7**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112206 T	St. Mary's Healthcare (Montgomery County)	Contingent Approval

CATEGORY 2: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Without Dissent by HSA
- Without Dissent by Establishment and Project Review Committee

CON Applications

Acute Care Services – Construction **Exhibit #8**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112059 C	New York Presbyterian Hospital – New York Weill Medical Center (New York County) Ms. Regan - Interest	Contingent Approval
2.	112259 C	North Shore University Hospital (Nassau County) Mr. Kraut – Recusal	Contingent Approval

CATEGORY 3: Applications Recommended for Approval with the Following:

- No PHHPC Member Recusals
- Establishment and Project Review Committee Dissent, or
- Contrary Recommendations by HSA

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Establishment and Project Review Committee Dissent, or
- Contrary Recommendation by HSA

Residential Health Care Facility – Construction **Exhibit #9**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	111435 C	The Wartburg Home (Westchester County) Mr. Fassler - Interest	Contingent Approval

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

Diagnostic and Treatment Center – Construction **Exhibit #10**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	101018 C	Doctors United, Inc. (New York County)	Disapproval

CATEGORY 6: Applications for Individual Consideration/Discussion

NO APPLICATIONS

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

Diagnostic and Treatment Center – Establish/Construct **Exhibit #11**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	101164 B	Mobile Health Services, LLC (New York County)	Contingent Approval
2.	112142 E	Primary Health Care Plus, Inc. (Nassau County)	Approval

Residential Health Care Facility – Establish **Exhibit #12**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	101068 E	Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC d/b/a Guilderland Center Rehabilitation and Extended Care Facility (Albany County)	Contingent Approval

Certificate of Amendment of the Certificate of Incorporation **Exhibit #13**

	Applicant	E.P.R.C. Recommendation
1.	BMA, Medical Foundation, Inc.	Approval

Certificate of Dissolution **Exhibit #14**

	Applicant	E.P.R.C. Recommendation
1.	Mary McClellan Hospital, Inc.	Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #15**

Number	Applicant/Facility	E.P.R.C. Recommendation
1959 L	Stat Staff Professionals, Inc. (Saratoga, Warren, Albany, Greene, Franklin, Washington, Rensselaer, Columbia, Clinton, Fulton, Otsego, Ulster, Essex, Montgomery, Schoharie, Hamilton, Schenectady, and Delaware Counties)	Contingent Approval

CATEGORY 2: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Without Dissent by HSA
- Without Dissent by Establishment and Project Review Committee

CON Applications

Acute Care Services – Establish **Exhibit #16**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112185 E	Inter-Lakes Health, Inc. (Essex County) Mr. Booth –Interest Dr. Rugge- Interest	Contingent Approval

Ambulatory Surgery Centers – Establish/Construct **Exhibit #17**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112244 E	Unity Linden Oaks Surgery Center, LLC (Monroe County) Mr. Booth – Interest Mr. Robinson – Recusal	Contingent Approval

Certified Home Health Agencies – Establish **Exhibit #18**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	102239 E	North Shore University Hospital, Inc., d/b/a North Shore Home Care (Nassau County) Mr. Kraut - Recusal	Approval

Residential Health Care Facility – Establish **Exhibit #19**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112218 E	***DEFERRED AT THE DEPARTMENT'S REQUEST** Waterfront Operations Associates, LLC d/b/a Waterfront Center for Rehabilitation and Health Care (Erie County) Mr. Booth - Interest Mr. Fassler – Recusal	Contingent Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #20**

	Number	Applicant/Facility	E.P.R.C. Recommendation
	1994 L	Independent Living for Seniors, Inc. (Monroe and Wayne Counties) Mr. Booth – Interest Mr. Robinson – Recusal	Contingent Approval

CATEGORY 3: Applications Recommended for Approval with the Following:

- No PHHPC Member Recusals
- Establishment and Project Review Committee Dissent, or
- Contrary Recommendations by or HSA

Ambulatory Surgery Centers – Establish/Construct **Exhibit #21**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	111552 B	The Surgery Center of Bayside, LLC (Queens County)	Contingent Approval
2.	112032 B	PBGS, LLC d/b/a Downtown Brooklyn Gynecology Center (Kings County)	Contingent Approval

CATEGORY 4: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Establishment an Project Review Committee Dissent, or
- Contrary Recommendation by HSA

HOME HEALTH AGENCY LICENSURES **Exhibit #22**

	Number	Applicant/Facility	E.P.R.C. Recommendation
	1640 L	Acute Care Experts, Inc. (Bronx, Queens, Kings, Richmond, Nassau, and New York Counties) Ms. Regan – Interest	Contingent Approval

1956 L	Advantage Management Associates, Inc. d/b/a Advantage Homecare Agency (New York, Westchester, Kings, Queens, Bronx, and Richmond Counties) Ms. Regan – Interest	Contingent Approval
1678 L	Amazing Grace Home Care Services, LLC (New York, Bronx, Kings, Richmond, and Queens Counties) Ms. Regan – Interest	Contingent Approval
1696 L	Diana's Angels, Inc. (Putnum, Bronx, Westchester and Dutchess Counties) Ms. Regan – Interest	Contingent Approval
1957 L	Evergreen Choice, LLC (New York, Bronx, Kings, Richmond and Queens Counties) Ms. Regan – Interest	Contingent Approval
1668 L	Five Borough Home Care, Inc. (Bronx, Kings, New York, Richmond, and Queens Counties) Ms. Regan – Interest	Contingent Approval
1733 L	Heritage Homecare Services, Inc. (New York, Kings, Queens, Bronx, Nassau, Suffolk and Richmond Counties) Ms. Regan – Interest	Contingent Approval
1835 L	Longevity Care, LLC (Westchester County) Ms. Regan – Interest	Contingent Approval
2004 L	Long Island Living Center, LLC d/b/a Long Island Living Center (Bronx, Kings, and Queens Counties) Ms. Regan – Interest	Contingent Approval

2079 L	Metrostar Home Care, LLC (Kings, Bronx, Queens, Richmond, New York and Nassau Counties) Ms. Regan – Interest	Contingent Approval
1875 L	ALJUD Licensed Home Care Services, LLC (Nassau and Suffolk Counties) Ms. Regan – Interest	Contingent Approval

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

Certified Home Health Agencies – Establish **Exhibit # 23**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	111096 E	L. Woerner, Inc., d/b/a HCR (Schoharie County)	To be presented at the Special Establishment/Project Review Committee on 2/2/12 No Recommendation
2.	121027 E	L. Woerner, Inc. d/b/a HCR (Delaware County)	To be presented at the Special Establishment/Project Review Committee on 2/2/12 No Recommendation

Residential Health Care Facility – Establish **Exhibit #24**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112031 E	Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center (Kings County)	To be presented at the Special Establishment/Project Review Committee on 2/2/12 11/17/11 E/PRC Contingent Approval

X. <u>PROFESSIONAL</u>

Report of the Committee on Health Personnel and Interprofessional Relations

Dr. Theodore Strange, Chair
Two Cases

XI. <u>NEXT MEETING</u>

March 22, 2012 – ALBANY
April 5, 2012 - ALBANY

XII. <u>ADJOURNMENT</u>

State of New York
Public Health and Health Planning Council

Minutes
December 8, 2011

The first meeting of the Public Health and Health Planning Council was held on Thursday, December 8, 2011, at the Albany Marriott, 189 Wolf Road, Albany, New York 12205. Chairman, Dr. William Streck, presided.

COUNCIL MEMBERS PRESENT:

Dr. William Streck, Chair
Dr. Howard Berliner
Dr. Jodumutt Ganesh Bhat
Mr. Christopher Booth
Dr. Jo Ivey Boufford
Mr. Michael Fassler
Mr. Howard Fensterman
Dr. Carla Boutin-Foster
Dr. Ellen Grant
Dr. Angel Gutierrez
Ms. Victoria Hines
Mr. Robert Hurlbut
Mr. Jeffrey Kraut
Dr. Glenn Martin
Ms. Ellen Rautenberg
Ms. Susan Regan
Mr. Peter Robinson
Dr. John Rugge
Dr. Theodore Strange
Dr. Ann Marie Theresa Sullivan
Dr. Anderson Torres
Dr. Patsy Yang
Commissioner Shah (ex-officio)

DEPARTMENT OF HEALTH STAFF PRESENT:

Dr. Guthrie Birkhead
Ms. Rachel Block
Anna Colello
Mr. Richard Cook
Ms. Barbara DelCogliano
Mr. Christopher Delker
Mr. James Dering
Ms. Ellen Flink
Ms. Becky Gray
Ms. Sandy Haff
Ms. Mary Ellen Hennessy
Mr. Mark Kissinger
Ms. Karen Lipson
Ms. Karen Madden
Mr. Keith McCarthy
Ms. Sylvia Pirani
Ms. Linda Rush
Mr. Robert Schmidt
Ms. Kelly Seebald
Ms. Lisa Thomson
Mr. John Ulberg

INTRODUCTION:

Dr. Streck called the meeting to order and welcomed Commissioner Shah along with Council members, meeting participants and observers.

Dr. Streck informed the meeting participants that the meeting would be broadcast over the internet which would give greater access to the public.

Next, Dr. Streck reminded the audience that the New York State Temporary Commission on Lobbying is requiring that a form be filled out before entering the meeting room which records their attendance.

MEETING OVERVIEW:

Dr. Streck gave a brief overview of what would be covered at the Council meeting.

APPROVAL OF THE MINUTES OF OCTOBER 6, 2011:

Dr. Streck asked for a motion to approve the August 4, 2011 Minutes of the Public Health and Health Planning Council meeting. Dr. Gutiérrez motioned for approval which was seconded by Dr. Berliner. The minutes were unanimously adopted. Please refer to pages 4 and 5 of the attached transcript.

REPORT OF THE DEPARTMENT OF HEALTH ACTIVITIES:

Dr. Streck introduced Commissioner Shah to give the Report on the Department of Health Activities.

Commissioner Shah began his report by welcoming the members.

Department of Health Appointments

Commissioner Shah announced that Yvonne Graham has been named the Director of the new Health Disparities Prevention Office. Ms. Graham has extensive experience in planning and policy and most recently served as the Deputy Borough President in Kings County, where she was active in community health projects. In her new position, Ms. Graham will develop programs and initiatives to continue New York's progress toward ending health disparities and ensuring that all people have access to affordable, high-quality health care.

Commissioner Shah advised that the Department named a new director for the Department's Bureau of Narcotics Enforcement, Terence O'Leary. Mr. O'Learyy who most recently served as a Narcotics Prosecutor for the City of New York and brings a wealth of experience to the Bureau. As BNE Director, Mr. O'Leary will be responsible for overseeing the Department's comprehensive approach to preventing prescription theft and abuse. This is a growing problem in states across the nation, and we are fortunate to have Mr. O'Leary leading our efforts.

HEAL Grants

Dr. Shah stated that on November 28, 2011, the Department announced that $450 million in grant funding will be made available in early 2012 to assist health care facilities across the state in their efforts to improve primary and community-based care, eliminate excess bed capacity, and reduce overreliance on inpatient care in hospitals and nursing homes. This funding, which supports a recommendation of the Medicaid Redesign Team, will serve as a critical tool to address the needs of these institutions as they transition to a more sustainable, patient-centered approach.

Dr. Shah explained that the funding is being provided through the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL), and the Federal-State Health Reform Partnership, known as F-SHRP. A Request for Applications will be issued with a focus on encouraging collaborative partnerships between providers, such as shared services agreements, bed consolidations, joint government arrangements, and mergers. The awards will primarily support capital projects, including the conversion of hospital inpatient space to outpatient and ambulatory care as well as shifts from nursing homes to less restrictive forms of long-term care.

Commissioner Shah further noted that under this RFA, some facilities could be eligible for temporary increases in their Medicaid payment rates to support the costs of operational activities that will facilitate transition to the delivery of more efficient and appropriate care services. Overall, these grants are a significant investment in New York's goal to transform our health care system.

MRT - Brooklyn Hospitals

Commissioner Shah stated that while many health care facilities are facing challenges, the number of facilities experiencing fiscal strain in Brooklyn is particularly acute. The week of December 27, 2011, the MRT's Health System Redesign: Brooklyn Work Group, led by Stephen Berger, released a report on both the challenges facing the borough's health care system and a roadmap of short- and long-term steps to improve the borough's health care delivery system. As the report notes, Brooklyn has 15 hospitals and nearly 6,400 licensed beds. Brooklyn's residents have high rates of chronic disease and too often use hospitals for routine health care. In Brooklyn, 15 percent of adult admissions and 46 percent of Emergency Department visits where there are not admissions could have been averted through accessible, quality primary care. This is not sustainable.

Dr. Shah advised that Mr. Cook will provide more details and noted that the report does not recommend any closures of private or not-for-profit hospitals. However, the report does include options for the boards of financially troubled hospitals to consider for merging or consolidating in order to achieve better, more cost-effective care, and to stabilize their financial situations. There is no question that some hospitals in Brooklyn and others in New York State will need to make fundamental and significant changes. The State is committed to seeing Brooklyn adapt to the changing environment. The Department is committed to helping with the transition where possible. However, the health care leaders, boards and management here must all take action to make the needed changes.

Commissioner Shah applauded the Brooklyn Hospital Work Group's efforts. It has been a collaborative, locally driven process and he looks forward to working with the stakeholders and the community to move forward with a realistic, workable plan that will create a sustainable, high quality health care system.

United Health Foundation Rankings

Next, Commissioner stated that he is pleased to announce that during the week of December 4, 2011, the United Health Foundation released the national health care rankings, and New York was cited for significant progress. Overall, the State is ranked 18th as opposed to 24th the previous year. This is the fourth year in a row New York has moved up in the rankings. Some of the fields where New York excelled include: a low cancer death rate, a significant decline in the adult smoking rate, a low infant mortality rate, and a high number of readily available primary care physicians.

State Health Improvement Plan

Commissioner Shah explained that the Council's Public Health Committee is set to begin an effort to develop New York's five-year State Health Improvement Plan for the period 2013-2017. The current plan, the *Prevention Agenda toward the Healthiest State*, established the framework for the time period 2008-2012. Currently, there is the need to build on the strengths of that plan and set priorities for the years ahead. This effort will include input from key public health and health care entities, along with other stakeholders throughout the state.

Dr. Shah noted that the next State Health Improvement Plan will outline health issues and areas for health improvement determine factors that contribute to these health issues; and identify assets and resources that can be mobilized to improve population health. This plan will serve as the State Community Health Assessment. Stakeholders will be included in the development plans to help identify New York's public health priorities and establish measurable objectives and evidence-based improvement strategies for each priority.

Dr. Shah indicated that policy changes necessary to accomplish these identified health objectives also will be identified. In addition, the plan will include the designated organizations that will have the responsibility to implement specific strategies. These will include other State agencies and non-Department stakeholders, as well as programs within the Department. The goal is to move toward a health-in-all-policies approach. The plan also will develop and issue a new Community Health Report card to monitor progress by county.

Commissioner Shah explained that the new plan will provide a framework for collaborative local public health and health services planning required of Local Health Departments that conduct Community Health Assessments and hospitals that conduct Community Service Plans in 2012-2013. Completing a state health assessment and state health improvement plan are two prerequisites of the Public Health Accreditation process. The State is starting the accreditation process application. The process will be challenging but this is critical to establishing, advancing, and ultimately achieving our public health objectives. Dr. Shah noted that Dr. Birkhead and Dr. Boufford will be speaking more about these activities in their respective reports.

Influenza

Next, Dr. Shah stated that the Department is currently closely monitoring influenza. So far this year, there have been very low flu numbers, only about 100 confirmed reports of flu and about 50 hospitalizations. The Department, in conjunction with local health departments and other partners, has done a great job encouraging people to get a flu vaccination.

Dr. Shah explained that his staff invited local TV stations to watch him receive his flu shot, a definition of taking one for the team and encouraged all to take one for the team. Even with low numbers to date, we cannot let up. So we're continuing to promote vaccinations. Typically, the number of flu cases begins to rise steadily from early December and reaches a peak in February or early March, so we still want those who have not been vaccinated this year to get their flu shot as soon as possible.

World AIDS Day

Dr. Shah mentioned that December 1st was World AIDS Day. The Department hosted a three-day observance last week, featuring the NAMES AIDS Memorial Quilt and a variety of activities to raise awareness and promote prevention. Great strides have been made in the 30 years since AIDS was first diagnosed, but the disease remains a serious public health threat. About 127,000 New Yorkers are currently living with HIV or AIDS, and in 2010, there were more than 5,100 new cases of HIV in New York and over 3,400 new reported AIDS cases. The C.D.C. reported that of a hundred people with H.I.V., eighty people know their status and only forty people are adequately treated. We have a long way to go.

Dr. Shah noted that in New York, we are doing well. In 2010, only three infants were diagnosed infected through mother-to-child transmission, a decrease of ninety-seven percent since such testing began in 1997. New York has a strong program for newborn H.I.V. testing and also provides pregnant women with access to perinatal health and education to prevent such transmission. In addition, we offer antiretroviral drugs to protect the health of both mother and infant. In the area of mother-to-child transmission and other issues related to H.I.V. and AIDS we still face some challenges. The progress is encouraging, but three cases is still three cases too many.

Commissioner Shah indicated that during the New York World AIDS Day observation, he had the opportunity to present distinguished services awards to honor individuals and groups who were assisting in the battle against H.I.V. or AIDS and many of these honorees were young people, students who recognize the toll the disease has inflicted. Even though most of them were not born at the beginning of the AIDS crisis, these young people understand the important role they can have in fighting H.I.V. or AIDS among their peers and it was really inspirational to see their involvement.

On that positive note, Dr. Shah concluded his report. Dr. Streck thanked Dr. Shah for his report and asked for Council member comments or questions.

To review Dr. Shah's full report and questions and comments from Council members, refer to pages 5 through 16 of the attached transcript.

Dr. Streck thanked Dr. Shah for his report and moved to the next item on the agenda and introduced Mr. Cook to give the Report on the Activities of the Office of Health Systems Management.

Report of the Office of Health Systems Management

Mr. Cook began his report by bringing the Council up to date on a few issues. He noted the Brooklyn report provides a model of how you evaluate a region and how you try to assess what changes need to be made in the region.

Mr. Cook briefly described a few recommendations. One recommendation was that there should be a borough-wide planning effort that should be funded and supported by the State to continue the work. The Department is aware that as they looked at the acute care side, particularly the troubled hospitals and primary care needs within that region, it would have been important to be able to spend some time looking at the long term care system, the issue that drove this report was concern with the fiscal conditions of several hospitals. An important thing about what came out of the report relating to recommendations for the hospitals is that the Department is trying to encourage those hospitals who are most troubled, particularly Brooklyn, Wyckoff, and Interfaith have been asked to come together in an active parent to integrate services, not to the benefit of any one individual facility, but for the benefit of what are the needs of the community.

Mr. Cook explained another recommendation is for Kingsbrook to essentially replace MediSys as the active parent for Brookdale. He expressed that in both of those instances there is a recognition by the Berger Commission that there truly planning needs to be done in order to evaluate the community need. Just as importantly, it is critical that you have active boards who are involved in asking critical questions relating to what systems are doing and look beyond the individual needs of those systems to what should be their role in the community. A core issue that this Council often grapples with, the needs of the community, not the individual facility and Those recommendations are going to be ones that will take some time, but having Mr. Berger out there making very clear, he does not mix words, that there is a need for integration, otherwise these systems will not be able to exist long term. The Department has already met with each of those hospitals individually and have also met with those hospitals together. So we are actively involved in reviewing the recommendations with these hospitals to encourage them to accept the recommendations of the Berger Report.

Next, Mr. Cook emphasized the R.F.A. that was issued for the $450 million HEAL grants. The Department has been engaged in numerous discussions over the last few months, not with just entities from Brooklyn, but with hospitals and systems across the state about this being announced and the availability of dollars. Mr. Cook re-emphasized that this is not solely related to Brooklyn, that we want to be able to support the integration throughout the state, and nursing homes are eligible for this application. He noted that the HEAL process often give the Department terrific ideas about how the world can change if there is a small amount of capital

support to move the systems forward.

Mr. Cook concluded his report and asked if there was questions. To review Mr. Cook's complete report and Council members questions and comments, please refer to pages 16 through 28 of the attached transcript.

Dr. Streck thanked Mr. Cook for his report and moved to the next item on the agenda and introduced Ms. Block to give the report on the activities of the Office Health Information Technology Transformation

Report of the Office of Health Information Technology Transformation Activities

Ms. Block began by stating that the Council recognizes New York's leadership in the area of health information technology and the very significant role that the HEAL New York grant program has played in advancing the Department's efforts. Currently, the Department is also shifting its attention somewhat, looking at the national strategy for health information technology. Ms. Block wanted to spend a few moments talking about how the Department's efforts and those at the national level are dovetailing, specifically with regard to increasing participation in the meaningful use program. She is hopeful that many of the people in attendance recognize that the E.H.R. incentive program for meaningful use was the largest funded activity in the high tech and A.R.R.A. legislation enacted at the federal level a couple years ago. Ms. Block recognized that both the Medicare and Medicaid programs really needed to emphasize E.H.R. use and the meaningful use of E.H.R.s in order to advance the important reforms the Department is now seeing in both the Medicare and Medicaid programs.

Through the HEAL 5 initiative, which was just recently wrapped up, the Department was able to provide twenty-five hundred physicians with E.H.R.s that are now implemented in the community. The Department now has seventy-five hundred physicians who are participating in health information exchange in some form or other, either providing data or accessing data through the health information exchange. The latter's requirements will increasingly emphasize the utilization of health information exchange as a component of how we define the meaningful use of E.H.R.s.

The Regional Extension Center Program, which was included within the High Tech A.R.R.A. Program, is being administered in New York State by two entities; statewide by the New York eHealth Collaborative; in New York City by the New York City Health Department under a program called New York City Reach. The Department is extremely pleased with the combined efforts of those aforementioned programs. A target of signing up ten thousand eligible professionals by the end of the year was and it looks as though they are both very likely to meet their respective targets by the end of December. The Department now has somewhere in the neighborhood of three hundred physicians who are participating in that program who have actually attested to and have been certified by the federal government to have achieved Meaningful Use. These numbers are expected to significantly increase as the months go by. These initial efforts through the HEAL program have certainly created an important starting point from which to achieve that success. It is clear that the Department needs to keep advancing its efforts towards E.H.R. adoption. Additionally, Ms. Block is pleased to announce that the Department has finally initiated the process of enrolling eligible professionals in the Medicaid

E.H.R. incentive program here in New York. She realizes that a number of committee members have been following this closely and have been anxiously awaiting an announcement. Ms. Block would like to add that there is a website specifically set up for any providers who have questions about how to enroll and what's involved in becoming part of that program where fellow providers will answer their questions. Inquiries should be directed to *hit@health.state.ny.us*. The Department will continue to work very closely with Medicaid and the Regional Extension Center Program in order to ensure combined efforts and hopefully facilitate the dramatic increase in the number of eligible professionals who will soon be registered to participate in the Medicaid component of the Meaningful
Use Program.

The Office of the National Coordinator has made it very clear to New York as well as every other state in the Nation that they expect the Department to "step up to the plate" in order to help them achieve their National goals for Meaningful use. Through the current efforts, the Department is well underway to doing just that. There clearly is more to be done offline of regularly scheduled Council meetings.

Ms. Block concluded her report and offered to speak to any council members or colleagues interested in learning more about what the Department is doing to achieve the National goals for Meaningful Use. To review Ms. Block's complete report and Council member's questions and comments, please refer to pages 28 through 35 of the attached transcript.

Dr. Streck thanked Ms. Block for her reported and moved to the next item on the agenda and introduced Mr. Ulberg to give the report on the activities of the Office of Health Insurance Programs.

Report of the Office of Health Insurance Programs

Mr. Ulberg has prepared a power point presentation for the meeting and it was distributed via e-mail to the participants. Mr. Ulberg thinks it important to keep the council apprised of the activities that have been underway within OHIP and within the Health Department. He opened by presenting his plan to go over M.R.T. phase one, the progress that the Department has made, and conclude with a brief discussion about what's in store for phase two. He begins by stating that the Department has moved approximately four billions dollars in prescription drug costs starting October 1st. The OHIP has shifted from service to managed care and believes that by all accounts it was a very smooth transition in spite of "a few bumps in the road". We commended the plans who did an excellent job. We were -- you know, on a daily basis as we unloading -- unrolling this that we were involved in stakeholders. As the Department moves forward, it is going to, on a month-to-month basis, very carefully monitor plans for drug usage as well as the shift from service to managed care. The OHIP was pleased with the Department's effort.

Mr. Ulberg suggests that his experience at D.O.B has allowed him to connect with both the Health Department and the Mental Hygiene agencies; he observed that the partnership is stronger now than he has ever seen it and provides the B.H.O. initiative as a key example. The mental hygiene agencies, primarily O.M.H. and OASAS, have been working very closely with each other and with the stakeholder community in order to roll out B.H.O.s. Contracts are

currently in place in four regions of the state; New York City; Hudson River; Central; and Western New York. Starting January 1, 2012 there will be concurrent reviews of every individual who is admitted for inpatient services. The Department has very high rates, state-wide, in terms of re-admissions and avoidable admissions for both mental health and acute care. Long Island will follow suit on February 1, 2012. As a result, there has been a lot of activity prepping the hospitals and informing community providers about the role of the B.H.O.

Additionally Mr. Ulberg notes considerable discussion between the two agencies on the role of the Psyche System. There was a plan -- we had a meeting with the plans this month where we are going to try to make available to the plans the use of the Psyche Systems and we may even mount it on our data warehouse in order to drive data back to plans and into emergency rooms quicker.

The Department has been very busy with Managed Care. The personal care benefit was folded into the plans August 1st as well as mandatory enrollment, recipient restriction, population. Efforts to advance the enrollment process were put in place. ESPMI (phonetic spelling), the chronically ill, no health population were brought in on October 1st, and there was the elimination of some exemptions. Managed care had an ambitious agenda and has made great progress. The same goes for Long-term care, Mark Kissinger and his group released a care coordination model guideline on November 15th. The draft regional rollout plan for mandatory managed care, as well as the C.C.M.s was posted on the M.R.T. website very recently and we're working on a weekly basis with C.M.S. on 11/15 waiver amendments.

Mr. Ulberg goes on to discuss Health Homes. This is one of the bigger initiatives within the Health Department and it is on track to begin phase one in the ten counties that were listed. This will begin with Bronx and Kings Counties, a large population base, starting January 1, 2012. Phase two, that will include sixteen counties, will begin April 1st, 2012 and phase three will include the remaining thirty-six counties on July 1st, 2012. These are very ambitious yet achievable deadlines for us to roll out the Health Home initiative. It is crucial to be sensitive to the placement and the alignment of the person with the health home provider. In order to achieve this, the Department has some sophisticated algorithms that were developed to provide a suitable match between the health home and the person that will be receiving the services. That connection, to the extent that one exists, needs to develop and if it cannot put people with the right health home provider could actually, you know, set us back. So we're spending a lot of time, we're working with our group of health homes as well as with consumer advocates to develop that list and that alignment.

Mr. Ulberg shifts his attention to global cap. There is statute that was part of last year's budget that sets the state share of Medicaid spending at fifteen point three billion dollars ($15,300,000,000.00) for '11-12 and then fifteen point nine billion dollars ($15,900,000,000.00) in the following year. It has been a considerable effort on the part of the Health Department as well as our colleagues in the Budget Division to monitor the global cap spending on a month-by-month basis as required by statute. From a fiscal and not a health care perspective, the department is concerned with the steady growth in enrollment. From April of this year to present, over seventy-two thousand new individuals were enrolled into the Medicaid program, which drives expenditures. This growth is primarily taking place within managed care, which is good in terms of controlling the spending under the cap. As of September 2011, the Department was a

hundred and thirty-four million dollars ($134,000,000.00) below the cap, which is less than two percent. These are volatile numbers. On a month-to-month basis, there have been significant spending swings. It is the Department's job to try to understand those swings and if a problem is anticipated and spending may go above the cap, the Commissioner has the authority to take action to reduce spending. There is a long way to go between now and the end of the year and it will be important to very carefully monitor the trends.

Mr. Ulberg addresses the Medical Indemnity fund. He points out that Laura Lefebvre and her group have been working to implement the indemnity fund, which is intended to provide health care coverage to those children that are injured during birth. Applications are made by the child's parents or the defendant and is applicable to all cases after April 1. The Department is administering this program through D.F.S. The qualifying health care costs are the expenses that the indemnity fund will pick up on a proactive basis when the child is deemed to be injured as part of the program. The qualifying health care costs then are not covered by collateral services such as Medicare and Medicaid.

Mr. Ulberg concludes by announcing that on December 13th, the remaining M.R.T. subcommittees are going to present their recommendations to the larger M.R.T. group and will include; affordable housing; basic benefit review; payment reform; and workforce flexibility. As the recommendations are released, it is the department's hope that they are all endorsed at that time. On December 31, 2012, a final M.R.T. report will be given to the governor for his consideration. Depending on the Governer's review of the recommendations, the Department presumes that there will be all good outcomes, the full plan will be released as part of the executive budget.

The final report, the summary of the phase one reforms and the approved recommendations of the ten workgroups, will establish when we bring all these recommendations together, will be the basis for a comprehensive action plan for the Medicaid program over the next ten years. Mr. Ulberg stressed the importance of setting the Deprartment's agenda for the next five years and to implement it. The phase one part of the implementation process is a disciplined approach and it will put the Department on a course for some meaningful change to the Medicaid program. The whole plan may involve an 11/15 waiver submission to the federal government depending on its final outcome.

Mr. Ulberg concluded his report and asked if there were questions. To review Mr. Ulberg's complete report and Council member's questions and comments, please refer to pages 35 through 50 of the attached transcript.

Dr. Streck thanked Mr. Ulberg for his report and moved to the next item on the agenda and introduced Dr. Guthrie Birkhead to give the report on the activities of the Office of Public Health.

Report of the Office of Public Health Activities

Dr. Birkhead begins by stating that the focus of the OPH report, which will be jointly presented with the Public Health Committee, will focus on the planning of the next phase of the State's Health Improvement Plan.

Dr. Birkhead introduces Dr. Boufford and allows her to make introductory comments.

Dr. Boufford provided context for the Public Health Committee's activities since their last meeting. She recognized the members of the Committee for their hard work, then went on to explain that at the last meeting, the Public Health Committee had established four priorities for the next year in addition to tracking the National Health Care change and Health Reform change as well as how it affects Public Health infrastructure and prevention. The first priority will be working with the planning committee, chaired by Dr. Rugge, in their efforts in modernizing, revising the CON process and try to strengthen the population health impact of that process in the redesign. She explains that there have been a couple of joint meetings held, both virtual and in the flesh, in an effort to explore all of the options available to meet, consistent with the law and receive feedback.

The second priority determined will be to serve as the formal leadership advisory group to the staff for the development of the State's Health Improvement Plan for 2013-2017 on behalf of this Council. Dr. Boufford referenced the commissioner's introduction of the Plan but she defers to Dr. Birkhead to provide more detail.

Dr. Boufford explains the third priority, which is to support the Health Department staff in pursuing national accreditation through the newly established process. She notes the excitement of the public health community in that New York State is going to be one of the pioneer states as far as moving in that direction. The last priority Dr. Boufford mentions is identifying a key health issue on which the Department wants to try to "move the needle" with some concerted effort. It is the Department's hope that the issue will emerge through this assessment process that we be gone through. Over the last couple of meetings the Department has had the opportunity to review, both the work plan and the time table that Dr. Birkhead will discuss and make some modifications to it.

Dr. Birkhead directs the council's attention to the next phase of the State's Health Improvement Plan for the years 2013 through 2017. He notes that these plans are generally five years in duration and that the Department has gone through the prevention agenda where 2012 will be the last year. As a reminder he mentions that the prevention agenda is the five-year term for Public Health Improvement Initiative spanning the years 2008 through 2012 and essentially is a call to action for local health departments, health care providers, hospitals in particular, health plans, and others to work together to identify and address health problems at the local level.

Dr. Birkhead explained that there are ten prevention priority areas, for which each has highlighted goals, numerical goals, and disease-specific goals. Counties and Hospitals in particular were asked to develop their community health plans and hospital community health assessments around these priority areas.

Dr. Birkhead comments on to present data on the status to date along with the fifty-one prevention agenda indicators that were spread over those ten areas. There have been thirty-five indicators where the Department has had some improvement and three indicators achieved their target. Those indicators were coronary heart disease hospitalizations, newly diagnosed H.I.V.

cases, and motor vehicle related mortalities. These three have met the target. Dr. Birkhead pointed out that these data are the most recent, from 2010, so it's really only two to three years into the five-year prevention agenda cycle. The Department has had fourteen of the indicators move in the wrong direction, one that was unchanged and one where there was no new data to report.

Dr. Birkhead highlights a couple of the priority areas. He describes area three of the priority prevention agenda; healthy mothers and healthy babies. He draws attention to the rate of change in the various indicators. For example, the Department would like to see an improvement in children being screened for lead poisoning. That's one of the measures where there has been improvement but still falls eleven percent short of DOH's goals. He adds that child immunization is an indicator where the DOH would like to see an increase, it is in fact moving in the wrong direction.

Dr. Birkhead notes there are a number of indicators that the Department would like to see a decrease in, one such example is the percentage of low birth weight which has decreased but is still above the state's target. The DOH would also like to see an increase in early prenatal care, another indicator that has been moving in the wrong direction. Physical activity and nutrition are two other key areas to be focused on. The Department wanted to improve the percentage of infants breast feeding at six months of age in the WIC program and that's another indicator that has moved in the wrong direction. On the other hand, data suggests that there has been an increase in adults eating five or more fruits and vegetable servings a day. Adult obesity is something the DOH would like to decrease and it is apparent that the state is well above the goal and that's an indicator that had moved in this two to three-year period in the wrong direction. However, the percentage of obese children in WIC program, aged two to four, is short of the goal but it's moving in the right direction. It is to be noted that in regard to WIC the DOH actually "turned the obesity curve". It is now flat or heading down which is a big achievement.

Dr. Birkhead mentions that most of the goals in the chronic disease area were to reduce various things. For example, reducing cancer mortalities, cervical cancer, breast cancer mortality. One of the measures which was met and surpassed is the coronary heart disease hospitalization measure, the Department has actually passed and now has gone below the target that was set. Data indicates the state is moving in the wrong direction when it comes to diabetes related hospitalizations and diabetes prevalence therefore, more work needs to be done there.

Dr. Birkhead adds that in the area of infectious disease, immunization rates of adults for pneumonia and influenza are not on target. He points out things are moving in the right direction. The rates of T.B. cases and gonorrhea are reduced. Dr. Birkhead indicated that the Department has met and surpassed the goal for newly diagnosed H.I.V. cases. The incidence of H.I.V. infections is decreasing in the state and has been going down now for several years.

Dr. Birkhead notes that in terms of moving forward to the next cycle of the State Health Improvement Plan (2013-2017), the Department would like to engage in a process that provides the public and stakeholders with the progress to date on the objectives, but allow stakeholders to identify what the priority areas would be for the next cycle of the State Health Improvement Plan. The Department would like to use the Public Health Committee and a new committee to try and get some of their input and develop a plan with strategies moving forward.

Dr. Birkhead referenced Dr. Shah and Dr. Boufford's remarks on the accreditation process and goes on to say that order to become an accredited State Health Department, there needs to be a process of setting objectives, getting stakeholder input, and developing a strategic plan.

Dr. Birkhead states that starting with the current prevention agenda, as an example, within the time period, the Department has had local health departments conducting activities in terms of their community health assessments. The community health assessment was actually synchronized in 2008-2009 for the local health departments and the hospital community service plans. He reveals that in going forward, those plans aren't exactly synchronized. That's one of the things the Department would like to address, to again try to synchronize the hospital and county health department planning processes and also reconcile them with the new requirements for hospitals in terms of their planning for the I.R.S. The Office of Public Health is working with the Office of Health Systems to figure out how to again make these planning processes coincide in time so they can occur jointly.

Dr. Birkhead proposed that the Department establish a statement health improvement plan advisory committee of this Council. There has been interest expressed by of a number of members of the current standing Public Health Committee and he invites interested stakeholders to participate in this effort and work with the Department to develop this plan.

Dr. Birkhead introduced the first steps of the plan, which are to look at the health status and areas for health improvement, focusing on disparities and factors that contribute to ill health. There has not been a big focus on evidence base and there will be review the evidence base. He mentions this was done a couple years ago with the prevention agenda. The Department will renew that information to look where there are clear strategies that can be employed to achieve success. This health assessment and the public's input will then be used to identify Public Health Priorities and establish some measurable objectives for each of them. Accordingly, the DOH would then, as was done with the prevention agenda, work with local and statewide organizations to take the lead in helping to implement these strategies. These organizations would include other state agencies, local health departments, hospitals, managed care, other community organizations, and statewide organizations that represent different groups. Again, as done with the prevention agenda, this process will be used in order to issue community health report cards, while updating the website in order to keep people focused on the end goal. This will be done in hopes of providing local public health and health services planning with a framework. Dr. Birkhead expressed his desire to have the timing of these steps synchronized.

Dr. Birkhead suggested that the committee, as an immediate first step, find out if there is a mechanism in the bylaws of the PHHPC to establish advisory committees, specifically one that assists specifically in the development of the state health improvement plan, where external as well as council members may sit on it. Currently, there are six members of the existing Public Health Committee who expressed interest and there will be an invitation process the original prevention agenda leadership group. This group should meet regularly during the next year in order to help create a plan ready to go in 2013.

Dr. Birkhead concludes his report and asks Dr. Boufford if there is anything she would to add.

Dr. Boufford brought to the councils attention that the Ad Hoc leadership group, as was pointed out by Dr. Birkhead, was constructed around the prevention agenda and did meet regularly for a couple of years. The committee is a very broad based group where the goal was to get statewide organizations representing various advocacy groups, professional associations, academic institutions to meet on a regular basis to look at how to connect different divisions and processes.

Dr. Boufford mentions the identified weaknesses of the previous leadership agenda group; there was not a lot of representation from the business community. She suggests that the committee develop some strategies for approaching the New York State Business Council and other groups.

Dr. Boufford concludes by expressing her hope that the advisory committee will bring in or be able to attract not only the multiple expert sections within the Department of Health but also look to the commissioner's guidance on bringing in some of his colleague commissioners from across New York State government, especially to deal with some of these broader determinants such as economic development and housing, transportation, education, agriculture.

Dr. Sreck thanks Dr. Boufford and Dr. Birkhead for their reports. He then asks for comments from the members of the council on the proposition of an advisory committee on strictly a business basis. To review Dr. Birkhead and Dr. Boufford's complete report and the Council member's comments and questions, please refer to pages 50 through 65 of the attached transcript.

HEALTH POLICY

Report on Activities of the Committee on Health Planning

Dr. Streck moved to the next item on the agenda under Health Policy and asked Dr. Rugge to give his report on the Activities of the Committee on Health Planning.

Dr. Rugge stated the work to date has included seeking stakeholder input from key stakeholders that are identified from around the state. The Committee is looking at advancing a number of committee meetings one day ahead of the standard committee so that there more time for the Committee to deliberate. The next committee meetings will be on January 18, 2012and on March 21, 2012. The Committee is expecting that in August it will be able to deliver a report with recommendations regarding a redesign of the CON process. There will be expert advice from those with a long history of CON and also from other commissioners as we look to integrate services including physical health, mental health, and substance abuse.

Dr. Rugge explained one of the steps is to profile the current CON process which should be relatively easy as there is an annual report that has all the relevant data. The Committee is working on putting this into narrative form. Following this step, is to understand the rationale for the CON, its benefits and drawbacks. There are drawbacks, there are time delays, there are false starts that we are experiencing, and there may be activities that we should be looking at as a Council that are simply now beyond our purview. Dr. Rugge noted that the question is how the

Council can expand that so that it can address the very rapid changes coming in the health delivery system.

Dr. Rugge noted that one chapter will describe the changing environment and the need to drive the nature of the reforms and the new recommendations that the Council is looking to achieve with a series of recommendations. The last chapter will begin with a restated purpose for CON. Dr. Rugge mentioned that he would like to be able to derive some guiding principles in terms of what does that restated purpose imply for the nature of change that is being created.

Dr. Rugge outlined the current criteria already established in law: financial feasibility, public need, and character and competence, and other matters. Other matters has is a wide open provision in statute whereby this Council can consider factors not included in the need, character and competence and financial feasibility. The Committee received many comments pertaining to administrative streamlining rather than the underlying concept of what CON needs to be which will be a significant part of the final series of recommendations.

Dr. Rugge stated that the Brooklyn report as a launching pad, a truly remarkable document which sets the stage for the kind of activity and the kind of thinking the Council does. The report will have accelerated the kind of preliminary work that otherwise we would have had to undertake. A few excerpts, one, perhaps the most inflammatory of all the statements, is a recognition that up until now New York has depended on a big box approach to health care when now those big boxes, those hospitals need to become the hubs or the organizers or the inspiration for a more disseminated network of activities that are more community based.

Dr. Rugge suggested taking as one of the headings from the Brooklyn report, something that we might regard as a charge, not only for the committee but for the entire health system, is how do we transform those big boxes into newly integrated systems that are truly aligned with public health community needs. Our challenge. Among specific recommendations, page forty-nine and fifty of the Berger Brooklyn report, is a list of things that we, as a Council, should be undertaken by way of review. A considerable list of considerations as proposals come for the redesign of the hospitals in Brooklyn and the care systems in Brooklyn. At this point, have no criteria.

He noted these are all an extension of what has, up to now, been the kind of analysis brought to the Council by the staff and the kind of deliberations and thinking we've been doing. So all these really need to be the basis for how do we reconsider the kind of deliberations and the kind of decision making and what are the criteria for those decisions going forward. Dr. Rugge suggests this is pointing toward a much more fundamental redesign and reform of the system than at least I had in mind two or three months ago. Driven by the fact that indeed it does not make sense to continue to make substantial investments in many institutions as they now exist, but those institutions are, by necessity -- often by financial necessity, changing already, and the question is to what degree does a C.O.N. process in the future help to shape and guide that change to better outcomes and better systems of care.

Dr. Rugge noted another specific mandate, a proposal, from the Birkhead Brooklyn report, and that is that there should be an Improva (phonetic spelling) board -- an Improva board that is essentially a planning agency with teeth. The board's activities should connect

to the work of this Council and be coordinated with it. Two unknowns: What may that Improva (phonetic spelling) board look like, and what would we look like in a redesigned system?

He mentioned the final observation of the Brooklyn report, that all this activity is not confined to Brooklyn. That Brooklyn is really simply one among many communities -- perhaps one among all the communities in New York that need the kind of transformation that is now being anticipated for that borough. And so the way in which we begin to address the C.O.N. applications as they come forward from that, the largest borough, should influence and indeed set the stage for all the changes and all the kinds of applications we will be looking for in the future.

In closing, Dr. Rugge commented that we have our work cut out for us, but I think that -- that we have been spending these last several months preparing. And with the help of staff and perhaps the addition of some additional outside resources, we will get the job done. No doubt to unending controversy and more fuss and feathers, but that's our job. Thank you.

Dr. Streck thanked Dr. Rugge for his report and asked Council member if they had any comments or questions. To review Dr. Rugge's full report and member's comments and questions please refer to pages 66 – 82 of the attached transcript.

Request for Stroke Center Designation

Dr. Rugge informed the Council because the Committee did not have a quorum at their last meeting he needed to convene a meeting to consider the designation of a stroke center. He then turned the meeting over to Ms. Colello, from the department, to introduce the application.

Ms. Colello introduced Columbia Memorial Hospital's application for a stroke center. She explained the designation process to the Council members. Ms. Colello informed members that Columbia Memorial has fulfilled the requirements of the application.

Dr. Streck then asked members for comments or questions. Dr. Berliner asked if the Council would receive data on the outcome results of the stroke centers. Ms. Colello informed members that the data was presented last summer. However, the one criteria that is being looked at was mortality rates, and what was found is that designated hospitals do have lower mortality rates for stroke patients than non-designated centers.

Dr. Berliner inquired if there would be a fuller report. Ms. Colello responded they are hopeful to gather more data. Dr. Rugge then asked for a motion to approve the application. Dr. Berliner seconded the motion. The motion to approve the application passed. Please refer to pages 82-85 of the attached transcript.

REGULATION

Report of the Committee on Codes, Regulations and Legislation

For Emergency Adoption

11-29 Section 760.5 – (CHHA Establishment – Determination of Public Need)

11-27 Amendment of Section 401.2 of Part 401 of Title 10 NYCRR
(Amendment to Limitations of Operating Certificates)

For Discussion

11-27 Amendment of Section 401.2 of Part 401 of Title 10 NYCRR
(Amendment to Limitations of Operating Certificates)

09-17 Addition of New Part 403 and Amendment of Sections 700.2, 763.13 and 766.11 of Title 10 NYCRR; Amendment of Sections 505.14 and 505.23 of Title 18 NYCRR (Home Care Services Worker Registry)

Amendment of 10 NYCRR Part 710 CON Notice Submissions

For Adoption

11-17 Amendment of Section 405.19 of Part 405 of Title 10 NYCRR
(Observation Unit Operating Standards)

11-03 Amendment of Sections 405.1, 700.2, 720.1, and 755.2 of Title 10 NYCRR
(Accreditation of General Hospitals and Diagnostic and Treatment Centers)

Before Dr. Gutierrez began his report, Dr. Streck indicated the order of the regulations will be reversed. Dr. Gutierrez began his report with the two items on the agenda for regular adoption. He described the observation unit proposal was an initiative of the Medicaid Redesign Team, creating a regulatory framework for observation units and a Medicaid rate for observation services. The intent behind this regulation is to reduce emergency department patient boarding, overcrowding, and premature discharges which might lead to adverse outcomes. Observation services are an intermediate setting between the emergency department and an inpatient admission intended for patients who can't be diagnosed or sterilized within the eight hour limit, which -- but could within twenty-four hours. Currently, the Department has granted approximately twenty waivers for the eight hour rule and allowed hospitals to create observation units. Medicaid did not pay for observation services, but began to do so in April '11 for units that operate under approved waivers. Once this regulation is adopted, Medicaid will pay for services in observation units that are in compliance with its provisions. Such provisions do not mandate that hospitals create observation units. They do require hospitals that do so to use discrete physical space, excluding critical access hospitals and sole community hospitals, limit the stay to twenty-four hours, and be under the direction of the emergency department. The beds are limited to five percent of bed capacity up to forty beds. Hospitals with less than one hundred beds can

have up to five observations beds. The observations units must comply with the National Architectural guidelines for observation units that were adopted in 2010. They are not subject to public need assessments, so there will not be a full review of these applications. If hospitals create a unit without construction, they can open one with a notice to the Department only. If they create one with construction, they must go through a limited review application. Existing observation units will be subject to a two great grace -- a two year grace period to come into compliance with the regulations. After a motion and a second, the Codes Committee unanimously voted to recommend adoption to the full Council. Dr. Gutierrez made a motion for approval, and Dr. Berliner seconded the motion. There was no discussion. The motion to approve the regulation passed.

The second item he described was the accreditation standards regulations. He noted hospital and diagnostic and treatment centers are routinely surveyed for compliance with operational standards. The Current provisions authorize the Commissioner to accept, as evidence of compliance with such standards accreditation of the Joint Commission or the American 8 Osteopathic Association, and also the Accreditation Association for Ambulatory Healthcare for freestanding and offsite based hospital-based ambulatory surgery centers. He explained that these accrediting organizations have been predominantly used over the years, additional 14 accrediting organizations have come into existence and have been granted deeming status by the federal Centers for Medicare and Medicaid Services, C.M.S. Newer accrediting agencies are being utilized by hospitals and other facilities more and more and recognized by C.M.S. for federal surveillance purposes. These provisions will remove named references to accreditation agencies and allow facilities to be accredited by an accreditation agency C.M.S. has granted deeming status and which the Commissioner has determined their accrediting standards are sufficient to assure the Commissioner that hospitals so accredited are in compliance with such operational standards. The Commissioner can choose to enter into collaborative agreements with such accreditation agencies so that the accrediting agencies accreditation survey may be used in lieu of a departmental survey. The Department will post on the D.O.H. website a list of accreditation agencies with which the Department has a collaborative agreement. After a motion and a second, the Codes /committee unanimously voted to recommend adoption. Dr. Gutierrez made a motion to approve the regulation and Dr. Berliner seconded. There was no discussion. The motion to approve the regulations passed.

Dr. Gutierrez went on to present two of the three items for discussion, adding that he will return to the third at a latter time. He first proposed to review a discussion item regarding the homecare registry. This proposal creates a Part 403 to Title 10 N.Y.C.R.R. that defines the rules for implementation of legislation requiring the Department to establish a homecare worker registry. This law also specifies the rights, duties, and obligations of homecare service workers, homecare service agencies, and a homecare training and education program. The intent of the law is to deter fraud in training programs and certification and give the public a registry in which they could go to look up individuals to determine if they were, in fact, trained and employable. The Department of Health determines whether the homecare worker is employable through a background investigation. This proposal covers home health aides, personal care aides, homecare services agencies, and training programs approved by the New York State Department of Health and Education. Information on every personal care and home health aide and every training program in the state must be entered into the registry that is accessible to both the public and to employers and prospective employers of such workers. The registry must be available to the

public through both a website and a toll free telephone number operated by the Department's Bureau of Credentialing.

Dr. Streck opens the floor for questions and comments in regard to this registry. To review the Council member's comments, please refer to pages 92 through 97 of the attached transcript.

Dr. Gutierrez proceeded to the next item for discussion which relates to a measure that will implement legislation adopted last session that streamlines and simplifies the C.O.N. process for projects relating to repair and maintenance for one replacement of equipment and for projects relating to nonclinical infrastructure. The new law specifies that, regardless of cost, these ategories of projects will no longer require prior approval through limited review, administrative review, or full review. They will only require the submission of a written notice on the part of the applicant describing the project and, where applicable, architecture and engineering certification and a plan for safety of patients during construction of the project. Such notices would be submitted through the New York State electronic C.O.N. system. The Department is currently working with the programmers to alter the system to accommodate these new notice policies. These changes will not exempt applicants from the requirement to be fully in compliance with the medical facility's construction code and hospital code and all relevant federal, state, and local laws. The Department intends to implement the law beginning on January the 20th, 2012, and expects N.Y.S.E. C.O.N. functionality to support the submission of notices on that date.

Dr. Streck asked members for comments and questions. There were none and Dr. Gutierrez proceeded with the next item.

Dr. Gutierrez introduced the next item, which was a second emergency adoption concerning limitation of operating certificates. The recent weather events required the temporary evacuation of facilities in the New York Metropolitan area and relocation of facilities in Broome and Tioga Counties due to flooding. Because Section 401.2 currently limits an operator's operating certificate to the site of operation set forth in the operating certificate, an operator of an impacted facility is not able to care for its patients or residents at any other site until the Commissioner has approved a certificate of need application for the relocation of the facility. This proposal would allow the Commissioner to permit an established operator to operate at an alternate or additional site approved by the Commissioner on a temporary basis in an emergency. This amendment gives operators of hospitals as defined under Article 28 of the Public Health Law the ability to temporarily operate at sites not designated on their operating certificates in times of emergency. It was adopted as an emergency at the October 6th full Council meeting, if it is not adopted again today, it will expire before the January/February Codes and full Council meeting. After a motion and a second, the Codes Committee unanimously voted to recommend adoption to the full Council. Dr. Gutierrez made a motion for approval, and Dr. Berliner seconded the motion. There was no discussion. The motion to approve the regulation passed.

Dr. Gutierrez continued on to the last of the items for discussion, which is connected to the last vote. An identical permanent version of the amendment to limitations of operating certificates proposal was also on the Code's agenda as a discussion item. It is currently winding its way through the regulatory process and will come before you when that is completed and it is ready for adoption.

Dr. Gutierrez introduced the last item for action. The first proposal amends certified home health agencies, CHHA, established in determination of public need provisions in Section 760.5 of Title 10. After an overview presentation of this regulation, there was considerable dialogue among Committee and Council members. Representatives from the New York Association of Healthcare Providers, Homecare Association of New York State, Leading Age, and the Healthcare Association of New York State addressed the committee and voiced their opposition to the proposal. A representative of the Health and Hospital Corporation spoke in support. At Codes, after a motion and a second, the Committee voted five to one to recommend adoption to the full Council. Subsequently, the Department received a lot of questions from Council members concerning this proposal in the days after the Committee meeting and is prepared to respond to the Council.

Dr. Gutierrez turned the floor over to Dr. Streck and Mr. Cook for comments and questions. Prior to discussion, Dr. Streck suggested that this debate remain formal and a motion be made.

After explaining the Codes Committee, after a motion and a second, the Committee voted five to one to recommend adoption to the full Council. Dr. Gutierrez made a motion and Dr. Berliner seconded the recommendation from the Committee be presented with an approval recommendation. The forum was then opened for discussion. To review the Council member's discussion, please refer to pages 102 through 150 of the attached transcript.

Ms. Hines agreed with Ms. Regan's suggestion that an amendment be made to the motion to develop a need methodology over the next three months to address the question in lieu of the motion previously made. Ms. Hines made a motion for the amendment and Ms. Regan seconds it. Dr. Streck called the amendment to a vote following discussion of the amendment and the amendment was defeated. To review the complete discussion of the Council members please refer to pages 150 through 159.

Dr. Streck moves to vote on the original resolution as proposed by the Committee on Codes and Regulation. The motion passed with a vote of fifteen in favor.

Dr. Streck thanked Dr. Gutierrez for his report and called on Mr. Booth to give his report on the Committee on Establishment and Project Review.

REPORT OF THE COMMITTEE ON ESTABLISHMENT OF HEALTH CARE FACILITIES

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

Acute Care – Construction **Exhibit #4**

Number	**Applicant/Facility**	**Council Action**

	Number	Applicant/Facility	Council Action
1.	111334 C	Lawrence Hospital Center (Westchester County)	Contingent Approval

Mr. Booth began his report by introducing application 111334 and asked for a motion for approval which was seconded by Dr. Berliner. There was no discussion. The motion to approve the application passed. Please refer to page 160 of the attached transcript.

Hospice – Construction **Exhibit #5**

	Number	**Applicant/Facility**	**Council Action**
1.	111548 C	Hospice of Orange & Sullivan Counties, Inc. (Orange County)	Approval

He then moved to application 111548 and asked for a motion for approval and was seconded by Dr. Berliner. There was no discussion. The motion to approve the application passed. Please refer to pages 160-161 of the attached transcript.

CON Applications

CATEGORY 2: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Without Dissent by HSA
- Without Dissent by Establishment and Project Review Committee

CON Applications

Acute Care Services – Construction **Exhibit #7**

	Number	**Applicant/Facility**	**Council Action**
1.	102167 C	Lincoln Medical and Mental Health Center (Bronx County) Dr. Bhat – Interest Dr. Boufford – Abstaining Dr. Boutin-Foster – Abstaining Dr. Sullivan - Recusal	Contingent Approval

Mr. Booth moved to applications in Category 2, he introduced 102167 and noted Dr. Sullivan's recusal; she exited the room, he then noted Dr. Bhat's, interest, and Drs. Boufford and Boutin-Foster clarified for the record they were abstaining on the application. Mr. Booth then asked for a motion for approval, it was seconded by Dr. Berliner. There was no discussion. The motion to approve passed and Dr. Sullivan re-entered the room. Please refer to pages 161-162 of the attached transcript.

	Number	Applicant/Facility	Council Action
2.	112030 C	Corning Hospital (Steuben County) Mr. Booth - Interest	Contingent Approval

He then introduced application 112030 and noted an interest by Mr. Booth. He asked for a motion for approval which was seconded by Dr. Berliner. There was no discussion. The motion to approve the application passed. Please refer to pages 162-163 of the attached transcript.

	Number	Applicant/Facility	Council Action
3.	112120 C	Coler-Goldwater Specialty Hospital and Nursing Facility (New York County) Dr. Bhat – Interest Dr. Boufford – Abstaining *Mr. Fassler – Interest Dr. Sullivan - Recusal	Contingent Approval

Mr. Booth noted for the record that Dr. Sullivan was rescuing from application 112120 and she exited the meeting room. He also noted Dr. Boufford abstained from the application and Mr. Fassler declared an interested. He asked for a motion to approve the application which was seconded by Dr. Berliner. There was no discussion. The motion to approve passed and Dr. Sullivan re-entered the room. Please refer to page 163 of the attached transcript.

Hospice – Construction **Exhibit #8**

	Number	**Applicant/Facility**	**Council Action**
1.	112069 C	Hospice Buffalo, Inc. (Erie County) Mr. Booth - Interest	Approval

Mr. Booth then moved to the applications under Hospice and introduced 112069 and noted an interest by Mr. Booth. He then asked for a motion for approval and Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed. Please refer to pages 163-164 of the attached transcript.

	Number	**Applicant/Facility**	**Council Action**
1.	111061 C	Shorefront Jewish Geriatric Center (Kings County) ***Relocated from Category One to Category Two** *Mr. Fassler - Interest	Contingent Approval

He then introduced 111061 and noted an interest by Mr. Fassler. He asked for a motion

to approve and Dr. Berliner seconded. There was no discussion. The motion to approve the application passed. Please refer to page 164 of the attached transcript.

CATEGORY 3: Applications Recommended for Approval with the Following:

- ❖ No PHHPC Member Recusals
- ❖ Establishment and Project Review Committee Dissent, or
- ❖ Contrary Recommendations by HSA

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- ❖ Establishment and Project Review Committee Dissent, or
- ❖ Contrary Recommendation by HSA

NO APPLICATIONS

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

Residential Health Care Facilities Ventilator Beds – Construction **Exhibit #9**

	Number	Applicant/Facility	Council Action
1.	072112 C	Oakwood Operating Co., LLC d/b/a Affinity Skilled Living and Rehabilitation Center (Suffolk County)	Deferred
2.	071024 C	Long Beach Memorial Nursing Home, Inc. d/b/a Komanoff Center for Geriatric and Rehabilitation Medicine (Nassau County) Dr. Bhat – Recusal *Mr. Fassler - Interest	Deferred
3.	112096 C	Nesconset Acquisition, LLC d/b/a Nesconset Center for Nursing and Rehabilitation (Suffolk County) Mr. Fensterman - Recusal	Deferred

4.	071077 C	North Sea Associates, LLC d/b/a The Hamptons Center for Rehabilitation and Nursing (Suffolk County) Mr. Fensterman- Recusal	Deferred

Mr. Booth noted the four ventilator applications were deferred at the Establishment/Project Review Committee and therefore no action was required. Please refer to page 164-165 of the attached transcript.

CATEGORY 6: Applications for Individual Consideration/Discussion

CON Applications

Residential Health Care Facility - Construction **Exhibit #10**

	Number	Applicant/Facility	Council Action
1.	102376 C	Albany County Nursing Home (Albany County) *Mr. Fassler -Interest	Deferred

Mr. Booth noted application 102376 was deferred at the Establishment/Project Review Committee and therefore no action was required. Please refer to page 165 of the attached transcript.

Acute Care Services – Construction **Exhibit #9**

	Number	Applicant/Facility	Council Action
1.			Contingent Approval

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

Ambulatory Surgery Centers – Establish/Construct **Exhibit #12**

	Number	Applicant/Facility	Council Action
1.	111488 B	Yorkville Endoscopy, LLC d/b/a Yorkville Endoscopy Center (New York County)	Contingent Approval

Mr. Booth moved to Applications for Establishment and Construction. He introduced application 111488 and asked for a motion of approval, with Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed. Please refer to page 165 of the attached transcript.

Residential Health Care Facility – Establish/Construct **Exhibit #13**

	Number	Applicant/Facility	Council Action
1.	112031 E	Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center (Kings County)	Contingent Approval

He then introduced application 112031 and asked for a motion to approve, Dr. Berliner seconded the motion. Dr. Streck asked members comments or questions. Mr. Fensterman commented the Committee received a letter from an attorney, in which he is alleging what appears to be wrongdoing regarding whether or not an individual should have been before us in establishment. He's essentially claiming that a Dr. Mowry who is supposed to be a member of this entity, that when an application was submitted for a receivership, he was part and parcel of that. And somehow thereafter, he is alleging that a law firm --Garfunkel Firm -- informed someone that Dr. Mowry is no longer with Alliance as a shareholder, and there seems to be a rather substantial legal dispute here. My concern is that I don't think that we should be approving an application in which potentially an individual who's supposed to be a member is not listed here. He obviously hasn’t been vetted for establishment. I don't know what the legal status of this is, but it is a concern of mine and particularly when I see one law firm actually casting aspersion against another firm as having misinformed someone that someone is a member of an entity or not. So I'm very concerned about this. And my view is that counsel for the Department should undertake to investigate this not in a capacity of adjudicating who's right or who's wrong because that's not our role, but rather to ascertain what the bona fides are of the position and determining whether or not this does create a problem for us or not because I'm very concerned about the allegations that have been made here, which, of course, were not brought before a set establishment, but the attorney is claiming that he ascertained thereafter this had gone forward. Dr. Streck then asked Committee members for their comments. Ms. Regan commented that she strongly agreed with what Mr. Fensterman said, and proposed to the Committee a motion of deferral. Ms. Rautenberg seconded the motion for deferral. The motion to defer the application passed. Please refer to 165-169of the attached transcript.

Certified Home Health Agencies – Establish **Exhibit #14**

Number	Applicant/Facility	Council Action

1.	112023 E	District Nursing Association of Northern Westchester County d/b/a Visiting Nurse Association of Hudson Valley (Westchester County)	Contingent Approval

Mr. Booth then moved to application 112023 and asked for a motion for approval. Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed. Please refer to page 169 of the attached transcript.

Certificate of Amendment of the Certificate of Incorporation **Exhibit #15**

	Applicant	Council Action
1.	Samaritan Foundation of Northern New York, Inc.	Approval
2.	Auburn Memorial Hospital	Approval
3.	Auburn Hospital System Foundation, Inc.	Approval

Mr. Booth batched the three Certificate of Amendment of the Certificate of Incorporation and asked for a motion to approve. Dr. Berliner seconded the motion. There was no discussion. The motion to approve the Certificates passed. Please refer to page 169 of the attached transcript.

Certificate of Dissolution **Exhibit #16**

	Applicant	Council Action
1.	Hudson Valley Health Specialties, Inc.	Approval
2.	Brooklyn Care, Inc.	Approval
3.	The Albert Lindley Lee Memorial Hospital	Approval

Mr. Booth batched the Certificate of Dissolution and asked for a motion to approve. Dr. Berliner seconded the motion. There was no discussion. The motion to approve the Certificate of Dissolution passed. Please refer to page 169 of the attached transcript.

HOME HEALTH AGENCY LICENSURES **Exhibit #17**

Number	Applicant/Facility	Council Action
1911	The Gerry Homes (Chautauqua County)	Contingent Approval

2050	Delaware County Public Health Services (Delaware County)	Contingent Approval
2051	Madison County Department of Health (Madison County)	Contingent Approval
2058	Wayne County Public Health (Wayne County)	Contingent Approval
2067	Herkimer County Public Health Nursing Service (Herkimer County)	Contingent Approval

Mr. Booth batched the following Home Health Agency Licensure applications 1911L, 2050L, 2051L, 258L, 2067L and asked for a motion to approve. Dr. Berliner seconded the motion. There was no discussion. The motion to approve the licensure applications passed. Please refer to page 170 of the attached transcript.

CATEGORY 2: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Without Dissent by HSA
- Without Dissent by Establishment and Project Review Committee

CON Applications

Acute Care Services – Establish **Exhibit #11**

	Number	Applicant/Facility	Council Action
1.	112194 E	Northeast Health, Inc. (Rensselaer County) * **Relocated from Category One to Category Two** *Mr. Fassler - Interest	Contingent Approval

Mr. Booth then moved to applications in Category 2. He introduced application 112194 and noted an interest by Mr. Fassler. He made a motion to approve the application with Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed. Please refer to pages 170-171 of the attached transcript.

Ambulatory Surgery Centers – Establish/Construct **Exhibit #18**

Number	Applicant/Facility	Council Action

1.	092069 B	WNY Medical Management, LLC (Erie County) Mr. Booth - Interest	Contingent Approval

He then moved to 092069 and noted for the record an interest by Mr. Booth. He made a motion to approve the application. Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed. Please refer to page 171 of the attached transcript.

2.	111362 B	Upstate Gastroenterology, LLC d/b/a University Gastroenterology at the Philip G. Holtzapple Endoscopy Center (Onondaga County) Mr. Booth - Interest	Contingent Approval

Mr. Booth introduced application 111362 and noted for the record an interest by Mr. Booth. He made a motion to approve the application. Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed. Please refer to pages 171 and 172 of the attached transcript.

Dialysis Centers – Establish/Construct **Exhibit #19**

	Number	**Applicant/Facility**	**Council Action**
1.	111504 B	Mills Pond Dialysis Center, LLC (Suffolk County) Dr. Bhat – Interest Mr. Fensterman - Recusal	Contingent Approval

Mr. Booth introduced application 111504 and noted for the record, Mr. Fensterman's recusal, and Dr. Bhat's interest. Mr. Fensterman exited the room. Mr. Booth made a motion for approval with Dr. Berliner seconded the motion. There was no discussion. The motion to approve the application passed and Mr. Fensterman re-entered the room. Please refer to page 172 of the attached transcript.

2.	111475 B	USRC Lake Plains, Inc. (Orleans County) Dr. Bhat – Interest Mr. Booth - Interest	Contingent Approval

Mr. Booth noted for the record Dr. Bhat and Mr. Booth's interest on application 111475. He made a motion to approve the application. Dr. Berliner seconded it. There was no discussion. The motion to approve the application passed. Please refer to pages 172-173 of the attached transcript.

Exhibit #20

Residential Health Care Facility – Establish

	Number	Applicant/Facility	Council Action
1.	111540 E	Fulton Operations Associates, LLC d/b/a Fulton Center for Rehabilitation and Healthcare (Fulton County) *Mr. Fassler - Recusal Mr. Fensterman - Recusal	Contingent Approval

Mr. Booth noted for the record Mr. Fassler and Mr. Fensterman's recusal of application 111540, they exited the room. He made a motion to approve the application, with Dr. Berliner seconded the motion. The motion to approve the application passed. Mr. Fassler re-entered the room. Mr. Fensterman remained out of the room because of a conflict on the following application. Please refer to page 173 of the attached transcript.

Certificate of Amendment of the Certificate of Incorporation **Exhibit #21**

	Applicant	Council Action
1.	ODA Primary Health Care Center, Inc. Mr. Fensterman – Recusal	Approval

Mr. Booth introduced the Certificate of Amendment of the Certificate of Incorporation and noted for the record that Mr. Fensterman was still out of the room due to a conflict. He made a motion to approve the Certificate and Dr. Berliner seconded the motion. There was no discussion. The motion to approve the Certificate was passed and Mr. Fensterman re-entered the room. Please refer to pages 173-174 of the attached transcript.

Certificate of Amendment of the Certificate of Incorporation **Exhibit #16**

4.	Comprehensive Care Management Diagnostic and Treatment Center, Inc. ***Relocated from Category One to Category Two** *Mr. Fassler - Recusal	Approval

Mr. Booth noted for the record Mr. Fassler's recusal on the Certificate of Amendment of the Certificate of Incorporation, Mr. Fassler exited the room. He made a motion to approve the Certificate with Dr. Berliner seconded the motion. There was no discussion. The motion to approve the Certificate passed and Mr. Fassler re-entered the room. Please refer to page 174 of the attached transcript.

HOME HEALTH AGENCY LICENSURES **Exhibit #22**

Number	Applicant/Facility	Council Action
1758 L	Comfort Home Care, LLC (Nassau, Suffolk Queens and Westchester Counties) Mr. Regan - Interest	Contingent Approval
1778 L	Restoration Home Care Agency, Inc. (Kings, New York, Queens and Richmond Counties) Mr. Regan - Interest	Contingent Approval
1826 L	Marian E. Howell d/b/a Golden Age Home Care (Bronx, New York, Queens, Kings, Richmond and Westchester Counties) Mr. Regan - Interest	Contingent Approval
1852 L	Five Star Home Health Care Agency, Inc. (Bronx, Kings, New York, Queens, Richmond and Westchester Counties) Mr. Regan - Interest	Contingent Approval
1952 L	Paramount Homecare Agency, Inc. (Bronx, Kings, Nassau, New York, Queens and Richmond Counties) Mr. Regan - Interest	Contingent Approval
1947 L	Surfside Manor Home for Adults, LLC d/b/a Surfside Manor LHCSA (Queens County) Mr. Regan - Interest	Contingent Approval

1705 L	Bestcare, Inc. (Nassau, Suffolk, Kings, Richmond, Queens, New York, Bronx, Dutchess, Rockland, Putnam, and Westchester Counties) *Mr. Fassler –Interest Mr. Regan - Interest	Contingent Approval
2073 L	VNA Home Health Services, Inc. (Westchester and Putnam Counties) Mr. Regan - Interest	Contingent Approval

Mr. Booth batched the home healthcare agency licensures and noted for the record Ms. Regan's interest on 1758-L, 1778-L, 1826-L, 1852-L, 1952-L, 1947-L, 1705-L, and 2073-L and Mr. Fassler's interest on 1705-L. He then made a motion to approve the applications, with Dr. Berliner seconded the motion. There was no discussion. The motion to approve the applications passed. Please refer to pages 174-175 of the attached transcript.

CATEGORY 3: Applications Recommended for Approval with the Following:

- ❖ No PHHPC Member Recusals
- ❖ Establishment and Project Review Committee Dissent, or
- ❖ Contrary Recommendations by or HSA

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- ❖ Establishment an Project Review Committee Dissent, or
- ❖ Contrary Recommendation by HSA

NO APPLICATIONS

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

NO APPLICATIONS

C. Proposed Resolution for Adoption **Exhibit #23**

Michael Stone, Assistant Counsel, DLA

Mr. Booth then turned to Mr. Stone of the Department for the final item on the agenda. Mr. Stone introduced a resolution that went before the Establishment and Project Review Committee for adoption. The resolution would require certificate of need applicants for establishment to submit their applications through the New York State Electronic Certificate of Need System as of January 1st, 2012. Mr. Booth made a motion for approval of the resolution and Dr. Berliner seconded the motion. There was no discussion. The motion to approve the resolution was passed. Please refer to page 175 of the attached transcript.

Dr. Streck thanked Mr. Booth for his report.

DESIGNATION OF A STROKE CENTER

Dr. Streck noted the Council needed to vote on Columbia Memorial Hospital as a Designated Stroke Center. The application went before the Planning Committee earlier in the day. Dr. Boufford made a motion to approve the application, Dr. Berliner seconded the motion. There was no discussion. The motion to approve Columbia Memorial Hospital as a Designated Stroke Center passed.

ADJOURNMENT:

Dr. Streck adjourned the meeting and wished all a happy holiday.

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2 NEW YORK STATE DEPARTMENT OF HEALTH

3 PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

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7 DATE: December 8, 2011

8 LOCATION: Albany, New York

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1 Planning Council - 12-8-2011
2 (The meeting commenced at 10:32 a.m.)
3 DR. STRECK: Good morning, everyone. It's my
4 pleasure to welcome you to this meeting of the Public
5 Health and Health Planning Council. I'm Dr. William
6 Streck, Chair of the Council, and I have the privilege
7 of calling the meeting to order today, close to on time.
8 I'd like to remind everyone that this meeting is subject
9 to the open meeting law and is broadcast over the
10 Internet. You can access the webcast at the Department
11 of Health website and they're available for seven days
12 after the meeting and a minimum of thirty days and then
13 a copy is retained for the historic records of the
14 Department.
15 There are ground rules for our meeting today as
16 usual. Because there's synchronized captioning, it's
17 important for people to not talk over one another.
18 Captioning cannot be done correctly with two people
19 speaking at the one -- at the same time, nor does it
20 actually help our deliberations. So the first time you
21 speak, please state your name and identify yourself as a
22 Council member or Department of Health staff.
23 Microphones are hot. They pick up every sound, so we
24 would request that rustling of papers and side
25 conversations be limited.

1 Planning Council - 12-8-2011
2 As a reminder to our audience, there is a form
3 that needs to be filled out before you enter the meeting
4 room which records your attendance. This is required by
5 the New York State Commission on Public Integrity. The
6 form is posted on the website. Thank you for your
7 cooperation in filling out those forms.
8 Next I'd like to provide an overview of what we
9 will cover in today's meetings. Our schedule is
10 slightly varied again today. We will begin with our
11 Department of Health reports. Under the Department of
12 Health reports, we will hear from Commissioner Shah.
13 Mr. Cook will then follow with an update on the Office
14 of Health Systems Management. Ms. Block will report on
15 the activities of the Health Information Technology
16 Office. Mr. Ulberg will give an update on the Office of
17 Health Insurance Program activities. And Dr. Birkhead
18 will give a report on the activities of the Office of
19 Public Health.
20 We will then move to the category of public
21 health services where Dr. Boufford will give an update
22 on the initiatives on the Committee on Public Health.
23 We will then move to the topic of health policy. Dr.
24 Rugge will give a report on the activities of the Health
25 Planning Committee. And immediately after that --

1 Planning Council - 12-8-2011
2 actually at that time we'll have a brief meeting of that
3 committee because we have some action that is required
4 and a forum was not fully available earlier today. We
5 will then break for lunch after these reports. We will
6 reconvene thirty minutes later and go directly to the
7 report of the Codes, Regulations, and Legislation
8 Committee. At that committee, Dr. Gutierrez will
9 present regulations for emergency adoption, adoption and
10 discussion. Following that meeting, we will move to the
11 Projects Review Recommendations and Establishment
12 actions. So we have a full agenda.
13 I would remind members of the Council and our
14 guests who regularly attend the meeting that we have
15 organized this -- the meeting by these categories and we
16 will then batch certificate of need applications to
17 facilitate those discussions. We do have -- I remind
18 the members that if there are conflicts, we need to have
19 those recorded. I'll pause for a moment to make sure
20 everyone has had a chance to read those.
21 And with that, I would move to the adoption of
22 the minutes of the prior meeting. May I have a motion
23 for the adoption of the October 6, 2011 minutes?
24 FROM THE FLOOR: I move.
25 DR. STRECK: Moved and seconded. Any

1 Planning Council - 12-8-2011
2 discussion? Hearing none, those in favor, aye?
3 ALL: Aye.
4 DR. STRECK: Thank you. Now it is a pleasure
5 to have Commissioner Shah present to us his thoughts
6 about the activities of the Department of Health.
7 Commissioner?
8 COMMISSIONER SHAH: Thank you, Bill.
9 Good morning. Welcome to all of you who made
10 the trip on this snowy day to Albany. Thank you for
11 your perseverance and I look forward to a really good
12 meeting today. I want to begin this morning by
13 introducing two new members of the Department of Health
14 staff. Yvonne Graham has been named the director of our
15 new health disparities prevention office. She has
16 extensive experience in planning and policy and most
17 recently served as the Deputy Borough President in Kings
18 County where she was active in community health
19 projects. In her new position, she will develop
20 programs and initiatives to make sure that New York
21 continues to progress towards ending health disparities
22 and ensuring that all folks have access to high quality
23 care across the state.
24 We've also named a new director of our
25 Department's Bureau of Narcotics Enforcement. Terrence

1 Planning Council - 12-8-2011
2 O'Leary most recently served as a narcotics prosecutor
3 in the City of New York and brings a wealth of
4 experience to the Bureau. As B.N.E. director, Terry
5 will be responsible for overseeing the Department's
6 comprehensive approach to preventing prescription drug
7 theft and abuse. This is a growing problem and a public
8 health emergency across the country and we're very
9 fortunate to have Terry leading our efforts in this
10 regard.
11 I'd like to shift to the topic of hospitals for
12 a few minutes. On November 28th, we announced the four
13 hundred and fifty million dollars in grant funding that
14 will be available -- made available in early 2012 to
15 assist health care facilities across the state in their
16 efforts to improve primary and community based care to
17 eliminate excess bed capacity and reduce over-reliance
18 on inpatient care in hospitals and nursing homes. This
19 funding which supports a recommendation of the Medicaid
20 redesign team will serve as a critical tool to help
21 address the needs of these institutions as they
22 transition to a more sustainable and patient centered
23 approach. The funding is being provided through the
24 Health Care Efficiency and Affordability Law for New
25 Yorkers, we know it as HEAL, and a Federal State Health

1 Planning Council - 12-8-2011
2 Reform Partnership known as FSHARP.
3 A request for applications will be issued
4 shortly and with a focus on encouraging institutions and
5 collaborative partnerships between providers such as
6 shared service agreements, bed consolidations, joint
7 government agreements, arrangements, and mergers. The
8 awards will primarily support capital projects,
9 including the conversion of hospitals, inpatient space
10 to outpatient and ambulatory care, as well as shifts
11 from nursing homes to less restrictive forms of longterm
12 care. It's worth noting that under this R.F.A., this
13 state-wide R.F.A., some facilities could be eligible for
14 temporary increases in their Medicaid payment rates to
15 support the costs of operational activities that will
16 facilitate transition to more appropriate delivery of
17 care. Overall, these grants are a huge and significant
18 investment in New York's goal to transform the health
19 care system.
20 While many health care systems are facing
21 challenges, the number of facilities in Brooklyn that
22 are facing these challenges are -- is particularly
23 acute. Last week M.R.T.'s health system redesign, the
24 Brooklyn workgroup, led by Steven Berger, presented
25 their report on both the challenges facing the borough's

1 Planning Council - 12-8-2011
2 health system as well as a roadmap for potential short
3 term and longterm steps to the borough's health care
4 needs. As the report notes, Brooklyn has fifteen
5 hospitals and nearly six thousand, four hundred licensed
6 beds. Brooklyn's residents have high rates of chronic
7 disease and too often use their hospitals for routine
8 needs. In Brooklyn fifteen percent of adult admissions
9 and forty-six percent of emergency department visits
10 where there are not admissions could have been averted
11 through accessible quality primary care. And I think
12 that's an underestimate. This is not sustainable.
13 Rick Cook will provide more details, but I want
14 to let you know that the report does not recommend the
15 closures of any private or not-for-profit hospitals.
16 However, the report does include options for boards of
17 financially troubled hospitals to consider merging or
18 consolidating their operations in order to achieve
19 better and more cost effective care and to stabilize
20 their financial situations. There's no question that
21 some hospitals in Brooklyn and others in New York State
22 will need to make fundamental and significant changes.
23 The State is committed to seeing that Brooklyn adapt to
24 the changing health care environment and we are
25 committed to helping with that transition. The four

1 Planning Council - 12-8-2011
2 hundred fifty million dollar R.F.A. I mentioned is just
3 one part of the broader solution that we hope to create.
4 I want to applaud Brooklyn's health work
5 group's efforts. It's been a collaborative, locally
6 driven process. They've visited every hospital.
7 They've had public discussions and the end report is
8 worth an eighty-eight-page read if you do get a chance.
9 I will look forward to working with all the stakeholders
10 to then come up with those plans that will lead to a
11 sustainable solution, not only in Brooklyn, but use that
12 as a template for the rest of the state in what
13 constitutes high quality, consolidated, thoughtfully
14 designed care.
15 I'm also pleased to announce that earlier this
16 week the United Health Foundation released its national
17 rankings of health care and New York State was cited for
18 significant progress. Overall, the state is ranked
19 eighteen, as opposed to twenty-four in the previous
20 year. So a smaller number is better. We're going in
21 the right direction. It's the fourth year in a row that
22 New York has moved up in the rankings. Of course, we
23 all want to be number one and I am hoping we'll get
24 there at some point. And some of the places where New
25 York State excelled were a low cancer death rate, a

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2 significant decline in adult smoking rate, a low infant
3 mortality rate, and a high number of readily available
4 primary care physicians. We know there are other
5 challenges, immunization rates, et cetera, which will
6 need to be improved and we're looking to work with all
7 of your to figure out how to do that.
8 I want to turn for a minute to our public
9 health agenda. The Council's Public Health Committee is
10 set to begin an effort to develop New York's five-year
11 state health improvement plan for the period 2013
12 through 2017. Our current plan, which we call the
13 prevention agenda toward the healthiest state,
14 established the framework for the time period of 2008 to
15 2012. Now we need to build on the strengths of that
16 plan and set priorities for the coming years. This
17 effort includes input from key public health and health
18 care entities along with stakeholders throughout the
19 state. The next state health improvement plan will
20 outline those health issues and areas for health
21 improvement, determine those factors that contribute to
22 these health issues, and identify those assets and
23 resources we have available at our disposal that can be
24 mobilized to improve population health. The plan will
25 also serve as the state's community health assessment.

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2 As we develop this plan, we'll engage stakeholders to
3 help us identify New York's priorities and measurable
4 objectives and evidence-based improvement strategies for
5 each of those priorities.
6 Policy change is necessary to accomplish these
7 identified health objectives will also be identified.
8 In addition, the plan will include the designated
9 organizations that will have the responsibility and
10 accountability to implement specific strategies. These
11 will include other state agencies and nondepartmental
12 stakeholders as well as programs within the Department
13 of Health. Our goal is to move toward a
14 health-in-all-policies approach. The plan will also
15 develop and issue a new community health report card to
16 monitor progress by county. Finally, the new plan will
17 provide a framework for collaborative local public
18 health and health services planning required of local
19 health departments that conduct community health
20 assessments and hospitals that conduct community service
21 plans in 2012 through 2013.
22 Completing a state health assessment and state
23 health improvement plan are the two prerequisites of the
24 public health accreditation process that you've started
25 to hear about. The State is starting that application

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2 right now and it's challenging, but it's really
3 important that New York take a lead in becoming
4 accredited. Dr. Birkhead and Dr. Boufford will be
5 saying more about these activities in their reports.
6 One area that we're currently monitoring at
7 this time of the year is the spread of influenza. And
8 so far, we've seen very low numbers of only about a
9 hundred confirmed reports of the flu with about fifty
10 hospitalizations. The Department, in conjunction with
11 local health departments and other partners, has done a
12 great job encouraging people to get a flu vaccination.
13 In fact, my staff invited local T.V. stations to watch
14 me get my flu shot and I think that's really the
15 definition of taking one for the team. I hope all of
16 you have taken one for your teams as well. And even
17 with low numbers of the flu to date, we can't let up.
18 We know that it's very important that we get everyone
19 vaccinated with the flu every year and so we're
20 continuing to strongly promote vaccinations. Typically,
21 the number of flu cases tend to rise steadily from early
22 December and reach a peak in February, maybe into early
23 March. So we'll still want to have those not vaccinated
24 to get their flu shot even now if you haven't done it.
25 Just a few days ago on December 1st was World

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2 AIDS Day. And we hosted a three-day observance last
3 week featuring the names, AIDS memorial quilt, and a
4 variety of activities to raise awareness and promote
5 prevention. We've made great strides in the thirty
6 years since AIDS was first diagnosed, but there remains
7 a serious threat to public health from H.I.V. and AIDS.
8 About one hundred and twenty-seven thousand New Yorkers
9 are currently living with H.I.V. or AIDS. And in 2010
10 there were more than five thousand, one hundred cases of
11 H.I.V. in New York State and three thousand, four
12 hundred new cases of AIDS. If you think nationally, the
13 C.D.C. reported that of a hundred people with H.I.V.,
14 eighty people know their status and only forty people
15 are adequately treated. We have a long way to go.
16 Well in New York, we're doing well. In 2010,
17 only three infants were diagnosed infected through
18 mother-to-child transmission, a decrease of ninety-seven
19 percent since such testing began in 1997. New York has
20 a strong program for newborn H.I.V. testing and also
21 provides pregnant women with access to perinatal health
22 and education to prevent such transmission. In
23 addition, we offer antiretroviral drugs to protect the
24 health of both mother and infant. In the other -- in
25 the area of mother-to-child transmission and other

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2 issues related to H.I.V. and AIDS we still face some
3 challenges. The progress is encouraging, but three
4 cases is still three cases too many.
5 During the New York World AIDS Day observation,
6 I had the opportunity to present distinguished services
7 awards to honor individuals and groups who were
8 assisting in the battle against H.I.V. or AIDS and many
9 of these honorees were young people, students who
10 recognize the toll the disease has inflicted. Even
11 though most of them weren't born at the beginning of the
12 AIDS crisis, these young people understand the important
13 role they can have in fighting H.I.V. or AIDS among
14 their peers and it was really inspirational to see their
15 involvement. On that positive note, I will conclude my
16 report.
17 Thank you.
18 DR. STRECK: Thank you, Commissioner.
19 Are there questions, thoughts, observations for
20 the Commissioner? Mr. Hurlbut?
21 MR. HURLBUT: Actually, it's I want to commend
22 the Health Department for the amount of work that they
23 put in on this new reg methodology that's going to be
24 implemented in approximately four years for nursing
25 homes and what a great job they did and how difficult it

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2 was. And at the end of the day, though, we came up with
3 a really good methodology that my understanding is the
4 plan amendment is going to be submitted December 15th.
5 And the thing I want to make sure of, though, is that
6 I'm hearing that there are some groups -- minority
7 groups that want change. And I'm hoping that all that
8 good work doesn't go and get undone and make sure
9 that -- I'm looking for assurances from you I guess to
10 make sure that what was presented to us stays and that
11 there are no changes to it. So it's -- because a lot of
12 people in this room worked hard on it and there's people
13 in the Health Department that aren't here that worked
14 really hard. And I just want to make sure that there
15 are no changes made to what was presented to us.
16 COMMISSIONER SHAH: Yeah, these are -- these
17 are difficult decisions we make every day and as time
18 progresses we -- our understandings evolve. This latest
19 rate of rates has been quite an achievement for the
20 Department and for all the people in this room. So I'm
21 hopeful that this will be the format that we continue to
22 see in the future.
23 DR. STRECK: Other comments or questions? Yes,
24 Ms. Regan?
25 MS. REGAN: Commissioner, I'm wondering if you

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2 could give us an update on where New York State is on
3 the health insurance exchanges? I've kind of lost track
4 of where we are. Maybe you can fill us in?
5 COMMISSIONER SHAH: Sure. So we -- we remain
6 committed to having our own version of a health
7 insurance exchange and we are currently having these
8 discussions with Ben Lawsky and others on a weekly basis
9 to make sure we have a viable solution. We still have
10 some time. We still have until the budget to figure out
11 what it will look like in New York State. I wish I
12 could report very specific progress on the aspects of
13 it, but at this point we're still in -- it's a work in
14 progress. Everyone knows it's important. Everyone
15 knows that we need to have our own solution. We can't
16 default and let the Feds decide for us. So that being
17 said, there are some important details to work out.
18 DR. STRECK: Other comments, questions for the
19 Commissioner?
20 All right. Well thank you very much,
21 Commissioner.
22 Mr. -- Mr. Cook is out at the moment, so -- oh,
23 I thought you were sitting up here, Rick. I beg your
24 pardon. Okay. So I'll turn the program over to Mr.
25 Cook for his Office of Health Systems Management report.

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2 MR. COOK: We have a very long day and I'm
3 going to keep my comments very, very short. I just
4 wanted to kind of touch on a couple of things that the
5 commissioner talked about, particular relating to the
6 Brooklyn report. I think the Brooklyn report provides a
7 model, quite frankly, of how you evaluate a region and
8 how you try to assess what changes need to be made in
9 the region. For those of you who haven't read it, I
10 hope you take a chance to -- to take a look at it. But
11 I want to kind of focus on a couple of recommendations
12 that were in there.
13 A recommendation that probably isn't getting
14 the level of press that I think it should is a
15 recommendation that there should be a borough-wide
16 planning effort that should be funded and supported by
17 the State to continue the work that we did. We know the
18 as we looked at the acute care side, particularly the
19 troubled hospitals, and we looked at the primary care
20 needs within that region, it was -- it would have been
21 important for us to be able to spend some time looking
22 at the longterm care system, but quite frankly, the
23 issue that drove this report was concern with the fiscal
24 conditions of several hospitals.
25 And I think the important thing about what came

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2 out of the report relating to recommendations for the
3 hospitals is that we are trying to encourage those
4 hospitals who are most troubled, particularly Brooklyn,
5 Wyckoff, and Interfaith who will -- have been asked to
6 come together in an active parent to integrate services,
7 not to the benefit of any one individual facility, but
8 for the benefit of what are the needs of the community.
9 And then the recommendation for Kings Brook to
10 essentially replace MediSys as the active parent for
11 Brookdale. I think in both of those instances there is
12 a recognition by the Berger Commission that there --
13 truly planning needs to be done in order to evaluate the
14 community need. But just as importantly, it is critical
15 that you have active boards who are involved in asking
16 critical questions relating to what systems are doing
17 and look beyond the individual needs of those systems to
18 what should be their role in the community. And I think
19 that is a core issue that this Council often grapples
20 with, the needs of the community, not the individual
21 facility, and I think those recommendations are going to
22 be ones that will take some time, but having Mr. Berger
23 out there making very clear, he does not mix words, that
24 there is a need for integration, otherwise these systems
25 will not be able to exist longterm.

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2 We have already met with each of those
3 hospitals individually and we have also met with those
4 hospitals together. So there were -- there was a
5 meeting that we had with both MediSys and Brookdale and
6 Kingsbrook and there was a meeting this week with
7 Brooklyn, Wyckoff, and with Interfaith. So we are
8 actively involved in reviewing the recommendations with
9 these hospitals to encourage them to accept the
10 recommendations of the Berger Report.
11 I think the other thing I want to emphasize,
12 the R.F.A. that was issued for the HEAL grants, four
13 hundred and fifty million dollars, we have been engaged
14 in numerous discussions over the last few months, not
15 with just entities from Brooklyn, but with hospitals and
16 systems across the state about this being announced and
17 the availability of dollars. So we're re-emphasizing to
18 the world that this is not solely related to Brooklyn,
19 that we want to be able to support the integration
20 throughout the state, and nursing homes are eligible for
21 this application. And so I think it's going to be,
22 again those of you who are familiar with the HEAL
23 process, the one thing that we do know is these
24 applications often give us terrific ideas about how the
25 world can change if there's a small amount of capital

2 support to move the systems forward.

3 I'm going to leave my talks there -- my talk

4 there. There's just an awful lot to do today. I'm

5 happy to answer any questions.

6 DR. STRECK: Questions or comments for Mr.

7 Cook? Dr. Berliner?

8 DR. BERLINER: Rick, what's the rest of the

9 process going forward for the recommendations from the

10 Berger Task Force?

11 MR. COOK: Right now, Howard, we're meeting

12 with the hospitals, as I said. They have -- the

13 application for the HEAL dollars is due January 17th.

14 So what we've been doing, quite frankly, is encouraging

15 the individual hospitals to come together and to -- to

16 put in joint applications that would fund the

17 integrations. On the health planning, Karen Lipson and

18 Laura were beginning to talk to the -- there are --

19 there's a HEAL award within Brooklyn that's led by SUNY

20 Downstate, the School of Public Health, and we're

21 talking to them about an extension of what they've been

22 doing, but also looking for something that might be more

23 borough-wide.

24 DR. BERLINER: I guess, specifically, the other

25 recommendations of the report, do they have to go

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2 through the full M.R.T.? Do they have to go to the
3 Legislature?
4 MR. COOK: Yeah, this was -- this was not --
5 actually was not a full component of the M.R.T. This
6 was driven by a letter that Commissioner Shah directed
7 to Mr. Berger to look specifically at Brooklyn because
8 of the financial problems. Obviously, any C.O.N.s or
9 any legislation that would be needed to implement that,
10 we would need to go through both the Legislature and
11 this Council.
12 MR. STRECK: Dr. Bhat?
13 DR. BHAT: The HEAL grant -- the HEAL grant
14 money that you're putting out there, are you making any
15 conditions for the hospital to implement Berger
16 Commission's reports? There have been a lot of
17 recommendations there as to changing the -- the board of
18 trustees, the administration, and things of that. Are
19 you going to say that if we give you the money this is
20 what we would like you to do?
21 MR. COOK: The discussions that we've had with
22 them is that's our starting point. We have a very
23 strong recommendation relating to a Commission that
24 spent considerable time. I mean obviously you never
25 close your eyes to whether or not there are

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2 alternatives, but I think, quite frankly, the evidence
3 is pretty clear that unless they can demonstrate a
4 better idea, that that's really what we're looking for.
5 And we've expressed that to each of the individual
6 applicants.
7 DR. STRECK: Dr. Boufford?
8 DR. BOUFFORD: Yeah, I had occasion, actually,
9 to read the report coming up on the train and it's -- I
10 think it's very impressive and outlying. It's -- I
11 think they -- the agenda is an ambitious one. It's not
12 altogether different from some of the hoped for
13 initiatives that were coming out of the first Berger
14 report. Having been on one of the New York City
15 Advisory Committees at that point in time, it's very
16 gratifying to see it in -- in print. But I remain a bit
17 concerned. Well to the degree it's going to be a model,
18 I think the opportunity for greater operational
19 involvement at this stage, not later, of the public
20 health community -- and I hear you saying the SUNY
21 Downstate, but there is a local health -- district
22 Health Department, the New York City District Health
23 Department in Brooklyn that knows the area very well and
24 was put there because of the conditions that you're
25 describing. And I know they were very involved in

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2 the -- in the assessment part of it and are mentioned in
3 later plans for an overall stakeholder group. But I
4 think thinking about how public health could be involved
5 in the creation of some of these systems now related to
6 incentives for ongoing public health engagement in
7 community planning, community health planning because
8 the report points out the really missed opportunities on
9 prevention and -- and some outreach in those
10 communities.
11 And similarly, the -- the statement about
12 incentives for primary care is really very gratifying.
13 Again, I think the existing incentives in the current
14 plan are probably not sufficient to sort of create the
15 kinds of changes that you're hoping for. So I'm also
16 hoping that in the restructuring conversations, the
17 primary care rationalization is as equally -- gets as
18 much attention, or maybe it will never get as much, but
19 gets a significant amount of attention in the thinking
20 about the health systems structures and organizations
21 because the tendency sometimes is the focus is on the
22 beds and acute care services and the -- the ambulatory
23 care is an afterthought and once the major achievements
24 are there, then we sometimes don't come back to getting
25 the prevention and the primary care part right.

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2 So I think this is a really exciting
3 opportunity and I just hope those kinds of stakeholders
4 on a selective basis can really be involved in some of
5 the thinking about creating these systems. Because
6 that's the goal really is to allow these systems to
7 manage populations and then to get the savings that they
8 can generate back.
9 MR. COOK: And that, I think even though, you
10 know, no report is ever written in a way that clearly
11 lines up all the thinking of a panel, but I think, you
12 know, in reading the report, the thing that I think is
13 striking compared to the previous Berger Commission,
14 which had a very different mission, is throughout this
15 report is mentioned the importance of that we can't look
16 at institutions in the context of preserving
17 institutions; we have to look at them in terms of how
18 well they're meeting the needs of the community. And it
19 is very clear that you have very troubled institutions
20 in Brooklyn that are financially extraordinarily
21 insecure and are also not meeting -- not efficient and
22 not meeting the needs of the community. And I think the
23 forty-six percent number of emergency room visits is
24 extraordinary. So primary care, I mean over and over
25 with this group, came back that we have to, one,

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2 probably do a better job at defining what we really want
3 to have good primary care to be, but it absolutely has
4 to be linked throughout the community.
5 DR. BOUFFORD: Just one comment. I think one
6 of the real reasons why a lot of these kinds of
7 institutions that are sort of borderline institutions
8 are in trouble, is because of the reimbursement model
9 for ambulatory care and primary care services. So
10 they're very connected in terms of the financial --
11 longterm financial viability to the issue of downsizing
12 inappropriate regionalization of services.
13 COMMISSIONER SHAH: Just to underscore your
14 point, I think New York City just came out with their
15 own report on primary care access and availability,
16 which just highlighted the problems for access in
17 Brooklyn relative to Manhattan and other parts -- other
18 boroughs, like no other report has. They did a
19 fantastic job. I've just seen this and I encourage
20 everyone to look at that.
21 And then to take the next step, I really
22 encourage those primary care providers to get to the
23 table. It's incumbent on them to come to the table
24 themselves and say we are part of the solution, this is
25 how we envision primary care access to be effective, and

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2 not relegate the roles to, you know, a third party or
3 the hospitals speaking on their behalf of what is
4 primary care. So it is important and we all know it's
5 important. We hope that primary care will come up with
6 their own solutions and be a part of the conversations
7 now as the report does suggest.
8 DR. STRECK: Dr. Bhat?
9 DR. BHAT: How do you ask primary care
10 physicians to come to the table? Because I think I am
11 one of the guys that practices in that part of Brooklyn.
12 We know that eighty-five or ninety percent of patients
13 require dialysis. Their first diagnose is the emergency
14 room. They don't have any other place to go. How do
15 you make primary care physicians go into those areas,
16 like say Green Point or the Williamsburg, Bed Sty.?
17 Those areas, you're absolutely right. It's not forty
18 percent; it probably might be about sixty percent --
19 seventy don't have a primary care physician.
20 COMMISSIONER SHAH: There are numerous venues
21 for you to get to the table. This is certainly one of
22 the tables. You have elected legislators who are
23 representing your views and they need to hear from you.
24 There are -- write to us directly. We want the primary
25 care providers to help design solutions, but they're

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2 practicing in some of the most difficult environments
3 with the reimbursement as it is with the demographics.
4 This is not going to happen overnight. This problem
5 didn't happen overnight. It's not going to be solved
6 overnight. And we need you to help us help you in a
7 sense on what is the solution. I don't know what the
8 answer is. We've seen other parts of the state that
9 have made significant gains in primary care over time
10 with primary care providers leading the way. And I
11 think that's -- that kind of model is ultimately what we
12 have to figure out for Brooklyn, for Queens, for the
13 North Country, for the rest of the state.
14 DR. RUGGE: Just to say the obvious, just as
15 the hospitals are weak in Brooklyn, so too are the
16 primary care providers and I think we can expect certain
17 associations to step forward and be very vigorous. I
18 would only note that in other areas in the city, rather
19 weak primary care providers have emerged amazingly
20 strong by taking over outpatient units. And I think we
21 can see a similar dynamic in Brooklyn, but it does
22 require support and to some degree an act of faith that
23 those currently weak institutions can become stronger.
24 I'm talking about primary care.
25 DR. STRECK: Other comments or questions? We

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2 appreciate your attempt to be brief, Mr. Cook, but the
3 topic is too compelling. So with that, we'll move to
4 Ms. Block with the report of the Office of Health
5 Information Technology transformation.
6 MS. BLOCK: Thank you, Mr. Chairman. I also
7 will attempt to be brief.
8 I think that the Council recognizes New York's
9 leadership in the area of health information technology
10 and the very significant role that the HEAL New York
11 grant program has played in advancing our efforts. But
12 we're now also shifting our attention somewhat to
13 looking at the national strategy for health information
14 technology and I just want to spend a few moments
15 talking about how our efforts and those at the national
16 level are dovetailing and specifically with regard to
17 increasing participation in the meaningful use program.
18 Hopefully many of you recognize that the E.H.R.
19 incentive program for meaningful use was the single
20 largest funded activity in the high tech and A.R.R.A.
21 legislation enacted at the federal level a couple years
22 ago. And I think that the significance of this was the
23 recognition that both the Medicare and Medicaid programs
24 really needed to emphasize E.H.R. use and the meaningful
25 use of E.H.R.s in order to advance the important reforms

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2 that we are now seeing in both the Medicare and Medicaid
3 programs.
4 Through the HEAL 5 initiative which we just
5 wrapped up recently, we were able to provide twenty-five
6 hundred physicians with E.H.R.s which are now
7 implemented out in the community. We have seventy-five
8 hundred physicians who are participating in health
9 information exchange in some form or other, either
10 providing data or accessing data through health
11 information exchange. And this is significant for
12 meaningful use because the meaningful use requirements
13 will increasingly emphasize the utilization of health
14 information exchange as a component of how we define the
15 meaningful use of E.H.R.s.
16 The regional extension center program, which
17 was included in the high tech A.R.R.A. program, is being
18 administered in New York State by two entities,
19 statewide by the New York eHealth Collaborative, in New
20 York City by the New York City Health Department under a
21 program called New York City Reach, and we're extremely
22 pleased that with the combination of those two programs
23 they had a target of signing up ten thousand eligible
24 professionals by the end of the year and it looks as
25 though by the end of December they are both very likely

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2 to meet their respective targets for -- for that part of
3 the program. And we now have somewhere in the
4 neighborhood of three hundred physicians who are
5 participating in that program who have actually attested
6 to and been certified by the federal government to have
7 achieved meaningful use. And we expect that number to
8 significantly increase as the months go by.
9 So our initial efforts through the HEAL program
10 have certainly created an important starting point to
11 allow us to achieve that success, but clearly we need to
12 keep advancing our efforts towards E.H.R. adoption.
13 Along those lines, I'm very pleased to announce that we
14 have finally initiated the process of enrolling eligible
15 professionals in the Medicaid E.H.R. incentive program
16 here in New York. I know a number of you have been
17 watching this closely and hoping to -- to have this
18 announced. And for any providers who have questions
19 about how to enroll and what's involved in becoming part
20 of that program, there is a website specifically set up
21 for providers to answer their questions. And that
22 website is H.I.T at health dot state dot NY dot US. We
23 will continue to work very closely between Medicaid and
24 the regional extension center program to align our
25 efforts and hopefully dramatically increase the number

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2 of eligible professionals who will soon be registered to
3 participate in the Medicaid component of the meaningful
4 use program.
5 The Office of the National Coordinator has made
6 it very clear to New York and every other state in the
7 nation that they really expect us to step up to the
8 plate to help them achieve their national goals for
9 meaningful use. I think through our current efforts we
10 are well underway to do that, but clearly more to be
11 done and offline of regularly scheduled Council
12 meetings, I'm very happy to speak to any Council members
13 or your colleagues who are interested in learning more
14 about what we're doing in that arena.
15 Thank you.
16 DR. STRECK: Questions? Comments? Dr. Martin,
17 yes?
18 DR. MARTIN: One of the things about meaningful
19 use is that occasionally it's -- it's very meaningful,
20 occasionally a little bit less so, from a physician's
21 point of view when they are trying to do their actual
22 work. There are some very meaningful things that can
23 occur from an integration point of view for activities
24 that are going on in the Department of Health and the
25 Office of Mental Health, one of them being the Bureau of

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2 Narcotic Enforcement where there -- as the Commissioner
3 pointed out, there's increasing emphasis on trying to
4 stop diversion and inappropriate prescribing of
5 controlled substances and there actually is an ability
6 for physicians to get some idea of patients that might
7 be abusing the system or physicians who are abusing the
8 system, but it's not at this point integrated at all
9 either into health information exchange or E-prescribing
10 which isn't ready yet at the state. I know Rachel's
11 aware of it and B.N.E. is now aware of it. Another
12 example being, O.M.H. has a psyches program, an
13 absolutely wonderful Q.A. program. It is superb, but,
14 again, isn't particularly well integrated yet. So I
15 think that anything that from a leadership perspective
16 that can continue to make these things that really are
17 of great clinical importance to the practitioners as
18 well as public health and to the patients really has to
19 be encouraged and as to be really at the forefront. I
20 know it is and it's particularly hard because it's a
21 very complex system but it's those things that are
22 really important in addition to just the meaningful use
23 which is also important.
24 MR. STRECK: Mr. Kraut?
25 MR. KRAUT: Dr. Martin, I just would point out

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2 on Long Island through the Long Island Regional RHIO
3 that actually is integrated where we have within our
4 emergency rooms, if a patient shows up and the physician
5 queries the system, they will see every emergency room
6 that they may have appeared in and where drugs might
7 have been prescribed. And we've actually been --
8 recently it's one of the things, I guess unintended
9 uses, where they've been significantly finding drug
10 seeking patients and able to kind of piece it together
11 in an instance. And I would only also add with respect
12 to the RHIO, just to inform people, the Long Island RHIO
13 is merging with the New York City RHIO. That approval
14 is pending the approval of the Attorney General right
15 now and hopefully that will be operational in January.
16 DR. MARTIN: If I may, the only point I make,
17 and I agree with you all and frankly all the RHIOs, when
18 functioning properly, will show E.R. visits and the like
19 and be an indicator. But specifically the Bureau of
20 Narcotic Enforcement allows physicians and -- I think
21 it's physicians -- you're not allowed to delegate it --
22 able to log on and see whether or not a patient of yours
23 has received within the last I think three months, two
24 or three prescriptions from two different doctors, not
25 just in E.R. And again that's something that, A, hasn't

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2 been publicized extremely well, B, it's not easy to get
3 into, and isn't particularly integrated. So I agree
4 with you a hundred percent, the RHIOs do provide this
5 and it's one of the things that any E.R. doc would love
6 to be able to get more information in an easy and fast
7 way, but examples in this where in the silos people are
8 doing really good work that's particularly helpful, but
9 it has to get coalesced.
10 COMMISSIONER SHAH: Just as a final follow-up,
11 you know, in 2010 we had a hundred and sixty-nine
12 thousand, eight hundred and sixteen patients in New York
13 State who saw five or more doctors during the year to
14 get controlled substance prescriptions. Those are the
15 doctor shoppers. Okay? We are working on this across
16 the agencies and with other external partners. Every
17 two weeks, I'm on a phone call with OASIS, O.M.H., and
18 researchers, and private groups around this public
19 health emergency. It includes health I.T., so stay
20 tuned.
21 MR. STRECK: Dr. Bhat?
22 DR. BHAT: Dr. Shah, the particular system that
23 you have, how often has it been used by physicians to
24 find out? Because there's a radio report a couple weeks
25 ago they were talking about this guy who entered the

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2 pharmacy where that particular individual was taking
3 medications from several sources. Well the physician
4 said really he went back to find out where exactly they
5 were getting that medication.
6 COMMISSIONER SHAH: Well we're very lucky Terry
7 O'Leary is taking charge of this and in our -- new
8 B.N.E. Director. He has -- I have an eleven-page memo
9 item that we're working on, everything from physician
10 education to making that drug lookup program better, to
11 having pharmacies have access to certain data. Across
12 the board, there are so many things that we're going to
13 be doing in the near future. That's why I say stay
14 tuned. It is an emergency. Luckily, for whatever it's
15 worth, New York State isn't as bad off as many, many
16 other states, like Florida where it's ten times the
17 problem it is in New York. That doesn't mean that we
18 don't have a problem. It means that we have less of a
19 problem. But we still do have a great opportunity. I'm
20 happy to discuss this with you offline.
21 DR. STRECK: Other comments or questions?
22 Thank you.
23 We'll know move to a report of the Office of
24 Health Insurance Program activities. Mr. Ulberg?
25 MR. ULBERG: Good morning. I'm Tom Ulberg.

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2 Commissioner, with respect to the snow, I was awoken
3 this morning by my wife with the words there's snow, and
4 so was my son and I found it curious that his reaction
5 to that was completely different than mine. It had
6 something to do with he had his mind on a sled and mine
7 involved a shovel. So we went about our way and started
8 our day.
9 We have -- again, I think I can go through my
10 piece here in -- in probably less than five minutes. I
11 do have a PowerPoint. I apologize. I only made fifteen
12 copies, but we are in the process of right now of
13 e-mailing to each of you a copy. I guess OHIP doesn't
14 go anywhere without PowerPoint slides. Mr. Cisto
15 (phonetic spelling) used to say when OHIP shows up with
16 their PowerPoints, you know, it's like drinking from a
17 fire hose. So I'll try to be brief here, but I think
18 these are important, you know, activities that have
19 been, you know, underway within OHIP and within the
20 Health Department that we wanted to keep you apprised
21 of. And I thought what I would do is, you know,
22 initially just go through M.R.T., the phase one, the
23 progress that we're making there, and then conclude with
24 a brief discussion about what's in store here for phase
25 two.

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2 So let me just quickly go to the next slide, and then
3 the one after that. So prescription drugs, starting in
4 October 1st, we moved approximately four billion dollars
5 in drug costs. We shifted from service to managed care
6 and we believe pretty much by all accounts while there
7 was some bumps in the road, it was a very smooth
8 handoff. We commended the plans who did an excellent
9 job. We were -- you know, on a daily basis as we
10 unloading -- unrolling this that we were involved in
11 stakeholders. And the Department moving forward, we're
12 going to monitor very, very carefully, on a
13 month-to-month basis with the plans, the drug usage and
14 as we shift from service, you know, into the plan. So
15 we were very pleased with that effort.
16 The next slide, please. B.H.O.s, I mean I
17 think and I've been involved in state government, my
18 experience at D.O.B. for quite some time and had a
19 chance to connect with both the Health Department and
20 the mental hygiene agencies, and I have to say that the
21 partnership I see from my perspective is stronger now
22 than I've ever seen it, and I think the B.H.O.
23 initiative is a key example of that. Mental hygiene
24 agencies, primarily O.M.H. and OASAS have been very
25 working you know very closely together as -- with the

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2 stakeholder community to roll out B.H.O.s. And
3 contracts are currently in place in four regions of the
4 state, New York City, Hudson River, Central, and Western
5 New York. And starting on January 1st there will be
6 concurrent reviews of every individual who is admitted
7 for, you know, inpatient services. We have very high
8 rates across -- across the state in terms of
9 re-admissions and avoidable admissions, you know, within
10 this population, not only for the mental health care,
11 but also for the acute care. And then Long Island will
12 also start shortly after on February 1st of 2012.
13 There's been a lot of activity in this area in terms of,
14 you know, prepping the hospitals, informing community
15 providers about, you know, the role of the B.H.O.
16 And I'll also note there at the very bottom,
17 there's been considerable discussion between the two
18 agencies on the role of the Psyche System. And actually
19 we had a plan -- we had a meeting with the plans this
20 month where we are going to try to make available to the
21 plans the use of the Psyche Systems and we may even
22 mount it on our data warehouse in order to drive data
23 back to plans and into emergency rooms quicker.
24 The next one is managed care. We've been very
25 busy in that area as well. The personal care benefit

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2 was folded into the plans August 1st. Mandatory
3 enrollment, recipient restriction, population August
4 1st. Efforts to basically advance the enrollment
5 process were put in place. ESPMI (phonetic spelling),
6 basically the chronically ill no health population were
7 brought in on October 1st, and there was elimination of,
8 you know, some exemptions. So you know, a very, very
9 ambitious agenda and people made great progress I think
10 within managed care. The same goes for longterm care.
11 Mark Kissinger and his group released a care
12 coordination model guideline on November 15th. The
13 draft regional rollout plan for mandatory managed care,
14 as well as the C.C.M.s was posted on the M.R.T. website
15 very recently and we're working on a weekly basis with
16 C.M.S. on 11/15 waiver amendments.
17 The next is health homes. We've heard a lot
18 about health homes. This is one of, you know, our
19 bigger initiatives, you know, within the Health
20 Department. We are on track to begin phase one in the
21 ten counties that we listed there, starting with Bronx
22 and Kings. That's a big population base starting
23 January 1, 2012. Phase two, sixteen counties, will be
24 April 1st, 2012, and then phase three, thirty-six
25 counties, the balance of the counties on July 1st, 2012.

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2 So this is very ambitious, but we think achievable
3 deadlines for us to roll out the health home initiative.
4 What's key in this -- next slide, please.
5 What's very key in terms of, you know, how we roll out
6 health homes is we have to be very sensitive to the
7 placement and the alignment of the person with the
8 health home provider. So we have some very
9 sophisticated algorithms that we've developed to try to
10 give good match between the health home and the person
11 that will be receiving the services because that
12 connection, to the extent that there is one that exists,
13 needs to grow and -- and cannot put people with the
14 right health home provider could actually, you know, set
15 us back. So we're spending a lot of time, we're working
16 with our group of health homes as well as with consumer
17 advocates to develop that list and that alignment.
18 Next is the global cap. There's statute -- I'm
19 sure many of you know that there was statute that was
20 part of last year's budget that sets the state share of
21 Medicaid spending at fifteen point three billion dollars
22 for '11-12 and then fifteen point nine billion dollars
23 in the following year. And this has been a considerable
24 effort on the part of the Health Department and as well
25 as our colleagues in the Budget Division to monitor the

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2 global cap spending on a month-by-month basis. That's
3 what's required in the statute. This first trend line
4 has us concerned from a fiscal perspective and I don't
5 think necessarily from a health care perspective, but
6 this line here is basically showing the growth in
7 enrollment and it's a pretty steady growth line. And I
8 believe since April of this year, to date, we've
9 enrolled over seventy-two thousand new individuals into
10 the Medicaid program. That, of course, drives
11 expenditures.
12 And the next slide is a little bit of good
13 news. What we're showing you here is the growth of the
14 seventy-two thousand individuals. It's primarily taking
15 place, you know, within managed care. And to the extent
16 that it's taking place within a more managed environment
17 is -- is, you know, good in terms of controlling the
18 spending under the cap.
19 The next slide, you won't be able to see the
20 numbers, but this is basically what it's showing you is
21 that through September we were a hundred and thirty-four
22 million dollars below the cap, which seems like a lot of
23 money but it's really, you know, less than two percent.
24 And these numbers are very volatile. It's on a
25 month-to-month basis. You can see, you know -- we'll

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2 see spending, you know, significant, you know, spending
3 swings. Our job is just to, you know, try to make sure
4 that we understand those swings and if we do think we
5 have a problem, that we think spending may go above the
6 cap, the Commissioner has the authority to take actions
7 to reduce spending. So between now and the end of the
8 year, we have a long way to go, even though it is
9 December, but we're going to have to watch our -- our
10 trends very, very carefully.
11 The next is, just very quickly, the medical
12 indemnity fund. Laura LeFave (phonetic spelling) and
13 her group have been working to implement the indemnity
14 fund and many of you know that the purpose of the fund
15 is really to provide health care coverage to those
16 children that are injured during -- you know, during a
17 birth. The applications can be made by the child's
18 parents or the defendant and applies to all cases
19 starting after April 1.
20 The next slide is we're administering this
21 program through D.F.S. What we're listing down here
22 below is basically the qualifying health care costs.
23 These are the expenses that the indemnity fund will pick
24 up on a going forward basis when the child is deemed to
25 be injured as part of a -- you know, as part of the

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2 program. And then the qualifying health care costs are
3 not covered by collateral services like Medicare and
4 Medicaid.
5 And then I'll just conclude here by saying that
6 next week, on December 13th, the remaining M.R.T.
7 subcommittees are going to present their recommendations
8 to the larger M.R.T. group and those will include
9 affordable housing, basic benefit review, payment
10 reform, and workforce flexibility. And then real
11 quickly, our game plan here as we release those
12 recommendations, we hope that they're all, you know,
13 endorsed on the 13th. On the 31st, there will be a
14 final M.R.T. report that will be given to the governor
15 for his consideration. And -- and in -- depending on,
16 you know, his -- his review on the recommendation, we
17 presume that these will all be good outcomes, that the
18 full plan will be released as part of the executive
19 budget release.
20 And then the final report, the summary of the
21 phase one reforms and the approved recommendations of
22 the ten workgroups, the combined product will establish
23 basically, you know, when we bring all these
24 recommendations together, they will be the basis for a
25 comprehensive action plan for the Medicaid program we

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2 think for like the next ten years to come.
3 So this is a very important -- actually, I
4 think I'm on the next slide here. So this is a -- you
5 know, we view this report as basically, you know,
6 setting our agenda for the next -- next five years to
7 implement it. And as part of our implementation process
8 with phase one, it's a very disciplined approach and --
9 but we think it would, you know, put us on a course, you
10 know, for some meaningful change, you know, real
11 meaningful change to the Medicaid program. And this
12 whole -- this whole plan may involve an 11/15 waiver
13 submission to the federal government you know depending
14 on its final outcome. So with that, I think I've tried
15 to get it within my five minutes. Any questions?
16 DR. STRECK: Questions or comments? Dr. Rugge?
17 DR. RUGGE: I wanted to comment on the pace of
18 enrollment in the home health program. Understandably
19 there's concern about enrolling too fast and
20 overwhelming the caregivers, the care managers. On the
21 other hand, if the pace is so slow, there won't be the
22 funds available to hire the care managers to do the job.
23 MR. ULBERG: That is all true. I think the
24 other thing we have to keep in mind is finding that
25 balance. And you know, Greg Allan his crew have been,

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2 you know, working night and day to launch the health
3 home initiative. We have submitted to C.M.S. a state
4 plan which we've been having conversations with them all
5 along. We don't expect any trouble there. But I think
6 finding the balance between the speed of enrollment is
7 very important.
8 The other thing to mention is that the health
9 home cost, ninety percent is basically picked up by the
10 federal government and there's a two-year clock on those
11 dollars. So it's in our best interest, right, to try to
12 maximize that ninety percent federal funding and then in
13 the interim, you know, show to the federal government
14 that there is a return on investment associated with
15 this -- with this program.
16 So I think we're just going to have to you know
17 move as quickly as we can as areas are ready and -- and
18 I -- certainly we've had a lot of participation and a
19 lot of interest. We've had, you know, webinars you know
20 with, you know, over six hundred people attending them.
21 So we know we have a lot of individuals' attention here.
22 DR. RUGGE: Will it be possible for the
23 Department to assess the readiness health home by health
24 home? Or is that too -- too much and too overwhelming
25 for you to do?

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2 MR. ULBERG: No; I think that's -- I think that
3 is part of our process here is that, you know, there's
4 an application that comes through. There's been a lot
5 of discussion about perhaps bringing, you know, two
6 groups, you know, together to form maybe even a
7 stronger, bigger network. That process is almost, you
8 know, concluded. Greg and his folks have been, you
9 know, spending considerable time there. But we're not
10 going to launch this until everybody's comfortable, us
11 and -- and, you know, the health home providers, that --
12 that they're ready.
13 MR. STRECK: Dr. Grant?
14 DR. GRANT: Hi. Could you just clarify
15 further, you say regulations are being amended to
16 clarify the responsibilities of hospital and aftercare
17 related to the initiative. And I'm wondering if that's
18 going to be able to keep pace with your expected
19 implementation deadline in terms of the massive
20 bureaucracy we're already doing.
21 MR. ULBERG: On the behavior health
22 organizations, yes, I think the B.H.O.s -- again, I
23 think this -- this -- I commend O.M.H. because they had
24 very ambitious, you know, deadlines that were needed to
25 be met in terms of getting these contracts in place and

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2 they have been, you know, put in place. I think the
3 process that has been undergoing over the past two to
4 three months is a communications strategy on the part of
5 O.M.H. with the provider community, hospitals, and
6 aftercare providers, clinics, in terms of their view of
7 how a B.H.O. will function within this system. And you
8 know -- and I've also seen, you know, through
9 communications through HANYS and Greater New York that,
10 you know, there is now, you know, certainly a
11 recognition that there is a role for a B.H.O. within the
12 system. And as I had mentioned, there is a significant
13 problem within this population in terms of overuse of
14 emergency rooms and the basically problems with people,
15 you know, lacking continuity of care between an
16 inpatient admission and an outpatient visit. We see
17 that -- in the data, we see that a lot. People just
18 bounce from the -- you know, from the emergency room up
19 to an inpatient psych stay and then there is no
20 follow-up care or drug treatment. So that's the role of
21 B.H.O. is to try to smooth that out and make sure that
22 when somebody's being discharged from an inpatient
23 setting that they are getting the follow-up care that's
24 so important.
25 DR. STRECK: Dr. Sullivan?

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2 DR. SULLIVAN: Just a question on -- just a
3 question on the growing number of Medicaid enrollees. I
4 think that the provider community is also concerned
5 about that and many things that you put in place should
6 help us contain costs with the health homes, the
7 prescription drug benefit, et cetera, but at some point
8 it would seem to me that if that Medicaid base keeps
9 growing and with the economy being what it is, it's
10 going to be a point of no return where we can't
11 necessarily control the costs as quickly as that's
12 moving, and then to get hit with a -- you know,
13 something, a further tax or whatever on the provider
14 system could be very difficult. So I'm just wondering
15 have you modeled out any concept of just how high that
16 enrollment can go before you reach a point where what
17 you are putting in place can't sustain the drop -- or
18 sustain that cap rate of growth?
19 MR. ULBERG: I think those exact words have
20 come out of my mouth from time to time when I look at
21 the chart and say when is that going to start to flatten
22 out for us here? I think that in part it's driven by
23 the economy. We're hoping to get a break on the economy
24 at some point here because there is definitely a
25 relationship when we modeled this out, when you look at

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2 unemployment rates and then there's a lag factor, but
3 eventually, you know, that converts over into Family
4 Health Plus and Medicaid, you know, enrollment. So --
5 so I don't know. I think that there's a recognition out
6 there that under a global cap, you know, environment,
7 that's not adjusted for enrollment and that was all, you
8 know, part of the deal, that, you know, we're just going
9 to need to be, you know, sensitive in terms of how far
10 that growth line continues to go before it causes undue,
11 you know, pressure on the system. I know it's not a
12 real clear answer, but I'll continue to hope that things
13 will eventually start to flatten out here.
14 I think one of the good things is that we do --
15 where we do see enrollment growth, a lot of it is a
16 growing rate with basically healthy moms and babies. So
17 as they're hitting the system and enrolling in -- in
18 managed care, they tend to be on the less expensive
19 range of our population base.
20 DR. STRECK: Other comments or questions for
21 Mr. Ulberg? Yes, Doctor?
22 DR. BOUTIN-FOSTER: I think Dr. Sullivan is
23 right that as the economy continues to decline and more
24 people are out of work, you're going to see increased
25 eligibility for Medicaid. But there's also an

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2 opportunity as you see the, I guess almost meteoric rise
3 in Medicaid enrollment, the opportunity to catch those
4 people and make sure we're reducing the rates of
5 emergency room visits, prevention, so there's the
6 opportunity to save costs by taking advantage of now you
7 have people with insurance, they shouldn't be going to
8 the emergency room. There should be greater prevention.
9 So there's opportunity to, you know, contain costs a bit
10 by offsetting some of the other expenditures.
11 DR. STRECK: Other comments or questions?
12 Thank you.
13 Now move to Dr. Birkhead with report of the
14 Office of Public Health.
15 DR. BIRKHEAD: Thanks very much.
16 The O.P.H. report today is going to focus on
17 the planning of the next phase of the State's Health
18 Improvement Plan and we're going to do this jointly with
19 the Public Health Committee which is scheduled next. So
20 we're going to combine the presentations and I'll ask
21 Dr. Boufford, I think she wants to make a few
22 introductory comments.
23 DR. BOUFFORD: Good morning. Yes, I'd just
24 like to -- to give a little bit of context on the
25 overall Public Health Committee's activities since our

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2 last meeting and then hand it over to Gus.
3 First of all, maybe I'll ask members of the Committee to
4 raise their hand so they can be identified because I
5 appreciate they've been very active.
6 The previous reports, we've advised you that
7 the Public Health Committee has established four
8 priorities for the next year in addition to the tracking
9 national health care change and health reform change and
10 how it affects the public health infrastructure and
11 prevention. One is that we'll be working with the
12 planning committee, chaired by Dr. Rugge, on his efforts
13 on modernizing, revising the certificate of need process
14 to try to strengthen the population health impact of
15 that process in the redesign. And we've had -- to that
16 end, we've had a couple of joint meetings, both in the
17 flesh and virtual. I think we've explored all of the --
18 of the options available to us to meet and consistent
19 with the law and, you know, can give you feedback on
20 those.
21 Secondly, we have determined we are -- we will
22 be serving as the formal leadership advisory group to
23 the staff for the development of the state's health
24 improvement plan for 2013-2017 on behalf of this
25 Council. And the commissioner, I think, gave a nice

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2 contextual introduction to that and Gus will go into
3 some more detail.
4 The third activity will be supporting the
5 Health Department staff in pursuing national
6 accreditation through the newly established process and
7 I think in general the public health community is quite
8 excited that New York State is going to be one of the
9 pioneer states moving in that direction. So that's
10 really good.
11 The fourth priority will be identifying a key
12 health issue on which we want to try to move the needle
13 with some concerted effort. And we hope that that will
14 emerge through this assessment process that we will
15 be -- will be going through. And we've had occasion our
16 last couple meetings to review the -- both the work plan
17 and the time table that Gus will discuss with you and
18 make some modifications in it. So we're delighted to
19 have the opportunity to have him present it to you now
20 and then I'll sort of come back and talk about next
21 steps.
22 DR. BIRKHEAD: Thank you. People should have
23 the slides at their places, but they'll also be
24 projected. So -- so the next phase of the state's
25 health improvement plan is for the years 2013 through

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2 2017. These plans are generally five years in duration
3 and unbelievably we've come through the prevention
4 agenda where 2012 will be the last year of that. Just
5 as by way of reminder, the prevention agenda is the term
6 for the last five-year public health improvement
7 initiative spanning the years 2008 through 2012 and
8 essentially this is a call to action for local health
9 departments, health care providers, particularly
10 hospitals, health plans, and others to work together to
11 identify and address health problems at the local level.
12 We have ten prevention priority areas. For
13 each of these we've highlighted goals, numerical goals,
14 disease-specific goals and asked counties and hospitals
15 particularly to develop their community health plans and
16 hospital community health assessments around these --
17 these priority areas.
18 And I'm just going to quickly present some data
19 on the status to date with the fifty-one prevention
20 agenda indicators that were spread over those ten areas.
21 We've had thirty-five indicators where we've had some
22 improvement and three indicators achieved their target.
23 Those were coronary heart disease hospitalizations,
24 newly diagnosed H.I.V. cases, and motor vehicle related
25 mortalities. So three -- three actually have met the --

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2 the target. I would point out that these data are --
3 the most recent are from 2010, so it's really only two
4 to three years into the five-year prevention agenda
5 cycle. We had fourteen of the indicators move in the
6 wrong direction, one that was unchanged and one where we
7 don't have any new data to report.
8 The next several slides have the same format
9 and I just want to highlight a couple of the priority
10 areas. What you see here are for one of the prevention
11 agenda, priority area three, healthy mothers and healthy
12 babies, and basically looking at the rate of change in
13 the various indicators. And those to the left of the
14 line are indicators where we would like to see an
15 improvement. For example, we'd like to see an
16 improvement in children being screened for lead
17 poisoning. So we're trying to move that to the right.
18 That's one of the measures where we've actually had a
19 decrease or a lack of -- lack things of -- well, excuse
20 me. It is improving, but still is eleven percent short
21 of our goal.
22 Children immunized is one where we also want to
23 see an increase and that's one where we've actually seen
24 things moving in the wrong direction. On the other
25 hand, low -- percent of low birth weight, those things

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2 to the right of the -- of the center are things that we
3 would like to see a decrease in, so we're looking for a
4 decrease in low birth weight. And even though we're
5 still far above the goal we have seen improvement in
6 that measure. And then early prenatal care, we'd like
7 to see an increase in that. That's one again where
8 we've seen things moving in the wrong direction. So
9 it's a -- it's a mixed picture. We've seen some
10 improvement. We obviously have -- even those areas
11 where we have had improvement have a way to go to reach
12 the goal and we've had some areas where we've had things
13 moving in the wrong direction.
14 Just -- I'll just highlight a couple more of
15 these. In the areas of physical activity and nutrition,
16 another key area, we've had the percentage -- we wanted
17 to improve the percentage of infants breast feeding at
18 six months of age in the WIC program and that's an
19 indicator that has moved in the wrong direction. On the
20 other hand, from our survey data, adults eating five
21 plus fruits and vegetable servings a day, we've seen an
22 increase. We still have a ways to go to reach the
23 target, but it's still a ways to go. In terms of adult
24 obesity, that's something we'd like to decrease and you
25 can see that we are well above the goal and that's an

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2 indicator that moved in these two to three-year period
3 in the wrong direction. However, the percent of
4 obesity, children in WIC program, age two to four, who
5 are obese, we're still short of the goal but that's an
6 indicator that's moving in the right direction. And in
7 fact, in WIC we've actually turned the obesity curve.
8 We bent the curb so it's now flat or heading down which
9 is -- which is a big achievement.
10 I'll just do a couple more of these. In the
11 chronic disease area, these were the goals that we set
12 for ourselves. Most of them are to reduce various
13 things, for example, reducing cancer mortalities,
14 cervical cancer, breast cancer mortality. One of the
15 measures which we actually met and surpassed is
16 indicated here, the coronary heart disease
17 hospitalization measure, we actually passed and now have
18 gone below the target that we set for ourselves. So
19 that's -- that's an objective met. And then we have
20 three indicators here in the area of diabetes,
21 hospitalizations and diabetes prevalence where we are
22 short of the goal and we are moving in the wrong
23 directions still on those indicators. So -- so an
24 indication of more work to be done there.
25 And finally, in the area of infectious disease,

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2 just to highlight some successes in rates of
3 immunization of adults for pneumonia and influenza. We
4 are still moving towards the goal, but things are moving
5 in the right direction, as are the cancer -- excuse
6 me -- the T.B. case rate and the gonorrhea rates are
7 reducing. We have, as I indicated, met the goal and
8 surpassed the goal for newly diagnosed H.I.V. cases. So
9 we've -- we are -- we met the goal and are now dropping
10 below the -- the objective that we set for ourselves in
11 2008. So that's a success and I would say that the
12 incidence of H.I.V. infections is moving -- is going
13 down in the state and has been going down now for -- for
14 several years.
15 So just in terms of moving forward to the next
16 cycle of the state health improvement plan, this would
17 cover the years 2013 through 2017, we'd like to engage
18 in a process that provides public and stakeholders with
19 the progress to date on these objectives as I've been
20 showing you, but then engage stakeholders in identifying
21 what the priority areas would be for the next cycle of
22 the state health improvement plan. And we'd very much
23 like to use the public health committee and a new
24 committee, which I'll talk about in a minute, to try and
25 get some of that input and develop a plan with

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2 strategies moving forward. And I'll just comment, a lot

3 of this -- this is, as Dr. Shah indicated in his

4 remarks, and Dr. Boufford, part of the accreditation

5 process is that we have a process of setting objectives,

6 getting stakeholder input, and developing a strategic

7 plan. Those are all elements that we will need to

8 demonstrate in order to become accredited as a state

9 health department.

10 The next slide just highlights the -- the

11 timeline here, starting out with the current prevention

12 agenda, 2008 through 2012. Within that time period

13 we've had local health departments conducting activities

14 in terms of their community health assessments. The

15 community health assessment, we actually synchronized

16 these in 2008-2009 for the local health departments and

17 the hospital community service plans and you can see

18 that going forward those plans aren't exactly

19 synchronized. That's one of the things we would like to

20 work on to again try to synchronize the hospital and

21 county health department planning processes and also

22 make that jive with the new requirements for hospitals

23 in terms of their planning for the -- for the I.R.S. So

24 we're working with the Office of Health Systems to

25 figure out how we -- how we again make these planning

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2 process coincide in time so they can occur jointly. And
3 that's something that we'll -- we'll work on and
4 hopefully achieve.
5 So the specific steps going forward, we'd like
6 to propose, and I think Dr. Boufford from the Public
7 Health Committee, today will propose that we establish a
8 statement health improvement plan advisory committee of
9 this Council. We have gotten the interest of a number
10 of members of the current standing Public Health
11 Committee and we would like to invite interest --
12 interested stakeholders to participate in this effort
13 and really work with the Department to develop this
14 plan. We -- part of the first steps of the plan are to,
15 again, look at the health status and areas for health
16 improvement, focusing on disparities and factors that
17 contribute to ill health. We do have a big focus on
18 evidence base and we'll review the evidence base. We
19 did this a couple years ago with the prevention agenda.
20 We'll renew that information to look where there are
21 clear strategies that we know we can employ to -- to
22 achieve success.
23 We will then use this health assessment and the
24 public's input, number three on the slide, to identify
25 the public health priorities going forward for the state

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2 and establish some measurable objectives for each --
3 each of those.
4 And then continuing, we would then, as we did
5 with the prevention agenda, work with local and
6 statewide organizations to take -- have them take the
7 lead in helping to implement these strategies
8 including -- and these organizations would include other
9 state agencies, local health departments, hospitals,
10 managed care, other community organizations, and
11 statewide organizations that represent different groups.
12 We -- we'll develop and issue community health report
13 cards through this process as we've done with the
14 prevention agenda, updating -- updating the website
15 periodically to try and keep -- keep people focused on
16 the -- on the end goal. And we hope what this will do
17 then is provide a framework for the local public health
18 and health services planning required by local health
19 departments and hospitals during this period. And as I
20 mentioned, we'll work towards trying to synchronize the
21 timing -- the timing of those -- of those steps.
22 So I think the one immediate step today that
23 Dr. Boufford may also want to address is to ask --
24 there's a mechanism in the bylaws of the PHHPC to
25 establish from time to time advisory committees and so I

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2 think an advisory committee that assists specifically in
3 the development of the state health improvement plan
4 where we can have external members as well as Council
5 members sit on it. We have six members of the existing
6 Public Health Committee who expressed interest and we
7 will do an invitation process with our original
8 prevention agenda leadership group which was a broadly
9 constituted group that worked with us. And we'll
10 propose to have the group meet regularly during the next
11 year to help us pull together and have a plan ready to
12 go in 2013.
13 So that's my report. I don't know, Dr.
14 Boufford, if you want to add any more to that.
15 DR. BOUFFORD: Just for a second. For the --
16 for the Council's information, the ad hoc leadership
17 group, as Gus said, was constructed around the
18 prevention agenda and did meet pretty regularly for a
19 couple of years. It is a very broad based group. The
20 goal was to get statewide organizations representing
21 various advocacy groups, professional associations,
22 academic institutions, public health leadership meeting
23 on a regular basis to -- to really look at how they
24 could connect their different divisions and
25 constituencies at the local level with local planning

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2 processes. And I think it was very helpful in beginning
3 to develop partnerships that emerged out of the first
4 round and so we will be tapping into their expertise.
5 The one thing I did want to mention is one of
6 the -- the identified weaknesses of the previous
7 leadership agenda group was we did not have a lot of
8 representation from the business community. So we're
9 hoping that we can -- we have some strategies for
10 approaching the New York State Business Council and some
11 other groups to try to really increase that in this next
12 ad hoc group because I think it really is an important
13 representation.
14 And then finally to say that, as Gus said, we
15 hope that the advisory committee will bring in or be
16 able to attract not only the multiple expert sections
17 within -- excuse me -- within the Department of Health,
18 but I think also we'll look forward to the
19 commissioner's guidance on bringing in some of his
20 colleague commissioners from across the -- across the
21 government, New York State government, especially to
22 deal with some of these broader determinants such as
23 economic development and housing, transportation,
24 education, agriculture. So that would be a very
25 exciting and important step forward for this process in

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2 terms of the health and all agenda. So we're very
3 excited to be underway.
4 Thank you.
5 DR. STRECK: Thank you.
6 Just on a business basis, there -- the group has
7 proposed the advisory committee, so I would ask for
8 comments about that from members of the Council, in
9 terms of council to the -- to the various groups here.
10 Are there thoughts about the committee approach? Yes?
11 DR. BOUFFORD: Just as I did not say this, what
12 we did in asking for volunteers from the Public Health
13 Committee was to get folks that were willing to meet
14 more frequently on this and work on this particular
15 agenda, but obviously anything that comes up there will
16 come back to the entire Public Health Committee and back
17 to the entire Council. So we're always happy to have
18 volunteers for those that are interested, but you will
19 be kept informed and briefed along the way and your
20 advice will be sought.
21 DR. STRECK: In the absence of further
22 comments, I think I would speak for the Council in
23 offering our consensus endorsement for that effort. And
24 so I think that we appreciate your consideration and
25 encourage that committee's formation and work.

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2 Are there other questions in regards to any of the
3 reports that have been presented? Mr. Kraut?
4 MR. KRAUT: Could you just tell me, on the data
5 you showed, what's the smallest unit of analysis? When
6 you say we'll -- you know, when you get into community,
7 how small is that where the data is valid?
8 DR. BIRKHEAD: The indicators that we chose for
9 the prevention agenda are measurable at the county level
10 is the smallest unit of analysis. Some of them may be
11 measurable at a smaller level, but they all were
12 measurable at a county level.
13 MR. KRAUT: Thank you.
14 DR. STRECK: I had a question with regard to
15 the immunization decline. Is this organizational and
16 structural or is this part of this phenomena that is
17 emerging in terms of young parents choosing not to
18 immunize?
19 DR. BIRKHEAD: That's a good question. I think
20 actually, if you look at the numbers, that the decline
21 is only a few percentage points and may even be within
22 the range of the error of the measurement which is done
23 by a survey. But I think we do -- we have certainly
24 experienced in New York some -- we think some of the
25 decline is related to parental concern and that's

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2 something that we're continuing to try to address.
3 DR. STRECK: Other questions or comments? Yes?
4 MS. RAUTENBERG: Coming from New York City,
5 I've been struck by the New York City Health
6 Department's Take Care New York efforts and a project
7 very complementary and similar to the prevention agenda
8 work and Dr. Freedan (phonetic spelling) particularly in
9 his first six years used everything in his armamentarium
10 as commissioner to get the Take Care New York agenda
11 actualized. And I would recommend that approach to you,
12 Dr. Shah, because I think it was hugely effective in
13 galvanizing and aligning the forces within that
14 department which are clearly a little bit different than
15 a state health department, but it really is quite
16 energizing and effective I think.
17 COMMISSIONER SHAH: Thank you. I know he's
18 done the same thing with his winnable battles at the
19 C.D.C. and we talk to him regularly about his approach
20 and how we can best align the state, the city, and the
21 feds around the same issues because for the most part
22 they are the same issues at all levels. Thank you.
23 DR. STRECK: Other comments or questions? If
24 not, we'll move to our next category, health policy, and
25 we've had a joint report, but I'll turn this over to Dr.

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2 Rugge for some specific follow-up.
3 DR. RUGGE: Good morning. I'm here to report
4 that the Health Planning Committee is on the runway,
5 engines are humming, brakes are off, and it's time to
6 fasten our seatbelts. The -- where's Colleen? Who is
7 moving the slides?
8 UNIDENTIFIED FEMALE: I am.
9 DR. RUGGE: Oh, there we are. Okay.
10 The work to date has included seeking stakeholder input
11 from key stakeholders that are identified from around
12 the state, which we'll get to. I'm trying to identify a
13 ame. We're looking at advancing a number of committee
14 meetings one day ahead of the standard committee so that
15 we have a long half-day for the committee to deliberate.
16 The next committee meeting will be on January 18, one
17 day prior to the scheduled multi-committee days. And
18 likewise, we are reserving March 21 as a committee day.
19 We expect and are hoping that as soon as possibly August
20 we will be able to deliver a report and that report
21 should include recommendations regarding a redesign of
22 the C.O.N. process. For sure, that timeframe may slip a
23 bit or two if but if we don't have a goal we'll never
24 get there.
25 Along the way we expect to obtain expert advice

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2 from those with a long history of C.O.N. and also from
3 other commissioners as we look to integrate services
4 including physical health and mental health and
5 substance abuse and all that we've heard of so far
6 today.
7 Our stakeholders tried to make clear we have no
8 preconceived notion of how thorough going this redesign
9 may be. And so at some five different areas of concern,
10 which I don't need to read, you can read them here and
11 may have already seen the letter, this request went to
12 this group of stakeholders. I'll give you plenty of
13 time to read line by line all those that responded.
14 We've received some five dozen suggestions and I guess
15 I'm happy to say that there will be no prolonged
16 controversy about those who want to make a change and
17 those who would like to keep C.O.N. exactly as it is.
18 We seem to have a consensus about the need for change.
19 We've also tried two different ways to have
20 committee meetings. One was by teleconference, which
21 was I think important to conduct as a way to get our
22 feet in the water, but it is difficult over hundreds of
23 miles with somewhat antiquated technology to have
24 meaningful discussions and good interactions. Some of
25 our meetings may, nonetheless, be by teleconference.

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2 Those that are, we're encouraging as many committee
3 members as possible to actually attend in person, either
4 in New York, if that is a venue for the following day's
5 activities, or in Albany, which would be the case in
6 March.

7 The committee report, I think, may look
8 something like this by way of chapter titles. Looking
9 at doing a brief review so that everyone understands the
10 context of -- of the history that has gone before us
11 over the last several decades.

12 Moving on to profiling the C.O.N. process as we
13 are now living it, this should be relatively easy as
14 there is an annual report that has all the relevant
15 data. We're trying to put this into narrative form so
16 we really understand what it is we are -- we are now
17 undertaking.

18 Following this, I think it will be important
19 for us to understand the rationale for the C.O.N., its
20 benefits and drawbacks. We've already discussed those
21 or glanced upon them in previous meetings. And as a
22 different topic, the shortcomings, we know there are
23 drawbacks, there are time delays, there are false starts
24 that we are experiencing, but there may be activities
25 that we should be looking at as a Council that are

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2 simply now beyond our purview. And the question is how
3 can we expand that so that we can address the very rapid
4 changes coming in the health delivery system.
5 A chapter which I suspect may be the longest
6 chapter, trying to describe the changing environment in
7 which we are trying to cope, because it's those changes
8 which need to drive the nature of the reforms and the
9 new recommendations that we're looking to achieve,
10 summing up, of course, with a series of recommendations.
11 And this last chapter, I would think should
12 begin with a restated purpose for C.O.N. so that we know
13 in this environment why we are doing this at all. What
14 is this we are about? Having said that, I'm hoping that
15 we might be able to derive some guiding principles in
16 terms of what does that restated purpose imply for the
17 nature of change that we're trying to create. And then
18 going point by point according to criteria already
19 established in law, financial feasibility, public need,
20 and character and competence with a new take on each of
21 those and adding to that mix such other matters, the
22 other wide open provision in statute whereby this
23 Council can consider factors not included in the top
24 three.
25 Of interest, among all the comments we've

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2 received, the plurality, almost the majority, pertain to
3 administrative streamlining rather than the underlying
4 concept of what C.O.N. needs to be. And therefore that,
5 no doubt, will be a significant part of the final --
6 final series of recommendations.
7 As a launching pad, we have the Brooklyn
8 report, which I think is a truly remarkable document and
9 does set the stage for the kind of activity and the kind
10 of thinking we need to do. And indeed, I am thinking
11 that report will have accelerated the kind of
12 preliminary work that otherwise we would have had to
13 undertake. A few excerpts, one, perhaps the most
14 inflammatory of all the statements, is a recognition
15 that up until now New York has depended on a big box
16 approach to health care when now those big boxes, those
17 hospitals need to become the hubs or the organizers or
18 the inspiration for a more disseminated network of
19 activities that are more community based.
20 Taking as one of the headings from the Brooklyn
21 report, something that we might regard as a charge, not
22 only for the committee but for the entire health system,
23 is how do we transform those big boxes into newly
24 integrated systems that are truly aligned with public
25 health community needs. Our challenge.

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2 Among specific recommendations, page forty-nine
3 and fifty of the Berger Brooklyn report, is a list of
4 things that we, as a Council, should be undertaken by
5 way of review.

6 A list -- a considerable list of considerations
7 as proposals come for the redesign of the hospitals in
8 Brooklyn and the care systems in Brooklyn for which we,
9 at this point, have no criteria. These are all an
10 extension of what has, up to now, been the kind of
11 analysis brought to the Council by the staff and the
12 kind of deliberations and thinking we've been doing. So
13 all these really need to be the basis for how do we
14 reconsider the kind of -- the kind of deliberations and
15 the kind of decision making and what are the criteria
16 for those decisions going forward. This strikes me as
17 pointing toward a much more fundamental redesign and
18 reform of the system than at least I had in mind two or
19 three months ago.

20 Driven by the fact that indeed it does not make
21 sense to continue to make substantial investments in
22 many institutions as they now exist, but those
23 institutions are, by necessity -- often by financial
24 necessity, changing already, and the question is to what
25 degree does a C.O.N. process in the future help to shape

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2 and guide that change to better outcomes and better
3 systems of care.
4 And yet another specific mandate, a proposal,
5 from the Birkhead Brooklyn report, and that is that
6 there should be an Improva (phonetic spelling) board --
7 an Improva board that is essentially a planning agency
8 with teeth. And that board's activities should connect
9 to the work of this Council and be coordinated with it.
10 Two unknowns: What may that Improva (phonetic spelling)
11 board look like, and what would we look like in a
12 redesigned system?
13 With a further and final observation of the
14 Brooklyn report, that all this activity is not confined
15 to Brooklyn. That Brooklyn is really simply one among
16 many communities -- perhaps one among all the
17 communities in New York that need the kind of
18 transformation that is now being anticipated for that
19 borough. And so the way in which we begin to address
20 the C.O.N. applications as they come forward from --
21 from that, the largest borough, should influence and
22 indeed set the stage for all the changes and all the
23 kinds of applications we will be looking for in the
24 future.
25 We have our work cut out for us, but I think

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2 that -- that we have been spending these last several
3 months preparing. And with the help of staff and
4 perhaps the addition of some additional outside
5 resources, we will get the job done. No doubt to
6 unending controversy and more fuss and feathers, but
7 that's our job. Thank you.
8 DR. STRECK: Any comments on fuss and feathers?
9 Comments for Dr. Rugge? Mr. Fensterman?
10 MR. FENSTERMAN: Yes. Speaking about the fuss
11 and feathers, as -- and we are -- we seem to be focusing
12 initially today on Brooklyn and the borough and the
13 Birkhead report. Are we -- what role, if any, do we see
14 keeping abreast the assemblypersons and state senators
15 who represent the constituents of the borough and even
16 perhaps the borough president of Brooklyn, who is very
17 active as it relates to the -- what we're doing and
18 what's being done. And I guess the question is for you,
19 Doctor, and for you, Commissioner, as well, because
20 that's a concern of mine because if we go after the
21 fact, it could be a problem. I think it could create a
22 bigger fuss and feather force, if you will. So are will
23 we, if at all, keeping them abreast of what we're doing?
24 COMMISSIONER SHAH: I think Jim Introne and I
25 have a meeting with the entire Brooklyn delegation in

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2 the planning stage probably in the next week or two. So
3 we are -- we were -- they were the first to know, and
4 they will continue to be up to their eyeballs in this.
5 And we hope that they will help us with coming out with
6 those solutions that we need.
7 DR. RUGGE: I think another question that has
8 come up is to what degree -- or is it possible that any
9 recommendations of the committee and the Council might
10 have -- might have to be carried to the -- to the
11 legislature for reconsideration of statute? And my take
12 is we don't know. I mean, we're not looking at -- at
13 reforming statute or reforming regulation or reforming
14 policy. We looking at doing the next best thing as we
15 face a very dynamic environment and updating a
16 regulatory structure which, in some ways, may be
17 archaic.
18 DR. STRECK: John, another part of the Birkhead
19 report is the consideration of for-profit involvement in
20 the state as a source of capital. And I -- I'm
21 wondering if -- is your group going to add that to your
22 deliberations or are you just going to stay focused on
23 the current arrangement?
24 DR. RUGGE: Good question. Certainly, when it
25 comes to financial feasibility, we -- we will be

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2 touching on that issue. I would think it's best for
3 this committee to try to focus very intently on the
4 C.O.N. process as it pertains to the work of this
5 committee without getting into broader financial and
6 policy decisions, but with the understanding that this
7 in a way is a stage setter for further responsibility
8 that, as a Council, we do have by statute in terms of
9 general health planning. But I think that -- that focus
10 very tightly initially on C.O.N. and then see where that
11 takes us in terms of how we can be most helpful and most
12 productive in terms of the larger life of the state.
13 DR. STRECK: Other comments or questions for
14 Dr. Rugge? Ms. Rautenberg.
15 MS. RAUTENBERG: I read the Birkhead report,
16 which I thought was a terrific report and very
17 forthright. I was struck, though, by the lack of
18 attention to quality in that report, and I'm not
19 talking -- I'm usually on the prevention and primary
20 care side of the spectrum, but I was more concerned
21 about the more tertiary activities that a lot of these
22 hospitals that are in great financial difficulty. There
23 are level three trauma centers, there are level three
24 perinatal centers, and I would hope -- and I think you
25 were going to include the clinical quality as part of

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2 our look see on the C.O.N. as -- as something that would
3 be quite important as we go forward to expand those that
4 have a good track record on that.
5 DR. RUGGE: Yeah, and I would think that up to
6 now, it's fair to say that -- that analysis of the
7 character and competence has been mostly about whether
8 the proposed operators have stayed out of jail or stayed
9 out of trouble. And what we have now available that was
10 not available thirty years ago is all kinds of -- of
11 documentation with regard to quality. And so I think
12 that rather than looking so much at character, although
13 that will still be necessary, competence really means
14 how do we understand and how we evaluate quality? How
15 do we measure one application against another? And what
16 does that imply by way of our decision making?
17 MS. RAUTENBERG: Thank you.
18 DR. STRECK: Other comments or questions? Dr.
19 Strange?
20 DR. STRANGE: An underlying theme here this
21 morning amongst all the committee reports has been the
22 need and the absolute necessity of primary care is
23 becoming the driver of the systems that we're going to
24 move forward to. And it's very important, whether it's
25 in C.O.N. reform, the insurance reform we spoke about,

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2 Dr. Birkhead's report, and one of the issues that we
3 need, I guess, to address -- and maybe it needs to be
4 addressed at subcommittees that are going to be
5 formed -- is the workforce that's going to be necessary
6 to do all these things, because currently, as we know
7 and we -- and we've seen, graduates of medical schools
8 are not choosing primary care as their -- as the
9 profession to go into for a multitude of reasons.
10 And until we understand that -- and especially in an
11 area like Brooklyn, but it happens in all the boroughs
12 where culture diversity becomes important -- do we need
13 to train culturally diverse physicians or nurse
14 practitioners? Liability reform, quality initiatives
15 that need to be implemented and not overtaxed, as Dr.
16 Sullivan stated, because the taxing could be that the
17 primary care provider just has it all in his head
18 without there being the proper reimbursement or
19 protection. There, and to Dr. Bhat's comment, that's
20 why sixty percent end up in emergency rooms and we end
21 up seeing the acuity being so high.
22 I think we need to address how are we going to
23 stimulate young people to go into the primary care
24 field? And that has to start at the college level, my
25 belief is, before they even get to medical school. That

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2 has to start with some innovation of trying to figure
3 out what it -- is necessary to give the perception of
4 primary care as not being the invasive, you know,
5 high-glitz thing that the other things -- the other
6 specialties were.
7 And so to the -- to that end, to make all of
8 this work -- and all of this is good stuff -- we need
9 the Indians to do the work, and -- and that's a real
10 issue both locally and nationally.
11 DR. STRECK: Any other -- I'm sorry, John. Go
12 ahead.
13 DR. RUGGE: The -- the -- the G.M.E. Council is
14 being reinvigorated, and I think that -- that I would
15 like to suggest that this Council and its Planning
16 Committee pay attention to recommendations and the work
17 of that and other councils and that that is within our
18 purview, that is within our charge. And ultimately,
19 we're in a nice position to integrate the thinking of
20 multiple advisory groups into a coherent whole. And
21 clearly, changes in the reimbursement, changes in
22 medical education, and changes in the regulatory
23 structures are all necessary for them to have a highly
24 functioning system.
25 DR. STRECK: Other comments or questions? Dr.

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2 Bhat?
3 DR. BHAT: I think there was an article in New
4 York Times probably about seven, eight months ago where
5 they were making a recommendation. The fellowship
6 program, instead of being funded by the federal
7 government, maybe the people that want to be
8 specialists, they have to pay for it. I think it's
9 something that -- you know, at -- at the present time
10 when an average graduate that gets out of the medical
11 school has about a hundred and fifty to two hundred
12 thousand dollars in debt. And the usual path probably
13 would be to into some specialization like G.I. or
14 cardiology just to make sure that they have the money to
15 pay it back.
16 So there's steps that can be done. I think
17 that's already been done at the federal level -- is to
18 encourage these recent graduates to go in and start
19 their practices in medically underserved areas. That's
20 probably one of the steps that needs to be done. And
21 coming back to Brooklyn, I think a lot of places, you
22 know, you might have primary care, but they're not
23 available in the evening. They're not there on the
24 weekend. Maybe some kind of a differential in
25 reimbursement if they're going to be opening up. If you

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2 see the patient after five p.m. or you open up your
3 office on a Saturday, they probably should be getting
4 paid more for doing that. I think that's -- those are
5 some of the things that probably can be easily
6 implemented, and we don't have to wait for that another
7 five years.
8 DR. RUGGE: As a way of relating that to this
9 committee's activity, one of the suggestions that came
10 forward was that we should take a look at the -- the
11 upgraded D.N.T. center designation which exists in -- in
12 statute, but has never been fully implemented, as a way
13 of rounding out the continuum of service. And in that
14 setting, it would be perfectly possible -- and there's
15 actually precedent for negotiating with all the payers
16 higher rates -- reimbursement rates for -- out of
17 consideration of extended hours, upgraded services. So
18 that's the -- that's a kind of bleeding out. I think we
19 go from -- from C.O.N. review to perhaps a second report
20 on how to flesh out the delivery system in a proactive
21 way rather than simply our waiting for applications to
22 come and considering criteria for review.
23 DR. STRECK: Dr. Sullivan?
24 DR. SULLIVAN: Just one quick -- I think you
25 briefly mentioned this on -- in -- under integration,

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2 but just to emphasize the importance of mental health
3 and substance abuse services and medical care, that as
4 we look at all this, we look at it as a creative way to
5 make sure this time around we don't keep siloed services
6 happening, and that the integration, whether it be
7 physical location or just requirements for people to be
8 paying attention to this in the various services that
9 this really be highlighted. Because I think it's great
10 opportunity --
11 DR. RUGGE: Yeah.
12 DR. SULLIVAN: -- to do what we've all been
13 wanting to do for a long time.
14 DR. RUGGE: On the list is co-integration --
15 or -- or co-licensing, I should say -- and co-location
16 of services. And one thought is, at one of our Standard
17 Committee meetings, to invite Commissioner Hogan and
18 Commissioner Sanchez to address what their perspectives
19 on how best to shmoosh together the -- the various
20 articles into one review process. It's a technical
21 term.
22 DR. STRECK: A rich agenda for the planning
23 committee. So we'll look forward to your August 1st
24 report before you move onto the next --.
25 DR. RUGGE: I did not say August 1st. I mean,

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2 the August one hundred and twentieth one, but --.
3 DR. STRECK: I -- I meant it will be your first
4 report, not necessarily August 1st. Any additional
5 comments? If not, I would ask Dr. Rugge to briefly
6 conduct a meeting of the Planning Committee.
7 DR. RUGGE: Having left a quorum at our meeting
8 of two weeks ago, I'd like to convene a meeting of the
9 Health Planning Committee to consider the designation as
10 a stroke center of the Auburn facility, and I believe
11 Anna Colello will help us with that presentation.
12 MS. COLELLO: Thank you, Dr. Rugge. It's
13 Columbia Memorial Hospital's application for a stroke
14 center --
15 DR. RUGGE: Down in Auburn.
16 MS. COLELLO: -- in Auburn was the most
17 recently designated center. And for those members who
18 are not familiar with the designation process, there is
19 an application. You have before you the criteria.
20 Basically, it's twenty-four/seven of a stroke team, a
21 educated staff in the E.D. I.C.U., and a specifically
22 designated stroke unit, education of E.M.S. and the
23 community. There is a prevention component as part of
24 the -- the designation and, of course, data.
25 Columbia Memorial has fulfilled the requirements of the

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2 application. And once you have approved, an onsite
3 visit will be conducted by our Capital Region staff
4 and -- and myself. And if they pass the onsite, the
5 Commissioner will sign a letter of designation. There
6 are currently a hundred and nineteen centers, and if
7 approved, this would be the hundred and twentieth.
8 There's a yearly ongoing review of all centers to assure
9 that they're compliant with the original designation
10 criteria, so --.
11 DR. STRECK: Are there questions for Anna? Is
12 there a motion to approve? Oh, I'm sorry. Dr.
13 Berliner?
14 DR. BERLINER: Anna, at one point, we were
15 going to be getting some of the data on the -- on the
16 outcome results of the stroke centers. Is that still on
17 track?
18 MS. COLELLO: That -- that was presented last
19 summer. The one criteria that we were looking at was
20 mortality rates, and what was found is that designated
21 hospitals do have lower mortality rates for stroke
22 patients than non-designated centers.
23 DR. BERLINER: But there was going to be a
24 fuller report, or am I just remembering that wrong?
25 MS. COLELLO: It is our hope to gather more

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2 data. What we gather right now is with regard to time
3 targets in the E.D. There are five time targets, and
4 there are thirteen performance measures. I would be
5 able to present that at a future meeting based on the
6 2011 report. We basically culled -- or get with the
7 guideline's data -- our state registry, and it's that
8 information that would be due in -- on March 1st, and I
9 could present that data after that.
10 DR. BERLINER: Great. Thank you. I move the
11 motion.
12 DR. STRECK: This is just for clarification.
13 The -- the Committee is voting on this, not the Council
14 as a whole.
15 DR. RUGGE: Right.
16 DR. STRECK: So members of the Committee feel
17 free to vote.
18 DR. RUGGE: And we know who we are, right? We
19 have a motion. Do we have a second? Any further
20 discussion? All in favor? Any opposed? Any
21 abstention? The motion is passed. Is there a motion to
22 adjourn the Committee meeting?
23 UNIDENTIFIED MALE: So moved.
24 DR. RUGGE: Any opposed? We are -- we stand
25 adjourned.

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2 DR. STRECK: So we'll return to the meeting of
3 the Public Health and Health Planning Council. And we
4 are about to adjourn, but before we do, I -- I would
5 just like to comment. And I am not one for gratuitous
6 comments or compliments, but I have to say to Dr. Shah
7 and the staff that the range of activities that have
8 been covered in this meeting that have been going on in
9 this state is quite phenomenal. I've had the privilege
10 of working on just one of these projects, the M.R.T.
11 payment and quality task force, which Mr. Ulberg has
12 led. And the amount of work involved in these efforts,
13 that being just one, but if we look at M.R.T., the
14 nursing home rates, Brooklyn, HEAL, C.O.N., the
15 behavioral health organizations, all of these activities
16 through Mr. Cook's office and all the staff, I think
17 it's just really quite phenomenal that this amount of
18 work has progressed and the state has advanced in many
19 ways along this -- along these paths.
20 So I think it warrants comment that we are
21 making progress even in these very difficult times with
22 some amazingly creative ideas. Even if some of them may
23 prove contentious at times, they -- they reflect an
24 immense amount of work and thought, and I -- I would
25 just want to get that officially on the record.

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2 The other thing I -- I would mention is that the room is
3 now a little bit warmer than it was during our nadir
4 about forty-five minutes ago. And this afternoon during
5 our discussion, we will try to balance the rhetoric with
6 the thermostat and keep everyone comfortable.
7 So with that, we are adjourned for lunch. And we will
8 meet -- we'll resume at one o'clock sharp. Thank you.
9 (Off the record)
10 DR. STRECK: -- Health Planning Council.
11 Our -- we now move to the report of the Committee on
12 Codes, Regulations, and Legislation. Dr. Gutierrez will
13 lead us. We will reverse the order a bit in terms of
14 the way the agenda outlines this so we can dispense of
15 some of the items before moving on to the issue that has
16 occupied most of the correspondence. Dr. Gutierrez?
17 (Off-the-record discussion)
18 DR. GUTIERREZ: It met on November 17th. There
19 are two items for emergency adoption, three for
20 discussion and two for regular adoption. They're
21 consistent with what was delineated by Dr. Streck. The
22 following two items were on the agenda for regular
23 adoption:
24 The observation unit proposal was an initiative
25 of the Medicaid Redesign Team, creating a regulatory

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2 framework for observation units and a Medicaid rate for
3 observation services. The intent behind this regulation
4 is to reduce emergency department patient boarding,
5 overcrowding, and premature discharges which might lead
6 to adverse outcomes. Observation services are an
7 intermediate setting between the emergency department
8 and an inpatient admission intended for patients who
9 can't be diagnosed or sterilized within the eight hour
10 limit, which -- but could within twenty-four hours.
11 Currently, the Department has granted approximately
12 twenty waivers for the eight hour rule and allowed
13 hospitals to create observation units. Medicaid did not
14 pay for observation services, but began to do so in
15 April '11 for units that operate under approved waivers.
16 Once this regulation is adopted, Medicaid will pay for
17 services in observation units that are in compliance
18 with its provisions. Such provisions do not mandate
19 that hospitals create observation units. They do
20 require hospitals that do so to use discrete physical
21 space, excluding critical access hospitals and sole
22 community hospitals, limit the stay to twenty-four
23 hours, and be under the direction of the emergency
24 department. The beds are limited to five percent of bed
25 capacity up to forty beds. Hospitals with less than one

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2 hundred beds can have up to five observations beds. The
3 observations units must comply with the National
4 Architectural guidelines for observation units that were
5 adopted in 2010. They are not subject to public need
6 assessments, so there will not be a full review of these
7 applications.
8 If hospitals create a unit without
9 construction, they can open one with a notice to the
10 Department only. If they create one with construction,
11 they must go through a limited review application.
12 Existing observation units will be subject to a two
13 great grace -- a two year grace period to come into
14 compliance with the regulations.
15 After a motion and a second, the Codes
16 Committee unanimously voted to recommend adoption to the
17 full Council, and I so move.
18 UNIDENTIFIED MALE: Second.
19 DR. STRECK: So the recommendation has been
20 moved and seconded and is now open for discussion before
21 members of the Council. Are there comments or questions
22 in regard to the recommendation? Hearing none, I would
23 ask for those in favor of the recommendation to say aye.
24 Opposed? The recommendation pass -- passes.
25 DR. GUTIERREZ: The second and last item on

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2 this concerns accreditation standards. Hospital and
3 diagnostic and treatment centers are routinely surveyed
4 for compliance with operational standards. Current
5 provisions authorize the Commissioner to accept, as
6 evidence of compliance with such standards.
7 accreditation of the Joint Commission or the American
8 Osteopathic Association, and also the Accreditation
9 Association for Ambulatory Healthcare for freestanding
10 and offsite based hospital-based ambulatory surgery
11 centers.
12 While these accrediting organizations have been
13 predominantly used over the years, additional
14 accrediting organizations have come into existence and
15 have been granted deeming status by the federal Centers
16 for Medicare and Medicaid Services, C.M.S. Newer
17 accrediting agencies are being utilized by hospitals and
18 other facilities more and more and recognized by C.M.S.
19 for federal surveillance purposes. These provisions
20 will remove named references to accreditation agencies
21 and allow facilities to be accredited by an
22 accreditation agency C.M.S. has granted deeming status
23 and which the Commissioner has determined their
24 accrediting standards are sufficient to assure the
25 Commissioner that hospitals so accredited are in

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2 compliance with such operational standards.
3 The Commissioner can choose to enter into
4 collaborative agreements with such accreditation
5 agencies so that the accrediting agencies accreditation
6 survey may be used in lieu of a departmental survey.
7 The Department will post on the D.O.H. website a list of
8 accreditation agencies with which the Department has a
9 collaborative agreement.
10 After a motion and a second, the Codes
11 Committee unanimously voted to recommend adoption to the
12 full Council, and I so move.
13 UNIDENTIFIED MALE: Second.
14 DR. STRECK: A motion has been made and
15 seconded. Is there discussion on the motion? Hearing
16 no discussion, I would ask for a vote on the motion.
17 Those in favor, please say aye. Those opposed? Thank
18 you. The motion passes.
19 DR. GUTIERREZ: I will present two of the three
20 items for discussion now, and we'll return to the third
21 later. The following proposal was a discussion item
22 regarding the homecare registry. This proposal creates
23 a Part 403 to Title 10 N.Y.C.R.R. that defines the rules
24 for implementation of legislation requiring the
25 Department to establish a homecare worker registry.

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2 This law also specifies the rights -- rights, duties,
3 and obligations of homecare services workers, homecare
4 services agencies, and a homecare training and education
5 program.
6 The intent of the law is to deter fraud in
7 training programs and certification and give the public
8 a registry in which they could go to look up individuals
9 to determine if they were, in fact, trained and if they
10 are employable. The Department of Health determines
11 whether the homecare worker is employable through a
12 background investigation. This proposal covers home
13 health aides, personal care aides, homecare services
14 agencies, and training programs approved by the New York
15 State Department of Health and Education.
16 Information on every personal care and home health aide
17 and every training program in the state must be entered
18 into the registry that is accessible to both the public
19 and to employers and prospective employers of such
20 workers. The registry must be available to the public
21 through both a website and a toll free telephone number
22 operated by the Department's Bureau of Credentialing.
23 That's the end of that informational.
24 DR. STRECK: So this is a topic for discussion.
25 Are there comments in regard to this registry? Yes,

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2 Doctor --?
3 DR. BOUTIN-FOSTER: I have two questions. What
4 implications does this -- it's -- maybe it's three.
5 Number one, is it mandatory registration for someone to
6 work as a home healthcare worker? And if so, are there
7 fines? Are individuals who work in -- under this
8 position and yet not certified through training, is
9 there a fine that can be imposed?
10 The second question is what implication would this have
11 on home healthcare workers who are undocumented? And
12 would that -- I -- I -- I mean, so I'm -- I'm just going
13 to leave it at that.
14 MS. REGAN: Great minds think alike. I -- I
15 wanted to raise the same question. And I -- I had a
16 brief talk with Beth Dichter, who might want to comment
17 further on this, but it's my understanding that -- that
18 the state is not offering ourselves up as an enforcement
19 agency for -- for ICE, and we're not looking to sort out
20 potentially undocumented homecare workers. So all --
21 all these regs are asking is that somebody show that
22 they are who they say they are. And so I -- I, just
23 from my own point of view, would like to be sure that
24 we're making it clear that we are not looking to enforce
25 immigration standards in any way. That if somebody

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2 is -- we're looking to enforce qualifications and
3 training standards.
4 DR. DICHTER: We are not looking to enforce
5 immigration laws, and we are not looking to identify
6 undocumented aliens and turn them over to ICE.
7 Regarding the fines, there -- there are no fines. If --
8 the -- the statute prohibits homecare services agencies
9 from using anybody to provide homecare who isn't already
10 on the homecare registry. If a homecare agency violates
11 that statutory requirement, it -- it is subject to our
12 enforcement. The individual is not subject to our
13 enforcement.
14 DR. STRECK: Are there other questions in
15 regard to this topic? Oh, I'm sorry. Mr. Hurlbut and
16 then Mr. Fassler.
17 MR. HURLBUT: I guess in the nursing home
18 world, we've been doing this for like two hundred years.
19 We -- as a matter of fact, on a monthly basis, we have
20 to look at the Medicaid -- we have to -- we have --
21 there's three sources we have to look at to make sure
22 that our employees are not on the exclusion list for
23 Medicare and Medicaid. And if they are, and we don't
24 get them off soon enough, there are fines. So the fact
25 that home healthcare isn't getting fined for this or

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2 possibly that there could be, to me, is a little
3 strange. I'm not -- I'm not going to deal with that
4 today because in the nursing home world, we already do.
5 So -- and I -- I guess I do sort of have an issue though
6 with undocumented workers that are here illegally if you
7 find out about it. I mean, aren't we breaking the law
8 on that? I mean, that -- that's just for discussion. I
9 just think it's a little -- because in -- in the nursing
10 home world, if we don't, we're dead. We get in trouble.
11 So how can home healthcare not be under the same
12 regulations as nursing homes or in hospitals?
13 DR. DICHTER: Homecare agencies are subject to
14 enforcement and to fines if they use as a homecare
15 worker somebody who isn't on the registry. It's the
16 worker -- it's the employee who is not subject to fines.
17 MR. HURLBUT: Well, I understand that part, but
18 the home -- home healthcare agencies, are they going to
19 be also mandated to check the Medicare and Medicaid
20 exclusion list for employees as well?
21 DR. DICHTER: I think they have to. Becky?
22 MS. GRAY: Home health agencies are now
23 currently required to meet specific standards in terms
24 of hiring personnel. And one of those standards that
25 they have is to do their I-9 checks and to ensure that

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2 the individual who is working for them meets all the
3 minimum qualifications and requirements to be employed
4 in New York State.
5 MR. HURLBUT: That's not my question. My
6 question is you've got an employee that works for you
7 right now. On a monthly basis in the nursing home
8 world, we're required to look at three different
9 websites to make sure that our current employees are not
10 on the Medicaid or Medicare exclusion list because of
11 something that they did.
12 MS. GRAY: Yes. At the time of hiring, they
13 have to check the Medicare and Medicaid exclusion list
14 to ensure that those individuals are not on it. There
15 is not a dictated frequency in the regulations, however,
16 that say you have to do it monthly and -- or -- to that
17 extent, they do have to do an annual evaluation of every
18 employee to ensure that they continue to meet the
19 standards.
20 MR. HURLBUT: So in other words, if someone's
21 been employed for six months and they don't check it,
22 and then six months later, they find out that they're on
23 the exclusion list, do home healthcare agencies get
24 fined like nursing homes do if a -- if a -- because they
25 want the Medicaid dollars back because that person

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2 has -- has been on the exclusion list and the case has
3 been with the Attorney General's Office that they want
4 Medicaid funds back for the -- what you've paid them?
5 And I want to -- and I'm just asking is home healthcare
6 the same thing?
7 MS. GRAY: Yes.
8 DR. STRECK: Mr. Fassler?
9 MR. FASSLER: All right. Just two comments.
10 First -- and again, in nursing homes, the certified
11 nursing attendants do have a registry right now that is
12 checked, so that's -- that's not new. The other
13 thing -- just maybe it would help if you explain why
14 this came about right now. What was the problem that
15 brought this about? Was --?
16 DR. DICHTER: O.A.G. found fraud in training
17 programs. There were organizations out there either not
18 approved by S.E.D. or by D.O.H. or approved by us who
19 were just issuing certificates to untrained people. So
20 O.A.G. felt that a homecare registry was one way to
21 deter fraud in the training world and then, in addition,
22 give the public access to some information about the
23 suitability of individuals to go into their homes and
24 provide care to, you know, their parents and families.
25 DR. STRECK: Other questions or comments on

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2 this topic? Thank you for those clarifying remarks.
3 That was helpful.
4 DR. GUTIERREZ: The next item for discussion
5 relates to a measure that will implement legislation
6 adopted last session that streamlines and simplifies the
7 C.O.N. process for projects relating to repair and
8 maintenance of one for one -- on one for one replacement
9 of equipment and for projects relating to nonclinical
10 infrastructure. The new law specifies that, regardless
11 of cost, these categories of projects will no longer
12 require prior approval through limited review,
13 administrative review, or full review. They will only
14 require the submission of a written notice on the part
15 of the applicant describing the project and, where
16 applicable, architecture and engineering certification
17 and a plan for safety of patients during construction of
18 the project.
19 Such notices would be submitted through the New
20 York State electronic C.O.N. system, and the Department
21 is currently working with the programmers to alter the
22 system to accommodate these policies -- what is now
23 notices. These changes will not exempt applicants from
24 the requirement to be fully in compliance with the
25 medical facility's construction code and hospital code

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2 and all relevant federal, state, and local laws. The
3 Department intends to implement the law beginning on
4 January the 20th, 2012, and expects N.Y.S.E. C.O.N.
5 functionality to support the submission of notices on
6 that date.
7 That's the end of that item, Dr. Streck.
8 DR. STRECK: Comments, questions about this
9 particular item? Thank you. You may proceed.
10 DR. GUTIERREZ: Continuing then, I will move
11 with the next item, which is a second emergency adoption
12 concerning limitation of operating certificates. The
13 recent weather events require the temporary evacuation
14 of facilities in the New York Metropolitan area and
15 relocation of facilities in Broome and Tioga Counties
16 due to flooding. Because Section 401.2 currently limits
17 an operator's operating certificate to the site of
18 operation set forth in the operating certificate, an
19 operator of an impacted facility is not able to care for
20 its patients or residents at any other site until the
21 Commissioner has approved a certificate of need
22 application or the relocation of the facility.
23 This proposal would allow the Commissioner to permit an
24 established operator to operate at an alternate or
25 additional site approved by the Commissioner on a

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2 temporary basis in an emergency. This amendment gives
3 operators of hospitals as defined under Article 28 of
4 the Public Health Law the ability to temporarily operate
5 at sites not designated on their operating certificates
6 in times -- in times of emergency.
7 It was adopted as an emergency at the October
8 6th full Council meeting. But if not adopted again
9 today, it will expire before the January/February Codes
10 and full Council meeting. After a motion and a second,
11 the Codes Committee unanimously voted to recommend
12 adoption to the full Council, and I so move.
13 UNIDENTIFIED MALE: Second.
14 DR. STRECK: It's been moved and seconded. Is
15 there discussion on this item? Hearing none, I'd ask
16 for a vote. Those in favor, aye. Opposed. Thank you.
17 That motion passes. Proceed.
18 DR. GUTIERREZ: And the last of the items for
19 discussion links up with the last vote. An identical
20 permanent version of the amendment to limitations of
21 operating certificates proposal was also on the Code's
22 agenda as a discussion item. It is currently winding
23 its way through the regulatory process and will come
24 before you when that is completed and it is ready for
25 adoption.

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2 DR. STRECK: Go ahead.
3 DR. GUTIERREZ: Last for action, the first
4 proposal amends certified home health agencies, CHHA,
5 established in determination of public need provisions
6 in Section 760.5 of Title 10. After an overview
7 presentation of this regulation, there was considerable
8 dialogue among Committee and Council members.
9 Representatives from the New York Association of
10 Healthcare Providers, Homecare Association of New York
11 State, Leading Age, and the Healthcare Association of
12 New York State addressed the committee and voiced their
13 opposition to the proposal. A representative of the
14 Health and Hospital Corporation spoke in support.
15 At Codes, after a motion and a second, the Committee
16 voted five to one to recommend adoption to the full
17 Council. The -- subsequently, the Department received a
18 lot of questions from Council members concerning this
19 proposal in the days after the Committee meeting and is
20 prepared to respond to the Council. I will now turn the
21 floor over to state -- Health Department staff to --
22 we'll start the discussion, but I'll hand over the --
23 this to Dr. Streck then.
24 DR. STRECK: So Mr. Cook, you're prepared to --
25 MR. COOK: We are.

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2 DR. STRECK: -- address this?
3 MR. COOK: What we're going to do is do two
4 things. I mean, Becky Gray, who is the Director of the
5 Homecare Program with the Department, will kind of go
6 through some detail as to trying to address some of the
7 questions that one of the Council members asked us, a
8 kind of history of the moratorium, rationale relating to
9 the reg, the types of criteria that we will use to
10 evaluate the programs, the process by which we will
11 evaluate the programs. Inherent with that, obviously,
12 is a rationale relating to why we believe this is
13 necessary in the context of Medicaid redesign reform.
14 And Mark Kissinger, who's the Deputy Commissioner for
15 Long-term Care, will highlight the rationale in that
16 context.
17 So I'm going to ask Becky to begin with just
18 kind of summarizing the paper that went out last
19 evening, and then turn it over to Mark.
20 DR. STRECK: Before we begin that process, I
21 think to keep the debate in the formal structure, it
22 would probably be appropriate to have the motion of the
23 Codes Committee placed on the floor. So Dr. Gutierrez,
24 if you would place --.
25 DR. GUTIERREZ: So the Codes Committee -- after

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2 a motion and a second, the Committee voted five to one
3 to recommend adoption to the full Council.
4 DR. STRECK: And you so --.
5 DR. GUTIERREZ: I so move.
6 UNIDENTIFIED MALE: Second.
7 DR. STRECK: So it has now been moved and
8 seconded that the recommendation from the Committee be
9 presented here with an approval recommendation. And
10 with that, we'll open the -- the formal discussion. Mr.
11 Cook has provided an outline of the introductory
12 presentation from the Department of Health staff, and
13 we'll begin with that. Thank you.
14 MS. GRAY: Hi. The CHHA need regulation 760.5
15 was originally filed in July -- on July 11th, 1974, and
16 was subsequently amended in February of 1986. The
17 regulation as it was written was intended to be used in
18 conjunction with planning standards and criteria in
19 Section 709.1 and represented a statement of basic
20 principles and planning decision making tools for
21 guiding and directing development and expansion of CHHAs
22 throughout the state based on the application of uniform
23 planning objectives that provided guidance, permitted
24 flexibility, and assisted the then health systems
25 agencies, the Councils, and the Commissioner in -- in

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2 determining the estimated need for CHHAs in the state.
3 The objective of the methodology was to ensure that an
4 adequate supply of CHHA's capacity was available and
5 accessible while, at the same time, avoiding the
6 proliferation of unneeded agencies.
7 In making determinations of need, calculations
8 were made based on a number of factors affecting the
9 planning area using the most currently available and
10 analyzed data in the 1980s considering the local
11 characteristics and demographics of that area. This
12 need methodology was used to establish CHHAs in the
13 state until 1994. In 1994, the State Hospital Review
14 and Planning Council recommended that a moratorium be
15 placed to establish new CHHAs or to allow the expansion
16 of existing CHHAs until such time that a revised new
17 methodology could be developed. With the exception of
18 the establishment of special need and special project
19 CHHAs, the moratorium has been in effect since that
20 time.
21 This year, the state legislature, as part of
22 the final state fiscal year 2011-2012 state budget,
23 endorsed a number of proposals which provide for cost
24 savings, expanded access, and improved administrative
25 efficiencies directly related to the provision of home

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2 health services. The timetable for implementation, as
3 you know, is relatively short. These initiatives which
4 are intended to reduce Medicaid expenditures and improve
5 healthcare delivery have been or are about to be
6 implemented and have resulted in the need for CHHAs to
7 change their service delivery practices.
8 The purpose of the proposed regulation is to facilitate
9 Medicaid redesign initiatives related to the shift of
10 Medicaid cases from traditional fee-for-service programs
11 to managed care, managed long-term care plans,
12 integrated health systems, and other types of
13 coordination models as well as to improve access to home
14 health services.
15 Currently in New York, there are one hundred
16 and thirty certified home health agency providers and
17 twenty-nine managed long-term care plans. Under the
18 final state budget agreement, the Department is
19 authorized to approve up to seventy-five certificates of
20 authority to establish managed long-term care plans. Of
21 the existing twenty-nine plans, fifteen currently have a
22 CHHA within their corporate structure, and fourteen do
23 not.
24 Currently, there are thirty-three counties that
25 have less than two CHHAs approved to serve the county.

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2 Of the one hundred and thirty CHHA providers, thirty-two
3 are county-operated agencies and sixteen of those are
4 sole providers within their county. In recent years,
5 seventeen county-operated CHHAs have closed, and an
6 additional eighteen have indicated to the Department
7 that they indeed to close or have closure plans in place
8 to occur over the next year.
9 The regulation amends 760.5 Title 10 and
10 authorizes the Commissioner to issue a request for
11 applications to establish new CHHAs or expand the
12 approved geographic service area and/or approve
13 population of existing CHHAs. Public need will be found
14 to exist based on specific criteria that have been
15 established in 709.1(a) of Title 10. And if approval of
16 the application will facilitate the implementation of
17 Medicaid redesign initiatives designed to shift Medicaid
18 beneficiaries from traditional fee-for-service programs
19 to managed long term care systems, integrated health
20 systems, or similar care coordination models, or assure
21 access to CHHA services in counties with less than two
22 existing certified home health agencies.
23 The regulation is not limited as to whom may
24 submit an application to establish a CHHA or to expand
25 an existing CHHA. The special need CHHAs, long term

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2 long healthcare programs, or other entities may apply as
3 the regulation indicates. And those applicants will
4 have to demonstrate that based on the criteria found in
5 709.1, that their application will facilitate Medicaid
6 redesign initiatives.
7 We envisioned the R.F.A. process to provide a
8 mechanism to identify candidates through a competitive
9 review process from -- from applications that have been
10 submitted to the Department. Applicants will be
11 required to demonstrate need and demonstrate also that
12 they will enhance care coordination, increase quality
13 and efficiency in providing home health services,
14 improve patient choice and access, improve cost
15 effectiveness and efficiency, and improve quality
16 outcomes. Applicants will be selected based on this and
17 other criteria through the R.F.A. to submit a
18 certificate of need application.
19 All potential CHHA applications will be
20 reviewed and approved by the Public Health and Health
21 Planning Council for final approval to operate a CHHA in
22 New York State. Final approval to establish or expand a
23 CHHA continues to rest with the Council.
24 MR. KISSINGER: Thanks, Becky. I just want to
25 say a little bit -- Becky gave you a lot of context

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2 about the Medicaid redesign process. You've been
3 briefed on it, and also about change. Change is hard,
4 and especially in this industry and in this state. And
5 what -- what we're talking about today is allowing a
6 process for change. No certified home health agency
7 will be approved today. We'll just -- we're starting
8 the conversation about -- about changing the current
9 process. Providers, plans, integrated health systems,
10 care coordination models, all these words and terms mean
11 a lot of different things to a lot of different people,
12 but what we know -- the one constant here we have in
13 this industry is change.
14 The Medicaid redesign team and the state
15 legislature enacted a broad mandate to the Department to
16 basically move everyone from fee for service to a
17 care-coordination model or a managed long-term care plan
18 for long-term care over -- over a certain period of
19 time. That rapid change -- it's got a legislative
20 mandate to start April 1, 2012, which is very close,
21 ninety days basically away. We've been working with
22 C.M.S. carefully on that. We've been talking to the
23 city about that we're going to start in the city to do
24 that. But what it means is it's a start of a rapid
25 change in long-term care in this state, moving from a

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2 fee-for-service environment to a managed care or a
3 care-coordination model environment.
4 So as we move in that environment, we need to
5 look at all these regulations and all -- all these
6 things. And frankly, we started here with -- with the
7 CHHA need -- need regulation, which was -- which was
8 established in 1986 -- last amended. 1986 is a lifetime
9 ago. 1994 is a lifetime ago. Change is happening
10 rapidly now. We need providers, plans, entities to have
11 options available. This R.F.P. process will allow
12 people to live and work in the new world of care
13 coordination and -- and managed long-term care and care
14 management for all over -- over five years.
15 So -- so what we're asking the Council to do basically
16 is take -- take what is before them, allow a process to
17 begin. Allow us to do an R.F.P. Allow us to look at --
18 look at different -- to -- to really look at this
19 CHHA -- the CHHA system as we have it now and be open to
20 change. Be open to expansions of service area,
21 expansions of population, expansions of new entities
22 coming into the CHHA world. So that, frankly, M.R.T. is
23 all about change. Rapid change has happened in the --
24 in the eleven months that this governor has taken
25 office, and -- and this will allow us to also allow

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2 providers to react to -- to that change.
3 DR. STRECK: Other comments? Rick, from the
4 staff?
5 MR. COOK: No, I -- I think Mark's final point
6 is -- is the critical issue, and -- and this is -- this
7 is a process. This is authorizing us to go forward and
8 to evaluate, you know, what proposals are out there that
9 can assist us in redesigning the system. And I think
10 that's -- the most critical issue is -- is to allow us
11 the tools to go forward with the process to see what's
12 out there that can assist the state as it transitions.
13 DR. STRECK: So we have a motion from the
14 Committee, and we've had some discussion from Department
15 of Health staff. I'm going to open this now to
16 discussion from Council members. I want to begin by
17 pointing out that, as a policy issue, this is not a
18 C.O.N. issue. So that there is not a disqualification
19 on the part of members of this Council by being
20 associated with CHHAs, having CHHAs within their
21 systems. Just like we vote on policy issues relating to
22 hospitals or other entities, this is a policy decision
23 that we are considering. So that, by our review and
24 in -- and in consultation with Council, all members are
25 eligible to participate and -- and vote in this

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2 discussion today.
3 So with that, I would open the floor for
4 discussion on the motion. Ms. Rautenberg?
5 MS. RAUTENBERG: I just really have actually
6 one question that relates to language. In paragraph
7 four, it talks about managed long-term care plans, and
8 then it goes, "Of the existing plans, fourteen do not
9 have a CHHA within their corporate structure," but
10 they -- they contract with other CHHAs. Does -- I'm --
11 I just don't understand the corporate structure
12 sentence. Does that mean they need to own their own
13 CHHAs? And I realize I'm naive about a lot of this.
14 And then there's -- in the fifth paragraph, it talks
15 about costly intermediaries. Is that similarly a
16 similar reference to not contracting for CHHA services,
17 but owning CHHA services within a long term -- a managed
18 long-term care plan?
19 MS. GRAY: A managed long-term care plan does
20 not have to have a certified -- can you hear me? Okay.
21 A managed long-term care plan does not have to have a
22 certified home health agency within its umbrella --
23 corporate umbrella to operate. However, some do. And
24 there are fourteen or fifteen -- I can't remember the
25 number without looking at it -- that do have within

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2 their corporate umbrella a certified home health agency
3 that they have.
4 Your second question was about costly
5 intermediaries, and I think that related to integrated
6 healthcare systems. And the premise of an integrated
7 healthcare system is that they are efficient and they
8 have to offer the continuum of services for their
9 patients, and they can do that because -- and by doing
10 so, they avoid other intermediaries that may be more
11 costly to their system. That's what the sentence meant.
12 MS. RAUTENBERG: So essentially it means that
13 there may not be a market and that there may be an
14 inability to contract with an efficient CHHA in its
15 area, sort of?
16 MR. COOK: Yes. And I think -- I mean, I
17 think, too, the context here is important. And the
18 context here, as Mark noted or as Becky noted, you know,
19 we now have authorization to approve almost an
20 additional fifty managed long-term care programs. And
21 as we move the entire state to a managed care
22 environment under long-term care, quite frankly, we need
23 to have some tools available to assist with the success
24 of that. And that's going to mean that some of these
25 providers, whether they're integrated system or managed

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2 long-term cares, we want to make sure that they can be
3 competitive in the market and receive the service that
4 they need at the best rate. And sometimes, that may
5 mean them owning that particular program or service.
6 DR. STRECK: Ms. Hines?
7 MS. HINES: And can I just for the record say
8 it's already warm in the room?
9 DR. STRECK: There is a point of order in
10 Robert's Rules, personal privilege. Anyone at any time
11 can interrupt any proceeding as a point of personal
12 privilege and say certain things such as "the room is
13 too hot." And so I want you all to be -- and that
14 interrupts all proceedings. So -- and the chair gets to
15 rule on that point of personal privilege and rules in
16 favor of Ms. Hines on this. So I -- I tried, but I -- I
17 don't know exactly how to deal with that thermostat at
18 the moment. And I'm not sure we have the expertise in
19 the room at the moment. But we're -- between Ms. Hines
20 and Dr. Yang, we have clear monitors of the temperature
21 here.
22 UNIDENTIFIED MALE: I can only tell you, it
23 just -- the cold air just started over here, so it
24 should be drifting --.
25 DR. STRECK: Oh, okay.

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2 MS. HINES: It should be drifting over here?
3 That would be a beautiful thing.
4 DR. STRECK: All right. Go ahead, Vicki.
5 MS. HINES: So I -- I obviously have a lot of
6 comments to make. I -- I do want to add -- add more to
7 the answer to your question. So as -- as Becky and Mark
8 and -- and Rick all outlined, they don't have to --
9 M.L.T.C.'s do not have to own their own CHHAs. It is an
10 option. And the way M.L.T.C.'s are expanding today is
11 by contracting with existing CHHAs. And to date, we
12 don't have evidence that I am aware of that would tell
13 you that there aren't -- there isn't enough capacity for
14 them to be able to build those networks. And we saw
15 that in one of the letters that was -- that was
16 presented to this Committee over the last couple weeks.
17 So I -- if -- if I could, since I have the microphone,
18 I -- I have several comments I'd like to make. And --
19 and -- and first, to the Department's suggestion --
20 appropriate suggestion that we really do need change, I
21 completely agree. And -- and my concern is the way in
22 which we do it. And I think primarily I -- I'm not
23 persuaded that we have an emergency. And given that
24 this is such a complex and -- we've had longstanding
25 moratorium, longstanding need methodology that we all

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2 know is no longer appropriate. We are all supportive, I
3 think, of doing the right kind of health reform. It's
4 how we do it.
5 And so from the emergency perspective, I guess
6 my concern is number one, we -- we don't have clear
7 evidence yet -- not that we won't -- but we don't have
8 clear evidence yet that we have an access problem for
9 CHHAs. We have CHHAs. We have long term home
10 healthcare programs. We have licensed agencies. Many
11 of the M.L.T.C.'s are actually contracting directly with
12 licensed agencies and not with CHHAs to expand their
13 networks, so I haven't heard a capacity issue. I
14 understand we may be pre-empting the thought that that
15 might occur, but I -- from my perspective, I would much
16 rather wait until we see that happen before we take such
17 a drastic measure as -- as this emergency adoption.
18 Secondly, in the last two weeks, we've received -- I --
19 I've only been on the Council now for less than six
20 months, but I don't remember an issue where we -- where
21 we have received in such a short timeframe so many
22 cogent and rational comments about this proposed rule,
23 and thirty-seven of them have been in opposition. Lots
24 of that opposition came from the counties, which we can
25 talk more fully about. Some of that opposition came

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2 from all of the provider networks. Some of it came from
3 M.L.T.C.'s themselves. So clearly it's a complex issue
4 that deserves a lot of public discussion, and I -- I
5 might respectfully suggest that we let that public
6 discussion happen.
7 I believe that there are ways that we can
8 accomplish all of the M.R.T.'s recommendations and
9 certainly find other ways of supporting the advancement
10 of the M.L.T.C. implementation without having to do a
11 broad-brushed change and instead taking what I would
12 call a more surgical intervention. There are both
13 intended consequences of this emergency rule proposal,
14 and there are unintended consequences of it. And some
15 of the unintended consequences are things like -- what
16 if we have suddenly an influx of CHHA applications that,
17 despite the Department's commitment to making sure that
18 those applications or those requests clearly articulate
19 why it's essential, since we haven't yet identified
20 the -- the clear criteria around which we'll make -- or
21 the Department, frankly, will make decisions about
22 whether those arguments stand and whether they come
23 forward for a C.O.N. review, we could have a bevy of
24 applications around which this Council certainly won't
25 have good criteria around which to have the right kind

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2 of discussion and -- and to determine whether those
3 applications are appropriate.
4 One of the -- one of the real issues that we
5 talked about at the Codes Committee -- and I think we
6 saw in some of the letters of opposition that came
7 forward to this Council -- clearly, the counties. So
8 many of them, I -- I would just respectfully put -- put
9 some additional definition around the data that was
10 shared. So while so many county CHHAs have closed, to
11 my knowledge, all of them have been purchased and are
12 operated by somebody else. So it isn't that we've had
13 closures with no replacement of service. So there is
14 access to CHHA services in all of those counties, but we
15 heard from many counties that they are in the process of
16 selling. We just approved two months ago sales of
17 counties to other agencies who are now saying, wow, you
18 know, my investment now is not worth anything, and --
19 and it has real impact. We heard from several county
20 legislators -- real impact on -- on the county's budget
21 situation. So -- so the -- the county CHHA impact is
22 very clear.
23 The -- the other impact is -- is -- we have a
24 real workforce issue. So in some of these, especially
25 rural county areas, we have a very scarce resource. And

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2 the -- the minute we try to spread that resource across
3 multiple agencies, it becomes a scarcer resource. And
4 one of the things we've seen happen over and over in the
5 CHHA world -- and I -- I would imagine, though I wasn't
6 part of the discussion back in 1994, that part of the
7 reason for the moratorium was because of some workforce
8 issues in addition to just the plethora -- the -- the
9 amazing growth that occurred with CHHAs. But -- so as
10 soon as you have multiple agencies competing for the
11 same scarce resource, you've got a bigger problem.
12 Costs rise. You've got continuity of care issues as --
13 as aides and nurses jump from one agency to the other
14 based on really a competitive desire to -- to build your
15 workforce. So I think that's a very real outcome of --
16 of -- of adding CHHAs without something, some specific
17 methodology -- need methodology that addresses that
18 concern.
19 Economies of scale. I spoke to this a couple
20 weeks ago. It's a very tough business to be in, you
21 know? We -- we talked earlier about the -- the primary
22 care issue in -- in the state is in part suffers from
23 the reimbursement -- the reimbursement approach, and the
24 same is true for homecare. And certainly, the pace of
25 change in the last year has been rapid with homecare.

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2 So -- so agencies are reeling. They're consolidating.
3 They're finding different ways of -- of doing business.
4 And -- but -- but one constant for the last ten years
5 has been that economies of scale that you can only reach
6 them by having volume over which you spread your fixed
7 costs, you know? It's -- it's a costly intervention to
8 have a single person in a single individual's home, and
9 there are -- there are lots of administrative costs
10 associated with managing that.
11 And so to the extent that we add CHHAs in areas
12 where there isn't a defined problem of access or a
13 defined problem of public need, we run the risk actually
14 of -- of ultimately increasing, not necessarily the cost
15 to the state, because the state's going to pay
16 M.L.T.C.'s, and M.L.T.C.'s are going to pay the CHHAs,
17 but -- but it'll be very difficult to -- to have a
18 stable business model for those CHHAs.
19 So I -- again, I would just respectfully say we
20 absolutely need to change. I think there are ways we
21 can do that without implementing an emergency rule that
22 really erases, you know, years worth of very defined
23 public need methodology. Some of the ways we can
24 address it: There are CHHAs -- there are special needs
25 CHHAs that could be -- could turn into full-service

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2 CHHAs. There are long-term home healthcare programs
3 that could become CHHAs. For integrated delivery
4 systems, like H.H.C., we could -- we could certainly
5 speak to -- if a patient is served somewhere in the
6 system, and that integrated system is trying to
7 coordinate that care, then that CHHA, even if it's not
8 currently certified to operate where the patient is
9 receiving other care, could serve that patient.
10 So I think there's some very specific, more surgical
11 approaches we could take that would not allow the
12 unintended consequences that we -- that I just talked
13 about.
14 DR. STRECK: Mr. Fassler?
15 MR. FASSLER: Just a couple comments. You
16 know, first of all, with the M.L.T.C., there are certain
17 continuity issues. You know, first of all, it is a
18 managed care program. Patients enter at the beginning
19 of the month, so if you -- if you find a patient today,
20 you have to arrange care for this. Being that, you
21 know, you don't -- right now, the way the model is, you
22 have to -- you have to refer the client off to another
23 agency. You can't follow them. Then you also have the
24 situation with -- as the patient -- as a Medicaid-only
25 organization, as the patient gets sicker, you don't have

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2 the ability to provide that level of care. Plus, when
3 they go to the hospitalization, you lose that. They're
4 going back to another organization -- to a CHHA.
5 It's in sharp contrast to, let's say, a PACE model where
6 you're controlling the whole level of care across the
7 spectrum. So here it is. We're talking about
8 continuity of care, yet you're providing -- unless you
9 change the model, you're requiring people to have all
10 these handoffs. And -- and we talked before how
11 handoffs are not the most desirable situation.
12 DR. STRECK: Dr. Sullivan and Dr. Bhat?
13 DR. SULLIVAN: I -- I just want to expand a
14 little bit about what was just said. I think there's a
15 critical issue here relative to timeliness. I mean,
16 maybe emergency is a very drastic word to say, but I
17 think timeliness is very important. If you're talking
18 about asking the kind of change in early of -- within
19 three months of next year to be able to ask managed
20 long-term care programs to really change the way they
21 deliver service and to make sure that we do things in
22 the most costly efficient way, I think you really need
23 to have available the -- key tools. And in my book,
24 homecare CHHAs are the key tool.
25 Working in a hospital, basically the big costs

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2 are those admissions and those beds. And if we're
3 serious about trying to do the right thing so that
4 Medicaid, I think, can actually bring down costs, but do
5 the right thing for patients, then the flexibility and
6 the availability and the ability to have seamless
7 handoffs and seamless continuity between those levels of
8 cares is critical. And the home-based service is
9 probably the most important piece of that continuum.
10 I think it's really -- while I realize it feels rushed,
11 and I realize it feels -- I don't know that it's
12 actually fair to ask managed care long-term to wait
13 months -- to wait a specific amount of time to get the
14 availability to design these services and have them
15 available for patients because I don't think they're
16 going to be able to do what we are asking them to do
17 without it. Having those wraparound services, I know,
18 even in our system, it has enabled us to keep patients
19 out of the hospital. But they're not easy to get a
20 handle on. They're not easy to work with. We've had to
21 work with it through our own CHHA because our home
22 health agency is more flexible because it kind of
23 belongs to us. I'm speaking of Health and Hospitals
24 Corporation.
25 So that flexibility -- that ability to really

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2 wrap the service around the patient when they need it, a
3 lot of our processes have traditionally not let things
4 happen quickly, have not let them happen in a flexible
5 way. And I think we're getting into a different world
6 here, and I think we have to kind of consider that. So
7 while -- when I read all the issues from these upstate
8 counties, I can appreciate what they're saying, but I
9 really think it would be a mistake to handcuff, in a
10 way, a major initiative of the state, which is the
11 long-term care, by not giving them one of the -- in my
12 book -- the major tools they need, which is the ability
13 to have flexible, accessible, really that kind of
14 continuum of care that can do what we want to have
15 happen.
16 DR. STRECK: Dr. Bhat?
17 DR. BHAT: Let me start out by say what Ms.
18 Rautenberg said. Everything in homecare is something
19 that's out there for physicians. All that I know is
20 that a lot of times, I -- I do order homecare. After
21 that, I don't know what happens to it. I think what I
22 would like -- maybe Mr. Cook or somebody to explain to
23 me -- doing this this way, the new way, how is it going
24 to be different? Give me some concrete examples.
25 Business as -- as ease. Every year, taking that into

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2 that long-term care. How is it going -- I know we are
3 throwing all these terminologies, managed care, reducing
4 the cost. Can you give me some concrete examples so I
5 that can understand this particularization?
6 MR. COOK: I -- I'm trying to -- I'm not sure I
7 understand your question. You want concrete examples of
8 what exactly?
9 DR. BHAT: How is it going to be different? I
10 think it's -- at the present time, we do have home care
11 and --
12 MR. COOK: Right.
13 DR. BHAT: -- we do have long-term management.
14 By doing this, how is it that patient care is going to
15 be better?
16 MR. COOK: Well, I mean the -- the -- all this
17 regulation does is -- is allow the -- the Department and
18 the Council to look at additional service lines for
19 additional CHHAs, different populations for special
20 needs CHHAs, and new entities to come into the -- the --
21 you know, to be established as a -- as a new CHHA. So
22 we -- we -- we can't tell you with certainly that things
23 will be different. This Council may vote them all down.
24 They may vote some of them down, may vote some of them
25 up.

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2 We're just saying allow us to open up this need
3 methodology, allow the entities to apply through a
4 competitive process, and then we'll bring all the
5 applications back, you know, obviously for -- for
6 approval. The -- the -- the change in -- in long-term
7 care is significant. It's -- it's far -- far reaching.
8 In April, the legislature passed -- basically moving
9 everyone from fee for -- for service to managed long
10 term care or care-coordination models. So that's
11 basically saying the fee-for-service Medicaid long-term
12 care program is -- is -- is over when that's fully
13 implemented. And the only way that agencies -- the only
14 way then to -- to get long term -- long-term care
15 services -- services over a hundred and twenty days --
16 will be through a plan or a care-coordination model.
17 So that'll significantly -- that significantly changes,
18 and hopefully improves, the condition for the -- for the
19 actual patient in that they'll be in a managed
20 environment. But for the provider community, it --
21 it -- it changes the world significantly. So you know,
22 the -- the goal of the legislature and the governor when
23 it -- when they enacted that was to -- to move everyone
24 into managed care or care-coordination models. So you
25 know, you'll get the services through a plan -- and --

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2 and over time, an integrated plan -- Medicare/Medicaid
3 integrated plan. So that's how -- that's how it would
4 change.
5 DR. BHAT: But there's no -- I think there's no
6 dispute about the way it's being done. It's just -- the
7 dispute is only about the -- the emergency nature in
8 which where we'll be pushing this through the Council.
9 MR. COOK: I -- I think there are a couple -- I
10 mean, I think that there's obviously a concern with --
11 with -- and I -- and I like Dr. Sullivan's distinction
12 between timeliness and -- and emergency, but I mean,
13 I -- I think, you know, from -- from my perspective on
14 the context of CHHA, what we're doing in some respects
15 is those of us who've run systems or have been in
16 systems, you know, when you have to contract for a
17 particular service, if you're going to be charged with
18 the management of care for individuals, there are
19 clearly times when it makes a lot of sense for you to
20 contract with outside entities who can assist you.
21 The idea here is that CHHA services are so important in
22 managing the quality and -- and cost effectiveness of
23 care for individuals to -- to give managed long-term
24 care providers or other providers who are involved in
25 this the opportunity to have that service in-house so

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2 that they can coordinate in their own way that care.
3 Many of them probably will not. As you've already
4 heard, you know, there are some who probably will not
5 seek to have a CHHA service. They'll make that choice.
6 They'll -- they'll make a choice if there are sufficient
7 services. But there are others who will compete in a --
8 in a very different marketplace because I think it's
9 really critical to understand the -- the radical
10 redesign -- and I don't mean radical in a negative way,
11 I mean it in a positive way -- of shifting the
12 population who needs long-term care into a managed care
13 environment.
14 And quite frankly, we're not -- you know, we
15 can't give you today a perfect vision of what all the
16 things will occur. We're trying to make sure that those
17 proposals that come before us, we have an opportunity to
18 give them a tool that I think all of us believe is vital
19 to managing the quality and cost effectiveness of care.
20 And I -- and I just want to make one point. I mean, I
21 think -- you know, and -- and Vicky and I have had
22 wonderful discussions about this, and -- and we have --
23 I have tremendous respect for her position, but I do
24 think it's -- we've got to be careful, too, not to judge
25 opposition by the volume of letters or mail. And --

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2 because that means -- trust me, you will get even more
3 in -- in every instance, you know? You'll have a test.
4 And -- and I really do think that, you know, the
5 challenge before us and the reason there is so many
6 letters of opposition is because people are looking at
7 the way the environment exists today and worried about
8 that impact. And the real question is what do we want
9 that environment to look like in the future? And I
10 think H.H.C.'s letter in support was a really good
11 letter in kind of laying out, you know, just one small
12 example of why some change is necessary.
13 And again, as Mark said and Becky said, you know, we're
14 not going to sit here and tell you we have all the
15 answers to all the -- all the ideas here. But I think
16 we are willing to engage in an open, public process that
17 will bring back to this table a whole host of issues and
18 proposals that you're going to have to test. And -- and
19 I think that we're confident that -- that we can come
20 back with recommendations, and I think we're confident
21 that the debate that will occur here will lead to some
22 better programs.
23 DR. STRECK: Dr. Berliner?
24 DR. BERLINER: I have, if you will, a
25 procedural question, which is -- I don't quite

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2 understand why, if the Council originally instituted the
3 moratorium at the behest of the Department, it just --
4 isn't a vote of the Council to -- you know, to -- to get
5 rid of the moratorium, why it's going through this
6 particular regulatory process.
7 DR. STRECK: Mr. Cook, do you want to address
8 that?
9 MR. COOK: I'll do my best. I mean, Mark and
10 Becky are probably better, but the -- the real issue is
11 there's two things that have to happen. One, we -- we
12 need to lift the moratorium, but if we only lifted the
13 moratorium without any criteria or guidance, we'd be
14 left to trying to implement the need criteria that is
15 specific in the regs that was based on 1982 data. So
16 what we've done here is basically identify several goals
17 that we would evaluate the applications. One, further
18 the reforms of the Medicaid redesign or to address
19 access issues where there are two or less CHHAs in
20 counties, and then to apply the utilization data indices
21 in allowing the applicants to respond to those. But if
22 we only lift the moratorium, we really -- we -- the need
23 methodology is irrelevant, and the reg would require us
24 to apply them.
25 DR. STRECK: Next is Dr. Yang. I'm keeping

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2 track of this. Okay. So --
3 DR. YANG: I think I --.
4 DR. STRECK: -- everyone's on the list.
5 DR. YANG: I think I've got this on, right? So
6 I appreciate that these -- these regs would lower a
7 drawbridge, right, for -- from what is probably a
8 uniquely closed-loop system for almost twenty years.
9 And I guess as a bureaucratic, I can particularly
10 appreciate needing to kick start sort of all the cogs
11 and wheels in -- in anticipation of a possibility of --
12 of shortage. Can you hear? All right. Okay.
13 And I -- and I -- and I understand that it'll all still
14 go through a C.O.N. process and a needs determination,
15 but I guess I have one -- one -- or actually two
16 requests of the Department, should these pass. One is
17 that the -- the issue of not just institutional need,
18 but community need and the way we determine it and
19 how -- how the Department evaluates it becomes -- we've
20 talked about it in terms of prevention. We've talked
21 about it in terms of hospitals. Clearly, we need to
22 talk about it here, and this will accelerate that --
23 that -- that -- addressing that -- that issue.
24 The other -- the other request, I guess, is based on,
25 you know, my -- my colleagues in local health

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2 departments. It is quite stunning, you know?
3 Thirty-two -- half of the thirty-two are -- of the
4 county -- of this public local health department owned
5 CHHAs are sole providers, and that seventeen are queued
6 up -- or eighteen are queued up right now to -- to
7 possibly hand off in the coming year. And I think
8 the -- the tipping point that led to the rapidity of
9 that process or -- or what -- what -- what we're seeing
10 now is -- is the change in business value of -- of the
11 CHHAs to local health departments because of the loss of
12 state aid. I don't know how many people know that,
13 but -- but local health departments used to get Article
14 6 local public health work state aid that included
15 subsidizing the CHHA. And that -- that ended this year
16 for reasons that I totally understand.
17 But given -- given what's happening here -- and -- and
18 I'm not saying that the -- the value of a business
19 shouldn't change. That is the cost of doing business.
20 But should -- should that pass and the -- the
21 marketplace change so rapidly that the Department pay
22 particular attention to those areas in New York State
23 where there are, in fact, one or two or fewer homecare
24 providers, that if there isn't sufficient step up by --
25 by providers, that the state consider some sort of

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2 assistance or some remediation or remedial assistance, I
3 guess, to -- to those areas to ensure that there is
4 still some core -- some core capacity that's -- that's
5 still there.
6 And I don't think it's just in the number of
7 CHHAs. I think it's also the case mix of the CHHA, you
8 know? There might be a focus and -- and a new emerging
9 market for long term that might draw away from the
10 existing CHHA case mix and leave a queue unsupportable.
11 So that would be my second request.
12 DR. STRECK: Mr. Torres?
13 MR. TORRES: There we go. I come from the
14 homecare world, and there are places in -- in the
15 marketplace where there's a saturation of -- of agencies
16 and rich resources, but I've also encountered challenges
17 on the other end where I have had patients that have had
18 a delay of close to two weeks in being seen by a
19 homecare entity in their area in their community because
20 of the lack of availability and tying up the person in
21 the hospital with extended stay.
22 I also remember recently -- four months ago --
23 this individual that moved from New York City into
24 Westchester County and had such a tremendous difficulty
25 in accessing services, and she ended up bounced into two

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2 other hospitals between Connecticut and -- and
3 Westchester. So I can understand that there is a need
4 and an opportunity in certain areas, and there are
5 people out there that are right now expressing or -- or
6 demonstrating that need and not having the resource to
7 tap into because of the location. So something should,
8 you know, be looked at in terms of that piece. I mean,
9 it's -- it's there. It's realistic.
10 I can understand the concern of -- of the
11 competition. When you look, for example, into Manhattan
12 and the availability of -- of, you know, maybe five
13 CHHAs. But when you go into other areas, it's -- it's a
14 realistic challenge.
15 DR. STRECK: Dr. Martin?
16 DR. MARTIN: Thank you. It may be that I
17 don't -- just don't understand the reg, but it is
18 about -- so if I understand it properly, there'll be an
19 R.F.P. or a -- or a request for proposal put out. It'll
20 then be vetted by the state. And then those who are
21 deemed worthy will be allowed to submit a C.O.N. that
22 will come to us. And those who are not deemed worthy, I
23 guess, can't submit to us, which strikes me as
24 potentially -- if -- if that's correct, that strikes me
25 as a little bit -- if it's -- if I'm -- if I'm wrong,

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2 then just interrupt me now and just say that's not -- I
3 am not reading it right. Because that's not how -- for
4 example, we were just looking at -- possibly at the
5 committee -- at -- at vent beds in nursing homes where
6 it seemed to me was a similar sort of process. The
7 state took a look at all of those who were applying,
8 said these guys are pretty good, we recommend them. But
9 everyone had a shot to come here. And in fact, one of
10 them did a pretty good job during the committee at least
11 of raising interesting questions about the methodology
12 that was being used to determine need, and it gave the
13 Council an opportunity to say, well, maybe the state
14 didn't do as great a job as they could have here, or
15 maybe they did. I mean, I don't think we voted on it
16 yet. But at least there was the opportunity to.
17 It seems to me this reg would not allow that -- our
18 oversight to be used to -- to do it. So if I've
19 completely -- you could have cut me off five minutes
20 ago, but --.
21 MR. COOK: Our -- our intention would be to
22 bring back all the proposals. We'd bring back the
23 proposals that we recommend, and we'd bring back the
24 proposals we don't recommend. Now that's going to be a
25 long day, but I mean -- you -- you know? And -- and but

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2 I -- I think we're -- look it -- we're prepared that
3 this is -- again, you -- you've got a moratorium that's
4 existed for seventeen years. You've got a total
5 redesign of the system, you know? They're -- we want to
6 have an opportunity for a public debate of whether or
7 not our view of the system, you know, matches, and we're
8 not missing something. So we're prepared to bring back
9 the proposals to this Council.
10 DR. STRECK: Ms. Regan?
11 MS. REGAN: I -- I've agreed with a lot of
12 things that have been said, but the thing that struck me
13 as -- as quite important is something Vicky said. I --
14 I think we're all concerned with access. And probably
15 the -- the worst thing you could do to assure access in
16 the many places around the state where it's dependent on
17 one agency is to rattle the industry in the way that
18 this reg has done. And I think that's what the letters
19 show us is that people are really rattled. And I think
20 the reason is because when your margins are thin and
21 your business model is delicate, the -- even just the --
22 the possibility that a competitor could do certain
23 things in your district can really cause problems. And
24 I -- I'm -- I don't want to sound like I'm
25 anticompetitive. That -- that's not my point. My point

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2 is that access -- if access is our purpose, we need to
3 avoid throwing a monkey wrench in a system which is
4 already delicately balanced.
5 The thing that I think is most dangerous about
6 this reg is that it really gives open-ended discretion
7 to the Department. And much as I -- and I do have
8 respect for the Department, and I know that their --
9 their criteria will be community need and -- and to
10 address those issues. That -- that's not widely
11 understood. And the message that goes out when you give
12 blanket authority to one individual or to a department
13 with no limitations -- well, there's two messages that
14 I'm worried about. One is that the world in general
15 thinks, oh, my god. We have no way to anticipate what
16 can happen. Anything can happen now. And that's a
17 dangerous thing to do at this moment in history.
18 The other thing is that when it -- when it comes back to
19 us, that's a good thing because it gives an opportunity
20 for public, you know, airing. But what it doesn't do is
21 give us any criteria. I mean, we're -- we would be
22 getting these applications with a recommendation for
23 approval for some and not for others, and we would have
24 no standard -- no legal standard by which to assess
25 those applications.

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2 So what I'm -- what I'm saying is I -- I don't
3 necessarily object to an emergency reg. I -- given a
4 ninety day timeframe, I think we do need that. But
5 if -- I think it would be worth the exercise to redraft
6 this -- this reg also as an emergency reg, but to limit
7 the criteria in such a way that it doesn't throw the
8 system into turmoil. And I -- I'm afraid that's what
9 we've been seeing a little bit with these letters.
10 DR. BOUTIN-FOSTER: I think I may have also
11 read what we received via e-mail similar to what Dr.
12 Martin did. So my understanding is that we would be
13 voting to lift a twenty year moratorium, yes. And then
14 as part of that, there's also a process issue where
15 there's an R.F.A. that the Department would vote upon,
16 and then we would only see those that go through the
17 R.F.A., similar to like the -- Commissioner Shah, you
18 may be more familiar with this -- like a grant that's
19 unscored at the N.I.H. does not come to the full
20 committee. So it's halted. So is this the same
21 process? That if it doesn't go -- if it's not an R.F.A.
22 that's deemed acceptable, then there wouldn't be an
23 opportunity for public input, and PHHPC wouldn't have an
24 opportunity to vote on it. And -- and that's how I --.
25 MR. COOK: Yeah. No, the -- that -- that is

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2 not -- if we misled anyone, we apologize. That's not
3 the process. We -- you have it almost correct. What we
4 would do is do a -- an R.F.A./R.F.P. process. And then
5 in the recommendation back, we would say these are
6 the -- we -- here's all the -- here's everyone that
7 applied. Here's the ones that we -- we recommend
8 approval, and here's the ones that we don't recommend
9 approval. So -- and then allow people to, you know,
10 obviously comment on -- on -- on -- on those
11 recommendations.
12 So if we misled you, I apologize. But the --
13 the -- you'll- get a shot at all of them. And it
14 just -- the R.F.A. process is a way basically to --
15 to -- to give you some sort of a look at those processes
16 and give our -- kind of our -- our recommendation to
17 that.
18 (Off-the-record discussion)
19 DR. STRECK: No, you were next, then John.
20 DR. GRANT: All right. My concern in -- in
21 terms of -- first of all, not one of us sitting around
22 this table is opposed to change. We know that it's
23 here, and that's the only thing that's certain in life.
24 We know that. The M.R.T., I understand that pressure
25 that we've got to get moving. We are making some great

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2 systems change, and I'm -- we're all applauding that.
3 My concern is that we're looking at the -- approving the
4 applications prior to the establishment of the
5 methodology, including access issues. And also, we're
6 looking at -- looking at all of them, those the
7 Department is recommending and those that -- that it
8 doesn't. I mean, that is a humungous job that I -- I'm
9 not sure that we're ready to take on in view of the fact
10 that you don't have the methodology and the access
11 established.
12 My -- my other concern is that I didn't get the
13 impression that the community was at the table with the
14 Department right from the beginning in -- in moving
15 this -- this change train along. And I think that's
16 where a lot of the opposition is coming from in the
17 provider community. So you know, I think we need to
18 take a look at -- at all those things in terms of making
19 sure that the community is feeling that they really had
20 some input into shaping the process as well as making
21 sure that there's clearly defined points of looking at
22 the methodology and the access issues.
23 DR. STRECK: Dr. Rugge?
24 DR. RUGGE: I just wonder -- I wonder if you
25 could just address for the record and -- and respond to

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2 those county officials that are concerned about the loss
3 of the economic value of the programs they're trying to
4 put up for sale.
5 MR. COOK: I'm sorry, John. I -- I -- I didn't
6 hear the question.
7 DR. RUGGE: You couldn't hear me? I'm hoping
8 that you would respond for the record to the concerns of
9 county officials that are losing -- losing the economic
10 value of the programs that are county owned that are now
11 on the -- on the block.
12 MR. COOK: Yeah. I mean, we've been engaged in
13 discussions with many of those counties right now, and
14 we're trying to look for some kind of potential solution
15 so that those that are under contract, there's --
16 there's some options that we can work with them and the
17 provider to assure that there isn't, you know, a
18 significant economic loss to that county. I mean, we're
19 just beginning, quite frankly, and it's over the last
20 few days that we really began to get all the letters.
21 So we're trying to sort out the context of those
22 contracts and what are the options that might be
23 available for us.
24 DR. RUGGE: I -- I would only suggest that --
25 that that extra value of having, if you will, a monopoly

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2 service is an extra burden on the Medicaid budget. And
3 so, you know, we're transferring from the general tax to
4 the Medicaid dollars when there is a cap, and that's of
5 concern to providers.
6 DR. STRECK: Mr. Kraut?
7 MR. KRAUT: On -- on the plus side here, nobody
8 spoke about not lifting a moratorium because it -- it --
9 you know, when this came through, it was just
10 inconceivable to me that the only service that we could
11 not speak about at this room was homecare. We could
12 talk about transplant, cardiac, and putting a D.N.T.C. a
13 hundred and fifty yards from each other, but we couldn't
14 say homecare. So I think that that's -- no matter what
15 we do today, that's an absolute thing. We've got to
16 walk out of this room with the ability to have the kind
17 of conversations Ms. Hines talked about.
18 This is, to me, the changing nature of care.
19 It's not about capacity, and it's not about the number
20 of providers. It's about the ability to manage the
21 health of a population, prepare for a new reimbursement
22 system, and give the providers the tools they need to
23 change. It is inconceivable to me that the Health and
24 Hospital Corporation that has a homecare company, but
25 causes a moratorium, they can't take care of their

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2 patients in Brooklyn? It doesn't make sense to me that
3 they can't extend their license in Brooklyn.
4 I mean, it's those kinds of things. And you
5 know, I think a lot of the issues that Vicki spoke about
6 are valid and that we have to address them, and they're
7 very complex. It's not as necessarily black and white
8 as I described it, but this is also about -- let's talk
9 about the elephant in the room. It's about the changing
10 nature of competition and the forces that change
11 competition and don't want to change. Protecting the
12 status quo and moving to a different system of care.
13 You know, notwithstanding our best efforts, that line on
14 Medicaid that we saw this morning on a number of
15 enrollees, if it flattens out and the economy turns, you
16 know, god bless us. But it's going to only turn a few
17 degrees. The -- I mean, the -- the -- the trend is a
18 little up.
19 And -- and -- and just like we had this
20 conversation with the impact on providers of ambulatory
21 surgery centers a decade ago and doctor office -- you
22 know, changing. And we bemoaned everything was going to
23 happen because of the nature of that, things changed.
24 And -- and it probably changed for the better. And I
25 was one of the people, you know, fighting that at the

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2 time.
3 I just want that opportunity to learn, discuss,
4 debate, and approve. But I want to have that ability to
5 do that, and I think at least this reg starts as -- as
6 imperfect as it may be, but it -- just if we have the
7 opportunity and we do have the data that -- that you
8 spoke about, when -- when those applications come
9 forward, we have to have the data. And it's not only
10 about utilization. It's about the economics, the
11 viability issues that -- that we need to have that
12 information so we can act in -- in an appropriate
13 manner.
14 DR. STRECK: Other comments? Oh, I'm sorry. I
15 identified Mike earlier, Ms. Hines. I'll come to you
16 next. Mr. Fassler?
17 MR. FASSLER: Okay. And clarification from the
18 Department. You know, there were some counties that
19 wanted to provide as -- as part of the C.O.N. process,
20 will -- will we have the ability to look at economic
21 viability of the existing agencies as part of this
22 process? As part of the approval?
23 MR. COOK: Yes.
24 MR. FASSLER: Okay.
25 DR. STRECK: Ms. Hines?

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2 MS. HINES: A couple of comments. So Jeff,
3 I -- I agree with, and -- and I think I started by
4 saying we absolutely need change. I -- I would say
5 there is no such thing as protecting the status quo for
6 CHHAs anymore because there is no status quo. If --
7 there -- it's been turned on its head in -- in a very
8 short timeframe, and so this is just yet another
9 significant change. So -- so I -- I don't want anyone
10 certainly to perceive my comments as trying to protect
11 something.
12 I think there are very real concerns about
13 trying to add providers, and one of the things that I
14 heard more clearly today, I think, than I heard a couple
15 weeks ago both from Mr. Fassler and Mr. Cook -- and --
16 and I want to -- I want to bust the assumption that
17 "make versus buy." I -- I heard very clearly that
18 there's a desire to have M.L.T.C.'s own all of the
19 components of the system through which they are
20 responsible for all of the care. And I -- I -- I
21 tacitly reject that assumption. I think we have
22 examples that work beautifully all throughout the
23 healthcare system and certainly with insurance
24 companies. That insurance companies do what they do
25 really well, and providers do what they do really well

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2 within sectors. And there are plenty of examples where
3 you can have a smooth coordinated-care process without
4 actually having to own it. So I -- I -- I don't want us
5 to ever leave our discussion believing that to implement
6 the M.R.T. recommendations, that M.L.T.C.'s have to own
7 CHHAs.
8 MR. COOK: Can I -- let me just respond to
9 that.
10 MS. HINES: Yeah.
11 MR. COOK: If I gave that impression, then
12 that's the wrong impression. I thought I said that what
13 we wanted to do is have the options available, and --
14 and I don't think -- you know, the one thing I think all
15 of us know about healthcare is there is no one model
16 that fits every market. And the issue here is providing
17 an option that if that entity wants to have that
18 program, we have an opportunity to give it to them.
19 So I clearly don't believe you need to own all
20 the services, but the one thing I do know is I don't
21 know the intricacies of every market and the dynamics of
22 every market. And I think this gives us a tool if
23 someone can make a case to provide this as an option for
24 that particular entity.
25 DR. STRECK: Mr. Kraut?

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2 MR. KRAUT: I -- I just -- Ms. Hines, I -- I --
3 I -- I apologize. I didn't meant to connect you. It
4 was probably the temporal nature of those comments, one
5 following the other. But I -- I -- I hear what you're
6 saying, and I -- I don't think -- you know, I -- I think
7 there's a willingness, and I think that that's the
8 important -- I'm not suggesting you are trying to
9 protect. And I don't -- even from the letters we've
10 received, I don't think people are trying to protect
11 with the -- maybe the exception of the counties. But --
12 but so I -- I just apologized. I -- I didn't mean to
13 suggest that.
14 MS. HINES: Jeff, no apology necessary. My --
15 the only final comment I wanted to make -- I apologize.
16 I -- I -- and Jeff, again, I agree with you. I think
17 that we need to find a way right now to begin to look at
18 this differently. I -- I share Susan's concern that I
19 think this emergency rule approach gives the Department
20 too much latitude. Because Mark, respectfully, the --
21 the way it is currently written is the way that Dr.
22 Boutin-Foster and Dr. Martin understood it. So it would
23 have to be changed to -- in order to reflect the intent
24 that you just articulated.
25 But -- but the bottom line is we can accomplish the same

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2 thing through a more public decisive discussion around
3 what are the reform issues that we need to support?
4 What are the -- what's the new need methodology around
5 which this Council would then appropriately be able to
6 evaluate any future C.O.N.'s that come forward? And I
7 think there's a -- there's a more responsible way to do
8 that without calling it an emergency and allowing the
9 Department to, by the R.F.A. process, have the -- have
10 individual providers define that as we go. I would
11 rather step back, clearly define where we think we have
12 problems we need to solve, where we think we have access
13 issues, where we have continuity care issues, and then
14 seek our -- seek request for proposals that fill those
15 needs rather than the other way around.
16 DR. STRECK: Okay. Mr. Dering (phonetic
17 spelling) had a point he wanted to make? And then
18 Glenn, I've got you.
19 MR. DERING: Yeah. In my review of the reg, I
20 think that what Mark and Rick had indicated in terms of
21 a process would be fully supported. I don't think that
22 the -- the regulation as drafted is inconsistent with
23 that. So I just wanted to make that point.
24 DR. MARTIN: Yeah. First of all, I just wanted
25 to thank anyone -- everyone for like an interesting and

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2 helpful discussion, because I have to admit I've gone
3 back and forth in my mind at least twice so far, but I
4 think where I'm ending is that if what we're saying --
5 it sort of seems to me that we all agree that we need to
6 allow more CHHAs, and we need to do that relatively
7 quickly because of what's there. And that it may not be
8 an "emergency" emergency the way I would normally think
9 of it, but I sort of buy that the way we use emergency
10 for regs, it fits.
11 The other issue about the R.F.A. why -- it almost seems
12 to me it is trying to improve the C.O.N. process that
13 we're going to be doing over the next few months, only
14 quickly for here, where they're basically going to put
15 down criteria that may or may not make perfect sense,
16 but are probably better than what we've had now. And
17 then we'll be allowed to look at how it scored when it
18 comes to us versus transparent criteria that were used
19 by the state. So if that's the case, then I have to say
20 this is beginning to make a lot more sense to me. And
21 it's -- and again, my confusion was that wasn't what was
22 in the e-mail about how things were done, but with
23 Council and with the state saying that, you know, it'll
24 be open what the R.F.A. is. The responses will be open.
25 We'll be able to see it and vet them and then decide,

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2 and everyone has an opportunity to take a shot at it.
3 This makes a lot more sense.
4 DR. STRECK: Other comments? Commissioner?
5 COMMISSIONER SHAH: Yeah. I just want to agree
6 with that -- the last comment. This conversation has
7 been incredibly helpful for me to understand the
8 diversity of views that are out there, in addition to
9 what we all read in a stack of letters. I -- I think at
10 the end of the day, you have to remember, we will be the
11 final arbiter of what goes or does not go forward. This
12 is an opportunity to be more transparent, to perhaps
13 accelerate the conversation in ways that we haven't had
14 the opportunity to before, and there will be unintended
15 consequences, both positive and negative. But we need
16 to start this debate sometime, and we believe pretty
17 strongly that the time is now.
18 With so much at risk with M.L.T.C.P.'s, at -- at this
19 time, there is -- there is no better way to do this.
20 We've tried. We've looked at what existing regs allow
21 us to do, and -- and we've examined all our
22 possibilities. And we believe that this is the best way
23 to bring the conversation to a head right now in time
24 for all of us to have together so that we can then look
25 at each individual application going forward and decide

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2 what are the criteria and what are the needs and how do
3 we make it work.
4 DR. STRECK: Ms. Hines?
5 MS. HINES: Yeah. I -- I do understand that
6 this kick starts that conversation, and I would just,
7 again, put on the table there's another way to do that.
8 The problem is with this kick start, instantly we're
9 going to be faced with more R.F.A.'s than we know what
10 to do with because everybody -- we heard from the
11 counties -- CHHAs in -- in areas where there's only one
12 CHHA will absolutely figure out how to protect their
13 flanks -- all of those CHHAs that are up for sale.
14 That's -- that's now going to be sort of in -- in limbo.
15 Integrated delivery systems are going to look
16 at what do I need to do to make sure that I don't get
17 lost in the shuffle? M.L.T.C.'s are going to figure
18 out -- so I think that we are going to create some chaos
19 by -- immediate chaos by doing it this way. An
20 alternative would be that we take all of this
21 discussion, and in a two month timeframe, three month
22 timeframe, have a public discourse, a smaller group
23 that -- but that -- but that allows full participation
24 by all of the affected parties to come up with a new
25 methodology for both identifying where we have new needs

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2 to be met and identifying criteria around which this
3 group will assure that the right C.O.N.'s get approved.
4 It's just -- I would propose that alternative.
5 DR. STRECK: Is there further discussion on the
6 motion as has been presented?
7 MS. REGAN: Dr. Streck?
8 DR. STRECK: Yes, Ms. Regan?
9 MS. REGAN: Could that be considered an
10 amendment to the motion? Because if so, I'd like to
11 second it.
12 DR. STRECK: Well, if -- you are free to -- do
13 you wish that as an amendment or as a suggestion?
14 MS. HINES: No. I -- I would more than willing
15 to make that as an amendment.
16 DR. STRECK: So this would be a motion to amend
17 the resolution as presented. It has been seconded.
18 We're now debating the amendment to the resolution.
19 (Off-the-record discussion)
20 DR. STRECK: The amendment was -- Ms. Hines,
21 would you clarify?
22 MS. HINES: I'm going to try. What -- what I
23 am suggesting -- so I -- I would propose that -- that
24 this committee appoint -- and we could send it to the
25 C.O.N. group so with discussion, maybe we can figure out

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2 the right place to take it -- the C.O.N. group back to
3 the Codes Committee, but that with a short timeframe,
4 say three months, we seek more full public input, have a
5 discussion, identify and clarify a new need methodology
6 for CHHAs that meets the Department's criteria to
7 support health reform. And then bring those -- bring
8 those -- that new need methodology back to this Council
9 for approval. Upon which, the Council will then
10 consider and approve future C.O.N.'s. I'm not sure I
11 said that well.
12 UNIDENTIFIED FEMALE: It's a new presentation.
13 DR. STRECK: So --.
14 MS. HINES: Is it different from what I said
15 before?
16 DR. STRECK: It's -- it's very similar. You
17 have -- is it two months or three months?
18 MR. DERING: Okay. You know what I'm
19 wondering? If procedurally it would make more sense
20 to -- to vote on the motion, see how that goes -- the
21 original one -- see how that goes, and then go from
22 there.
23 DR. STRECK: It might make more sense, but I'm
24 not sure by Robert's Rules --
25 MR. DERING: Okay.

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2 DR. STRECK: -- that we can do it that way.
3 UNIDENTIFIED FEMALE: Doesn't he have to accept
4 the amendment before it can be voted on?
5 DR. STRECK: No, you don't have to -- the --
6 the -- you're -- it's -- we -- we can -- we do have
7 Robert's Rules here in the house, so relax. We'll get
8 through this. I believe that an amendment to a motion
9 has to be considered and voted upon, and then you can
10 return back to the original motion either as amended or
11 as originally presented. So right now, we are in the
12 phase of voting on whether to amend the original
13 proposal. And so that is the topic that's up for
14 discussion now. And that is essentially -- if I may
15 truncate the -- the discussion, it is a three month
16 effort -- two to three month effort to develop a need
17 methodology and bring it back to this group.
18 So if that's a fair summary of the topic, that topic is
19 open for discussion to the members of the Council. Mr.
20 Kraut?
21 MR. KRAUT: In the history of which I've been a
22 member of this Council and the predecessor council, we
23 have never been able to effectively develop a need
24 methodology in three months, much less a year. And it
25 gets to the point of, I guess, the concern the

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2 Department has because the M.L.T.P.'s are going -- are
3 going independently of this for -- you know, for April
4 1st. You know, if they had brought the process through
5 the regular way, which I think we may have all been
6 comforted by, we'd probably be eighteen months before it
7 went to the planning committee. We developed need
8 methodology. We had a public hearing. Then it got
9 written up into code and regulation. Then it got
10 presented back to us two months, three months later for
11 discussion and information. Then it went into the
12 register. It came back for public comment. And then we
13 had to vote. You know, we -- it's a very elongated
14 process.
15 The -- the issue is -- and we can't even meet
16 between meetings without -- you know, we can't meet as a
17 committee. We -- you know, and so as a practical
18 matter, I understand the desire to do that and -- and --
19 and the comfort level we might have, but I don't see why
20 this can't be done concurrently either. That, you know,
21 we have criteria that at least initiates the process.
22 And -- and maybe, you know, an amendment to the
23 amendment would be -- okay -- wait -- wait. I'm not
24 making it. But I'll tell you what I will make. An
25 amendment -- you know, I would say then, you know, if

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2 you're going to do that, then exempt anybody that's
3 coming in from the M.L.T.P. process from that -- from
4 that issue, and let's go. And so at least they -- they
5 have to be starting. I mean, you know, this is a
6 significant undertaking that -- that's going to occur to
7 start some of these programs. So I -- I -- you know, I
8 just don't see how, as a practical matter, we're
9 actually going to meet that deadline.
10 DR. STRECK: Other discussion on the amendment?
11 Ms. Regan?
12 MS. REGAN: What about -- I'm -- I'm trying
13 to -- I -- I'm really troubled by the legal implications
14 of open discretion on the part of the Department because
15 I just think it's unhealthy. What about making the
16 R.F.P. process more public? What about building things
17 into that process where the industry can have an
18 opportunity to express parameters that they think will
19 avoid some of this chaos? I'm worried about chaos, and
20 I'm worried about, you know, giving the impression that,
21 you know, it's all up for sale or some awful thing that
22 might -- some really negative interpretation of how this
23 is going.
24 DR. STRECK: I think we're all assured we'll
25 get to chaos, so it's just a question of the path.

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2 Rick?
3 MR. COOK: You know, I have to -- the idea that
4 the Department is in total control is just wrong. I
5 mean, these applications come back to this Council. And
6 if we were in total control, we wouldn't have spent the
7 last two and a half hours talking about this reg. So
8 it -- it -- it -- it's just -- it -- it -- that's just
9 not true. And I think, you know, all of us who are
10 devoted to healthcare policy and doing right for our
11 communities, we all would like to have more deliberative
12 times to be able to examine issues. But I happen to
13 know all of you in business, you know, you often have
14 deadlines that you have to hit, and you haven't got
15 enough time to do all the things you would like.
16 DR. STRECK: Okay.
17 MR. COOK: I think the value of this proposal
18 if -- and I think the value is that we will learn a
19 tremendous amount of information over the next ninety
20 days with the applications that are submitted that will
21 help us identify going forward what significant changes
22 in policy may or may not need to be made.
23 DR. STRECK: Okay. Thank you. We are speaking
24 only to the amendment, so I'll entertain comments on the
25 amendment only, and this will be tightly judged. Dr.

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2 Sullivan?
3 DR. SULLIVAN: I'd like to speak in opposition
4 to the amendment. I think -- first of all, I really do
5 think timeliness is a critical issue here, and I think
6 that I tend to agree that so far what I've seen of the
7 process of this Council is that if we can't afford to
8 kind of go through any lengthy discussions about the
9 kind of thing you were describing before, our -- our
10 prior processes.
11 The other thing is I don't -- I honestly don't see why
12 this is an open-ended thing. I mean, I think if all
13 these proposals are coming back here, then I don't
14 understand why the final responsibility for okaying or
15 not okaying doesn't lie with this group. So I don't
16 really see it as the -- the Department can just do
17 whatever it wants because everything's coming back here.
18 And then, lastly, there was a lot of
19 stakeholder input into the Medicaid redesign teams.
20 There was a lot of involvement in that in terms of
21 looking at redesigning the system of care. So it's not
22 like this came out of the blue, and I think that the
23 goals of that redesign team are part of the criteria
24 that the Department is going to be using to get out the
25 R.F.A. So I don't think there hasn't been a process.

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2 It may not have been entirely our process, but I think
3 there's been a process.
4 And I also think that we need to get used to, to some
5 extent, a timelier way to do these things. And I think
6 if we don't, then we're going to hamper the very goals
7 of what we're trying to do with Medicaid redesign. So I
8 would speak in -- I would speak against the amendment.
9 DR. STRECK: Further discussion? Ms. Hines?
10 MS. HINES: I'll -- I'll try to make it my last
11 comment. To the issue of timeliness, I want to remind
12 us that we have a letter from the M.L.T.C.'s, the
13 majority of whom believe that access to CHHAs is not a
14 limiting factor to expanding M.L.T.C.'s across the
15 state.
16 DR. STRECK: Thank you. Now with that
17 discussion of the amendment, I would like to -- unless
18 there is further discussion, then I would like to call a
19 vote on the amendment. So the amendment is, in
20 paraphrase, "To develop a need methodology over the next
21 three months to address the question in lieu of the
22 motion previously made." So it is --.
23 MR. KRAUT: I have a clarification.
24 DR. STRECK: A clarification from Mr. Kraut.
25 MR. KRAUT: If the methodology is not done in

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2 three months, do we automatically approve the other way?
3 I mean, what -- what's the consequence of it not being
4 done in three months if it's not done in three months?
5 DR. STRECK: That's for another motion.
6 MR. KRAUT: Okay.
7 DR. STRECK: Okay? So we have a motion.
8 MS. GRANT: I'm sorry.
9 MR. KRAUT: I'm sorry.
10 DR. STRECK: We have a motion.
11 MS. GRANT: I'm sorry about that. I'm -- I'm
12 not sure if this is a clarification or not, but I'm
13 wondering if, in fact, we can move the process along at
14 the same time working along with the stakeholders that
15 have some skin in the game, so to speak.
16 DR. STRECK: It is my impression that that is
17 the process as it has been articulated. Is that
18 incorrect, Mr. Cook?
19 MS. GRANT: In -- in the amendment?
20 DR. STRECK: No, no. Not in the amendment.
21 Now we're -- you're -- you're suggesting that this
22 process, as represented in the amendment, be part of the
23 efforts of the state in parallel. Is that what you were
24 suggesting?
25 MS. GRANT: Yes. If there's stakeholder input

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2 along with the --.
3 UNIDENTIFIED FEMALE: That was -- that was part
4 of the amendment.
5 UNIDENTIFIED MALE: Yeah, that was part of the
6 amendment.
7 UNIDENTIFIED FEMALE: The stakeholder input
8 would be part of that.
9 MS. GRANT: That's part of the amendment?
10 Okay.
11 DR. STRECK: Okay. That's -- okay. So that is
12 part of the amendment.
13 MS. GRANT: Okay.
14 DR. STRECK: Okay. We're back to the amendment
15 with stakeholder input. So those in favor of the
16 amendment as proposed, please raise your hand. Those
17 opposed to the amendment as proposed, please raise your
18 hand. So the amendment is defeated.
19 We will now move to a vote on the original
20 resolution as proposed by the Committee on Codes and
21 Regulation. So I would ask for those who are in favor
22 of the original motion as presented by that committee
23 and Dr. Gutierrez to raise your hand, those in favor.
24 So with a vote of fifteen in favor, that motion passes.
25 Thank you. Thank you for a thoughtful debate on a

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2 complex topic.
3 So having left our usually controversial codes and
4 regulations discussions, we'll now move to the
5 lighthearted establishment and C.O.N. area. And so
6 reporting for the Committee on Establishment and Project
7 Review will be Mr. Booth as vice chair. Chris?
8 MR. BOOTH: Okay. Let's start with the first
9 project. Project 111334C, Lawrence Hospital Center,
10 construct a new three story building to house a
11 therapeutic radiology center, including a new C.T.
12 simulator, a LINIC (phonetic spelling) and an oncology
13 center. Both O.H.S.M. and the committee recommends
14 approval with conditions and contingencies. There was
15 no discussion in the meeting. I move it for approval.
16 UNIDENTIFIED MALE: Second.
17 DR. STRECK: The motion has been made and
18 seconded. Is there discussion? Those in favor aye,
19 please. Opposed? Thank you. The motion passes.
20 MR. BOOTH: Application 111548C, Hospice of
21 Orange and Sullivan Counties, certified to existing
22 residence beds as duly certified for inpatient beds when
23 needed. Both O.H.S.M. and the committee recommends
24 approval. There was no discussion in the meeting. I
25 move it for approval.

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2 UNIDENTIFIED MALE: Second.
3 DR. STRECK: The motion made and seconded.
4 Discussion? Hearing none, those in favor, aye. Thank
5 you.
6 MR. BOOTH: Application 102167C, Lincoln
7 Medical and Mental Health Center, a recusal by Dr.
8 Sullivan, who is leaving the room. Interest declared by
9 Dr. Bhat, Dr. Boufford, and Dr. Boutin-Foster. Renovate
10 the emergency department resulting in a hundred and six
11 treatment statements -- stations, forty-five of which
12 will be private rooms. Both O.H.S.M. and the committee
13 recommends approval with conditions and contingencies.
14 There was no discussion at the meeting. I move it for
15 approval.
16 DR. STRECK: We -- we have one clarification.
17 Dr. Boufford has a clarification on her status here.
18 MR. BOOTH: I'm sorry. It's --.
19 DR. BOUFFORD: Yeah. I -- I have just been
20 formally appointed to the board of H.H.C., so I know --
21 I now have to recuse myself from this application and
22 112120C as opposed to being --.
23 DR. STRECK: So you are recused and excused.
24 DR. BOUFFORD: Abstaining.
25 DR. STRECK: Okay.

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2 DR. BOUFFORD: -- I'm leaving.
3 DR. STRECK: Okay. Thank you. So the motion
4 with the clarification of interests and conflicts is --.
5 MR. BOOTH: One clarification also --
6 DR. STRECK: Yes?
7 MR. BOOTH: -- that Dr. Boutin-Foster is
8 abstaining.
9 DR. STRECK: Okay. So with those
10 clarifications, the motion has been made. Did we secure
11 a second yet?
12 UNIDENTIFIED MALE: So moved.
13 DR. STRECK: A second has been obtained. Is
14 there discussion? Those in favor, aye. Opposed? Thank
15 you.
16 MR. BOOTH: 112030C, Corning Hospital,
17 construct a replacement hospital to include sixty-five
18 beds, thirty-four less than the current certified
19 capacity. Interest declared by Mr. Booth. Both
20 O.H.S.M. and the committee recommends approval with
21 conditions and contingencies. There was no discussion
22 in the meeting. I move it for approval.
23 UNIDENTIFIED SPEAKER: Second.
24 DR. STRECK: Moved and seconded. Is there a
25 discussion? Hearing none, those in favor, aye.

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2 Opposed? Thank you.
3 MR. BOOTH: 112120C, Coler-Goldwater Specialty
4 Hospital and Nursing Facility, recusal declared by Dr.
5 Sullivan, who is not in the room. Interest declared by
6 Dr. Bhat, a recusal by Dr. Boufford, and an interest by
7 Mr. Fassler. Renovate the former North General Hospital
8 Building to accommodate two hundred and one long-term
9 care acute beds transferred Coler-Goldwater's Roosevelt
10 Island site. Note on page six of the programmatic
11 analysis, the second paragraph has been deleted and
12 replaced with "No changes will occur at the Coler
13 Division, which is currently licensed for two hundred
14 and ten beds, as a result of this application".
15 O.H.S.M. and the committee recommended approval with
16 conditions and contingencies. There was no discussion
17 in the meeting, and I move it for approval.
18 UNIDENTIFIED SPEAKER: Second.
19 DR. STRECK: Moved and seconded. Those in
20 favor, aye. Opposed? Thank you. The motion passes.
21 MR. BOOTH: 112069C, Hospice Buffalo, interest
22 declared by Mr. Booth. Convert eight residence hospice
23 beds into eight inpatient hospice beds, resulting in a
24 total of thirty-two certified inpatient hospice beds
25 with minor upgrade to the facility. Both O.H.S.M. and

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2 the -- and the committee recommend approval. There was
3 no discussion at the meeting. I move it for approval.
4 UNIDENTIFIED SPEAKER: Second.
5 DR. STRECK: Moved and seconded. Discussion?
6 Those in favor, aye. Opposed? Thank you. The motion
7 passes.
8 MR. BOOTH: 111061C, Shorefront Jewish
9 Geriatric Center. Upgrade the sprinkler system and
10 renovations to patient rooms, common spaces, and nursing
11 stations. Interest declared by Mr. Fassler. O.H.S.M.
12 and the committee recommend approval with conditions and
13 contingencies. There was no discussion at the meeting.
14 I move it for approval.
15 UNIDENTIFIED SPEAKER: Second.
16 DR. STRECK: Moved and seconded. Discussion?
17 Those in favor, aye. Opposed? Thank you.
18 MR. BOOTH: The following four ventilator
19 applications were deferred at the -- the meeting by the
20 committee agreed to by the Department and the
21 applicants. They are 072112C, Oakwood Operating;
22 071024C, Long Beach Memorial Nursing Home; 112096C,
23 Nesconset Acquisition, and 071077C.
24 DR. STRECK: Mr. Fensterman is noted as a
25 recusal. Oh, that's right. Those are deferred anyway.

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2 MR. BOOTH: We're not going to do it.
3 DR. STRECK: Go ahead.
4 MR. BOOTH: The -- the following project was
5 also deferred by the committee, 102376C, Albany County
6 Nursing Home.
7 The next application is 111488B, Yorkville
8 Endoscopy, establish and construct a single specialty
9 free-standing ambulatory service center specializing in
10 gastroenterology. Both the O.H.S.M. and the committee
11 recommended approval for a five year limited life with
12 conditions and contingencies. There was no discussion
13 at the meeting, and I move it for approval.
14 UNIDENTIFIED SPEAKER: Second.
15 DR. STRECK: Moved and seconded. Those in
16 favor, aye.
17 MR. BOOTH: Can I -- there's only -- okay.
18 112031E, Alliance Health Associates, establish Alliance
19 Health Associates and -- and -- as the new operator of
20 Ruby Western Manor Residential Healthcare Facility;
21 112023E, District Nursing Association of Northwestern --
22 Northern Westchester County, acquire Putnam Hospital's
23 Center Certified Home Health Agency and add Putnam
24 County to its existing operating certificate. In both
25 cases, O.H.S.M. and the committee recommended approval

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2 with contingencies. There was no discussion on either
3 item. I move them for approval.
4 UNIDENTIFIED SPEAKER: Second.
5 MR. FENSTERMAN: Mr. Chairman, I have a comment
6 on that.
7 DR. STRECK: Yes, Mr. Fensterman?
8 MR. FENSTERMAN: My comment is relegated
9 solely to the Alliance Healthcare Associates, Inc.,
10 application. I believe that we are in receipt of a
11 letter from an attorney who I do not personally know,
12 but enjoys a very fine reputation -- Mr. Kornreich, from
13 the Proskauer Firm -- in which he is alleging what
14 appears to be wrongdoing regarding whether or not an
15 individual should have been before us in establishment.
16 He's essentially claiming that a Dr. Mowry (phonetic
17 spelling), who is -- is supposed to be a member of this
18 entity, that when an application was submitted for a
19 receivership, he was part and parcel of that. And
20 somehow thereafter, he is alleging that a law firm --
21 that is, the Garfunkel Firm -- informed someone that Dr.
22 Mowry is no longer with Alliance as a shareholder, and
23 there seems to be a rather substantial legal dispute
24 here.
25 My concern is -- is that I don't think that we

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2 should be approving an application in which potentially
3 a individual who's supposed to be a member is not listed
4 here. He obviously haven't been vetted for
5 establishment. I don't know what the legal status of
6 this is, but it is a concern of mine and particularly
7 when I see one law firm actually casting aspersion
8 against another firm as having misinformed someone that
9 someone is a member of an entity or not. So I'm -- I'm
10 very concerned about this.
11 And my -- my view is -- is that counsel for the
12 Department should undertake to investigate this not in a
13 capacity of adjudicating who's right or who's wrong
14 because that's not our role, but rather to ascertain
15 what the bona fides are of the position and determining
16 whether or not this does create a problem for us or not
17 because I -- I'm very concerned about the allegations
18 that have been made here, which, of course, were not
19 brought before a set establishment, but the attorney is
20 claiming that he ascertained thereafter this had gone
21 forward.
22 DR. STRECK: Thank you. In that case, we -- we
23 need to backtrack on this batching process.
24 MR. BOOTH: So I would change my -- my motion
25 to the 112031B only for approval.

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2 UNIDENTIFIED SPEAKER: Second.
3 DR. STRECK: Wait a minute. Now you're -- the
4 one of your concern, Mr. Fensterman --.
5 MR. FENSTERMAN: My concern is the 112031E. I
6 have no objection and -- to the 112023E. So my issue is
7 with the letter that was written to us, which is --
8 relates to the 112031E issue.
9 DR. STRECK: Okay. So let's just -- so you
10 made a motion in regard to that, so that now is under
11 discussion. Do we have a second for that motion to
12 discuss? Okay. So you've expressed your concerns.
13 It's now open for discussion. The motion was for
14 approval. There has been a concern raised, so now we're
15 discussing the concern raised about this motion. Okay.
16 Ms. Regan, Ms. Rautenberg, others? Go ahead.
17 MS. REGAN: I'd like to agree strongly with
18 what Mr. Fensterman has said, and I guess we should
19 propose that we should defer it while Council --
20 MR. FENSTERMAN: That's my view.
21 MS. REGAN: -- figures it out.
22 MS. RAUTENBERG: I concur with the deferral.
23 DR. STRECK: So we have a motion to defer and a
24 second. Is there discussion on the motion to defer?
25 Hearing none, those in favor of the motion to defer this

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2 particular application, please raise your hand. And
3 that passes. And so the motion on 112031E is to defer
4 for further consideration. We can then move on, Mr.
5 Booth. Thank you.
6 MR. BOOTH: Yes. 112023E, I move it for
7 approval.
8 UNIDENTIFIED SPEAKER: Second.
9 DR. STRECK: Moved and seconded. Discussion?
10 Hearing none, those in favor? Opposed? Thank you.
11 MR. BOOTH: The next three are batched. They
12 are name changes for Samaritan Foundation of Northern
13 New York, Auburn Memorial Hospital, and Auburn Hospital
14 System Foundation. They were all approved with no
15 discussion, and I move them for approval.
16 UNIDENTIFIED SPEAKER: Second.
17 DR. STRECK: Moved and seconded. Discussion?
18 Hearing none, those in favor, aye. Opposed? Thank you.
19 MR. BOOTH: We'll batch the next three, which
20 are all certificates of dissolution. Hudson Valley
21 Health Specialties, Brooklyn Cares, and the Albert
22 Lindley Lee Memorial Hospital. All three were approved
23 in terms of the dissolutions with no discussion. I move
24 the approval.
25 UNIDENTIFIED SPEAKER: Second.

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2 DR. STRECK: Moved and seconded. Discussion?
3 Hearing none, those in favor, aye. Opposed? Thank you.
4 MR. BOOTH: The following home health agency
5 licensure applications were recommended for approval:
6 1911-L, 2050-L, 2051-L, 2058-L, 2067-L, all for approval
7 without discussion at the meeting. I move them for
8 approval.
9 UNIDENTIFIED SPEAKER: Second.
10 DR. STRECK: Motion made and seconded.
11 Discussion? Those in favor, aye. Opposed? Thank you.
12 Now to Category Two.
13 MR. BOOTH: 112194E, Northeast Health,
14 establish Northeast Health as the active parent and
15 operator of the following not-for-profit facilities:
16 Albany Memorial Hospital, Sunnyview Hospital
17 Rehabilitation Center, Samaritan Hospital, Eddy Heritage
18 House Nursing and Rehabilitation Center, and James A.
19 Eddy Memorial Geriatric Center. St. Peter's Health
20 Partners has become the sole member and passive parent
21 over Northeast Health, Seton Health System and St.
22 Peter's Healthcare Services through affiliation. Both
23 O.H.S.M. and the committee recommend approval with
24 contingencies. There was no discussion in the meeting,
25 and I move it for approval.

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2 UNIDENTIFIED SPEAKER: Second.
3 DR. STRECK: Moved and seconded. Discussion?
4 Heating none, those in favor, aye. Opposed? Thank you.
5 MR. BOOTH: 092069B, Western New York Medical
6 Management, interest declared by Mr. Booth, establish
7 and construct a diagnostic and treatment center to be
8 certified as a single specialty ambulatory surgery
9 center specializing in pain management procedures.
10 O.H.S.M. and the committee recommends approval for five
11 year limited life with conditions of contingencies. I
12 move it for approval.
13 UNIDENTIFIED SPEAKER: Second.
14 DR. STRECK: Moved and seconded. Discussion?
15 Those in favor, aye. Opposed? Thank you.
16 MR. BOOTH: 111362B, Upstate Gastroenterology,
17 interest declared by Mr. Booth, establish and construct
18 a single specialty free-standing ambulatory surgery
19 center to perform endoscopy and colonoscopy services.
20 The application is for the conversion of an existing
21 not-for-profit private practice which is run through the
22 Department of Medicine Medical Services Group at the
23 SUNY Health Science Center at Syracuse. O.H.S.M. and
24 the Committee recommend approval with a -- for a five
25 year limited life with conditions and contingencies.

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2 It -- that was approved without discussion at the
3 committee meeting, and I move it for approval.
4 UNIDENTIFIED SPEAKER: Second.
5 DR. STRECK: Moved and seconded. Those in
6 favor, please raise your hand. Thank you. Just a
7 little variety here. The voice vote is -- was
8 attenuating. We had to -- okay. Let's move on. All
9 right.
10 MR. BOOTH: 111504B, Mills Pond Dialysis
11 Center. Mr. Fensterman declared a conflict and is
12 leaving the room, and interest is declared by Dr. Bhat.
13 Establish and construct a twelve station renal dialysis
14 center to be located within Mills Pond Nursing and
15 Rehabilitation Center. Both O.H.S.M. and the committee
16 recommends approval with conditions and contingencies.
17 There was no discussion at the meeting, and I move it
18 for approval.
19 UNIDENTIFIED SPEAKER: Second.
20 DR. STRECK: Moved and seconded. Discussion?
21 Those in favor, please say aye. Opposed? Thank you.
22 MR. BOOTH: 111475B, U.S.R.C. Lake Plains,
23 interest declared by Mr. Booth and Dr. Bhat. Establish
24 two chronic dialysis diagnostic and treatment centers
25 through the transfer of ownership of two hospital

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2 extension clinics from Orleans Community Health's Medina
3 Memorial Hospital to the U.S.R.C. Lake Plains. O.H.S.M.
4 and the committee recommend approval with conditions and
5 contingencies. There was no discussion in the meeting,
6 and I move it for approval.
7 UNIDENTIFIED SPEAKER: Second.
8 DR. STRECK: Moved and seconded. Discussion?
9 Those in favor, aye. Opposed? Thank you.
10 MR. BOOTH: 11154E (sic), Fulton Operations
11 Associates, recusal by Mr. Fassler, who's leaving the
12 room, and Mr. Fensterman. Transfer ownership of the
13 Fulton County Residential Healthcare Facility from the
14 County of Fulton to Fulton Operations Associates. Both
15 O.H.S.M. and the Committee recommend approval with
16 contingencies. There was no discussion at the meeting,
17 and I move it for approval.
18 UNIDENTIFIED SPEAKER: Second.
19 DR. STRECK: Moved and seconded. Discussion?
20 Hearing none, those in favor, aye. Opposed? Thank you.
21 MR. BOOTH: We have a certificate of amendment
22 for a name change for O.D.A. Primary Healthcare Center.
23 Mr. Fensterman has declared a conflict and is not in the
24 room. We also have a recusal. Oh, that's a different
25 one. We have a -- so we'll do what -- we have to do

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2 them separately, so that was up for approval, and it was
3 approved by the committee with no discussion. I move it
4 for approval.
5 UNIDENTIFIED SPEAKER: Second.
6 DR. STRECK: Moved and seconded. Discussion?
7 Hearing none, those in favor, aye. Opposed? Thank you.
8 MR. BOOTH: And the second name change,
9 Comprehensive Care Management Diagnostic and Treatment
10 Center. Mr. Fassler has recused himself and is not in
11 the room. And that also passed the committee without
12 discussion. And I move it for approval.
13 UNIDENTIFIED SPEAKER: Second.
14 DR. STRECK: Moved and seconded. Discussion?
15 Hearing none, those in favor, say aye. Opposed? Thank
16 you.
17 MR. BOOTH: So we have a batch of home
18 healthcare agency licensures recommended for approval:
19 1758-L, 1778-L, 1826-L, 1852-L, 1952-L, 1947-L, 1705-L,
20 and 2073-L. Ms. Regan has declared an interest in each
21 of those cases. Mr. Fassler also had an interest on
22 1705-L. They all were approved by the committee without
23 discussion, and I move them as a batch for approval.
24 UNIDENTIFIED SPEAKER: Second.
25 DR. STRECK: Moved and seconded. Further

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2 discussion? Hearing none, those in favor, aye.
3 Opposed. Thank you.
4 MR. BOOTH: And the final item is a resolution.
5 Is -- is Mr. Stone still here? Mr. Stone?
6 MR. STONE: At the Establishment and Project
7 Review Committee, a resolution was recommended for
8 adoption. The resolution would essentially require
9 certificate of need applicants for establishment to
10 submit their applications through the New York State
11 Electronic Certificate of Need System as of January 1st,
12 2012.
13 MR. BOOTH: And the committee approved that at
14 the meeting, and I would move it for approval.
15 UNIDENTIFIED SPEAKER: Second.
16 DR. STRECK: Moved and seconded. Discussion?
17 Hearing none, those in favor, aye. Opposed?
18 MR. BOOTH: That concludes my report.
19 DR. STRECK: Thank you.
20 (Off-the-record discussion)
21 DR. STRECK: Are there other items --?
22 (Off-the-record discussion)
23 DR. STRECK: Oh, right. We have to -- those of
24 you who were here long ago this morning, we -- the --
25 the Planning Committee approved stroke center

1 Planning Council - 12-8-2011
2 designation for a particular institution. And I would
3 ask the chair of the Planning Committee to make a motion
4 to -- or someone in his stead on -- on your behalf --
5 his behalf to make a motion for this approval. So that
6 would -- do you want to make that -- the moving approval
7 for Columbia Memorial Hospital as a stroke center as
8 recommended by the Planning Committee by Dr. Boufford.
9 UNIDENTIFIED SPEAKER: Second.
10 DR. STRECK: That's been seconded. Is there
11 further discussion? Hearing none, those in favor, aye.
12 Opposed? Thank you. That will conclude with an
13 approval.
14 So with that, a long day's work well done
15 relatively timely given our agenda. I thank you all.
16 The next committee day will be January 19th, 2012. And
17 the full Council has a respite until February the 2nd of
18 2012. I wish you all the best of holidays, and thank
19 you for your attention today.
20 (The meeting concluded at 2:58 p.m.)
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1 Planning Council - 12-8-2011

2 STATE OF NEW YORK
I, Howard Hubbard, do hereby certify that the foregoing
3 was reported by me, in the cause, at the time and place,
as stated in the caption hereto, at Page 1 hereof; that
4 the foregoing typewritten transcription, consisting of
pages 1-176, is a true record of all proceedings had at
5 the hearing.
IN WITNESS WHEREOF, I have hereunto
6 subscribed my name, this the 13th day of December, 2011.

7 ___________________
Howard Hubbard, Reporter
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STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

2011 ANNUAL REPORT

FEBRUARY 2, 2012

I. General Council Activities in 2011

The Public Health and Health Planning Council (PHHPC) was constituted on December 1, 2010. The PHHPC held an Orientation Session, followed by a Business Meeting on June 9, 2011. At the Business Meeting, the Council adopted new bylaws, elected a Vice Chairperson, and appointed members to their respective committees. On June 10, 2011, the Council held their first Committee Meetings, discussing vigorous initiatives. The PHHPC convened on June 16, 2011 for the first Full Council Meeting.

II. Membership

William Streck, M.D., Chair
Jeffrey A. Kraut, Vice Chair
Howard S. Berliner, SC.D.
Jodumutt Ganesh Bhat, M.D.
Christopher C. Booth
Jo Ivey Boufford, M.D.
Michael Fassler
Howard Fensterman
Carla Boutin-Foster, M.D.
Ellen Grant, Ph.D.
Angel Alfonso Gutierrez, M.D.
Victoria G. Hines
Robert W. Hurlbut
Arthur A. Levin, MPH
Glenn Martin, M.D.
John M. Palmer, Ph.D.
Ellen L. Rautenberg, M.H.S.
Susan Regan
Peter G. Robinson
John Rugge, M.D., MPP
Theodore Strange, M.D.
Ann Marie Theresa Sullivan, M.D.
Anderson Torres, Ph.D., LCSW-R
Patsy Yang, Dr.P.H.
Dr. Nirav Shah, Commissioner of Health – Ex-Officio

The PHHPC consists of the following Standing Committees and Ad Hoc Committee

- Committee on Codes, Regulations and Legislation
- Committee on Establishment and Project Review
- Committee on Health Planning
- Committee on Public Health
- Ad Hoc Committee to Lead the State Health Improvement Plan

III. Major Accomplishments of Committees in 2011

A. Committee on Codes, Regulations and Legislation

Members

Angel Alfonso Gutierrez, M.D., Chair	Robert W. Hurlbut
John M. Palmer, Ph.D., Vice Chair	John Rugge, M.D., MPP
Jodumutt Ganesh Bhat, M.D.	Ann Marie Sullivan, M.D.
Jo Ivey Boufford, M.D.	Patsy Yang, Dr.P.H.
Michael Fassler	

EMERGENCY ADOPTIONS

The Committee recommended, and the Council subsequently Adopted, the following Emergency Regulations in 2011:

Amendment to Limitation of Operating Certificates – This regulation authorizes the Commissioner to permit an established operator of a facility to operate at an alternate or additional site approved by the Commissioner on a temporary basis in an emergency.

Certified Home Health Agency (CHHA) Establishment – Determination of Public Need – The 2011 budget mandated moving persons in need of home community based care over 120 days into managed long term care coordination models effective April 1, 2012. This regulation shifts participants from fee for service to managed care and will permit a request for applications (RFA) for the licensure of new CHHAs on a limited need basis.

REGULAR ADOPTIONS

The Committee recommended, and the Council subsequently Adopted, the following Regular Regulations in 2011:

Public Water Systems – This measure revised various sections of Subpart 5-1 of Title 10 NYCRR to implement the federal Ground Water Rule (GWR) promulgated with the intent to reduce exposure to fecal contamination that may be present in drinking water from ground water sources at public water systems. The rule: (1) enhances requirements for sanitary surveys for public water supplies; (2) requires monitoring of source waters for E. coli when triggered by detection of coliform bacteria during routine distribution system monitoring; (3) schedules and requires actions to correct significant deficiencies or otherwise reduce the risk of fecal contamination reaching public water system customers; (4) has ongoing requirements for measurements and record keeping to demonstrate adequate performance to ensure safe drinking water quality; and (5) improves procedures for notifying the public in the event that water may not be safe to drink.

Children's Camps, Swimming Pools, Bathing Beaches – This regulation implements chapter laws pertaining to camp permit fees, the summer day camp definition, and sleeping cabins at overnight camps. It would incorporate Public Health Law (PHL) requirements for screening camp staff through the State Sex Offender Registry and provide meningococcal meningitis information to parents. It also modifies the requirements for camp aquatic directors and lifeguards, clarifies first aid and CPR requirements, and adds reflective triangles as an acceptable alternative to flares required for vehicles.

Sexually Transmitted Disease Reporting and Treatment Requirements – These provisions clarify and update the official list of STDs in NYS including NYC based on current medical technology and understanding. They clarify and simplify local health department services responsibilities relating to STD control. They also remove archaic language in order to make the regulations consistent with current reporting practices.

Accreditation Standards – This regulation removes references to specific accrediting organizations by name and amends those provisions to authorize that a facility has full accreditation by a CMS approved accrediting agency as approved by the Commissioner. It will allow for collaborative agreements with CMS approved accrediting agencies other than just The Joint Commission (TJC), American Osteopathic Association (AOA) and the Accreditation Association for Ambulatory Health Care (AAAHC). The Department enters into collaborative agreements with accrediting agencies with the intent of reduction of duplication of effort with respect to routine surveys. These changes will allow the findings of more CMS approved accrediting agencies to be accepted as evidence of compliance with operational standards.

Observation Unit Operating Standards – This measure creates operating standards for observation units. Observation services delivered in observation units that comply with these provisions will be eligible for Medicaid reimbursement. Patients will be permitted to stay in observation units for up to twenty-four hours from assignment to the observation unit from the emergency service. After this time patients must be discharged, admitted as an inpatient or transferred to another hospital.

DISCUSSION REGULATIONS

The following proposals were Discussed by the Codes and Regulations Committee in 2011:

Adverse Event Reporting – This regulation conforms to a recent change in law that would allow the Department the ability to conform to the National Quality Forum's (NQF) reporting definitions and share New York Patient Reporting System (NYPORTS) de-identified data and findings. It amends both general hospital and diagnostic and treatment center provisions and authorizes the Department to add, modify, or eliminate reporting requirements after consultation with experts in the interest of patient safety and consistency with NQF standards. It also directs the Department to analyze event reports, root cause analyses, and corrective action plans to determine patterns of systemic failure, identify methods to correct those failures and communicate the findings with facilities.

(NOTE: PHHPC may adopt and amend regulations subject to the approval of the Commissioner of Health pursuant to the general authority of Public Health Law Article 28 (Hospitals). This regulatory revision, however, is not pursuant to such general authority. Rather, it is pursuant to Public Health Law section 2805-l which specifically authorizes the Commissioner of Health to make, adopt and promulgate regulatory provisions regarding adverse event reporting. As a result, this regulation will be a Commissioner's regulation rather than a PHHPC regulation)

Amendment to Limitation of Operating Certificates (Permanent Version) – This regulation authorizes the Commissioner to permit an established operator of a facility to operate at an alternate or additional site approved by the Commissioner on a temporary basis in an emergency.

(NOTE: This is identical to the emergency version (See Above). While the emergency version is in effect the permanent version is winding its way through the regulatory process. It is expected to be Adopted in 2012.)

Home Care Registry – This proposal defines the rules for implementing Chapter 594 of the Laws of 2008 requiring the Department to establish a Home Care Registry. This Registry tracks training and employment information for all individuals who have successfully completed approved home health and/or personal care aide training programs. The regulations outline the responsibilities of State approved training entities, home care services agencies and home care trainees and aides.

Certificate of Need (CON) Notice Requirements - This regulation is pursuant to legislation that eliminates requirements for limited review, CON administrative review and CON full review for projects confined to non-clinical infrastructure, repair and maintenance, and one-for-one equipment replacement. In place of the former limited review and CON requirements for those categories of projects, only the submission of a written notice, applicable architect/engineer certification, and a plan for patient safety during construction will be required.

2012 OBJECTIVES

Various initiatives are currently under development in the Department that will need to go through the Codes, Regulations and Legislation Committee. Some of the major initiatives include, but are not limited to:

- An update of the Chronic Renal Dialysis provisions;
- Part 405 Pediatric Amendments; and
- An update of the Transplant provisions.

B. Committee on Health Planning

Members

John Rugge, M.D., Chair	Jeffrey Kraut
Ellen Grant, Ph.D., Vice Chair	Arthur Levin
Howard Berliner	Glenn Martin, M.D.
Christopher Booth	John Palmer, Ph.D.
Michael Fassler	Ellen Rautenberg
Carla Boutin-Foster, M.D.	Peter Robinson
Angel Gutiérrrez, M.D.	

The Health Planning Committee's charge is to advise the Council on need methodologies, health facility plans, and emerging health care issues; monitor major health care initiatives and advise the Council on progress and/or problems. The Committee also has the responsibility to develop and review appropriateness standards (Part 708) for various services, evaluate health technology equipment, and advise the Council on such specialized services as organ transplants. The Committee takes into consideration matters relative to the collaboration with the Rural Health Council. The Committee also advances a framework for CON to ensure interoperable health information technology is an underpinning to health care delivery and supports health care stakeholders and advises the Department on health information policy relevant to health care stakeholders.

The Committee's work in 2011 focused on redesign of Certificate of Need process. The first step in that project was to seek input from 86 health care stakeholders. Key questions were how to relate CON to: new models of care and technology; public health priorities; quality consideration; and local and regional planning. The Committee received over sixty recommendations which have been sorted among the following categories: CON repurposing, principles for re-design, character and competence, public need, financial feasibility, quality, planning, and administrative streamlining.

Based on this input, the Committee is preparing recommendations on administrative streamlining with a report to be issued in June 2012. The Committee is concurrently considering how best to restructure CON in the context of the emerging 21st Century Health Care System with recommendations to be presented in the fall of 2012.

C. Committee on Public Health

Members

Jo Ivey Boufford, M.D. , Chair	Victoria G. Hines
Anderson Torres, Ph.D., Vice Chair	Arthur Levin
Christopher Booth	Ellen Rautenberg
Carla Boutin-Foster, M.D	Susan Regan
Angel Gutiérrrez, M.D.	Patsy Yang, Dr.P.H.

The Public Health Committee of the Public Health and Health Planning Council (PHHPC) was established in 2011 to address the statewide governmental public health infrastructure (including workforce, information technology, laboratory and other organizational capacity consistent with the Essential Public Health Services) and supporting actions to assure readiness for future public health agency accreditation. The PHC also promotes interagency collaborations across government to support a "Health in All Policies" approach by State leadership.

At the first two meetings of the year, the committee discussed a variety of projects it could consider and determined that it would focus its efforts on three:

- Work together with the Council's Health Planning Committee to reform Certificate of Need and health planning, including incorporating public health considerations into the CON review process.

- Supporting the DOH in its efforts to become an accredited public health agency, including updating the state's health assessment and its health improvement plan (The Prevention Agenda toward the Healthiest State) for 2013-2017.

- Identify one Prevention Agenda area with significant disparities and help focus attention, resources, policy and stakeholder attention to move the needle on the problem.

During 2011-12, the Public Health Committee has convened three meetings with the Health Planning committee to discuss incorporating population health concerns into the CON modernizing process. The committee also met on its own three times.

To support the Department of Health's efforts to become an accredited health department, the Public Health Committee established the Ad Hoc Advisory Committee to lead the development of New York's five year state health improvement plan for the period 2013-2017. The plan will consist of an assessment of progress on the 2008-2012 *Prevention Agenda toward the Healthiest State*, the identification of new public health priorities for community based prevention for 2013-2017, and a plan for multi-sector action for the next 5 years on these priority health issues. Completing a State Health Improvement Plan and a State Health Assessment are prerequisites for accreditation by the Public Health Accreditation Board. As the Department of Health's governing body, the involvement and support of the Public Health and Health Planning Council is essential. The Ad Hoc Committee consists of 25 representatives, including six members of the public health committee and another 19 from public health, health care, statewide community

based organizations, professional associations and businesses and other key stakeholder organizations.

When progress on the Prevention Agenda priorities is reviewed, candidate health issues for the Committee's attention and action will be identified, and more detailed plans for action will be taken up next year in conjunction with the state health improvement planning process.

D. Committee on Establishment and Project Review

Members

Jeffrey Kraut , Chair
Christopher Booth, Vice Chair
Howard Berliner
Howard Fensterman
Ellen Grant, Ph.D.
Victoria G. Hines
Arthur Levin
Glenn Martin, M.D
Susan Regan
Peter Robinson
Ann Marie Theresa Sullivan, M.D
Anderson Torres, Ph.D.
Patsy Yang, Dr.P.H.

SEE BELOW FOR REPORTS

New York State Department of Health

Certificate of Need Annual Report
Public Health and Health Planning Council
2011

TABLE I
Median Processing Times

(Acknowledgement to Director Action in Days)

Admin	Full	Ltd
179	268	66

TABLE I (A)
Historical Project Volume and Values

	Number of Projects				Value of Projects *(in thousands)*				Average Value *(in thousands)*	
Year [1,2,3]	Admin	Full		Total	Admin	Full		Total	Admin	Full
1994	428	241		669	$389,639	$1,032,743		$1,422,382	$910	$4,285
1995	561	265		826	532,750	1,394,735		1,927,485	950	5,263
1996	393	179		572	445,148	731,651		1,196,799	1,133	4,087
1997	383	176		559	609,796	1,173,851		1,783,647	1,592	6,670
1998	341	173		514	588,550	1,035,393		1,623,943	1,726	5,985
1999	348	184		532	630,286	615,616		1,245,902	1,955	3,346
2000	196	140		336	427,590	914,871		1,342,461	2,181	6,535
2001	199	150		349	446,917	756,778		1,203,695	2,246	5,012
2002	212	140		352	552,566	883,911		1,436,477	2,606	6,314
2003	281	172		453	605,072	1,242,984		1,848,056	2,153	7,227
2004	198	141		339	432,515	1,049,534		1,482,049	2,184	7,444
2005	234	163		397	469,406	1,845,890		2,315,297	2,015	11,324
2006	211	142		353	484,771	2,232,572		2,717,342	2,297	15,722
2007	190	115		305	619,756	1,309,918		1,929,674	3,261	12,357
2008	205	108		313	805,085	3,385,133		4,190,218	3,985	31,343
2009	202	102		304	$467,328	$1,452,895		$1,920,223	$2,313	$14,244

	Number of Projects				Value of Projects *(in thousands)*				Average Value *(in thousands)*		
Year	Admin	Full	Ltd	Total	Admin	Full	Ltd	Total	Admin	Full	Ltd
2010	187	127	446	760	685,588	1,946,825	445,542	3,077,955	3,666	15,329	999
2011	187	119	660	966	822,219	827,405	764,474	2,414,098	4,397	6,953	1158

1 January 1996, CON threshold increased from $400K to $1M; administrative limit increased from $4M to $6M (and, in some cases, up to $25M)

2 November 1998, CON threshold increased from $1M to $4M; administrative limit increased from $3M to $10M (and, in some cases, up to $25M)

3 July 2010, CON thresholds increased for administrative reviews from $3M to $6M and for full reviews $10M to $15M for non-general hospital facilities, $50M for general hospitals and no upper limit for upper limit for HIT projects

TABLE I (B)

Projects Reviewed and Related Capital Expenditures by Region
Last Two Calendar Years

2011

Region	Number of Projects				Value Of Projects *(in thousands)*			
	Admin	Full	Ltd	Total	Admin	Full	Ltd	Total
Western	17	20	83	120	24,751	22,463	54,771	101,985
Finger Lakes	15	3	56	74	31,183	0	65,793	96,976
Central	22	12	54	88	85,660	54,304	65,751	205,715
NY Penn	3		19	22	240	0	7,072	7,312
Northeast	14	4	50	68	10,793	6,740	41,487	59,020
Hudson Valley	24	13	95	132	93,702	3,375	97,321	194,398
New York City	81	53	211	345	433,600	740,520	310,038	1,484,158
Long Island	11	14	92	117	142,290	3	122,241	264,534
Total	187	119	660	966	$822,219	$827,405	$764,474	$2,414,098

2010

Region	Number of Projects				Value of Projects *(in thousands)*			
	Admin	Full	Ltd	Total	Admin	Full	Ltd	Total
Western	17	14	45	76	52,933	171,832	17,547	242,312
Finger Lakes	12	10	37	59	94,594	226,388	29,763	350,745
Central	19	13	49	81	19,050	142,087	45,160	206,297
NY Penn	7	1	1	9	39,588	0	52	39,640
Northeast	16	10	37	63	25,927	132,472	18,538	176,937
Hudson Valley	18	10	66	94	32,049	133,745	59,000	224,794
New York City	80	53	150	283	302,462	1,045,243	216,602	1,564,307
Long Island	18	16	61	95	118,985	95,058	58,880	272,923
Total	187	127	446	760	$685,588	$1,946,825	$445,542	$3,077,955

TABLE II (A)
Disapprovals
2011

Hospital Cardiac Projects

052112	Sisters of Charity Hospital Certify and construct a freestanding adult diagnostic cardiac catheterization service (supercedes project 972632), Revised: May 6, 2011 - Move in site of project from 3rd floor to 5th floor, reduction in costs	$0
102142	Mount St. Mary's Hospital and Health Center Certify a PCI capable cardiac catheterization laboratory to be jointly certified with Mercy Hospital of Buffalo to be located at 5300 Military Road, Niagara Falls (Amends and Supercedes Project No. 032334)	$0
102143	Mercy Hospital of Buffalo Certify a PCI capable cardiac catheterization laboratory at Mount St. Mary's Hospital, at 5300 Military Road, Niagara Falls	$0
102151	Niagara Falls Memorial Medical Center Certify cardiac catheterization at Niagara Falls Memorial Medical Center; perform renovations to accommodate relocation of Kaleida Health Buffalo General Hospital cardiac cath lab to Niagara Falls Memorial Medical Center -Companion to 102152	$0
102152	Buffalo General Hospital Relocate existing cardiac catheterization lab from Buffalo General Hospital to Niagara Falls Memorial Medical Center - Companion to CON # 102151	$0

RHCF Ventilator Bed Projects

031039	Bronx Center for Rehabilitation and Health Care, LLC Certify a 16 bed ventilator dependent service	$0
062217	Fieldston Lodge Care Center Cert. six (6) additional ventilator dependent beds by conversion of six (6) RHCF beds for a revised capacity of 16 ventilator beds; Rev.: June 24, 2011 - Reduction in number of ventilator dependent beds requested, from 6 to 5	$0
071010	Long Island Care Center Incorporated Convert 30 residential health care facility beds to 30 ventilator dependent beds resulting in a revised capacity of 40 vent beds; Superceded 548328.	$0
062380	Cliffside Rehabilitation and Residential Health Care Center Certify 20 additional ventilator beds by conversion of 20 existing residential health care facility beds	$0
092002	Promenade Rehabilitation and Health Care Center Construct 20 additional ventilator dependent service beds by converting 20 existing residential health care facility beds	$0
082176	Lutheran Augustana Center for Extended Care and Rehabilitation, Inc. Certify a 22 bed ventilator dependent service by conversion of 22 existing residential health care facility beds	$0
101016	Fort Tryon Center for Rehabilitation and Nursing Construction and certification of a 15-bed ventilator-dependent unit through the conversion of 15 existing residential health care facility beds	$0
111174	Sheepshead Nursing & Rehabilitation Center Certify a vent bed service with a 20 bed capacity through the conversion of 20 residential health care facility beds with no change to the total number of beds	$0

TABLE II(B)
Withdrawals
2011

Withdrawals by Applicant	99
Withdrawals by Department	250
Total	349

TABLE III

Bed Changes by Facility Type by Region

2011

HOSPITALS	Central	Finger Lakes	Hudson Valley	Long Island	New York City	North East	NY Penn	Western	TOTAL
Bed Category									
Chemical Dependency, Detox		-11							-11
Chemical Dependency, Rehab						-2			-2
Coronary Care									0
Intensive Care		-1	6	5	25				35
Maternity Beds			-9		9	-2		-6	-8
Medical/Surgical		-2	-10	-5	-35	-7		6	-53
Neonatal Intensive Care			9		6				15
Neonatal Continuing Care					1				1
Neonatal Intermediate Care					2				2
Pediatric			-14		19				5
Pediatric ICU					3				3
Physical Medicine & Rehabilitation					44	-20			24
Psychiatric			4						4
New York State Total	0	-14	-14	0	74	-31	0	0	15

RESIDENTIAL HEALTH CARE FACILITIES	Central	Finger Lakes	Hudson Valley	Long Island	New York City	North East	NY Penn	Western	TOTAL
Bed Category									
RHCF Beds	250		-160		-202			-83	-195
Behavioral Intervention									
Tramatic Brain Injury			120		20				140
Ventilator, Adult					220			20	240
Ventilator, Pediatric									
New York State Total	250	0	-40	0	38	0	0	-63	185

TABLE IV
Projects Receiving Commissioner Action by Facility Type
2011

TABLE IV (A)
Administrative Review Projects

Region	CHHA	D&TC	HOSPICE	HOSPITAL	LTHHCP	RHCF	TOTAL
Western		4		11		2	17
Finger Lakes				14		1	15
Central		3		18		1	22
NY-Penn				1		2	3
Northeastern		3		10	1		14
Hudson Valley		5		15		4	24
New York City	1	21		47	8	4	81
Long Island		1		9		1	11
New York State Total	1	37	0	125	9	15	187

TABLE IV (B)
Full Review Projects

Region	CHHA	D&TC	HOSPICE	HOSPITAL	LTHHCP	RHCF	TOTAL
Western	1	2	2	9		6	20
Finger Lakes	1	1		1			3
Central	2	5		2		3	12
NY-Penn							0
Northeastern		2		2			4
Hudson Valley	2	3	1	3	1	3	13
New York City	1	21		8	1	21	52
Long Island	1	1		5		8	15
New York State Total	8	35	3	30	2	41	119

TABLE IV (C)
Limited Review Projects

Region	D&TC	HOSPITAL	RHCF	TOTAL
Western	7	36	40	83
Finger Lakes	6	34	16	56
Central	5	32	17	54
NY-Penn	1	11	7	19
Northeastern	2	29	19	50
Hudson Valley	11	45	39	95
New York City	34	106	71	211
Nassau-Suffolk	7	56	29	92
New York State Total	73	349	238	660

TABLE V

Public Health and Health Planning Council
Establishment Projects Reviewed by Facility Type
2011

	2011			2010	2009	2008
	Approvals	Disapprovals	Deferrals	Total	Total	Total
Facility Type						
Hospitals	6	0	0	4	5	6
Residential Health Care Facilities	26	0	1	21	18	18
Diagnostic and Treatment Centers	38	0	0	26	26	22
Certified Home Health Agencies	8	0	0	3	2	5
Hospices	0	0	1	0	2	0
Long Term Home Health Care	1	0	0	1	0	2
New York State Total	79	0	2	55	53	53

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

REGULATION

Report of the Committee on Codes, Regulations and Legislation **Exhibit #3**

Angel Gutiérrrez, M.D., Chair

For Emergency Adoption

11-27 Amendment of Section 401.2 of Part 401 of Title 10 NYCRR
(Amendment to Limitations of Operating Certificates)

For Adoption

11-27 Amendment of Section 401.2 of Part 401 of Title 10 NYCRR
(Amendment to Limitations of Operating Certificates)

For Discussion

11-24 Amendment of Parts 763 and 766 of Title 10 NYCRR
(Certified Home Health Agency (CHHA) and Licensed Home Care
Services Agency (LHCSA) Requirements)

Pursuant to the authority vested in the Public Health and Health Planning Council, and subject to the approval of the Commissioner of Health by Section 2803(2)(a) of the Public Health Law, section 401.2 of Part 401 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended to be effective upon filing with the Secretary of State, to read as follows:

Section 401.2 is amended to read as follows:

401.2 Limitations of operating certificates. Operating certificates are issued to established operators subject to the following limitations and conditions:

(a) The medical facility shall control admission and discharge of patients or residents to assure that occupancy shall not exceed the bed capacity specified in the operating certificate, except that a hospital may temporarily exceed such capacity in an emergency.

(b) An operating certificate shall be used only by the established operator for the designated site of operation, except that the commissioner may permit the established operator to operate at an alternate or additional site approved by the commissioner on a temporary basis in an emergency. [provided that an] An operating certificate issued for a facility approved to provide:

(1) chronic renal dialysis services shall also encompass the provision of such services to patients at home;

(2) comprehensive outpatient rehabilitation facility (CORF) services shall also encompass the provision of the following services offsite: physical therapy, occupational

therapy, speech pathology and in addition, home visits to evaluate the home environment in relation to the patient's established treatment goals; and

(3) outpatient physical therapy, occupational therapy and/or speech-language pathology services shall also encompass the provision of home visits to evaluate the home environment in relation to the patient's established treatment goals.

(c) An operating certificate shall be posted conspicuously at the designated site of operation.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The authority for the promulgation of these regulations is contained in section 2803(2)(a)(v) of the Public Health Law, which authorizes the Public Health and Health Planning Council to adopt and amend rules and regulations, subject to the approval of the Commissioner, that define standards and procedures relating to hospital operating certificates.

Legislative Objective:

The regulatory objective of this authority is to permit the Commissioner of the Department of Health to ensure access to health care in communities where a crisis has prevented or limited an existing local health care facility operator from operating at the site designated on its operating certificate.

Needs and Benefits:

This amendment would give the Commissioner the ability to safeguard the health and welfare of residents of areas affected by emergency situations by permitting operators of health care facilities to resume operations at temporary sites. Under the existing regulation, the Commissioner has no authority to permit an operator to operate its health care facility at any site other than that designated on the operating certificate. In the event all or part of a facility cannot be used due to circumstances related to an emergency such as a natural disaster or a fire, this amendment would permit the

Commissioner to act quickly to ensure that the patients or residents of the operator are temporarily served at an alternate or additional site appropriate under the circumstances. The operator of the affected facility would be able to continue to meet the needs of its patients or residents at a safe and appropriate alternate or additional site pending the repair, replacement or relocation of the designated site of operation.

COSTS:

Costs for the Implementation of, and Continuing Compliance with this Regulation to Regulated Entity:

None. The ability to receive revenue through continued operations during the temporary relocation would be a benefit to the regulated entity.

Cost to the Department of Health:

There will be no costs to the Department.

Local Government Mandates:

This amendment will not impose any program service, duty or responsibility upon any county, city, town, village school district, fire district or other special district.

Paperwork:

This amendment will increase the paperwork for providers only to the extent required by the temporary relocation of their operations.

Duplication:

This regulation does not duplicate, overlap or conflict with any other state or federal law or regulations.

Alternatives:

No alternatives were considered, as § 401.2 (b) presents the only barrier to allowing a health care facility operator to operate at a site not designated on its operating certificate.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment will become effective upon filing with the Secretary of State.

Contact Person:

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REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Businesses and Local Governments:

No impact on small businesses or local governments is expected.

Compliance Requirements:

This amendment does not impose new reporting, record keeping or other compliance requirements on small businesses or local governments.

Professional Services:

No new professional services are required as a result of this proposed action.

Compliance Costs:

This amendment does not impose new reporting, recordkeeping or other compliance requirements on small businesses or local governments.

Economic & Technology Feasibility:

This amendment does not impose any new financial or technical burdens upon regulated entities.

Minimizing Adverse Impact:

There is no adverse impact.

Opportunity for Small Business Participation:

Any operator of a hospital as defined under Article 28 of the Public Health Law, regardless of size, may need to operate its facility at another or additional location in an emergency. This amendment would allow it to do so.

No Amelioration or Cure Period Necessary:

This amendment does not involve the establishment or modification of a violation or of penalties associated with a violation. It merely gives operators of hospitals as defined under Article 28 of the Public Health Law the ability to temporarily operate at sites not designated on their operating certificates in times of emergency. Therefore, as no new penalty could be imposed as a result of this amendment, no cure period was included.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Number of Rural Areas:

This rule will apply to all operators of hospitals as defined under Article 28 of the Public Health Law. These businesses are located in rural, as well as suburban and metropolitan areas of the State.

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

No new reporting, recordkeeping or other compliance requirements and professional services are needed in a rural area to comply with the proposed rule.

Compliance Costs:

There are no direct costs associated with compliance.

Minimizing Adverse Impact:

There is no adverse impact.

Opportunity for Rural Area Participation:

Any operator of a hospital as defined under Article 28 of the Public Health Law, including those in rural areas, may need to operate its facility at another location in an emergency. This amendment would allow it to do so.

JOB IMPACT STATEMENT

Nature of Impact:

It is not anticipated that there will be any impact of this rule on jobs or employment opportunities.

Categories and Numbers Affected:

This rule will apply to all operators of hospitals as defined under Article 28 of the Public Health Law.

Regions of Adverse Impact:

This rule will apply to operators of hospitals as defined under Article 28 of the Public Health Law in all regions within the State, but it will have no adverse impact on those operators or their employees.

Minimizing Adverse Impact:

The rule would not impose any additional requirements upon regulated entities, and therefore there would be no adverse impact on jobs or employment opportunities.

Self-Employment Opportunities:

The rule is expected to have no impact on self-employment opportunities.

EMERGENCY JUSTIFICATION

The amendment to 10 NYCRR 401.2 (b) will give the Commissioner the ability to safeguard the health and welfare of residents of areas affected by emergency situations by permitting operators of health care facilities licensed pursuant to Public Health Law Article 28 ("facilities") to resume or continue operations at temporary sites.

Recent weather events have required the temporary evacuation of facilities in the New York metropolitan area and relocation of facilities in Broome and Tioga Counties due to flooding. Section 401.2 (a) of Title 10 allows operators to temporarily exceed the bed capacities stated on their facilities' operating certificates, which, during the recent emergencies, has allowed operators of facilities impacted by those weather events to transfer their patients or residents to other facilities temporarily. This was effective in the New York metropolitan area due to the availability of adequate space in surrounding facilities and due to the lack of any significant damage to the evacuated facilities. In Broome and Tioga Counties, however, the heavy flooding caused lasting damage to facilities, thereby threatening patients' access to health care in clinic space and requiring residents of nursing homes to be moved to space in other nursing homes in the area.

Because section 401.2 (b) of Title 10 currently limits an operator's operating certificate to the site of operation set forth in the operating certificate, an operator of an impacted facility is not able to care for its patients or residents at any other site until the Commissioner has approved a certificate of need application for the relocation of the facility. In Broome County, a hospital filed applications to relocate some of its extension clinics, but a more expedient process could have better mitigated issues of access to

health care. Residents of flooded nursing homes have been cared for in other local nursing homes that had adequate space due to the recent decertification of beds in that area. Although an application to relocate one of the flooded nursing home is expected, currently, nursing homes in Broome County are now at capacity and are unable to accept hospital patients who need to be discharged to nursing home level of care. The number of such patients has been steadily increasing.

This amendment to 10 NYCRR 401.2 (b) is necessary now to allow appropriate arrangements by operators of affected facilities in a manner that will not adversely impact the ability of hospitals in Broome County to properly discharge patients to area nursing homes. The amendment is also necessary to ensure access to appropriate health care for patients or residents during the next time of emergency.

Pursuant to the authority vested in the Public Health and Health Planning Council, and subject to the approval of the Commissioner of Health by Section 2803(2)(a) of the Public Health Law, section 401.2 of Part 401 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 401.2 is amended to read as follows:

401.2 Limitations of operating certificates. Operating certificates are issued to established operators subject to the following limitations and conditions:

(a) The medical facility shall control admission and discharge of patients or residents to assure that occupancy shall not exceed the bed capacity specified in the operating certificate, except that a hospital may temporarily exceed such capacity in an emergency.

(b) An operating certificate shall be used only by the established operator for the designated site of operation, except that the commissioner may permit the established operator to operate at an alternate or additional site approved by the commissioner on a temporary basis in an emergency. [provided that an] An operating certificate issued for a facility approved to provide:

(1) chronic renal dialysis services shall also encompass the provision of such services to patients at home;

(2) comprehensive outpatient rehabilitation facility (CORF) services shall also encompass the provision of the following services offsite: physical therapy, occupational

therapy, speech pathology and in addition, home visits to evaluate the home environment in relation to the patient's established treatment goals; and

(3) outpatient physical therapy, occupational therapy and/or speech-language pathology services shall also encompass the provision of home visits to evaluate the home environment in relation to the patient's established treatment goals.

(c) An operating certificate shall be posted conspicuously at the designated site of operation.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The authority for the promulgation of these regulations is contained in section 2803(2)(a)(v) of the Public Health Law, which authorizes the Public Health and Health Planning Council to adopt and amend rules and regulations, subject to the approval of the Commissioner, that define standards and procedures relating to hospital operating certificates.

Legislative Objective:

The regulatory objective of this authority is to permit the Commissioner of the Department of Health to ensure access to health care in communities where a crisis has prevented or limited an existing local health care facility operator from operating at the site designated on its operating certificate.

Needs and Benefits:

This amendment would give the Commissioner the ability to safeguard the health and welfare of residents of areas affected by emergency situations by permitting operators of health care facilities to resume operations at temporary sites. Under the existing regulation, the Commissioner has no authority to permit an operator to operate its health care facility at any site other than that designated on the operating certificate. In the event all or part of a facility cannot be used due to circumstances related to an emergency such as a natural disaster or a fire, this amendment would permit the

Commissioner to act quickly to ensure that the patients or residents of the operator are temporarily served at an alternate or additional site appropriate under the circumstances. The operator of the affected facility would be able to continue to meet the needs of its patients or residents at a safe and appropriate alternate or additional site pending the repair, replacement or relocation of the designated site of operation.

COSTS:

Costs for the Implementation of, and Continuing Compliance with this Regulation to Regulated Entity:

None. The ability to receive revenue through continued operations during the temporary relocation would be a benefit to the regulated entity.

Cost to the Department of Health:

There will be no costs to the Department.

Local Government Mandates:

This amendment will not impose any program service, duty or responsibility upon any county, city, town, village school district, fire district or other special district.

Paperwork:

This amendment will increase the paperwork for providers only to the extent required by the temporary relocation of their operations.

Duplication:

This regulation does not duplicate, overlap or conflict with any other state or federal law or regulations.

Alternatives:

No alternatives were considered, as § 401.2 (b) presents the only barrier to allowing a health care facility operator to operate at a site not designated on its operating certificate.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment will become effective upon publication of a Notice of Adoption in the New York State Register.

Contact Person:

Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
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REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Businesses and Local Governments:

No impact on small businesses or local governments is expected.

Compliance Requirements:

This amendment does not impose new reporting, record keeping or other compliance requirements on small businesses or local governments.

Professional Services:

No new professional services are required as a result of this proposed action.

Compliance Costs:

This amendment does not impose new reporting, recordkeeping or other compliance requirements on small businesses or local governments.

Economic & Technology Feasibility:

This amendment does not impose any new financial or technical burdens upon regulated entities.

Minimizing Adverse Impact:

There is no adverse impact.

Opportunity for Small Business Participation:

Any operator of a hospital as defined under Article 28 of the Public Health Law, regardless of size, may need to operate its facility at another or additional location in an emergency. This amendment would allow it to do so.

No Amelioration or Cure Period Necessary:

This amendment does not involve the establishment or modification of a violation or of penalties associated with a violation. It merely gives operators of hospitals as defined under Article 28 of the Public Health Law the ability to temporarily operate at sites not designated on their operating certificates in times of emergency. Therefore, as no new penalty could be imposed as a result of this amendment, no cure period was included.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Number of Rural Areas:

This rule will apply to all operators of hospitals as defined under Article 28 of the Public Health Law. These businesses are located in rural, as well as suburban and metropolitan areas of the State.

Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

No new reporting, recordkeeping or other compliance requirements and professional services are needed in a rural area to comply with the proposed rule.

Compliance Costs:

There are no direct costs associated with compliance.

Minimizing Adverse Impact:

There is no adverse impact.

Opportunity for Rural Area Participation:

Any operator of a hospital as defined under Article 28 of the Public Health Law, including those in rural areas, may need to operate its facility at another location in an emergency. This amendment would allow it to do so.

JOB IMPACT STATEMENT

Nature of Impact:

It is not anticipated that there will be any impact of this rule on jobs or employment opportunities.

Categories and Numbers Affected:

This rule will apply to all operators of hospitals as defined under Article 28 of the Public Health Law.

Regions of Adverse Impact:

This rule will apply to operators of hospitals as defined under Article 28 of the Public Health Law in all regions within the State, but it will have no adverse impact on those operators or their employees.

Minimizing Adverse Impact:

The rule would not impose any additional requirements upon regulated entities, and therefore there would be no adverse impact on jobs or employment opportunities.

Self-Employment Opportunities:

The rule is expected to have no impact on self-employment opportunities.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Article 36 of the Public Health Law, Sections 763.3, 763.6, 763.7, 766.3, 766.4, 766.5 and 766.9 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 763.3 is amended as follows:

763.3 Patient care.

*   *   *

(b) An agency shall provide at least one of the services identified in paragraph (1) of subdivision (a) of this section [nursing, physical therapy, speech-language pathology or occupational therapy] directly, while any[additional] other services may be provided directly or by contract arrangement. For purposes of this Part, the direct provision of services includes the provision by employees compensated by the agency or individuals under contract with the agency, but does not include the provision of services through contract arrangements with other agencies or facilities.

Section 763.6 is amended as follows:

763.6 Patient assessment and plan of care.

*   *   *

(c) The plan of care shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, need for palliative care, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

* * *

(e) The plan of care shall be reviewed as frequently as required by changing patient conditions but at least every 6[2]0 days.

Section 763.7 is amended as follows:

763.7 Clinical records. (a) The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include:

* * *

(3) medical orders and nursing diagnoses to include all diagnoses, medications, treatments, [and] prognos[i]es, and need for palliative care. Such orders shall be:

Section 766.3 is amended as follows:

766.3 Plan of care. The governing authority or operator shall ensure that:

* * *

(b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, need for palliative care,

mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential;

Section 766.4 is amended as follows:

766.4 Medical orders.

* * *

(d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, need for palliative care, and other pertinent patient information relevant to the agency plan of care; and

Section 766.9 is amended as follows:

Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:

* * *

(l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons [including a physician if professional health care services are provided]. The committee shall meet at least four times a year to:

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law ("PHL") §3612(5) authorizes the Public Health and Health Planning Council to adopt and amend rules and regulations to effectuate the provisions and purposes of Article 36 with respect to certified home health agencies. 3612(6) requires the commissioner to adopt, and amend as needed, rules and regulations to effectuate the purposes of Article 36 as regards quality of care and services.

Legislative Objectives:

To provide quality home care services to residents of New York State and to assure adequate availability as a viable alternative to institutional care.

Needs and Benefits:

On February 24, 2011 Governor Cuomo accepted a report from the Medicaid Redesign Team meeting the Medicaid spending target contained in the Governor's 2011-2012 budget. The report included 79 recommendations to redesign and restructure the Medicaid program to be more efficient and get better results for patients. Included among the recommendations accepted are proposal numbers 109 and 147. These proposals are attached.

These amendments add a requirement that the plans of care and medical orders required for patients of certified home health agencies (CHHAs) and licensed home care services agencies (LHCSAs) address the patient's need for palliative care. This is in response to MRT proposal number 109, which seeks to expand access to palliative care services.

The amendments also eliminate the need for a physician to serve on the quality improvement (QI) committee of LHCSAs, in response to MRT proposal number 147, which seeks to reduce regulatory burdens on providers.

Finally, some minor amendments were made to align these regulations with federal requirements and to correct errors. First, the amendments remove the requirement that CHHAs provide more than one qualifying service directly, to coincide with the federal standards as defined in 42 CFR §484.14(a). The current regulation appears to require CHHAs to provide more than one service directly, which the Department does not require, and this has led to confusion among interested agencies. Similarly, the amendments change the maximum period of time that may lapse before a comprehensive assessment is reviewed from 62 days to 60 days, as this was an error in the regulations as originally drafted. Federal regulations, at 42 CFR §484.55(d)(1), require review at least every 60 days.

Costs:

The only additional requirement that is imposed on agencies because of these regulations is that requiring the plan of care to address palliative care, which is not anticipated to result in any appreciable burden to agencies and should not add additional costs to current operations. All other amendments are cost neutral or will decrease costs.

Local Government Mandates:

There are no mandates in this rule specific to local government. There are 17 existing county-based LHCSAs and approximately 36 county based CHHAs, and these entities will be required to comply with the same requirements as other licensed agencies.

Paperwork:

Providers are not expected to have increased paperwork as a result of these amendments.

Duplication:

Proposed rules will not be duplicative of other requirements.

Alternatives:

The MRT proposals are specific in their mandates. The Department has made only those changes required to implement the MRT proposals and to remove language that is inconsistent with laws and regulations as they relate to timeframes for assessment.

Federal Standards:

There are no federal health care standards for LHCSAs. This provider type is a New York State construct. Federal regulations governing CHHAs are at 42 CFR Part 484.

Compliance Schedule:

Immediate compliance is expected.

Contact Person:

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

Licensed home care services agencies (LHCSAs) and certified home health agencies (CHHAs) operated by county health departments provide public health services in the home as required by Public Health Law. There are approximately 17 county-based LHCSAs and approximately 36 county-based CHHAs. The small businesses that will be affected are agencies employing fewer than 100 persons. Based on agency reports, the Department estimates that 860 LHCSAs and 168 CHHAs have less than 100 employees, and would be categorized as small businesses.

Compliance Requirements:

There is one new requirement imposed on agencies as a result of these amendments, which is to include the need for palliative care in each patient's plan of care and medical orders.

Professional Services:

No additional professional staff will be required because of these amendments. The requirement that agencies address the need for palliative care will be handled as a part of procedures already undertaken by agencies.

Compliance Costs:

It is not anticipated that there will be any increase in costs incurred by agencies as a result of these amendments. The amendments either remove existing obligations or add a minimal requirement that may be assumed with no increase in cost as part of current operations.

Economic and Technological Feasibility:

These rules can be implemented with no clear economic or technological impact. The only requirement imposed by these regulations is an unappreciable addition to current operations, and no additional technology will be required to comply.

Minimizing Adverse Impact:

The MRT proposals are specific in their mandates. The Department has made only those changes required to implement the MRT proposals and to remove language that is inconsistent with laws and regulations governing the scope of practice for LPNs.

Small Business and Local Government Participation:

The Department will meet the requirements of SAPA Section 202-b(6) in part by publishing a notice of proposed rulemaking in the State register with a comment period. All agencies and associations were able to participate in the MRT process.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

All counties in New York State (NYS) have rural areas with the exception of 7 downstate counties. Approximately 80% of licensed home care services agencies (LHCSAs) and 86% of CHHAs are licensed to serve counties with rural areas in NYS.

Reporting, Record Keeping and Other Compliance Requirements and Professional Services:

There is one new requirement imposed on agencies as a result of these amendments, which is to include the need for palliative care in each patient's plan of care and medical orders. This requirement adds only a minimal recordkeeping burden on agencies, as plans of care and medical orders are already required for every patient serviced by a LHCSA or CHHA. No new professional staff is required to comply.

Costs:

It is not anticipated that there will be any increase in costs incurred by agencies as a result of these amendments. The amendments either remove existing obligations or add a minimal requirement that may be assumed with no increase in cost as part of current operations.

Minimizing Adverse Impact:

The MRT proposals are specific in their mandates. The Department has made only those changes required to implement the MRT proposals and to remove language that is inconsistent with laws and regulations governing the scope of practice for LPNs

Rural Area Impact:

There is no impact specifically to rural areas as a result of these amendments, and the impact to all agencies is minimal.

JOB IMPACT STATEMENT

Nature of Impact:

The Department has determined that the proposed rules will not have a substantial adverse impact on jobs and employment opportunities.

Categories and Numbers Affected:

None

Regions of Adverse Impact:

None

Minimizing Adverse Impact:

Not applicable.

Self Employment Opportunities:

Not applicable.

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

Acute Care Services – Construction **Exhibit #4**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112074 C	University Hospital (Suffolk County)	Contingent Approval

Diagnostic and Treatment Center – Construction **Exhibit #5**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112250 C	Smile New York Outreach, LLC d/b/a Smile Program Mobile Dentists (Queens County)	Contingent Approval

Long Term Home Health Care Program – Construction **Exhibit #6**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112116 C	Dominican Sisters Family Health Service, Inc. (Westchester County)	Contingent Approval

Transitional Care Units - Construction **Exhibit #7**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112206 T	St. Mary's Healthcare (Montgomery County)	Contingent Approval

Public Health and Health Planning Council

Project # 112074-C

University Hospital

County: **Suffolk (Stony Brook)**
Purpose: **Construction**

Program: **Acute Care Services**
Submitted: **August 5, 2011**

Executive Summary

Description

University Hospital, a 571-bed public hospital located at East Loop Road, Stony Brook, is requesting approval to expand its bone marrow transplant (BMT) unit through the certification of an additional 6 BMT beds, which will bring the unit's certified bed count to 10.

The hospital will have 603 certified beds upon completion of this application and the following CONs, both of which were contingently approved by the State Hospital Review and Planning Council (SHRPC) on 3/27/08 and 11/18/10, respectively:

CON #072077-C
Major renovation including an additional 6 neonatal intensive care unit (NICU) beds

CON #102025-C
Certification of an additional 14 medical/surgical beds, and 6 added intensive care beds.

University Hospital is a tertiary hospital, Level 1 Trauma Center, and academic medical center. The hospital has earned other regional designations from the New York State Department of Health which includes: AIDS center, burn center, perinatal center, safe center, and stroke center.

Total project costs are estimated at $844,955.

DOH Recommendation

Contingent approval

Need Summary

University Hospital requests approval to add 6 Bone Marrow Transplant (BMT) beds to the existing capacity of 4 BMT beds.

Service	Existing Capacity	Requested Change	Proposed Capacity
BMT	4	+6	10
Acute Care Beds	569	0	569
Total	*571*	*+6*	*579*

Program Summary

Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

Financial Summary

Project costs will cover renovations and moveable equipment, and be met via funding from the hospital's accumulated resources.

Incremental Budget	*Revenues:*	*$ 2,050,363*
	Expenses	*1,363,722*
	Gain/ (Loss)	*$ 686,641*

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

The project will involve the relocation of 6 medical surgical (M/S) beds from the 16-bed Level 19 South unit, which currently houses BMT and LLT services consisting of 4 BMT bed and 12 M/S beds, with 5 beds being placed on 9 North and 1 bed being moved to level 17 North. This will involve renovations to accommodate the new BMT beds and the relocated M/S beds.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]

Approval conditional upon:

1. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
2. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to start of construction [AER].
3. The applicant shall complete construction by June 1, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date
February 2, 2012.

Need Analysis

Background

The hospital operates as part of a group of organized activities on the Stony Brook campus of the State University of New York, and is also known as Stony Brook University Hospital or SBUH. University Hospital is certified for the following beds and services:

Certified Beds	
Bone Marrow Transplant	4
Burns Care	6
Coronary Care	10
Intensive Care	44
Maternity	36
Medical/Surgical	341
Neonatal Continuing Care	8
Neonatal Intensive Care	18
Neonatal Intermediate Care	14
Pediatric	38
Pediatric ICU	12
Psychiatric	40
Total	*571*

Licensed Services	
Ambulance	Neonatal Continuing Care
Ambulatory Surgery-Multi Specialty	Neonatal Intensive Care
Audiology O/P	Neonatal Intermediate Care
Burns Care	Nuclear Medicine-Diagnostic
Cardiac Catheterization-Electrophysiology (EP)	Nuclear Medicine-Therapeutic
Cardiac Catheterization-Percutaneous Coronary Intervention (PCI)	Pediatric
Cardiac Surgery-Adult	Pediatric Intensive Care
Certified Mental Health Services O/P	Pharmaceutical Service
Clinical Laboratory Service	Primary Medical Care O/P
Comprehensive Psychiatric Emergency Program	Psychiatric
Coronary Care	Radiology-Diagnostic
Emergency Department	Renal Dialysis-Acute
Intensive Care	Therapy-Physical O/P
Linear Accelerator	Therapy-Speech Language Pathology
Lithotripsy	Transplant-Bone Marrow
Magnetic Resonance Imaging	Transplant-Kidney
Maternity	Therapy-Occupational O/P
Medical Social Services	
Medical/Surgical	**Other Authorized Locations: 18**

Inpatient Utilization

Table 1:
Inpatient Utilization, by Major Service Category.

Service	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*
			Discharges			
Medical/Surgical	19,058	19751	20,445	20,995	21,619	22,638
Pediatric	2,738	2686	2,650	2,502	2,590	2,332

Table 1: Inpatient Utilization, by Major Service Category.						
Service	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*
Obstetric	3,518	3,688	3,808	3,826	4,335	4,199
General Psychiatric	686	743	800	810	1,031	1,011
Chemical Dependency	138	156	205	200	184	212
High Risk Neonates	655	612	754	680	683	774
Subtotal	26,793	27,636	28,662	29,013	30,442	31,166
Healthy Newborns	2,673	2,890	2,838	2,921	3,329	3,156
Grand Total	*29,466*	*30,526*	*31,500*	*31,934*	*33,771*	*34,322*
Average Daily Census						
Medical/Surgical	298	304	303	328	353	357
Pediatric	27	26	26	23	23	20
Obstetric	32	35	37	35	40	39
General Psychiatric	39	39	38	44	41	39
Chemical Dependency	2	2	2	2	3	3
High Risk Neonates	32	33	36	30	30	33
Subtotal	430	438	443	462	489	491
Healthy Newborns	19	21	20	21	24	22
Grand Total	*449*	*459*	*463*	*483*	*513*	*513*
Average Length of Stay						
Medical/Surgical	5.70	5.60	5.40	5.70	6.00	5.80
Pediatric	3.60	3.50	3.60	3.40	3.20	3.20
Obstetric	3.30	3.50	3.50	3.40	3.30	3.40
General Psychiatric	20.90	19.10	175	19.70	14.60	14.00
Chemical Dependency	4.00	4.60	4.20	4.40	5.20	4.40
High Risk Neonates	17.80	19.70	17.60	16.10	16.00	15.80
Subtotal	5.90	5.80	5.60	5.80	5.90	5.80
Healthy Newborns	2.60	2.60	2.60	2.60	2.60	2.50
Grand Total	*5.60*	*5.50*	*5.40*	*5.50*	*5.50*	*5.50*

Source: SPARCS 2005- 2010

Table 2: Occupancy Rates, by Major Service Category							
Service	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*Current Beds*
Occupancy Rate							
Medical/Surgical	73.60	74.90	74.80	80.90	87.10	88.20	405
Pediatric	54.00	51.20	51.80	46.00	45.60	40.40	50
Obstetric	88.60	97.50	101.70	98.10	110.30	108.10	36
General Psychiatric	98.30	97.30	96.00	109.30	103.30	97.00	40
Chemical Dependency	0.00	0.00	0.00	0.00	0.00	0.00	0
High Risk Neonates	80.00	82.50	91.00	75.00	75.00	83.50	40
Total	*75.30*	*76.70*	*77.50*	*80.90*	*85.70*	*86.00*	*571*

Source: SPARCS 2005- 2010.

University Hospital at Stony Brook Cancer Services

University Hospital at Stony Brook (SBUH) provides a wide variety of cancer services. The main programs include diagnostic and treatment services for cancers or suspected cancers of the: breast; colorectal; upper GI and general oncology; gynecology oncology; head and neck; thyroid; lung; leukemia, lymphoma, and transplantation management;

melanoma; neurologic oncology; pediatric oncology; sarcoma; and urologic oncology. SBUH has made investments in robotic surgery, bone marrow transplant/leukemia/lymphoma program, and advanced imaging.

SBUH has achieved accreditation for its program in many areas. Cancer Care Program was granted a three-year accreditation by the American College of Surgeons Commission on Cancer as a Teaching Hospital level-approved cancer program, receiving commendations in all possible areas plus an Outstanding Achievement Award. The Carol M. Baldwin Breast Care Center was accredited by the National Accreditation Program for Breast Centers. The Cytogenetics Lab received certification from the Children's Oncology Group for the analysis of chromosomal abnormalities in childhood leukemia. The Radiation Oncology Medical Physics Residency Program has received full accreditation from the American Radiology Commission on Accreditation of Medical Physical Education Programs.

Bone Marrow Transplant (BMT) Program Expansion

The Leukemia, Lymphoma and Transplant (LLT) program provides services not found at other area hospitals. The LLT treats blood-related cancers and cancers of the lymphatic system with modalities that include the most current diagnostic testing, chemotherapy, immunotherapy, radiation, new drug development in clinical trials, and stem cell transplantation. Additionally, the Blood and Marrow Stem Cell Transplant Program is the only program in Suffolk County that is specifically designed for patients receiving stem cell transplantation, both autologous and allogeneic.

SBUH reports that team members involved in the transplant process meet weekly to discuss each patient's treatment plan, as well as the medical and psychosocial issues involved. They work closely together to ensure that each patient's needs are met and that the complex transplant procedure is carried out seamlessly. Oncology-certified nurses coordinate the Leukemia/Lymphoma Bone Marrow Transplant Services and serve as point persons to provide support for the patient and family during the entire process.

Michael W. Schuster, M.D., the former Director of Bone Marrow and Blood Stem Cell Transplantation at New York-Presbyterian Hospital, was recruited as the new Director of Bone Marrow and Stem Cell Transplantation and Director of Hematologic Malignancies at SBUH. Dr. Schuster has been principal investigator for more than 150 clinical trials and has worked extensively in the areas of stem cell transplantation, oncology new drug development, and the treatment of cancer cachexia. With the recruitment of Dr. Schuster and his team, Stony Brook has made a major commitment to the Bone Marrow and Stem Cell Transplantation program, which includes renovating the program's inpatient unit. The unit, when complete, will expand inpatient capacity and provide Suffolk County residents with access to life saving services without leaving Suffolk County.

Autologous Transplants						
Calendar Year Comparisons of Volume	*2006*	*2007*	*2008*	*2009*	*2010*	*2011 (PROJECTED)*
Autologous Transplants	18	16	19	9	33	27

Allogeneic And Other Transplants						
Calendar Year Comparisons of Volume	*2006*	*2007*	*2008*	*2009*	*2010*	*2011 (PROJECTED)*
Matched Unrelated Donor Transplants	0	0	0	0	8	8
Matched Related Donor Transplants	4	2	4	1	6	8
Cord Transplant	0	0	0	0	1	8

Combined Transplant Volume						
Calendar Year Comparisons of Volume	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*
Transplants	22	18	23	10	48	51

Source: SBUH

Blood Cancers

Blood cancer is a form of cancer which attacks the blood, bone marrow, or lymphatic system. There are three kinds of blood cancer: leukemia, lymphoma, and multiple myeloma.

Leukemia

Leukemia is a type of cancer that affects the blood and bone marrow, the spongy center of bones where our blood cells are formed. The disease develops when blood cells produced in the bone marrow grow out of control. About 43,050 people are expected to develop leukemia in 2010.

The four most common types of leukemia are:

- acute myeloid leukemia (AML)
- acute lymphoblastic leukemia (ALL)
- chronic myeloid leukemia (CML)
- chronic lymphocytic leukemia (CLL)

Each main type of leukemia is named according to the type of cell that's affected (a myeloid cell or a lymphoid cell) and whether the disease begins in mature or immature cells.

Other types of leukemia and related disorders include:

- hairy cell leukemia
- chronic myelomonocytic leukemia (CMML)
- juvenile myelomonocytic leukemia (JMML)

Lymphoma is the name for a group of blood cancers that develop in the lymphatic system. The two main types are Hodgkin lymphoma and non-Hodgkin lymphoma (NHL). In 2010, about 628,415 people are living with lymphoma or are in remission (no sign of the disease). This number includes about 153,535 people with Hodgkin lymphoma and 474,880 people with NHL. Hodgkin lymphoma has characteristics that distinguish it from other diseases classified as lymphoma, including the presence of Reed-Sternberg cells. These are large, cancerous cells found in Hodgkin lymphoma tissues, named for the scientists who first identified them. Hodgkin lymphoma is one of the most curable forms of cancer. NHL represents a diverse group of diseases distinguished by the characteristics of the cancer cells associated with each disease type. Most people with NHL have a B-cell type of NHL (about 85 percent). The others have a T-cell type or an NK-cell type of lymphoma. Some patients with fast-growing NHL can be cured. For patients with slow-growing NHL, treatment may keep the disease in check for many years.

Myeloma is a type of cancer that begins in the bone marrow. It affects the plasma cells. Myeloma has several forms:

- Multiple myeloma is most common: More than 90 percent of people with myeloma have this type. Multiple myeloma affects several different areas of the body.
- Plasmacytoma - only one site of myeloma cells evident in the body, such as in the bone, skin, muscle, or lung.
- Localized myeloma - a few neighboring sites evident.
- Extramedullary myeloma - involvement of tissue other than bone marrow, such as skin, muscles or lungs.
- Doctors divide myeloma into groups that describe how rapidly or slowly the disease is progressing:
- Asymptomatic or smoldering myeloma progresses slowly and has no symptoms even though the patient has the disease.
- Symptomatic myeloma has related symptoms such as anemia, kidney damage and bone disease.
- Myeloma belongs to a spectrum of disorders referred to as "plasma cell dyscrasia."

New Cases, Incidence and Deaths

New Cases

Approximately every 4 minutes one person in the United States is diagnosed with a blood cancer.

An estimated combined total of 137,260 people in the US will be diagnosed with leukemia, lymphoma or myeloma in 2010.

New cases of leukemia, lymphoma and myeloma will account for 9.0 percent of the 1,529,560 new cancer cases diagnosed in the US this year.

Incidence

Incidence rates are the number of new cases in a given year not counting the preexisting cases. The incidence rates are usually presented as a specific number per 100,000 population. Overall incidence rates per 100,000 population reported this year for leukemia, lymphoma and myeloma are close to or the same as data reported last year:

- Leukemia 12.3, 2010 vs. 122, 2009;
- Non-Hodgkin lymphoma [NHL] 19.6, 2010 vs. 19.5, 2009;
- Hodgkin lymphoma 2.8, 2010, same as 2009;
- Myeloma 5.6, 2010, same as 2009.

Deaths

Every 10 minutes, someone in the US dies from a blood cancer. This statistic represents nearly 148 people each day, or more than six people every hour.

Leukemia, lymphoma and myeloma will cause the deaths of an estimated 54,020 people in the US this year. These diseases will account for nearly 9.5 percent of the deaths from cancer in 2010, based on the total of 569,490 cancer deaths.

Local Incidence and Mortality

	Incidence – New York State					
	Males			Females		
Cancer	*Average Annual Cases*	*Rate per 100,000 Males*	*95% CI (+/-)*	*Average Annual Cases*	*Rate per 100,000 Females*	*95% CI (+/-)*
Hodgkin lymphoma	351.4	3.7	0.2	299.6	2.9	0.2
Non-Hodgkin lymphomas	2300.8	25.5	0.5	2033.2	17.5	0.3
Multiple myeloma	718	8.1	0.3	663.6	5.5	0.2
Leukemias	1530.8	17.4	0.4	1202.2	10.4	0.3

	Incidence – Suffolk County					
	Males			Females		
Cancer	*Average Annual Cases*	*Rate per 100,000 Males*	*95% CI (+/-)*	*Average Annual Cases*	*Rate per 100,000 Females*	*95% CI (+/-)*
Hodgkin lymphoma	25	3.4	0.6	26.6	3.6	0.6
Non-Hodgkin lymphomas	189	27	1.8	162	18.6	1.3
Multiple myeloma	56.4	8	1	50	5.6	0.7
Leukemias	133.4	19.3	1.5	100.4	11.8	1

Suffolk County has a higher incidence rate than New York State (rate per 100,000) for non-hodgkin lymphomas and leukemias for males and higher incidence rate than New York State (rate per 100,000) for hodgkin lymphoma, non-hodgkin lymphomas, multiple myeloma and leukemias for females.

Cancer	Mortality – New York State					
	Males			Females		
	Average Annual Deaths	*Rate per 100,000 Males*	*95% CI (+/-)*	*Average Annual Deaths*	*Rate per 100,000 Females*	*95% CI (+/-)*
Hodgkin lymphoma	49.4	0.5	0.1	39.8	0.4	0
Non-Hodgkin lymphomas	669.4	7.8	0.3	620.4	5	0.2
Multiple myeloma	332.4	3.9	0.2	309.2	2.5	0.1
Leukemias	775.8	9.2	0.3	617.4	5.1	0.2

Cancer	Mortality – Suffolk County					
	Males			Females		
	Average Annual Deaths	*Rate per 100,000 Males*	*95% CI (+/-)*	*Average Annual Deaths*	*Rate per 100,000 Females*	*95% CI (+/-)*
Hodgkin lymphoma	3	0.4	0.2	2.4	0.3	0.2
Non-Hodgkin lymphomas	55.6	8.5	1	44.8	4.9	0.7
Multiple myeloma	26.2	4	0.7	23.6	2.7	0.5
Leukemias	63.6	10	1.1	45	5	0.7

Suffolk County has a higher mortality rate than New York State (rate per 100,000) for non-hodgkin lymphomas, multiple myeloma and leukemias for males and a higher mortality rate than New York State (rate per 100,000) for multiple myeloma for females.

Service Area Population

	Suffolk County	*Nassau County*	*New York State*
Total population, 2010	1,493,350	1,339,532	19,378,102
Total population, 2000	1,419,369	1,334,544	18,976,457
Percent change, 2000-2010	5.2%	0.4%	6.0%
Persons 65+	13.5%	15.3%	13.5%

Source: U.S. Census

Bone Marrow Transplants Volume

The three largest providers of bone marrow transplants for residents of Suffolk County are: Memorial Sloan Kettering Cancer Center (MSKCO), North Shore University Hospital (NSUH), and University Hospital and Stony Brook.

BMT Utilization – MSKCC	*2009*	*2010*
Suffolk County	31	37
Nassau County	28	24
Others	283	357
Total	*342*	*418*

BMT Utilization – North Shore University Hospital	*2009*	*2010*
Bronx	0	1
Kings	1	2
Nassau	31	26

Queens	14	13
Suffolk	21	23
Westchester	1	0
Total	*68*	*65*

BMT Utilization – University Hospital at Stony Brook	*2009*	*2010*
Bronx	0	1
Nassau	1	8
Suffolk	8	36
Unknown	0	2
Total	*9*	*47*

Source: SPARCS

In 2010 with the recruitment of a new director of the Bone Marrow Transplant (BMT) program, Stony Brook has experienced a dramatic increase in bone marrow transplant volume without having a negative impact on the North Shore University Hospital BMT program.

Bone marrow transplants are a highly specialized procedure with an average length-of-stay of approximately 27 days. Access for patients and families is an important consideration.

It appears that improved access to a quality program has resulted in significant growth in the utilization of Stony Brook's BMT program.

University Hospital at Stony Brook's Projected Utilization					
2011		1st Year		3rd Year	
Discharges	*Patient Days*	*Discharges*	*Patient Days*	*Discharges*	*Patient Days*
51	1,520	56	1,661	64	1,884

Source: University Hospital at Stony Brook

The National Marrow Donor Program (NMDP) requires that the transplant center demonstrate that allogeneic recipients achieve acceptable survival rates.

University Hospital reports that they have reviewed the data for allogeneic transplants for the past two years.

NMDP has an expected one-year rate for allogeneic transplants of 53%. NMDP has documented University Hospital's one year survival rate at 67%. University Hospital reports that they have documented an 80% (100 day) survival rate.

Conclusion

University Hospital recruited a new director of the Bone Marrow Transplant Program, Dr. Michael W. Schuster. With the recruitment of Dr. Schuster and his team, Stony Brook has made a major commitment to the Bone Marrow and Stem Cell Transplantation program.

The utilization of the BMT program grew from 9 transplants in 2009 to 47 transplants in 2010. Of these 47 transplants, 36 were for residents of Suffolk County.

The enhanced bone marrow transplant program at Stony Brook has improved access to this highly specialized program for the residents of Suffolk County. Since the average length-of-stay for these transplants is 27 days, access to patients and families is an important consideration, where possible.

The Stony Brook BMT program is certified by the National Marrow Donor Program (NMDP).

NMDP has had an expected one-year survival rate for allogeneic transplants of 53%. NMDP has documented University Hospital's one-year survival rate at 67%.

Based on the recent growth of the BMT program, Stony Brook projects the number of transplants to grow from 51 transplants to 64 transplants by the third year. This is an increase of 25.5%.

The demonstrated success of the BMT program supports the need to expand the existing unit from four beds to ten beds.

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Background
University Hospital at Stony Brook is requesting to add four bone marrow transplant (BMT) beds, for a total of ten BMT beds, and to do requisite renovations. The expanded bone marrow transplant program will result in 14 additional health care FTEs by the third year.

Compliance with Applicable Codes, Rules and Regulations
The medical staff will continue to ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

The facility was fined:

$10,000 in 2002 for deficiencies in the facility's pharmacy control
$54,000 in 2002 based on pharmaceutical overdose due to dropped decimal point
$77,000 in 2006 related to the pediatric cardiology program
$20,000 in 2009 related to ineffective ER diagnosis and treatment resulting in death

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

Recommendation
From a programmatic perspective, approval is recommended.

Financial Analysis

Total Project Cost and Financing
Total project costs for renovation and acquisition of moveable equipment is estimated at $844,955, itemized as follows:

Renovation & Demolition	$294,498
Design Contingency	27,953
Construction Contingency	27,953
Architect/Engineering Fees	25,156
Other Fees	50,953
Movable Equipment	411,831

CON Application Fee	2,000
CON Processing Fee	4,611
Total Project Cost	$844,955

Project costs are based on a January 1, 2012 start date with a five month construction period.

The applicant's financing plan appears as follows:

Cash Equity (Applicant)	$844,955

Operating Budget
The applicant has submitted the operating budget, in 2011 dollars as summarized below:

	Current Year	Third Year Incremental	Cumulative
Revenues:			
Inpatient	$8,188,041	$2,050,363	$10,238,404
Expenses:			
Operating	$4,882,233	$1,275,958	$6,158,191
Capital	0	87,764	87,764
Total Expenses	$4,882,233	$1,363,722	$6,245,955
Excess Revenue over Expenses	$3,305,808	$686,641	$3,992,449.
Utilization:			
Discharges-	51	13	64
Patient Days	1,520	364	1,884
Inpatient Occupancy *	104.11%		51.62%
Average Length of Stay	29.80 days		29.44 days
Cost per Discharge	$95,730.06	$104,901.69	$97,593.05

**The applicant state's BMT unit is operating at capacity and when they generate their "revenue/volume report" it can only be done by case. Thus a BMT patient who may have spent a little time in a Medical/Surgical bed will cause the occupancy percentage to be slightly over capacity.*

Inpatient utilization by payor source for the third year:

Payor	Outpatient
Medicaid Fee -for-Service	1.79%
Medicaid Managed Care	24.51%
Medicare Fee-for-Service	17.63%
Medicare Managed Care	3.95%
Commercial Fee-for-Service	34.60%
Commercial Managed Care	17.52%

The budget is based on the hospital's current experience in operating its BMT unit, adjusted for additional volume, and the applicant expects the majority of the cases will come under to the following Diagnosis Related Groups (DRG): DRG 803 - Allogeneic Bone Marrow Transplant; DRG 804 - Autologous Bone Marrow Transplant; and DRG 9 - Bone Marrow Transplant.

Capability and Feasibility
Stony Brook University Hospital will satisfy the project costs of $844,955 from accumulated funds. Presented as BFA Attachment A is Stony Brook University Hospital 2009 & 2010 certified financial summary, which indicates the availability of sufficient resources for this purpose.

Working capital requirements are estimated at $227,287, which appears reasonable based on two months of third year expenses. Review of Attachment A shows the facility has adequate resources to provide the working capital.

Stony Brook University Hospital projects first and third year incremental revenues over expenses to be $95,429 and $686,641, respectively. As shown above, by the third year the BMT unit is expected to generate a surplus in the neighborhood $3,992,449. Revenues are based on current and projected federal and state governmental reimbursement methodologies while commercial payers are based on experience. The budget appears to be reasonable.

Review of BFA Attachment A shows working capital increased by $12,468,000 between 2009 and 2010, going from $183,360,000 in 2009, to $195,828,000 by the end of 2010.
At the end of 2010, net assets were at $347,882,000, an increase of $31,209,000 from the 2009's balance of $316,673,000. And for the years of 2009 and 2010, excess revenues over expenses averaged $32,968,000.

Recommendation
From a financial perspective, approval is recommended.

Architectural Analysis

Review Summary
The project will involve the relocation of 6 medical surgical beds from the 16 bed Level 19 South unit which currently houses BMT and LLT services consisting of 4 BMT bed and 12 medical surgical beds. The 6 medical surgical beds will be relocated with 5 beds being placed on 9 North and 1 bed being moved to level 17 North.

The project will involve renovations to accommodate the new BMT beds and the relocated medical surgical beds.

At project completion the expanded BMT program will be a fully compliant protective environment consistent with current NYS DOH, FGI Guideline design standards.

Environmental Review:
The Department has deemed this project to be a TYPE II Action and will not have a significant effect on the environment. An Environmental Impact Statement is not required. However, any agency that has an interest in this project may make their own independent determination of significance and necessity for an EIS in accordance with the procedures specified within Part 97.8 of Title 10: Rules and Regulations.

Recommendation
From an architectural perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary for 2009 and 2010, Stony Brook University Hospital, Stony Brook University

Public Health and Health Planning Council

Project # 112250-C

Smile New York Outreach, LLC
d/b/a Smile Program Mobile Dentists

County: **Queens (Long Island City)**
Purpose: **Construction**
Program: **Diagnostic and Treatment Center**
Submitted: **October 26, 2011**

Executive Summary

Description

Smile New York Outreach, LLC d/b/a Smile Program Mobile Dentists (Smile New York), an existing limited liability company, requests approval to expand its Article 28 mobile D&TC service area to include Westchester County schools. The services offered will be dental exams, cleaning, and sealant for students who have not received this from their own dentist.

On September 24, 2010, via CON #101116-B, Smile New York received Public Health Council contingent approval for a five-year limited life to provide dental services to children in 10 New York City elementary and middle schools. Subsequently, the New York City Board of Education determined a Request for Proposal (RFP) was necessary before Smile of New York Outreach, LLC could go forward with its school-based dental program.

As it is estimated the RFP process could take over a year to complete, the applicant in the meantime seeks permission to expand its service area to Westchester County, to enable it to serve children attending the following 10 elementary and middle schools which are located in the City of Mount Vernon:

School	Address
Hamilton Elementary	20 Oak St., Mount Vernon
Grimes Elementary	58 South 10th Ave., Mount Vernon
Columbus Elementary	455 N. High St. ,Mount Vernon
Cecil H. Parker Elementary	461 South 6th Ave., Mount Vernon
Lincoln Elementary	170 E. Lincoln Ave., Mount Vernon
Edward Williams Element.	9 Union Lane, Mount Vernon
Martin Traphagen Element.	72 Lexington Ave., Mount Vernon
Longfellow Elementary	625 S. Fourth Ave., Mount Vernon
Pennington Elementary	20 Fairway, Mount Vernon
A.B. Davis Middle School	350 Gramatan Ave., Mount Vernon

When the mobile dental van is not providing dental services at the schools it will be parked at 31-00 47th Avenue, Long Island City (Queens), which is the operator's main office for administrative services.

The sole member of Smile New York Outreach, LLC is Matthew C. Harrison, Jr. As under CON #101116-B, the dental services will be provided through a clinical services agreement with Big Smiles Dental New York, PLLC, an existing professional limited liability company solely-owned by Elliot P. Schlang, D.D.S.

DOH Recommendation

Contingent approval for a 5-year limited life.

Need Summary

The 10 proposed Mount Vernon schools have high levels of poverty, with many students covered by Child Health Plus, Medicaid Managed Care, or fee-for-service Medicaid.

Program Summary

Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

Financial Summary

There is no project cost associated with this application.

Budget:		
	Revenues:	*$ 7,328,122*
	Expenses:	*5,173,024*
	Gain/(Loss):	*$ 2,155,098*

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

As with contingently-approved CON #101116-B, there are no architectural or engineering issues.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval for limited life of five years from the date of the issuance of an operating certificate is recommended contingent upon:

1. The applicant will provide a timeline showing the number of schools served, the number of students enrolled in those schools and the number of students they actually plan to serve (out of the enrollment total), during the first 3 years of operation, to reach the goal of 41,450 visits. [RNR]
2. The applicant will agree to submit annual reports beginning in the second year of operation, listing the schools served, the number of students served, and the number and type of additional services provided in the van. [RNR]
3. The applicant will provide annual documentation beginning in year 2 to the Department that it continues to actively provide school dental programs in New York State. This contingency has been imposed because Smile NY does not have a site where dental services are provided other than the mobile dental clinic. [RNR]

Council Action Date
February 2, 2012.

Need Analysis

Background

Smile New York Outreach, LLC d/b/a Smile Program Mobile Dentists (Smile New York) proposes to serve students attending elementary and middle schools located in the City of Mount Vernon in Westchester County. These schools have high levels of poverty. Demographic data are presented in this application, which reflect the student population of these 10 schools.

These 10 schools and their addresses are as follows:

School	Address
Hamilton Elementary	20 Oak Street, Mount Vernon, NY 10553
Grimes Elementary School	58 South 10th Avenue, Mount Vernon, NY 10550
Columbus Elementary	455 N. High Street, Mount Vernon, NY 10550
Cecil H. Parker Elementary School	461 South 6th Avenue, Mount Vernon, NY 10550
Lincoln Elementary School	170 E Lincoln Avenue, Mount Vernon, NY 10550
Edward Williams Elementary	9 Union Lane, Mount Vernon, NY 10552
Martin Traphagen Elementary	72 Lexington Avenue, Mount Vernon, NY 10550
Longfellow Elementary	625 S. Fourth Avenue, Mount Vernon, NY 10550
Pennington Elementary	20 Fairway, Mount Vernon, NY 10552
A.B. Davis Middle School	350 Gramatan Avenue, Mount Vernon, NY 10550

Analysis

The following two tables present enrollment data on the 10 elementary and middle schools. As shown in Table 1, there are 4,824 children enrolled in the 10 schools. In Table 2, demographic data are presented on the percentage of children eligible for free or reduced price lunches as well as data on the race/ethnicity of students enrolled in the 10 schools.

Table 1:
Smile New York Outreach, LLC Initial Participating Schools

School	Enrollment
Hamilton Elementary	386
Grimes Elementary	497
Columbus Elementary	550
Cecil H. Parker Elementary	357
Lincoln Elementary	758
Edward Williams Elementary	452
Traphagan Elementary	315
Longfellow Elementary	365
Pennington Elementary	319
A.B. Davis Middle School	825
TOTAL	*4,824*

The data in Table 2 portray a student population coming from mostly low-income families. The percentage of children eligible for the free lunch program ranges from a high of 81 percent (Hamilton Elementary) to a low of 24 percent (Pennington Elementary). This indicates that a high percentage of these students are likely to be enrolled in Medicaid, with some additional students enrolled in Child Health Plus. There is considerable racial/ethnic diversity among the schools, with seven having a majority of Black/African American students and three others having a combined majority of Black/African American and Hispanic/Latino students.

Table 2:
Smile New York Outreach, LLC Initial Participating Schools Demographic Data (Percent)

School	Free Lunch	Reduced Lunch	Black/African American	Hispanic/Latino	White	Asian	Other
Hamilton	81	9	57	36	3	1	3
Grimes	71	15	92	6	0	0	2
Columbus	69	17	46	44	7	1	2
Cecil H. Parker	79	10	94	3	0	3	0
Lincoln	46	14	49	24	21	1	5
Edward Williams	73	5	82	15	2	0	2
Traphagan	49	17	86	7	3	3	1
Longfellow	63	17	94	5	1	0	0
Pennington	24	3	44	13	40	4	0
A.B. Davis Middle School	57	12	74	17	7	1	0

The NYS Oral Health Plan states that there are clear socioeconomic disparities in the distribution of oral health problems. "Children from low-income families have a higher prevalence of dental caries, higher frequency of untreated disease and a lower utilization of preventative services." The reasons for these disparities include lack of awareness of the importance of oral health, unfamiliarity with the dental health care delivery system, lack of providers willing to participate in the public financial program and lack of resources to pay for care. The report goes on to state that although oral diseases are easily preventable and treatable, access to dental care providers is extremely limited for many children in rural and inner city areas.

The report goes on to identify the following objectives:

- Objective 3.8: By 2008, explore options that will encourage Article 28 facilities to establish comprehensive school-based oral health programs in areas of high need.
- Objective 3.9: By 2010, increase the number of Article 28 facilities providing dental services across the state and approve new ones in areas of highest need.

Strategies identified in the Plan to meet those Objectives include the following:

- Promote services that allow patients greater access to oral health care, including:
  - mobile and portable dental programs
  - school-based prevention and treatment
  - case management and care coordination

While most low-income children are enrolled in Medicaid or Child Health Plus, this does not assure that they will access oral health services. The 2005 Oral Health Plan reported that for New York State children continuously enrolled for a year in 2003, 45% in Medicaid and 40% in Child Health Plus visited a dentist.

According to Federal Medicaid Panel Expenditure Panel Survey data, the majority of U.S. children do not access dental care in a year. In 2004, 55% of U.S. residents under age 21 had no dental visit. Disparities in dental utilization by income are evident, as 69% of poor children, 66% of low-income children, 53% of middle-income children and 48% of higher income children did not receive care. Two-thirds of Black and Hispanic children did not have a dental visit in 2004 compared to less than half of white children (47%).

Conclusion

Smile New York, LLC will provide on-site basic dental services at 10 schools in Mount Vernon, Westchester County. These schools have high levels of poverty. Many of the students are covered by Child Health Plus, Medicaid Managed Care, or fee-for-service Medicaid. The services offered will be dental exams, cleaning, and sealant for students who have not received this from their own dentist. These services will be provided in a temporary setting in the school building using portable equipment that will be transported to the school in two cargo vans.

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Compliance with Applicable Codes, Rules and Regulations

The medical staff will continue to ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

Conclusion

Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Software License and Services Agreement

In satisfying a contingency under CON 101116 the applicant has submitted an executed software license services agreement with ReachOut Healthcare America, Ltd., which is summarized as follows:

Date:	November 1, 2010
Provider:	ReachOut Healthcare America, Ltd. (RHA)
Facility:	Smile New York Outreach, LLC
Term:	Agreement shall continue in effect unless terminated by either party for cause.
Services Provided:	Provide an exclusive software license restricted to the territory of the City of New York and Westchester County; full time access of RHA's computer system for receiving and transmitting dental records and instant retrieval storage system for each dental visit to a school; clerical data entry and statistical reporting. Pursuant to clinic's direction; purchase supplies and equipment and provision of fully equipped dental vans for lease. Financial services includes; accounting, bookkeeping, monitoring and payment of accounts. Assist in preparation of physical audits of equipment and supplies.
Compensation:	$400 per day per school visited (paid monthly)

Lease Rental Agreement

In satisfying a contingency under CON 101116 the applicant submitted an executed lease for the proposed administrative office and parking for the mobile dental vans. The terms are summarized below:

Date:	March 17, 2011
Premises:	5,500 gross square feet for office and parking of the mobile dental vans, located at 31-00 47th Avenue, Long Island City, New York (Queens County)
Landlord:	CF 31-00 Faichi, LLC and Ianvil Holdings, LLC
Lessee:	Smile New York Outreach, LLC
Rental:	$66,000 per year ($12 per sq. ft.) with 3% annual increase
Term:	3 Years starting May 1, 2011
Provisions:	Lessee pays utilities, maintenance and increase in taxes over base

The applicant has indicated the lease will be an arm's length arrangement.

Operating Budget

The applicant has submitted an operating budget, in 2012 dollars for the first and third years of operation, as summarized below:

	First Year	Third Year
Total Revenues	$3,226,570	$7,328,122
Expenses:		
Operating	$2,280,113	$4,891,414
Capital	231,274	281,610
Total Expenses	$2,511,387	$5,173,024
Excess of Revenues over Expenses	$715,183	$2,155,098
Utilization: (visits)	18,144	41,580
Cost Per Visit	$138.41	$124.41

Utilization by payor source for the first and third years is as follows:

Medicaid Fee-For-Service	55.0%
Medicaid Manage Care	20.0%
Commercial Manage Care	15.0%
Charity	10.0%

Expense and utilization assumptions are based on the ReachOut Healthcare America's historical experience in coordinating similar size mobile dental services. First year breakeven point is expected to be approximately 11,800 visits or 65% of projected utilization and by the third year it is estimated the breakeven point will be at 40% or 16,700 visits.

It should be noted the projected revenues and operating surpluses have increased over the original estimates under CON 101116. First year revenues increased by $910,556 going from $2,316,014 to $3,226,570, boosting operating results from an original loss of $156,647 to a operating surplus of $715,183. Third year revenues climbed $2,155,944, going from $5,172,178 to $7,328,122 thus causing the projected operating surplus to rise, almost dollar for dollar, going from the original estimate of $20,887 to $2,155,098. The applicant has provided the following explanations for these increases:

- Changes within the Ambulatory Patient Group (APG) rates which includes: base payments, weights, and how the reimbursements for providing multiple procedures will be reimbursed during a visit;

- The original CON application assumed the program would initiate operations in 2010 - the point in time when APG's were at a 50% phase in stage. The current application assumes 2012 will be the start of the program – the point in time when the APG's are completely phased-in.
- The mix of services has been modified following additional discussions among the dental professional team members. In the original CON application, it was anticipated an initial visit would include: a comprehensive exam, teeth cleaning, and an x-ray. The current CON application adds fluoride and two sealants to the comprehensive exam, teeth cleaning, and an x-ray.

Capability and Feasibility

There are no project costs associated with this application. The working capital of $858,548 and its funding remain the same as under CON 101116. As described under CON 101116, Matthew C. Harrison Jr. will contribute half or $429,274 from his personal assets, with the balance being provided from ReachOut Healthcare America, LTD through a 5-year loan at 8% interest.

Presented as Attachment A is a pro forma balance sheet showing operations will start off with $600,540, which is the same as shown under CON 101116. Presented as Attachment B is Matthew C. Harrison Jr.'s net worth statement, which is consistent with the one presented under CON 101116.

The budget shows a $715,183 operating surplus in the first year. By the third year operations are expected to generate a $2,155,088 surplus. Medicaid revenues are based on 2012 APG rates, Child Health Plus/Medicaid Manage Care are based on estimates of local managed care rates, and commercial payers are based on estimates of local commercial rates. The budget appears reasonable.

On December 28, 2010, ReachOut Healthcare Holdings Inc. (RHHI) a holding company that owns all of the outstanding stock of ReachOut Healthcare America Ltd. (RHA) was acquired by ROHH Holdings Inc. though a merger transaction, with the surviving entity remaining ReachOut Healthcare Holdings, Inc (RHHI). It was stated that ROHH had no prior operations and used cash and issuance of debt to retire substantially all of RHHI outstanding shares of common and preferred stock, leaving approximately 4% of the common shares outstanding, which continues to be owned by key employees. Presented as BFA Attachment C is ReachOut Healthcare Holdings, Inc. and Subsidiary and Consolidated Affiliates (RHHI) 2010 certified financial summary that shows a $364,406 operating loss. The loss results from a one time financial advisory fee of $3,039,000 that was associated with the December 28, 2011 merger transaction. Presented as BFA Attachment D is ReachOut Healthcare Holdings, Inc. and Subsidiary and Consolidated Affiliates (RHHI) internal financial summary of October 31, 2011 indicating operations are profitable.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Net Worth Statements for Proposed Member of Smile New York Outreach, LLC
BFA Attachment B	Pro-forma Balance Sheet for Smile New York Outreach, LLC
BFA Attachment C	Financial Summary for 2010, Reachout Healthcare Holdings, Inc, and Subsidiary and Consolidated Affiliates.
BFA Attachment D	Internal Financial Summary as of October 31, 2011, Reachout Healthcare Holdings, Inc, and Subsidiary and Consolidated Affiliates.
BFA Attachment E	Organization Chart for Smile New York Outreach, LLC
BFA Attachment F	Establishment Checklist

Public Health and Health Planning Council

Project # 112116-C
Dominican Sisters Family Health Service, Inc.

County: **Westchester (Ossining)**
Purpose: **Construction**
Program: **Long-Term Home Health Care**
Submitted: **August 24, 2011**

Executive Summary

Description
Dominican Sisters Family Health Service, Inc. (Dominican Sisters) is an existing not-for-profit corporation located at 299 North Highland Avenue, Ossining, which operates a long term home health care program (LTHHCP) and certified home health agency (CHHA) in Bronx, Suffolk and Westchester Counties. The applicant is seeking approval to expand its LTHHCP to provide pediatric services to residents in Bronx, Kings, New York and Queens Counties. The pediatric service will result in 50 slots for Bronx County, 50 slots for Kings County, 75 slots for New York County and 50 slots for Queens County, for a total program expansion of 225 slots, bringing Dominican Sisters' program capacity to 565 slots.

The expansion of Dominican Sisters' LTHHCP will coincide with the closure of Elizabeth Seton Pediatric Center's LTHHCP, which serves Bronx, Kings, Queens and New York Counties. Dominican Sisters received approval on August 12, 2011 from the Department of Health, Bureau of Quality Assurance and Licensure for a management agreement that will allow Dominican Sisters to manage Elizabeth Seton Pediatric Center's LTHHCP during their closure phase, and will allow transition of the existing patients with ease.

DOH Recommendation
Contingent approval

Need Summary
Dominican Sisters plans to maintain all existing LTHHCP services including AIDS home care program, audiology, home health aide, homemaker, housekeeper, medical social services, medical supplies equipment and appliances, nursing, nutritional, personal care, occupational therapy, physical therapy, respiratory therapy and speech language pathology therapy.

Program Summary
The Department of Health approved a management agreement between Dominican Sisters Family Health Care Service, Inc. and New York Foundling Hospital for Pediatric, Medical and Rehabilitative Care, Inc. d/b/a Elizabeth Seton Pediatric Center that allows Dominican Sisters Family Health Care Service, Inc. to manage Elizabeth Seton Pediatric Center's LTHHCP during the closure process

Dominican Sisters Family Health Service, Inc. LTHHCP is currently in compliance with all applicable codes, rules and regulations.

Financial Summary
There are no project costs associated with this application.

Budget:	*Revenues:*	*$ 6,944,435*
	Expenses:	*5,818,054*
	Gain/(Loss):	*$ 1,126,381*

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary
This project involves a long term home health care program; therefore, no Architectural review is required.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. The closure of New York Foundling Hospital for Pediatric, Medical and Rehabilitative Care, Inc. d/b/a Elizabeth Seton Pediatric Center's Long Term Home Health Care Program. [CHA]

Approval conditional upon:

2. The additional capacity being limited to solely the pediatric population. [CHA]

Council Action Date
February 2, 2012.

Programmatic Analysis

Background
The following chart illustrates the allocation of Dominican Sisters Family Health Service, Inc. LTHHCP capacity:

County	Currently Approved Capacity	Additional Capacity Requested	Revised Capacity
Bronx	50	50	100
Kings	0	50	50
Queens	0	50	50
New York	0	75	75
Suffolk	100	0	100
Westchester	240*	0	240
Total	*390*	*225*	*615*

** Fifty (50) slots were conditionally approved under CON # 112154 administratively with the condition that additional capacity be limited to the pediatric population.*

The New York State Department of Health approved a management agreement between Dominican Sisters Family Health Care Service, Inc. and New York Foundling Hospital for Pediatric, Medical and Rehabilitative Care, Inc. d/b/a Elizabeth Seton Pediatric Center that allows Dominican Sisters Family Health Care Service, Inc. to manage Elizabeth Seton Pediatric Center's LTHHCP during the closure process. By providing pediatric LTHHCP services, Dominican Sisters will ensure the continuity of LTHHCP services to an existing pediatric population in need of care and will avoid the need for many of these pediatric patients to be placed in an institutional setting.

Dominican Sisters Family Health Service, Inc. LTHHCP is currently in compliance with all applicable codes, rules and regulations.

Recommendation
From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Operating Budgets
The applicant has submitted an operating budget for the first and third years, in 2012 dollars, which is summarized below:

	Year One	Year Three
Revenue	$4,995,976	$6,944,435
Expenses	4,324,554	5,818,054
Net Income	$671,422	$1,126,381

Incremental expenses and utilization are further broken down as follows:

Year One

	Total Cost	Visits/Hours	Cost/Visit/Hour
Nursing	$698,543	6,100	$114.52
Physical Therapy	573,817	5,900	$97.26
Speech Pathology	207,414	2,400	$86.42
Occupational Therapy	477,720	4,600	$103.85
Home Health Aide*	1,742,529	92,820	$18.77
Homemaker*	5,374	277	$19.40

Housekeeper*	1,775	80	$22.18
Personal Care*	388,997	21,320	$18.25
Medical Social Service	184,609	1,600	$115.38
Nutrition	19,024	200	$95.12
Respiratory Therapy	19,476	200	$97.38
Audiology	5,276	50	$105.51
Total	$4,324,554		

Year Three

	Total Cost	Visits/Hours	Cost/Visit/Hour
Nursing	$944,930	8,479	$111.44
Physical Therapy	767,415	8,201	$93.58
Speech Pathology	292,914	3,336	$87.80
Occupational Therapy	644,428	6,394	$100.79
Home Health Aide*	2,344,216	129,000	$18.17
Homemaker*	7,296	385	$18.95
Housekeeper*	2,388	111	$21.32
Personal Care*	522,791	29,635	$17.64
Medical Social Service	237,585	2,224	$106.83
Nutrition	20,698	278	$74.45
Respiratory Therapy	26,198	278	$94.24
Audiology	7,195	70	$102.78
Total	$5,818,054		

** Reported in Hours*
Utilization for years one and three is 100% Medicaid.
Expense and utilization assumptions are based on the historical experience of Dominican Sisters Family Health Services, Inc. and Elizabeth Seton Pediatric Center.

Capability and Feasibility

There are no project costs associated with this application.

The submitted budget indicates excess revenues of $671,422 and $1,126,381 during the first and third years of operation. Based on 2011 ceiling payments for Dominican Sisters and budgeted Medicaid utilization, the projected revenues will decrease by $95,068 and $112,109 in year one and three, respectively, resulting in a revised net income of $576,354 and $1,014,272. Revenue is based on current payment rates for LTHHCP services. The budget appears reasonable.

Presented as BFA Attachment A, financial summary of Dominican Sisters Family Services, Inc, indicates that the facility has maintained positive working capital, positive net assets, generated a negative net income of $62,205 for 2009, and experienced positive net income of $417,840 for 2010. The 2009 loss was due to losses on investments. Presented as BFA Attachment B, internal financial summary of Dominican Sisters Family Services as of October 31, 2011, the facility has maintained positive net assets and experienced negative working capital and a loss from operations of $485,191. The applicant has stated that the operating losses were due to the 2011-2012 New York State budget, which reduced Medicaid payments for patients that exceed utilization thresholds. The operating losses are to the CHHA and not the LTHHCP, which is seeking the expansion. The CHHA has changed its admission and retention procedures in order to reduce the loss. The negative working capital is due to an increase in current liabilities, which is due to a corresponding increase in days in accounts receivable. Many third-party payers have slowed down their claims payment process, which resulted in a temporary cash flow problem, which in turn has required Dominican Sisters to increase its days in accounts payable. As cash flow improves, Dominican Sisters will pay down its accounts payable.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary, Dominican Sisters Family Services, Inc.
BFA Attachment B	Internal Financial Summary as of October 31, 2011, Dominican Sisters Family Services, Inc.

Public Health and Health Planning Council

Project # 112206-T

St. Mary's Healthcare

County: **Montgomery (Amsterdam)**
Purpose: **Demonstration – Construction**
Program: **Transitional Care Unit**
Submitted: **October 5, 2011**

Executive Summary

Description

St. Mary's Healthcare (St. Mary's), a not-for-profit hospital located in Amsterdam, requests approval to create an 11-bed Transitional Care Unit (TCU). St. Mary's consists of two campuses. The main campus, St. Mary's Hospital campus, consists of 120 acute care beds. The former Amsterdam Memorial Hospital (Memorial Campus, two miles away) consists of 10 beds certified for physical medicine and rehabilitation. On September 1, 2010, the Department of Health requested applications in accordance with the provisions of Section 2802-a, of the Public Health Law for a TCU Demonstration Program.

The former Amsterdam Memorial Hospital had a "swing-bed" program (closed due to hospital unification), which provided a unique continuum of rehabilitation medicine to area residents. The TCU will be located in an existing nursing unit on the third floor adjacent to the Acute Rehabilitation Unit.

The patients to be served in the TCU would include the most costly, complex convalescing elders who, while clinically stable, would otherwise remain in a medical/ surgical bed; those patients for whom a regimen of coordinated multi-level rehabilitation Medicine would be quality enhancing, and the frail elders who still require extensive follow-up and would benefit from the continuity of care by the same team of therapists and physicians.

Total project costs are estimated at $317,105.

DOH Recommendation

Contingent approval

Need Summary

Section 2802-a of the Public Health Law was amended by Chapter 58 of 2010, authorizing the Commissioner to approve an additional 13 general hospitals to operate TCUs on a demonstration basis.

Program Summary

The proposed 11-bed TCU would serve several roles – replace the highly utilized swing bed program and re-establish the continuum of care afforded by coordination/integration with the Acute Rehabilitation Unit; further the hospital's efforts to reduce the length of stay at the main campus; facilitate the hospital's efforts at reducing the number of unnecessary re-admissions, which has been on the increase with the closure of the swing bed program, and enhance the hospital's capacity to serve the under 65 population.

Financial Summary

Project costs will be met with accumulated funds from the Hospital.

Incremental Budget:	*Revenues:*	*$ 1,974,240*
	Expenses:	*1,306,884*
	Gain/(Loss):	*$ 667,356*

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

St Mary's Healthcare is requesting approval to renovate an existing hospital medical/surgical unit to form an 11-bed Transitional Care Unit (TCU) at the Memorial Campus, located 2 miles from St Mary's main campus. The Memorial Campus serves an elder population in need of post-acute and long term care services.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]

Approval conditional upon:

1. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
2. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01 prior to the applicant's start of construction. [AER]
3. The applicant shall complete construction before July 1, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date
February 2, 2012.

Need Analysis

Background
Section 2802-a of the Public Health Law was amended by Chapter 58 of 2010 authorizing the Commissioner to approve an additional 13 general hospitals to operate transitional care units (TCUs) on a demonstration basis. The original TCU enabling legislation of 2005 authorized five demonstration projects.

Transitional Care Unit Purpose
Section 2802-a of PHL defines "transitional care" as sub-acute care services provided to inpatients of a general hospital who no longer require acute care inpatient services, but continue to need specialized medical, nursing and other hospital ancillary services and are not yet ready for discharge. TCUs should be limited in length of stay and designed to meet and resolve patients' specific sub-acute medical care needs. Discharges from these units are to be timely and appropriate.

The improvement of quality outcomes for the TCU population through the provision of appropriate services, delivered in the most efficient manner, is the primary goal of the TCU demonstration program. Hospitals selected for this program are required to demonstrate an overall decrease in length of stay, quantify the clinical benefits of the program for TCU patients, and illustrate a synergistic relationship with long term care providers in the community. Collaboration between hospitals and nursing homes in local service areas will help bring about more efficient allocation of patients between the two settings.

In accordance with Section 2802-a of PHL, all providers in this demonstration program must meet all Conditions of Participation (CoP) for skilled nursing facilities (SNFs) as defined under Title XVIII of the Federal Social Security Act (Medicare). In order to qualify for Medicare certification, providers must comply with Part 415 of Title 10 of the New York Compilation of Codes, Rules and Regulations (10 NYCRR). In this demonstration, providers not currently licensed to operate nursing home beds will not be required to obtain Public Health and Health Planning Council establishment approval. Additionally, TCU units are not recognized as RHCF beds as defined in 10 NYCRR Section 709.3.

As part of this demonstration program, specific State SNF regulations that may impede the development of TCUs or their ability to provide appropriate services to patients may be subject to waiver, at the discretion of the Department. Such issues will be reviewed on an individual basis.

Applicants must demonstrate the need for any services proposed within the TCU and emphasize the benefits of such a program to a specific community, including, but not limited to, addressing the absence of sufficient post-discharge services in nursing homes and community-based care.

Transitional care units should be limited in length of stay and designed to meet and resolve specific sub-acute medical care needs. The average length of stay for patients served in a TCU ranges from 5 to 21 days, following a qualifying acute care stay. TCU services will be reimbursed at the applicable Medicare per diem SNF rate.

Transitional Care Unit Criteria and Requirements
Section 2802-a requires all providers applying to participate in this demonstration program to meet all applicable requirements as defined under Title XVIII of the Federal Social Security Act (Medicare). Additionally, Transitional Care Units must:

- Have a length of stay of not less than 5 days and not in excess of 21 days;
- Have a pre-opening survey, separate Medicare Number, and SNF certification;
- Be staffed by qualified staff dedicated to the TCU;
- Serve patients who will benefit from active rehabilitation. (It is expected that patients will actively participate in three hours or more of Occupational Therapy/Physical Therapy/Speech Therapy, every day, either three hours consecutively or in combination between rehabilitative sessions); and

- Collect information and submit reports to the Department on an annual basis to demonstrate an overall decrease in length of stay; quantify the clinical benefits of the program for TCU residents and illustrate a synergistic relationship with long term care providers.

Applications must address the configuration of the Transitional Care Unit. However, the applicant must adhere to the following requirements:

- Beds must be located at one geographic location; and
- Beds must be located contiguously within a distinct unit/space within the hospital.

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Background
The principal elements of the proposed TCU program are:

- An 11-bed unit that will serve several roles, including: 1) replacing the now closed swing bed program; 2) reduce the length of stay at the Main Campus; 3) help reduce unnecessary hospital readmissions; and 4) enhance St. Mary's ability to serve the under 65 population.

- The patients served will include: 1) most costly, complex convalescing elders that are clinically stable and would otherwise remain in an M/S bed; 2) those in need of coordinated multi-level rehabilitation; and 3) frail elders still requiring extensive follow-up.

- The TCU will be located in an existing, out of service medical/surgical bed wing on the 3rd floor of the hospital, adjacent to the existing Acute Rehabilitation Unit. Renovation work is expected to be minor.

- Operation by a facility with dedicated staff with access to specialist acute care professionals.

- All patient rooms will be single bed spaces and will include an existing private toilet room. Two patient rooms will be renovated to include ADA size toilet rooms. There is an on-unit dining space, physical therapy room and activity space.

The TCU will focus on patients that if not discharged to the TCU would otherwise continue to be served in a Med/Surg bed. These patients will remain in the TCU for a short stay of no more than 20 days.

The TCU will focus on medically complex elderly patients who while clinically stable still require on-going physician oversight and the specialized services of hospital staff. Other patients expected to be routinely admitted include those who may need an additional few days of rehabilitation prior to discharge to home as well as those needing more extensive rehabilitation therapy prior to discharge to an Acute Rehabilitation Facility. In addition, the TCU is expected to fill the void created by the loss of the swing bed program.

The TCU will be under the direct responsibility of the Hospital CEO and will include a senior team consisting of a Licensed Nursing Home Administrator who will be employed part-time as the TCU Administrator, Nurse Manager with hospital experience, and a part-time Physician Medical Director. The team will also include an MDS Coordinator, Registered Nurses; Certified Nurse Aides, a Social Worker, and Activities and Therapy staff. An interdisciplinary care team will be responsible for the coordination and continuity of patient care.

The applicant will submit an annual progress report on TCU operations to the Department of Health.

Recommendation
From a programmatic perspective, approval is recommended.

Financial Analysis

Total Project Costs

Total project costs for renovations and the acquisition of movable equipment is estimated at $317,105, broken down as follows:

Renovation & Demolition	$118,000
Design Contingency	11,000
Construction Contingency	11,000
Arch/Engineering fees	8,000
Movable Equipment	165,381
Application Fee	2,000
Additional Processing Fee	1,724
Total Project Cost	$317,105

Project costs are based on an April 1, 2012 start date and a three month construction period. St. Mary's Healthcare will finance total project costs through accumulated funds.

Operating Budget

The applicant has submitted an incremental operating budget in 2011 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues:	$ 987,120	$1,974,240
Expenses:		
Operating:	992,161	1,275,792
Depreciation & Rent:	31,092	31,092
Total expenses:	$1,023,253	$1,306,884
Net Income:	($ 36,133)	$667,356
Utilization (patient days)	1,825	3,650

Utilization by payor source for the first and third years is as follows:

	Year One	Year Three
Medicare - FFS	100.0%	68.5%
Medicare - MC		19.2%
Commercial – MC		12.3%

Expense and utilization assumptions are based on the historical experience of St. Mary's Healthcare.

Capability and Feasibility

Project cost will be satisfied by accumulated funds from St. Mary's Healthcare. Presented as BFA Attachment A is the financial summary of the applicant showing sufficient funds.

Working capital of $217,814 based on two months of third year expenses will come from hospital operations.

The submitted incremental budget indicates a net income of ($36,133) for year one and $667,356 for year three of operation. Revenues were based on the expected distribution of patient day by RUGS-IV category and by Payor. The budget appears reasonable.

Presented as attachment A, St. Mary's Healthcare has maintained positive working capital and net asset positions and generated net operating gains of $2,031,000 and $1,298,000 for the years 2009 and 2010, respectively. Presented as attachment B, the 2011 internal financial statements through September 30, 2011, St. Mary's Healthcare has maintained positive working capital and net assets and has generated net operating income of $2,516,959.

Recommendation
From a financial perspective, approval is recommended.

Architectural Analysis

Review Summary
This project will consist of renovations to 8,695 SF of the third floor of the existing 5 story hospital building. The renovation will take place in a medical/surgical bed wing that is not in service, to form an 11 bed Transitional Care Unit (TCU).

The proposed TCU will include 9 single bedrooms, 2 ADA compliant single bedrooms, nursing station, medications room, nourishment area, bathing area, clean utility, soiled utility, housekeeping closet, stretcher and wheelchair storage, equipment storage and general storage. The unit will also include a visitors lounge, dining room, physical therapy, activity room, public toilet, patient toilet, nurse manager office, multipurpose room, staff lounge and staff toilet.

This TCU unit will occupy the same floor as an existing 10 bed Physical Medicine and Rehab Unit and will be able to share the activity and rehab spaces.

The renovation work will be minor to include modification to existing walls and doors. Finishes will include new paint, VCT flooring and acoustic ceiling tiles in reconfigured space. Minor upgrades to the existing mechanical systems will be required to accommodate the enlarged ADA toilet rooms.

Environmental Review
The Department has deemed this project to be a TYPE II Action and will not have a significant effect on the environment. An Environmental Impact Statement is not required. However, any agency that has an interest in this project may make their own independent determination of significance and necessity for an EIS in accordance with the procedures specified within Part 97.8 of Title 10: Rules and Regulations.

Recommendation
From an architectural perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary - St. Mary's Hospital at Amsterdam (a.k.a. St. Mary's Healthcare) 2010 and 2009 audited.
BFA Attachment B	Financial Summary - St. Mary's Hospital at Amsterdam (a.k.a. St. Mary's Healthcare) Internal, January 1. 2011 through September 30, 2011.

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 2: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Without Dissent by HSA
- Without Dissent by Establishment and Project Review Committee

CON Applications

Acute Care Services – Construction **Exhibit #8**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112059 C	New York Presbyterian Hospital – New York Weill Medical Center (New York County) Ms. Regan - Interest	Contingent Approval
2.	112259 C	North Shore University Hospital (Nassau County) Mr. Kraut – Recusal	Contingent Approval

Public Health and Health Planning Council

Project # 112059-C
New York Presbyterian Hospital – New York Weill Cornell Center

County: **New York (New York)**
Purpose: **Construction**
Program: **Acute Care Services**
Submitted: **October 24, 2011**

Executive Summary

Description
New York Presbyterian Hospital-New York Weill Cornell Center (NYP-Weill Cornell), an 850-bed not-for-profit hospital located at 525 East 68th Street, New York, requests approval to convert 32 of its 68 inpatient psychiatric beds to inpatient medical/surgical (M/S) beds. In addition, the hospital seeks approval to add 12 net new M/S beds to its overall M/S capacity, to create a 44-bed medical/surgical unit to be located on the South Wing of the 11th floor of the Greenberg Pavilion.

This application is the result of the lack of bed availability in the adult M/S units, which has impacted specialized care. Rather than admitting patients to specialized M/S units according to diagnosis, patients at times are admitted to any adult M/S unit that has available beds. This is not optimal patient care, since cohorting patients by appropriate service leads to improved patient outcomes, better communication and greater efficiency.

Total project costs are estimated at $19,846,422.

DOH Recommendation
Contingent approval.

Need Summary
The proposed reconfiguration will enable NYP/Weill Cornell to:

- Meet growing community demand for inpatient M/S services;
- Improve access to care;
- Improve the alignment of patients with the appropriate inpatient units and level of care;
- Enhance quality of patient care with efficient, timely and effective patient centered treatment; and
- Reduce the hospital's medical/surgical occupancy rate closer to the desired planning optimum of 85.0%.

Program Summary
Based on the results of this review, a favorable recommendation can be made pursuant to Section 2802-(3)(e) of the New York State Public Health Law.

Financial Summary
Project costs will be met via equity from operations.

Incremental Budget:	*Revenues:*	*$ 27,960,195*
	Expenses:	*30,561,025*
	Gain/(Loss):	*$ (2,600,830)*

The applicant has indicated that the incremental operating loss will be supplemented by the applicant's available financial resources.

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary
This project involves the conversion and renovation of a 32-bed inpatient psychiatric unit to a 44-bed adult M/S inpatient unit on the south wing of the 11th floor of the existing Greenberg Pavilion. The project will consist of 19,230 SF of renovations.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fIfty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of documentation of final approval from the NYS Office of Mental Health. [RNR]
3. New York Presbyterian Hospital shall submit a certificate of need application to fully sprinkler the Greenberg Pavilion atrium in accordance with 1999 NFPA 13. The construction of the atrium sprinkler project must be complete at the time of the pre-occupancy survey of project 112059. [AER]

Approval conditional upon:

1. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
2. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's request for, and Department's granting approval for the start of construction. [AER]
3. The applicant shall start construction on or before December 3, 2012 and complete construction by August 19, 2013 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 710.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.10(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date
February 2, 2012.

Need Analysis

Background

New York Presbyterian Hospital - New York Weill Cornell Center (NYP/Weill Cornell) is an 850-bed acute care hospital located at 525 East 68th Street New York, New York, New York County. The facility is seeking CON approval to renovate a unit on its campus, convert 32 inpatient psychiatric beds to medical/surgical (M/S) beds and add 12 net new medical/surgical beds. Upon project completion, the total number of certified inpatient beds at NYP/Weill Cornell will increase by 12 to 862.

New York Presbyterian Hospital-New York Weill Cornell Center has the following certified beds and services:

Table 1:
New York Presbyterian Hospital - New York Weill Cornell Center: Certified Beds by Service

Bed Category/Capacity	Current	Proposed	Upon Completion
AIDS	30		30
Bone Marrow Transplant	15		15
Burns Care	40		40
Chemical Dependence - Rehabilitation	14		14
Chemical Dependence - Detoxification	3		3
Coronary Care	20		20
Intensive Care	65		65
Maternity	68		68
Medical / Surgical	402	+44	446
Neonatal Continuing Care	16		16
Neonatal Intensive Care	15		15
Neonatal Intermediate Care	19		19
Pediatric	33		33
Pediatric ICU	20		20
Physical Medicine and Rehabilitation	22		22
Psychiatric	68	- 32	36
Total Beds	*850*	*12*	*862*

Table 2:
New York Presbyterian Hospital - New York Weill Cornell Center: Certified Service

AIDS	AIDS Center
Ambulance	Ambulatory Surgery - Multi Specialty
Audiology O/P	Burn Center
Burns Care	Cardiac Catheterization - Adult Diagnostic
Cardiac Catheterization - Electrophysiology (EP)	Cardiac Catheterization - Pediatric Diagnostic
Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)	Cardiac Surgery - Adult
Cardiac Surgery – Pediatric	Certified Mental Health Services O/P
Chemical Dependence – Detoxification	Chemical Dependence - Rehabilitation
Chemical Dependence - Rehabilitation O/P	Chemical Dependence - Withdrawal O/P
Clinic Part Time Services	Clinical Laboratory Service
Coronary Care	CT Scanner
Dental O/P	Emergency Department
Epilepsy Comprehensive Services	Family Planning O/P
Health Fairs O/P	Intensive Care
Linear Accelerator	Lithotripsy
Magnetic Resonance Imaging	Maternity
Medical Social Services	Medical/Surgical
Methadone Maintenance O/P	Neonatal Continuing Care
Neonatal Intensive Care	Neonatal Intermediate Care

Table 2: New York Presbyterian Hospital - New York Weill Cornell Center: Certified Service	
Nuclear Medicine – Diagnostic	Nuclear Medicine - Therapeutic
Pediatric	Pediatric Intensive Care
Pediatric O/P	Pharmaceutical Service
Physical Medical Rehabilitation	Physical Medicine and Rehabilitation O/P
Prenatal O/P	Primary Medical Care O/P
Psychiatric	Radiology - Diagnostic
Radiology-Therapeutic	Renal Dialysis - Acute
Renal Dialysis – Chronic	Respiratory Care
Therapy - Occupational O/P	Therapy - Physical O/P
Therapy - Speech Language Pathology	Transplant - Bone Marrow
Transplant – Kidney	Transplant - Liver

New York Presbyterian Hospital - New York Weill Cornell Center State Designations:

- AIDS Center;
- Burn Center;
- Regional Perinatal Center;
- Regional Trauma Center;
- SAFE Center; and
- Stroke Center.

There has been increased demand for inpatient and emergency services at NYP/Weill Cornell. However, lack of available M/S beds has impacted inpatient specialized care, forcing the hospital to admit patients to any medical/surgical unit rather that to specialized M/S units based on diagnosis.

To ameliorate the situation, NYP/Weill Cornell proposes to create a new 44-bed inpatient medical/surgical unit, by converting 32 inpatient psychiatric beds to M/S beds and adding 12 net new medical/surgical beds.

The facility is certified to operate 68 inpatient psychiatric beds consisting of two 32-bed psychiatric units and 4 scatter beds. As a result of this project, NYP/Weill Cornell will be decreasing its inpatient psychiatric beds from 68 to 36. The hospital has and will develop future programs to provide a range of behavioral health services for this patient population. These programs include:

- existing Day Treatment and outpatient services;
- a Comprehensive Psychiatric Emergency program with 6 extended observation beds;
- physical expansion of its Partial Hospitalization program to allow for full use of the 30 licensed slots; and
- length of stay initiatives to create capacity within the inpatient psychiatric unit.

NYP/Weill Cornell anticipates that these programs will facilitate length of stay reductions and create more short-term hospitalizations for patients in need of psychiatric services.

In order to create the new medical/surgical unit, NYP/Weill Cornell will undertake the process in two stages:

Stage 1:

- Temporarily close its Greenberg 11 North 32-bed psychiatric unit;
- Reconfigure the unit and create a Comprehensive Psychiatric Emergency Program (CPEP) and new support care for the existing psychiatric beds; and
- Renovate its Partial Hospitalization Program to utilize all 30 slots.

Stage 2:

- Upon completion of stage 1,close the 2nd psychiatric unit and relocate beds and services to the newly renovated area; and
- Reconfigure the vacated space to a 44-bed inpatient medical/surgical unit.

Analysis

Service Area and Population
An analysis of SPARCS inpatient discharge data shows that approximately 80.0 percent of NYP/Weill Cornell's patients live in Bronx, Kings, New York, Queens and Westchester Counties. Collectively, the census population of these counties increased by 2.0 percent going from 8,488,009 in 2000 to 8,655,516 in 2010.

Emergency Department and Inpatient
In 2008, NYP/Weill Cornell recorded 65,161 total Emergency Department visits, of these, 28.3 percent resulted in an inpatient admission. By 2010, said visits increased by 12.6 percent to 73,358 and the percentage of these visits that were admitted to the hospital increased slightly to 29.2 percent.

NYP/Weill Cornell recorded 41,728 total inpatient discharges in 2006. By 2010, these discharges increased by 11.6 percent to 46,572. The majority of the hospital's inpatient discharges are apportioned to major service category medical/surgical. During the same period said discharges increased by 9.4 percent from 27,377 to 29,961. The facility's discharges in general psychiatric increased by 10.4 during the interval, from 1,225 to 1,353.

NYP/Weill Cornell experienced marked changes in the average daily census (ADC) associated with the aforementioned discharges. The ADC for its medical/surgical patients increased by 7.0 percent from 503 patients on any given day in 2006 to 538 in 2010. The average daily census for its psychiatric patients declined by 4.9 percent going from 61 patients on any given day in 2006 to 58 in 2010. Both major service categories under review experienced declines in average length of stay (ALOS) during the interval. M/S patients average length of stay decreased by 1.5 percent,from 6.7 days in 2006 to 6.6 days in 2010. General psychiatric patients recorded a significant decline in ALOS of almost 3 days during the period. ALOS for these patients declined by 14.8 percent from 18.3 days in 2006 to 15.6 in 2010.

During the interval, the increase in M/S discharges and average daily census resulted in a 6.8 percent increase in the hospital's M/S occupancy rates, from 84.7 percent in 2006 to 90.5 percent in 2010. The hospital's 2010 M/S occupancy rate was more than 5 percentage points above the desired planning optimum rate of 85.0 percent. NYP/Weill Cornell's general psychiatric occupancy rate declined by 6.0 percent, from 90.3 percent in 2006 to 84.9 percent in 2010 (Table 3).

Table 3:
Inpatient Utilization by Major Service Category Medical/Surgical and General Psychiatric

Service Category	2006	2007	2008	2009	2010	Current Beds
Discharges						
Medical/Surgical	27,377	28,399	27,185	29,183	29,961	
General Psychiatric	1,225	1,270	1,192	1,299	1,353	
Total	41,728	43,811	42,385	45,251	46,572	
Average Daily Census						
Medical/Surgical	503	527	477	514	538	
General Psychiatric	61	64	57	62	58	
Total	728	778	704	752	779	
Average Length of Stay						
	2006	2007	2008	2009	2010	
Medical/Surgical	6.7	6.8	6.4	6.4	6.6	
General Psychiatric	18.3	18.5	17.5	17.3	15.6	

Table 3: Inpatient Utilization by Major Service Category Medical/Surgical and General Psychiatric						
Service Category	**2006**	**2007**	**2008**	**2009**	**2010**	**Current Beds**
Total	6.4	6.5	6.1	6.1	6.1	
Occupancy Based on Current Beds						
Medical/Surgical	84.7	88.7	80.3	86.4	90.5	594
General Psychiatric	90.3	94.6	83.8	90.6	84.9	68
Total	81.5	87	78.4	84	87	850

Source: SPARCS, 2006- 2010

Need for Beds
Between 2006 and 2010, the hospital's general psychiatric average daily census and average length of stay declined by 4.9 percent and 14.8 percent, respectively. The hospital will continue to work on initiatives to reduce ALOS as well as to reduce inpatient psychiatric admissions; thereby freeing-up these beds for other uses.

NYP/Weill Cornell's 2010 medical/surgical occupancy rate was more than 5 percentage points above the desired planning optimum of 85.0 percent. Using the hospital's 2010 ADC to recalculate its occupancy rate with the additional beds, NYP/Weill Cornell's revised M/S occupancy rate would be about a percentage point less than the planning optimum of 85.0 percent. The additional beds would give the hospital some relief and allow NYP/Weill Cornell to place its M/S patients appropriately.

Recommendation
From a need perspective, contingent approval is recommended.

Programmatic Analysis

Compliance with Applicable Codes, Rules and Regulations
The medical staff will continue to ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

Conclusion
Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

Recommendation
From a programmatic perspective, approval is recommended.

Financial Analysis

Total Project Cost And Financing

Total project cost, which is for renovations and the acquisition of moveable equipment, is estimated at $19,846,422, broken down as follows:

Renovation and Demolition	$11,200,000
Design Contingency	1,200,000
Construction Contingency	1,200,000
Planning Consultant Fees	70,000
Architect/Engineering Fees	1,344,000
Construction Manager Fees	484,161
Other Fees (Consultant)	937,600
Moveable Equipment	3,300,114
CON Fee	2,000
Additional Processing Fee	108,547
Total Project Cost	$19,846,422

Project costs are based on a December 1, 2012 construction start date and a nine month construction period.

The hospital will provide equity from operations to meet the total project cost.

Operating Budget

The applicant has submitted an incremental operating budget that is relative to the additional med/surg beds and the decertifying of the psychiatric beds, in 2011 dollars, for the first and third years, summarized below:

	Year One	Year Three
Revenues:		
Inpatient	$27,960,195	$27,960,195
Total Revenues	$27,960,195	$27,960,195
Expenses:		
Operating	$29,321,894	$29,321,894
Capital	1,478,955	1,239,131
Total Expenses	$30,800,849	$30,561,025
Excess of Revenues over Expenses	$(2,840,654)	$(2,600,830)
Cost Per Discharge	$16,262.33	$16,135.70
Utilization:		
Discharges	1,894	1,894

Incremental utilization by payor source for inpatient services is as follows:

	Years One and Three
Medicaid Fee-For-Service	8.76%
Medicaid Managed Care	7.02%
Commercial Fee-For-Service	1.69%
Commercial Managed Care	16.26%
Medicare Fee-For-Service	54.22%
Medicare Managed Care	10.66%
Private Pay	1.21%
Other	.18%

Capability and Feasibility

The hospital will provide equity of $19,846,422 via operations to meet the total project cost. Presented as BFA Attachment A, is a financial summary for New York Presbyterian Hospital, which indicates the availability of sufficient funds for the equity contribution.

The submitted budget projects an excess of incremental revenues over expenses of $(2,840,654) and $(2,600,830) during the first and third years, respectively. Revenues are based on the facility's current reimbursement rates for med/surg patients. The applicant has indicated that the reasons for the incremental losses are the result of the psychiatric beds operating in a profitable manner, and they are being decertified. The incremental loss will be offset by hospital operations. As this project becomes operational, management will review other strategic initiatives to offset the forecasted operating loss as part of the budget process. These strategic initiatives include revenue enhancement and operational throughput efficiencies such as Barrier Reduction Teams, Nurses Station Beds and the ED- Inpatient Unit Pull Program.

As shown on BFA Attachment A, the applicant had an average positive working capital position and an average positive net asset position during 2009 and 2010. The hospital achieved an average excess of operating revenues over expenses of $82,034,000 and $114,833,000 during 2009 and 2010.

Presented as BFA Attachment B, is the June 30, 2011 internal financial statements of New York Presbyterian Hospital. As shown on Attachment B, the hospital had a positive working capital position and a positive net asset position during the period through June 30, 2011. Also, the facility achieved an excess of operating revenues over expenses of $67,974,000 during the period through June 30, 2011.

The applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

Recommendation

From a financial perspective, approval is recommended.

Architectural Analysis

Review Summary

This project involves the conversion and renovation of a 32-bed inpatient psychiatric unit to a 44-bed adult medical/surgical inpatient unit on the south wing of the 11th floor of the Greenberg Pavilion.

The 11th floor will consist of 19,230 SF of renovations and will include 15 double-bedded rooms and 14 private rooms of which 2 will be isolation rooms. Also included will be 2 nursing stations, nurse touchdown alcoves, and medication, nutrition, conference, consult, and exam rooms. There will also be a family lounge area, clean and soiled utility rooms, an equipment storage room, and public and staff toilet rooms.

Environmental Review

The Department has deemed this project to be a TYPE II Action and will not have a significant effect on the environment. An Environmental Impact Statement is not required. However, any agency that has an interest in this project may make their own independent determination of significance and necessity for an EIS in accordance with the procedures specified within Part 97.8 of Title 10: Rules and Regulations.

Recommendation

From an architectural perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary- New York Presbyterian Hospital
BFA Attachment B	Summary- Internal Financial Statements of New York Presbyterian Hospital

Public Health and Health Planning Council

Project # 112259-C
North Shore University Hospital

County: **Nassau (Manhasset)**
Purpose: **Construction**
Program: **Acute Care Services**
Submitted: **November 2, 2011**

Executive Summary

Description
North Shore University Hospital (NSUH), an 804-bed, not-for-profit hospital located in Manhasset, requests approval to undertake major modernization of the maternity and obstetrics units with no change to beds or services. The purpose of this project is to decompress the current postpartum and antepartum obstetrics units, to provide patients with a new and renovated physical facility comprised of 73 single-bed maternity rooms on four units.

The project will be completed with a phased approach to provide construction with no disruption to patient care. The phases are as follows:

Phase 1:
- New construction of 5th floor of the Lippert Pavillion (19 beds)
- Gut and renovation of the 4th floor of the Lippert Pavillion (16 beds)

Phase 2:
- Gut and renovation of the existing antepartum unit on 3rd floor of the Lippert Pavilion (13 antepartum beds)
- Renovation/cosmetic upgrade of the existing postpartum unit on 3rd floor of the Monti Pavillion (25 beds)

This application amends and supersedes CON #081135-C, contingently approved by the Public Health Council on October 2, 2008, and is considered an amendment pursuant to 10 NYCRR 710.5(b)(2) because total basic cost of construction has increased in excess of $15,000,000.

Total project costs are estimated at $53,949,769.

DOH Recommendation
Contingent approval.

Need Summary
This modernization project will provide patient and family privacy, comfort, individual climate control and amenities to encourage a sense of well-being and ameliorate stress.

Program Summary
Based on the results of this review, a favorable recommendation can be made pursuant to Section 2802-(3)(e) of the New York State Public Health Law.

Financial Summary
Project costs will be met with accumulated funds of $5,394,977 and DASNY tax-exempt bonds of $48,554,792 (30 yrs. @ 6.5%).

Incremental Budget:		
	Revenues:	*$ 4,478,000*
	Expenses:	*8,940,400*
	Gain/(Loss):	*$ (4,462,400)*

Subject to the noted condition, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary
This amendment expands the construction scope of work and increases the project costs required to complete a major modernization of the existing maternity and obstetrics services. While the basic project goal has not changed, the work required to achieve this goal has increased significantly.

Unanticipated site/field conditions, phasing requirements, local building code restrictions and numerous mechanical, electrical, plumbing and architectural design changes have resulted in significant increases in both the required scope of work and complexity of the project. As a reflection of this increased scope of work, the overall size of the project has increased by nearly 12,900 SF from 45,819 SF to 58,711 SF.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]

Approval conditional upon:

1. This project is approved to be initially funded with North Shore-Long Island Jewish Hospital (NS-LIJ) obligated group equity, with the prospect that the project will be 90% financed as part of a future NS-LIJ obligated group tax exempt bond financing through the Dormitory Authority. The bond issue is expected to include a 6.5% interest rate and a 30 year term. Financing is conditioned upon the Department having the opportunity to review the final financing proposal in advance to ensure that it meets approval standards. [BFA]
2. The applicant shall complete construction by March 1, 2012 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 710.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.10(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date
February 2, 2012.

Need Analysis

Background
North Shore University Hospital (NSUH) is an 812-bed acute care hospital located at 300 Community Drive, Manhasset, Nassau County. The facility seeks CON approval to undertake major modernization of its maternity and obstetrics service with no change to beds or services (Amends and Supersedes CON #081135-C).

NSUH is certified for the following beds and services:

Certified Beds	
AIDS	30
Bone Marrow Transplant	4
Coronary Care	15
Intensive Care	79
Maternity	73
Medical / Surgical	486
Neonatal Continuing Care	5
Neonatal Intensive Care	32
Neonatal Intermediate Care	14
Pediatric	33
Pediatric ICU	7
Psychiatric	26
Total Beds	*804*

Certified Services		
AIDS	AIDS Center	Ambulatory Surgery - Multi Specialty
Audiology O/P	Burns Care	Cardiac Catheterization - Adult Diagnostic
Cardiac Catheterization - Electrophysiology (EP)	Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)	Cardiac Surgery - Adult
Certified Mental Health Services O/P	Chemical Dependence - Rehabilitation O/P	Chemical Dependence - Withdrawal O/P
Clinical Laboratory Service	Coronary Care	CT Scanner
Dental O/P	Emergency Department	Family Planning O/P
Intensive Care	Linear Accelerator	Lithotripsy
Magnetic Resonance Imaging	Maternity	Medical Social Services
Medical/Surgical	Neonatal Continuing Care	Neonatal Intensive Care
Neonatal Intermediate Care	Nuclear Medicine - Diagnostic	Nuclear Medicine – Therapeutic
Pediatric	Pediatric Intensive Care	Pharmaceutical Service
Primary Medical Care O/P	Psychiatric	Radiology - Diagnostic
Radiology-Therapeutic	Renal Dialysis - Acute	Respiratory Care

Certified Services		
Therapy - Occupational O/P	Therapy - Physical O/P	Therapy - Speech Language Pathology
Therapy - Vocational Rehabilitation O/P	Transplant - Bone Marrow	Transplant – Kidney

NSUH has eight extension clinics and the following State designations:

- AIDS Center;
- Regional Perinatal Center;
- Regional Trauma Center;
- SAFE Center; and
- Stroke Center

Inpatient Utilization

In 2006, NSUH recorded 5,340 obstetric discharges; by 2010, these discharges increased by 7.7 percent to 5,752. During the same period under review, high-risk-neonatal discharges increased by 5.8 percent going from 603 in 2006 to 638 in 2010. The hospital's healthy newborns increased significantly by 14.5 percent from 4,705 in 2006 to 5,386 in 2010. The average daily census (ADC) of NSUH's obstetric patients remained stabled during the interval at 49-50 patients on any given day, while high-risk-neonates ADC ranged between 30 and 34 patients on any given day. On the other hand, the ADC of its healthy newborns increased each year from 35 patients on any given day in 2006 to 42 in 2009 and stood at 40 in 2010 (Table 1).

Table 1:
North Shore University Hospital: Inpatient Utilization, by Major Service Category

Service	2006	2007	2008	2009	2010*	Current Beds
Discharges						
Obstetric	5,340	5,333	5,580	5,976	5,752	
High Risk Neonates	603	640	616	568	638	
Healthy Newborns	4,705	4,934	5,135	5,541	5,386	
Average Daily Census						
Obstetric	49	49	50	50	50	
High Risk Neonates	32	31	34	31	30	
Healthy Newborns	35	37	39	42	40	
Occupancy Based on Current Beds						
Obstetric	67.1	66.6	67.8	69.0	69.0	73
High Risk Neonates	62.5	61.2	65.7	61.6	59.2	51

Source: SPARCS 2006- 2010 (*Reporting for 2010 is incomplete)*

North Shore University Hospital projects modest increase in its obstetric discharges of 268 and 458 during the 1st and 3rd years of operation, respectively. The modernized obstetric units will provide both mothers and babies with enhanced quality care and family centered maternity services. The modernized inpatient units will provide a hospitable and friendly environment for patients, families' visitors and staff. The provision of all private rooms will provide patient and family privacy, comfort, individual climate control and amenities to encourage sense of well being and ameliorate stress.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

North Shore University Hospital requests approval to modernize their obstetrical facilities. There will be no changes to the bed complement or services concurrent with approval of this application.

Compliance with Applicable Codes, Rules and Regulations

The staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections.

While there have been numerous enforcements across the North Shore – Long Island Jewish Health System (System) over the past ten years, there have been none related to obstetrical services, as evidenced by the list below:

- Huntington Hospital was fined $16,000 in 2002 based on the investigations of two occurrences. The first involved the performance of a tubal ligation without the consent or knowledge of the patient. The second involved the placement of a stent on the wrong side.

- North Shore University Hospital was fined $10,000 based on a 2002 investigation a patient who was admitted with a brain tumor on the left side as identified by MRI and CT scan. A left frontal craniotomy biopsy of the dura was planned and a consent form signed. The surgeon proceeded to do the craniotomy on the right side.

- Long Island Jewish Medical Center was fined $6,000 in 2003 based on violations of the resident working hours regulations in that residents in ICU/PICU worked over 24 consecutive hours as was noted in two surveys.

- Staten Island University Hospital was fined $8,000 based on a 2006 investigation of a patient admitted for a left sided mediastinotomy (insertion of a tube into the chest). The procedure was begun on the right side of the chest and the error was noticed by the anesthesiologist after ten minutes.

- Forest Hills Hospital was fined $12,000 based on a 2006 investigation regarding a patient who entered the hospital for left side hernias repair. The surgery was performed on the patient's right side.

- Southside Hospital was fined $14,000 based on a 2006 complaint investigation where a patient was admitted with a large dermoid cyst on her left ovary. Although a consent form was signed for left-sided surgery, the physician performed a right ovarian cystectomy. It was noted that much of the accompanying documentation referred to a right sided cyst.

- North Shore University Hospital was fined $18,000 based on a 2007 survey Based on post operative care rendered to an elderly patient. Following surgery for an aneurysm, the patient developed multiple decubiti, fell out of bed resulting in a dislocated femur and developed renal failure. Follow-up care was delayed or inadequately administered.

- Staten Island University Hospital was fined $12,000 based on a 2007 complaint that an overdose of a controlled substance by the hospital had caused the patient's death. Findings included that nursing administered a drug at a higher rate than was ordered and continued the administration even after it was discontinued by the surgical resident.

- Syosset Hospital was fined $42,000 based on a 2009 investigation of the care to a child having an adenotonsillectomy. It was determined that the patient was improperly cleared for surgery and that despite multiple comorbidities was not kept for observation post-operatively. The patient expired after discharge.

Additionally, Glen Cove Hospital has a pending enforcement related to a peritonitis death. The facility and the Department are in discussions regarding the enforcement and stipulation. Other than the pending enforcement, North Shore University Hospital and the other facilities in the System are deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations.

Conclusion
Based on the results of this review, a favorable recommendation can be made pursuant to Section 2802-(3)(e) of the New York State Public Health Law.

Recommendation
From a programmatic perspective, approval is recommended.

Financial Analysis

Background
NSUH is a member of North Shore-Long Island Jewish Health System, Inc. (NS-LIJ), a comprehensive integrated delivery system formed to ensure the delivery of a broad range of quality healthcare services to the communities it serves and to achieve economies of scale through consolidation, cooperation, and joint planning among its members. Also, the Hospital is a member of the NS-LIJ Obligated Group, formed to provide its members an enhanced credit position and expanded access to capital markets.

Total Project Cost and Financing
Total project cost for construction, renovations and movable equipment, is estimated at $53,949,769, itemized as follows:

New Construction	$19,298,071
Renovation & Demolition	15,849,641
Site Development	320,750
Asbestos Abatement or Removal	1,471,390
Surveys & Test Borings	316,500
Construction Contingency	1,754,363
Planning Consultant Fees	174,600
Architect/Engineering Fees	4,657,405
Construction Manager Fees	1,583,402
Consultant Fees	1,043,751
Movable Equipment	4,606,321
Financing Costs	2,576,485
Application Fees	2,000
Additional Processing Fees	295,090
Total Project Cost	$53,949,769

The applicant's financing plan appears as follows:

Cash	$ 5,394,977
Tax Exempt Bonds, Dormitory Authority of the State of New York, 6.5%, 30 years	$48,554,792

Operating Budget

The applicant has submitted an incremental operating budget, in 2012 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues	$3,151,700	$4,634,700
Expenses:		
Operating	$2,498,000	$3,141,700
Capital	5,986,500	5,899,600
Total Expenses	$8,484,500	$9,041,300
Excess (Loss) of Revenue over Expenses	($5,332,800)	($4,406,600)
Utilization (discharges)	268	458

Utilization by payor source and projected average payment rates, itemized by inpatient services for the first and third years is as follows:

Inpatient	Year One
Commercial Managed Care	87.7%
Medicare Fee for Service	0.4%
Medicare Managed Care	0.2%
Medicaid Fee for Service	2.9%
Medicaid Managed Care	8.6%
Private Pay	0.2%

Inpatient	Year Three
Commercial Managed Care	86.4%
Medicare Fee for Service	0.4%
Medicare Managed Care	0.1%
Medicaid Fee for Service	3.0%
Medicaid Managed Care	9.7%
Private Pay	0.4%

Expenses and utilization assumptions are based on the historical operations of North Shore University Hospital, as well as market trends.

Capability and Feasibility

NSUH will finance $48,554,792 through the Dormitory Authority at stated terms, with the remaining $5,394,977 as equity from the hospital. A letter of interest from Citigroup has been submitted by NSUH. Presented as BFA Attachment A, is the financial summary of North Shore-Long Island Jewish Health System, Inc., which indicates the availability of sufficient resources for this project.

The hospital projects an incremental loss of revenues over expenses of $5,332,800 and $4,406,600 during the first and third years, respectively, which will be offset from operations. As shown on BFA Attachment A, the hospital has maintained positive working capital and net asset positions, and generated annual net revenue of $109,447,000 in 2010. As of September 30, 2011, NSUH has generated annual net revenue of $92,946,000, as shown on BFA Attachment B.

Recommendation

From a financial perspective, approval is recommended.

Architectural Analysis

Architectural Summary

To implement the desired decompression and modernization of maternity services, the proposed project will completely renovate two existing maternity units, and create two additional maternity units. Although there will be no change to the facility operating certificate, this project will provide the additional space required to fully implement the current licensed capacity of 73 maternity beds in maternity units having all single bed rooms.

The hospital is currently licensed for a total of 812 beds, including 73 maternity, 32 neonatal intensive care, 14 neonatal intermediate care and 5 neonatal continuing care beds. Supporting OB services including LDR's, C-section rooms and the NICU located on the third floor of the adjacent and connected Levitt Pavilion, are NOT included in this project.

Existing Conditions

The current facility configuration provides two separate maternity units providing only 62 of 73 licensed maternity beds. The two existing maternity units are located on the third level of separate buildings connected via an elevated pedestrian walkway. These existing maternity units and the supporting mechanical / HVAC systems are extremely dated and require extensive renovation or replacement. Each unit includes multi-bed patient rooms (2 and 3 beds/rm @ 50 of 62 beds), making the provision of patient and family privacy and comfort extremely difficult.

New Construction

- New General Construction

New rooftop mechanical / HVAC systems and a new building façade will provide increased comfort, energy efficiency, reliability and general modernization for the entire building, effectively increasing the useful life of the structure.

- Fifth Floor, Lippert Bldg. (14,555 SF)

A new fifth floor will be constructed on top of the existing 4 level Lippert building to create a new **19 bed** maternity (Post-Partum) unit with all single bed private patient rooms, nurseries and associated support space.

Renovation of Existing

- Fourth Floor, Lippert Bldg. – (12,455 SF)

The existing Infectious Disease Department at the fourth floor is being relocated to allow the gut renovation and new construction of a 17 bed maternity (Post-Partum) unit having all single bed private patient rooms, nurseries and associated support space.

- Third Floor, Lippert Bldg. – (12,568 SF)

The existing obsolete maternity unit with multi bed patient rooms will be completely gutted to allow construction of a new 13 bed maternity (Ante-Partum) unit having all single bed private patient rooms, nurseries and associated support space.

- Third Floor, Monti Bldg. – (15,065 SF)

The existing maternity unit at this building will receive extensive interior renovations required to create a new **24 bed** maternity (Post-Partum) unit having all single bed private patient rooms, nurseries and associated support space.

- Second Floor, Lippert Bldg. – (1,486 SF)

Additional power for the Lippert building was to be provided by a separate major renovation project which has since been cancelled. Required power upgrades were incorporated into this project and include the gut renovation of limited areas in order to create 2 separate electrical rooms – one for normal power and another for emergency power.

- First Floor, Lippert Bldg. – (793 SF)

Elevators serving the Lippert Bldg. and DSU pavilion were upgraded to energy efficient hydraulic units. A new elevator machine room, elevator pit and counterweights were provided.

Two non code compliant egress stairs (stair “A” & “B”) were upgraded to meet code.

- Ground Floor, Lippert Bldg. – (1,789 SF)

Elevators serving the Lippert Bldg. and DSU pavilion were upgraded to energy efficient hydraulic units. A new elevator machine room, elevator pit and counterweights were provided.
Two non code compliant egress stairs (stair “A” & “B”) were upgraded to meet code.

The completed project will provide 4 separate maternity units with a total of 73 single bed patient rooms, providing state of the art care and technology in a comfortable, convenient and secure environment. These maternity units are designed to create a welcoming and reassuring atmosphere by encouraging family centered maternity care by allowing newborn rooming-in 24 hours per day.

The vertical configuration of maternity services will also provide several program advantages over the current configuration including: centralized access to all maternity units, greater program and building identity, and limited travel through patient units providing increased unit security. Specific areas of focus include facility improvement to patient rooms, nurseries, patient corridors, public areas, lobbies, and infrastructure. The modernized patient floors will provide a hospitable and friendly environment for patients, families, visitors and staff. The all single bed, private rooms will provide increased patient and family privacy, comfort, individual climate controls and other amenities to encourage a sense of well being, while providing superior maternity care.

The vertical configuration of the proposed project allows phased construction, decanting and occupancy of all maternity units with minimal disruption of patient care. The proposed construction and renovation project has increased from a total of 45,819 to 58,711 gross square feet in a vertical configuration phased as follows:

<u>Phase I</u>:

- Lippert Pavilion 5th floor - New Construction (19 beds/14,555 gsf)
- Lippert Pavilion 4th floor - Gut Renovation (17) beds/12,455 gsf)
- Lippert Pavilion 3rd floor - Gut Renovation (13 beds/12,568 gsf)
- Lippert Pavilion 2nd floor – (1,486 gsf)
- Lippert Pavilion 1st floor – (793 gsf)
- Lippert Pavilion Gnd floor – (1,789 gsf)

<u>Phase II</u>:

- Monti Pavilion 3rd floor – Renovation (24 beds/15,065 gsf)

Construction for this project was previously approved under prior CON 081135 and is currently in progress. The revised targeted completion date has been extended from December 1, 2010 to March 1, 2012. The project is being completed in phases in order to minimize disruption to patient care and day to day hospital functions.

Environmental Review

The Department has deemed this project to be a TYPE I Action and the lead agency shall be the county of Nassau or the authority having jurisdiction.

Recommendation
From an architectural perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary, North Shore-Long Island Jewish Health System, Inc. 2010
BFA Attachment B	Internal Financial Summary, North Shore-Long Island Jewish Health System, Inc. as of September 30, 2011
BFA Attachment C	Summary of Detailed Budgets
BFA Attachment D	Organizational Chart of North Shore-Long Island Jewish Health System, Inc.

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 4: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Establishment and Project Review Committee Dissent, or
- Contrary Recommendation by HSA

Residential Health Care Facility – Construction **Exhibit #9**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	111435 C	The Wartburg Home (Westchester County) Mr. Fassler - Interest	Contingent Approval

Public Health and Health Planning Council

Project # 111435-C

The Wartburg Home

County: **Westchester (Mount Vernon)**
Purpose: **Construction**
Program: **Residential Health Care Facility**
Submitted: **May 18, 2011**

Executive Summary

Description

The Wartburg Home is a 240-bed not-for-profit residential health care facility (RHCF), with two respite beds and an 80-slot Adult Day Health Care Program (ADHCP), located at 55 Bradley Avenue, Mount Vernon. The applicant requests approval to decertify 30 RHCF beds and construct a replacement nursing facility for their Pavilion Building, which currently houses 80 RHCF beds. The new building will house 50 RHCF beds, an 80-slot ADHCP located in the antiquated Berkemeier Building and rehabilitation therapy services relocated from Wartburg's Waltemade Building. The applicant's total RHCF beds will decrease from 240 to 210.

The Wartburg Foundation, Inc. was created to support the charitable, educational, scientific, religious, and literary purposes of The Wartburg Home of the Evangelical Lutheran Church and other not-for-profit organizations.

Total project costs are estimated at $27,635,934.

DOH Recommendation

Contingent approval.

Need Summary

The decertification of 30 RHCF beds which will assist surrounding facilities operating at a lower capacity, enabling them to increase occupancies to the 97% planning optimum.

Program Summary

The construction of the new building will significantly improve the quality of life for residents in The Wartburg Home. The nursing home will be able to offer a rehabilitation program in space which meets contemporary standards, while relocation of the ADHCP from an antiquated building may eventually result in higher utilization for the chronically under-utilized program.

As a condition of approval, Wartburg will be required to commit to a modernization program for the Waltemade Building as soon as adequate funds are obtained.

Financial Summary

Project costs will be met with a $23,232,000 HEAL-NY 20 Grant, $903,934 unrestricted net assets from The Wartburg Foundation, and $3,500,000 in unrestricted, undesignated net assets from the facility.

Budget:	*Revenues:*	*$ 32,769,465*
	Expenses:	*33,512,012*
	Gain/(Loss):	*$ (742,547)*

The Wartburg Home has stated they will fund losses from contributions.

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

The replacement tower will consist of approximately 65,332 SF on three floors. The 1st floor will include the ADHCP, physical therapy, occupational therapy, speech therapy, kitchen, staff locker rooms and support space. Floors 2 and 3 will be organized into four small neighborhoods of residential space with a 12-bed and 13-bed neighborhood on each floor with private rooms, including a full bathroom and shower in each room. Each neighborhood will also include a large common area with its own pantry and country kitchen, a nurse work area, clean and soiled utility rooms, and private staff areas.

Recommendations

Health Systems Agency

There will be no HSA recommendation for this application.

Office of Health Systems Management

Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of and programmatic review and approval of the final floor plans. [LTC]
3. Confirmation that each resident bedroom will include a shower of minimum 4 foot by 5 foot dimensions, or submission of plans showing a shower of 4 foot by 5 foot or larger dimensions in each spa room. [LTC]
4. Submission of an executed HEAL NY - Phase 20 grant that is acceptable to the Department. [BFA]
5. Submission of documentation of the pledge from the Wartburg Foundation that is acceptable to the Department. [BFA]

Approval conditional upon:

1. A commitment to undertake a renovation and/or bed reduction project for the Waltemade Building to enhance resident rooms to a standard similar to the bedrooms in the new building, and an updating of the facility to provide a more homelike and resident centered living environment. [LTC]
2. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
3. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's request for, and Department's granting approval for the start of construction. [AER]
4. The applicant shall complete construction by May 1. 2015. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

February 2, 2012.

Need Analysis

Background

The Wartburg Home seeks approval to decertify 30 residential health care facility (RHCF) beds, demolish an outdated building, and construct a modern replacement building to house a 50 -bed facility with a focus on short term nursing and rehabilitation care and program space for Medical and Social Adult Day Health Care Programs (ADHCP). The new facility will consist of two nursing home floors that will contain 12- and 13-bed neighborhoods. This project is part of a HEAL 20 grant.

Analysis

County RHCF Bed Need	*Westchester*
2016 Projected Need	6,716
Current Beds	6,711
Beds Under Construction	290
Total Resources	7,001
Unmet Need	-285

RHCF Utilization	*2007*	*2008*	*2009*
The Wartburg Home	Did Not Report	96.3%	96.8%
Westchester County	94.0%	92.3%	91.8%

The Wartburg Home reported occupancy rates of 96.3% and 96.8% in 2008 and 2009, respectively.

Conclusion

The Wartburg Home will consolidate all rehabilitation services into one building, which will help to improve quality and efficiency of care. The Wartburg Home was operating a 40 bed rehabilitation unit, which will increase to 50.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Facility Information

	Existing	*Proposed*
Facility Name	The Wartburg Home	Same
Address	Bradley Avenue Mount Vernon, NY 10552	Same
RHCF Capacity	240 + Respite 2	210 + Respite 2
ADHC Program Capacity	80	Same
Type of Operator	Voluntary	Same
Class of Operator	Corporation	Same
Operator	The Wartburg Home of the Evangelical Lutheran Church	Same

Project Review

- PROGRAM REVIEW:

The Wartburg Home (Wartburg) is a 240 bed voluntary nursing home located on Bradley Avenue in Mount Vernon. Wartburg is also certified for a Respite 2 program and an 80 slot adult day health care program. Consistent with a recently awarded HEAL 20 grant, Wartburg proposes to replace the outdated 80 bed Pavilion Building with a modern 50 bed nursing facility which will also include space to relocate Wartburg's adult day health care and social day care programs. Upon completion the applicant will demolish the Pavilion Building, resulting in the decertification of 30 nursing facility beds. The HEAL 20 project also includes the construction of 60 units of affordable senior housing.
.
- PHYSICAL ENVIRONMENT

The Wartburg Home is a unique nursing facility encompassing three buildings situated on a wooded 36 acre campus, which is also home to an assisted living facility, independent living cottages, an administration building and a museum. The nursing home is comprised of two buildings: the 160 bed Waltemade Building, constructed in 1995, and the 80 bed Pavilion building, constructed in 1968, which adjoins Waltemade. Wartburg's 40 bed rehabilitation unit is located in the Pavilion building. In addition, Wartburg operates an 80 slot adult day health care program from space in the Berkemeier Building, a circa 1910 building which is connected to The Pavilion by a sky bridge. Wartburg states that the substandard space in Berkemeier, formerly an auditorium and originally intended only as temporary accommodations, has impeded the adult day health care program from attaining its fully certified capacity of 80 slots.

Due to site and zoning constraints, Wartburg is constrained from expanding Waltemade to incorporate the rehabilitation unit from the Pavilion. Alternatively Wartburg has opted to construct a new building to replace the antiquated Pavilion, to be located on a sloping site to the North and East of the Berkemeier Building. The proposed crescent shaped building will consist of three floors, with the nursing home beds on the two upper floors, and the day care programs located on the lower floor. Entry to the day care programs will be made from the terrace floor, with the residential units accessed from the opposite side on the first floor. The nursing units will consist of similar 25 bed units divided into fully functional neighborhoods of 12 and 13 beds, each with its own dining area with pantry and country kitchen. The nursing facility will be generally programmed for short term rehabilitation occupancy with 100% single-bedded rooms complete with bathroom and shower. As a contingency of approval, showers will have to be shown to be accessible to residents confined to a wheelchair, which equates to an area with minimum dimensions of four feet by five feet. The bedrooms will be comfortably sized—nearly the square footage of the double bedrooms in the Waltemade Building.

The new building will function as a full service nursing home incorporating all ancillary and support spaces, including a full kitchen. The second floor public area offers amenities including a café and large multipurpose room, which will also be made available to the adult day health care program. A training apartment to transition residents completing their rehabilitation prior to returning home is located adjacent to the occupational therapy suite. Outside activity space will be offered on terraces located on the terrace and second levels.

The adult day health care program will be located on the terrace level, adjacent to the relocated social day care program. Entrance into the day care areas will be made from a new drop-off drive. The adult day care program space will be fully compliant with the new space requirements of 10 NYCRR 714.4.

- COMPLIANCE

The Wartburg Home is in current compliance with all codes, rules and regulations.

<u>Project Review – Analysis</u>:
The construction of the new building will significantly improve the quality of life for residents in The Wartburg Home. The nursing home will be able to offer a rehabilitation program in space which meets contemporary standards. The relocation of the adult day health care program from an antiquated building may eventually result in higher utilization for the chronically under-utilized program. However the continued usage of the Waltemade Building poses a "have/have not" issue relative to the new nursing home building.

An analysis of the Waltemade Building shows that while the building is wholly code conforming, and in generally good condition devoid of major operational issues, it suffers in contrast to the modern design of the new building. Waltemade is a squarish conventional twentieth century building with resident bedrooms surrounding an open courtyard. The building includes only 18% single bedrooms, and is somewhat institutional in nature. In recognition of its shortcomings Wartburg has embarked upon a master plan to renovate Waltemade to create a more appealing residential environment, most notably an increase in the number of single bedrooms and additional square footage in the resident rooms and bathrooms. As a condition of approval Wartburg will be required to commit to a modernization program for the Waltemade Building as soon as adequate funds are obtained.

Recommendation

From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Total Project Cost and Financing

Total project costs are estimated at $27,635,934 broken down between two subprojects, residential health care facility (RHCF) and adult day health care program (ADHCP), as follows:

RHCF

New Construction	$14,504,652
Renovation & Demolition	229,536
Site Development	2,014,094
Asbestos Abatement or Removal	40,411
Design Contingency	736,709
Construction Contingency	736,709
Planning Consultant Fees	125,626
Architect/Engineering Fees	1,251,569
Construction Manager Fees	636,091
Other Fees	190,775
Movable Equipment	739,114
Telecommunications	93,003
Financing Costs	41,700
Interim Interest Expense	157,500
Processing Fee	2,000
Additional Processing Fee	118,236
Total Project Cost (Subproject 1)	$21,617,725

ADHCP

New Construction	$4,061,178
Renovation & Demolition	62,985
Site Development	552,666
Asbestos Abatement or Removal	11,089
Design Contingency	206,208
Construction Contingency	206,208
Planning Consultant Fees	34,373
Architect/Engineering Fees	343,430
Construction Manager Fees	174,543
Other Fees	52,200
Movable Equipment	157,913
Telecommunications	25,447
Financing Costs	18,300
Interim Interest Expense	78,750
Additional Processing Fee	32,919
Total Project Cost (Subproject 2)	$6,018,209

Project costs are based on a March 1, 2012 construction start date and a fourteen month construction period.

Project cost per bed, exclusive of ADHC and CON fees, is $429,950, compared to a geographic bed limitation of $352,000.

Reimbursable project cost will be $23,738,445, as shown below:

$352,000 per bed cap x 50 beds	$17,600,000
ADHC Costs	5,985,290
CON Application Fee	2,000
Additional Processing Fee	151,155
Total Reimbursable Project Cost	$23,738,445

The applicant's financing plan appears as follows:

HEAL-NY Phase 20	$23,232,000
Cash (unrestricted, undesignated net assets)	$3,500,000
The Wartburg Foundation (unrestricted net assets)	$903,934

A commitment letter from The Wartburg Foundation certifying a pledge of up to $3,000,000 has been submitted by the applicant.

Operating Budget

The applicant has submitted an operating budget for the RHCF and ADHC in 2011 dollars, for the first and third years of operation, summarized below:

RHCF

	Years One and Three
Revenue	$29,233,771
Expenses	
Operating	27,573,673
Capital	3,368,542
Total Expense	$30,942,215
Net Income/Loss	$(1,708,444)
Utilization (patient days)	75,334
Occupancy	98.28%

The following is noted with respect to the submitted RHCF operating budget:

- Medicare and private pay assume current rate of payment.
- Medicaid rate is based on the facility's 2011 Medicaid rate published by DOH.
- Utilization by payor source for years one and three are expected as follows:

Commercial Fee for Service	1.9%
Medicare Fee for Service	22.3%
Medicare Managed Care	2.9%
Medicaid Fee for Service	61.7%
Private Pay/Other	11.2%

- The operating budget and payor mix are specifically for the RHCF and does not include ADHC and LTHHCP.

ADHCP

	Years One and Three
Revenue:	$3,535,694
Expenses:	2,569,797
Net Income:	$965,897
Visits:	20,444
Cost per Visit	$125.70

Utilization by payor source is as follows for years one and three are expected as follows:

Medicaid Fee for Service	89%
Private Pay/Other	11%

Expense and utilization assumptions are based on the historical experience of current services within the facility.

The combined revenues and expenses for the first and third years of operation are as follows:

Revenues:	$32,769,465
Expenses:	33,512,012
Net Income:	$(742,547)

The Wartburg Home has stated they will fund the losses from contributions.

Capability and Feasibility

Project cost of $27,635,934 will be met with a $23,232,000 HEAL-NY 20 Grant, $3,500,000 unrestricted, undesignated net assets from the facility and $903,934 unrestricted net assets from The Wartburg Foundation. Presented as BFA Attachments A and B are the financial summaries of The Wartburg Home and The Wartburg Foundation, respectively, which indicate the availability of sufficient resources.

The submitted budget indicates a net loss of $742,547 during the first and third years of operation. The Wartburg Home has stated that they will fund the losses from contributions. The budget appears reasonable.

As shown on BFA Attachment C, The Wartburg Home has maintained positive working capital and equity and experienced net losses of $3,489,193 and $4,098,540 for 2009 and 2010, respectively. The applicant has stated the losses were due to the facility planning a merger with another facility that never materialized. Several employees were hired in anticipation of the merger causing $2,192,000 of unplanned expenses and no recognized revenues to offset these costs. In 2010, the plan for a merger was abandoned and the facility incurred legal costs of approximately $1,100,000. The facility plans to reduce employee F.T.E.'s to the number existing pre-merger planning.

As of August 31, 2011, the facility generated a loss of $1,344,408. The reasons for the loss are a volume reduction in early 2011, due to extreme inclement weather in the region, a greater number of nursing home discharges than was expected, and the facility received a lower Medicaid rate than what was budgeted. Management has put a hiring freeze on all open positions, cancelled planned salary increases for non-union employees, extended the agreement with SEIU-1199 through July 2010, which will eliminate wage increases, and only slightly add on to pension and health benefit funds, and started the renegotiation process with several vendor contracts.

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Architectural Analysis

Background

The applicant is proposing this project to achieve two objectives: 1) modernize and increase its rehabilitation therapy specialty of RHCF beds; and 2) provide purpose-built space for the adult day health care program so it can reach licensed capacity. Currently, the existing therapy services (physical, occupational, and speech) occupy two relatively small rooms in the Waltemade Building that total approximately 1,300 square feet. By comparison, the new rehabilitation therapy suites will provide more than 3,000 square feet, dramatically improving the environment for both residents and therapists. With this expanded focus, ten more beds will be dedicated to sub-acute rehabilitation.

The replacement facility will be all new construction, and will consist of the following:

- Terrace Level (18,483 SF)

The Terrace Level is the ground level floor and contains a relocated medical adult day health care program as well as service areas for the entire building. These include receiving, mechanical and electrical rooms, trash and other waste disposal rooms. (This lower level will also house an existing social model ADC, relocated from existing space on campus, but excluded from this CON). There will also be a major commercial kitchen which will prepare food for both the ADHC and two skilled nursing floors above.

- First Floor (21,088 SF)

This floor has a 12 resident bed neighborhood and a 13 resident bed neighborhood each with shared common and service spaces in the center. Each neighborhood of 12 or 13 beds provides all private rooms with a full bathroom with shower in each room. A large common area for each neighborhood provides dining space with its own pantry and country kitchen to allow residents to dine in their own neighborhood. . Also within this common area is a nurse work area, including medical records/medicine prep room, clean and soiled utility rooms, and a spa/bathing area. This also includes a staff area with kitchenette and private staff toilet, as well as a treatment room for residents. At the end of each neighborhood is a conference room for staff use. This room is intended for care planning and small staff meetings but can also be used for private conversations between staff/physicians and family members.

At the first floor entry, a covered drop-off leads to a vestibule designed to reduce drafts into the lobby. On the south side of the lobby is an administrative suite which houses admissions and the SNF's director. On the north side of the lobby is a café, which opens to its own exterior terrace and will be available to residents, their families and staff from both the SNF and other areas of Wartburg.

At the end of the lobby is a reception desk, which is positioned to monitor arrivals to the building from the front drop-off as well as the elevator from the Terrace Level parking areas. A multi-purpose room, programmed for the adult day program during the weekdays, will be available to the SNF residents and the Wartburg community at large at other times. Adjacent to the multi-purpose room is the social work office, and around the corner is the hair salon dedicated to serve the skilled nursing residents.

- Second Floor (20,891 SF)

This floor has a 12 and a 13 resident neighborhood in the same configuration as the first floor.

The central portion of the second floor is shared by the physical therapy suite. In addition to the therapy areas, it houses office space for the director of physical therapy and staff, as well as a testing area. Across the hall is the occupational therapy suite. In addition to the open areas, a one-bedroom apartment has been designed to simulate a true residential environment with clearances and room configurations that most closely represent a residential environment that rehabilitation patients will be navigating upon their return home. The OT suite opens to small roof-top terraces which provide outdoor surface training. Adjacent to the therapy suite are offices for speech therapy and the OT/PT staff.

Environmental Review

The Department has deemed this project to be a TYPE I Action and the lead agency shall be the county of Westchester or the authority having jurisdiction.

Recommendation

From an architectural perspective, approval is recommended.

Attachments

BFA Attachment A	2009-2010 Financial Summary, The Wartburg Home of the Evangelical Lutheran Church
BFA Attachment B	Financial Summary, The Wartburg Foundation
BFA Attachment C	Financial Summary, The Wartburg Home of the Evangelical Lutheran Church

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

Diagnostic and Treatment Center – Construction **Exhibit #10**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	101018 C	Doctors United, Inc. (New York County)	Disapproval

Public Health and Health Planning Council

Project # 101018-C

Doctors United, Inc.

County: **New York (New York)**
Purpose: **Construction**
Program: **Diagnostic and Treatment Center**
Submitted: **January 27, 2010**

Executive Summary

Description

Doctors United, Inc., a proprietary diagnostic and treatment center (D&TC), requests approval to certify an extension clinic at 1970 7th Avenue, New York. The applicant is a D&TC with a main site at 1 Bridge St, Ardsley, New York (Westchester County) and extension clinics in the Bronx, White Plains and Yonkers.

All of the operator's existing sites are certified for podiatry, primary medical care, diagnostic radiology and physical therapy. Most of the services provided by Doctors United are physical therapy. According to information provided by the applicant, in 2008, physical therapy comprised 85.66% of utilization at its existing sites. In 2009 the percentage was 82.32%, and for the first quarter of 2010 the percentage was 79.33%. The applicant requests certification for health fairs, nutrition, podiatry, primary medical care, and physical therapy at the proposed extension site.

The proposed clinic would occupy space presently in use as a private practice by a physiatrist and physical therapist. The applicant contends that the new clinic is not the conversion of a private practice, because the existing practice will not be part of the new clinic, and its providers will not join the staff.

DOH Recommendation

Disapproval.

Need Summary

Because there is no specific need methodology for D&TCs, the Department is guided by the factors for determining public need for health services and medical facilities set forth in Section 709.1. As such:

- The applicant has not met the requirement of 709.1(a)(5) to demonstrate the need for its proposed mix of services, which are predominantly non-primary care and oriented toward physiatry and physical therapy;

- In proposing no plan for charity care nor a sliding fee scale nor an outreach program or other effort to promote its services, the applicant has not met the requirement of 709.1(a)(7) to demonstrate the potential contribution of the proposed facility to meet the health needs of medically underserved groups;

- In considering the evaluative criteria set forth in 709.1(b), the Department notes the existence of a considerable number of other D&TC services and physician primary care resources in the service area and concludes that there is no need for the proposed facility and its mix of non-primary care services not integrated with other providers.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this project.

Office of Health Systems Management
Disapproval.

Council Action Date
February 2, 2012

Need Analysis

Project Description

Doctors United, Inc., a diagnostic and treatment center located in Ardsley, NY, proposes certification of an extension clinic at 1970 7th Avenue, New York (New York County). The applicant is a D&TC with a main site at 1 Bridge St, Ardsley, New York (Westchester County) and extension clinics in the Bronx, White Plains and Yonkers.

All of the operator's existing sites are certified for podiatry, primary medical care, diagnostic radiology and physical therapy. Most of the services provided by Doctors United are physical therapy. According to information provided by the applicant, in 2008, physical therapy comprised 85.66% of utilization at its existing sites. In 2009 the percentage was 82.32%, and for the first quarter of 2010 the percentage was 79.33%. The applicant requests certification for health fairs, nutrition, podiatry, primary medical care, and physical therapy at the proposed extension site.

The proposed clinic would occupy space presently in use as a private practice by a physiatrist and physical therapist. The applicant contends that the new clinic is not the conversion of a private practice, because the existing practice will not be part of the new clinic, and its providers will not join the staff.

Analysis

The applicant defines its primary service area as Zip Codes 10026, 10027, 10030, 10037, and 10039. Most of the primary service area is designated as a medically underserved or professional shortage area (MUA/P) by the Department of Health and Human Services.

In describing the health needs of the proposed service area, the applicant furnishes information that repeats the health care profiles for Central Harlem from the New York City Department of Health's community profiles and the New York State Department of Health's county profiles. The applicant's submission describes the well-known prevalence of asthma, cardiovascular disease, and diabetes in Central Harlem.

The prevalence of these chronic disease problems is evident in the Prevention Quality Indicators[1] for the Central Harlem area as shown in the following table:

Prevention Quality Indicators – Central Harlem

PQI	DESCRIPTION	Unadjusted Rate	Adjusted Rate	Statewide Rate	Percent Difference
1	Diabetes short-term complication	75.44	79.02	37.24	112.18%
2	Diabetes long-term complication	236.25	270.52	105.85	155.57%
3	Pediatric asthma	253.45	244.11	72.59	236.28%
4	Hypertension	117.79	131.12	40.21	226.08%
5	Congestive heart failure	538.67	604.94	334.36	80.93%
6	Uncontrolled diabetes	66.18	73.66	29.95	145.95%
7	Adult asthma	343.45	363.56	126.00	188.55%

Despite the prevalence of these conditions in the proposed service area and their persistence at levels well above statewide averages, the services proposed for the applicant's extension site do not address the prevention or management of these chronic ailments. A key to such prevention and management is primary care, preferably following the Patient-Centered Medical Home Model (PCMH), designed to provide patient-centered medical care as part of a comprehensive program to track and manage care over time and across a variety of treatment settings.[2] Yet

[1] Prevention Quality Indicators (PQIs) are a set of measures used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe episodes.

[2] NCQA. Patient-Centered Medical Home (PCMH) 2011. January 21, 2011

only a minority of the visits for the proposed D&TC extension site would be for primary care that would be compatible with the PCMH model or other arrangements for effective disease prevention and management:

Doctors United - Projected First and Third Year Visits		
Service	*First Year Incremental*	*Third Year Incremental*
Primary Medical Care	2,194	3,375
Physiatry	1,463	2,250
Neurology	1,316	2,025
Cardiology	366	563
Physical Therapy	2,072	3,187
Podiatry	350	700
TOTAL	7,761	12,100

Based on the projected utilization by service category, primary medical care and podiatry would equal 2,544 visits in the first year and 4,075 visits in the third year of operation. Of the total volume of visits, primary medical care and podiatry would account for 32.8% of visits in the first year and 33.7% of visits in the third year. Physiatry and physical therapy, on the other hand, would account for 45.5% of total visits in the first year and 44.9% of total visits in the third year. Collectively, physiatry, physical therapy and neurology would account for over 60% of total visits in both the first and third years of the proposed clinic's operation. The applicant has not documented a need for such a mix of non-primary care services in the service area, nor does the applicant propose to collaborate with primary care providers in arrangements where these services might be appropriate as part of a comprehensive prevention and disease management program, in a PCMH or other model of integrated services anchored by primary care.

The mix of services at Doctors United's existing sites further attest to the applicant's orientation toward more specialized, non-primary care services, with a clear orientation toward those involving physical medicine and physical therapy:

Type of Service	*2008*	*2009*	*2010 1st Quarter*
Primary Care (includes Cardiology)	559	1,548	700
Physical Medicine and Rehab/Neurology/Physicians assistant	10,867	12,841	3,679
Podiatry	0	655	159
Physical Therapy	68,271	70,038	17,655
Total Visits	***79,697***	***85,082***	***22,193***

In 2009, physiatry and physical therapy accounted for 70,038 of the total of 85,082 clinic visits or 82.3% of the total visits.

The Central Harlem area is well-served by D&TCs providing primary care and other needed services. There are 11 D&TC's and associated extension sites in the service area and 27 physicians in private practice that serve the Medicaid population.[3]

Health Services	*Providers*
Diagnostic & Treatment Centers	11
Hospital Outpatient Center	1
Hospital O/P Labs	1
Physician Services	27
Nurse-Midwife	1

Data from the Office of Medicaid Management also show a high ratio of primary care visits annually by Medicaid clients in the service area:

[3] Physicians filing total Medicaid claims of $5,000 per year or more.

Zip Code	Total Medicaid Recipients	HMO Enrollment	MA Fee for Service Recipients	Annual Primary Care Visits	Primary Care Use Per Eligible Year
10026	13,418	7,616	5,802	34,490	5.94
10027	20,319	11,385	8,934	57,850	6.48
10030	11,825	6,946	4,879	28,852	5.91
10037	6,660	3,661	2,999	17,432	5.81
10039	10,894	6,658	4,236	24,560	5.80
Total	**63,115**	**36,266**	**26,849**	**163,184**	**6.08**
Statewide	**3,878,955**	**2,096,705**	**1,782,250**	**10,279,812**	**5.77**

The annual primary care visits equals 6.08 visits, compared to the statewide average of 5.77 Medicaid visits for primary care. This level of utilization demonstrates that the Medicaid population is able to access primary care providers.

The persistence of poor health indicators, as documented by the PQI's referred to above, in an area with a large number of primary care providers, may be attributable to factors such as an absence of sufficient outreach efforts to underserved populations. It may further be due to the fact that 24 percent of the Central Harlem population does not have health insurance, and therefore cannot access the primary care services available in the service area. Despite these circumstances, the applicant proposes no plan to provide charity care and makes no mention of use of a sliding-fee scale at the proposed site. The applicant also projects that only 2.91% of its patients will be self-pay clients.

The Department also notes its recent approval of The Institute for Urban Family Health, a federally qualified health center (FQHC), to open the Family Health Center as an extension clinic on the campus of the former North General Hospital to serve patients from Central Harlem and East Harlem. This FQHC is certified as a Level 3-NCQA Patient Centered Medical Home. The projected primary care visits are 65,852 in the first year and 79,051 in the third year, which should have a favorable impact on health indicators in the service area. The opening of an additional D&TC would not be well-advised before this facility is fully operational and its impact on the service area assessed. As noted, Doctors United has also made no mention of any plan to collaborate with the Institute for Urban Family Health or any other provider in implementing a PCMH or other program of coordinated care.

Conclusion

Because there is no specific need methodology for D&TCs, the Department is guided by the factors for determining public need for health services and medical facilities set forth in Section 709.1.

- The applicant has not met the requirement of 709.1(a)(5) to demonstrate the need for its proposed mix of services, which are predominantly non-primary care and oriented toward physiatry and physical therapy;

- In proposing no plan for charity care nor a sliding fee scale nor an outreach program or other effort to promote its services, the applicant has not met the requirement of 709.1(a)(7) to demonstrate the potential contribution of the proposed facility to meet the health needs of medically underserved groups;

- In considering the evaluative criteria set forth in 709.1(b), the Department notes the existence of a considerable number of other D&TC services and physician primary care resources in the service area and concludes that there is no need for the proposed facility and its mix of non-primary care services not integrated with other providers.

Recommendation

From a need perspective, disapproval is recommended.

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

Diagnostic and Treatment Center – Establish/Construct **Exhibit #11**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	101164 B	Mobile Health Services, LLC (New York County)	Contingent Approval
2.	112142 E	Primary Health Care Plus, Inc. (Nassau County)	Approval

Residential Health Care Facility – Establish **Exhibit #12**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	101068 E	Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC d/b/a Guilderland Center Rehabilitation and Extended Care Facility (Albany County)	Contingent Approval

Certificate of Amendment of the Certificate of Incorporation **Exhibit #13**

	Applicant	E.P.R.C. Recommendation
1.	BMA, Medical Foundation, Inc.	Approval

Certificate of Dissolution **Exhibit #14**

	Applicant	E.P.R.C. Recommendation
1.	Mary McClellan Hospital, Inc.	Approval

HOME HEALTH AGENCY LICENSURES

Exhibit #15

Number	Applicant/Facility	E.P.R.C. Recommendation
1959 L	Stat Staff Professionals, Inc. (Saratoga, Warren, Albany, Greene, Franklin, Washington, Rensselaer, Columbia, Clinton, Fulton, Otsego, Ulster, Essex, Montgomery, Schoharie, Hamilton, Schenectady, and Delaware Counties)	Contingent Approval

Public Health and Health Planning Council

Project # 101164-B
Mobile Health Services, LLC

County: **New York (New York)**
Purpose: **Establishment and Construction**
Program: **Diagnostic and Treatment Center**
Submitted: **June 29, 2010**

Executive Summary

Description
Mobile Health Services, LLC (MHS), a to-be-formed limited liability company, requests approval to establish and construct an Article 28 diagnostic and treatment center (D&TC). The D&TC will consist of a main site at 229 West 36th Street, New York, and four extension clinics – located in Brooklyn, Hempstead, Staten Island, and Queens. Despite the name Mobile Health Services, LLC, no mobile services are proposed. The D&TC will provide primary care services. The sole member and manager of MHS is Bert Brodsky.

The precursor entities to MHS are Mobile Health Management Services, Inc. and Mobile Health Medical Services, PC (both owned by Mr. Brodsky), both of which will be folded into the LLC. Mobile Health Management Services, Inc. is an existing entity that provides management services to Mobile Health Medical Services, PC. Under contract with home health agencies, the PC provides home health workers in New York State with annual health and pre-employment screenings. The applicant will continue to provide these services to home health agencies.

With this CON application, the establishment of a new Article 28 D&TC with five sites will not only continue to provide health screening and diagnostic services for employees of current home health agency clients, but will expand services to provide primary care, preventive and diagnostic services to current patients who require care. The new sites will expand the patient base beyond home health agency clients to serve the general population in the service area.

Total project costs are estimated at $195,621.

DOH Recommendation
Contingent approval.

Need Summary
While proposing to provide services to the employees of their home care agency clients, the D&TC and its 4 extension clinics will also be open to the public. The number of projected visits for the combined five sites is as follows:

First Year:	8,999
Third Year:	10,650

Program Summary
Based on the information reviewed, staff found nothing which would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Summary
Project costs will be met via equity from the proposed member personal resources.

Budget:		
	Revenues:	*$ 827,561*
	Expenses:	*792,575*
	Gain/(Loss):	*$ 34,986*

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary
The proposed project comprises renovations at 5 separate sites including a main primary care facility and 4 extension clinics. Currently, the facilities provide only health screenings for home health workers. The proposed project will expand the services of each facility to include primary care, preventive and diagnostic treatment services to home health workers, their clients and the general population located within the service area.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of the marketing and advertising plan acceptable to the Department detailing information on the community outreach programs. [RNR]
3. Submission of a statement from the governing body of the Article 28, acceptable to the Department, that states the Organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations, such as racial and ethnic minorities, women and handicapped persons, and the commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of a written commitment that at least 5 percent of total visits to the approved extension clinics annually will be uninsured or under-insured patients by the second year of operation. [RNR]
5. Submission of a written agreement that the percentage of total visits annually by Medicaid managed care and fee-for-service beneficiaries, in the aggregate, to the approved extension clinics, will be at least 60 percent. [RNR]
6. Submission of a written commitment that at least 50 percent of total visits to the approved extension clinics will be for primary care. [RNR]
7. Written acknowledgement, executed by the governing body, that the third year of operation the approved extension clinics will achieve at least Level 1 practice certification under the NCQA Patient-Centered Medical Home standards and guidelines. [RNR]
8. Submit a comprehensive plan to achieve the "Prevention Agenda's 2013 Objectives" in the identified service area. [RNR]
9. Submission of a letter of agreement to provide annual reports to the Department beginning in the second year of operation that track the applicant's progress in achieving the "Prevention Agenda's 2013 Objectives". [RNR]
10. Submission of executed transfer and affiliation agreements, acceptable to the Department, with a local acute care hospital. [HSP]
11. Submission of an executed amended lease agreement for the Queens site with a 10 year term that is acceptable to the Department. [BFA]
12. Submission of an executed amended lease agreement for the State Island site with a 10 year term that is acceptable to the Department. [BFA]
13. Submission of an executed asset purchase agreement that is acceptable to the Department. [BFA]
14. Queens site: This clinic is provided with two exit stair enclosures that are accessible by a single corridor and are not adequately separated. Separation of the two exits in compliance with NFPA 101 will be required. [AER]
15. Brooklyn site: One of two waiting areas at this site must be reconfigured to ensure patient privacy in adjacent exam rooms. [AER]
16. All sites: Confirmation that the ventilation systems at all sites are in compliance with applicable regulation is to be provided. [AER]
17. Submission of a photocopy of the applicant's executed proposed articles of organization, which are acceptable to the Department. [CSL]
18. Submission of a photocopy of the applicant's executed proposed operating agreement, which is acceptable to the Department. [CSL]

Approval conditional upon:

1. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
2. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
3. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]

4. The clinical space must be used exclusively for the approved purpose. [HSP]
5. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
6. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by March 1, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date
February 2, 2012.

Need Analysis

Background
Mobile Health Services, LLC (MHS) proposes to establish and construct a diagnostic and treatment center (D&TC) in leased space on the 10th floor of the building located at 229 West 36th Street, New York. Four extension clinics will also be established at the following locations:

1. Brooklyn: 50 Court Street, Brooklyn, 11201
2. Hempstead: 129 Jackson Street, Hempstead, 11550
3. Queens: 97-77 Queens Blvd., Rego Park,11374
4. Staten Island: 294 New Dorp Lane, 2nd Floor, Staten Island, 10306

The applicant proposes to provide the following services:

Site of Clinic	***Proposed Certified Services***				
Manhattan (Main)	Primary Care O/P	Diagnostic Radiology O/P	Pulmonary Function Testing	Electro-cardiology	Bone Densitometry
Queens	Primary Care O/P		Pulmonary Function Testing	Electro-cardiology	Bone Densitometry
Staten Island	Primary Care O/P		Pulmonary Function Testing	Electro-cardiology	Bone Densitometry
Hempstead	Primary Care O/P	Diagnostic Radiology O/P	Pulmonary Function Testing	Electro-cardiology	Bone Densitometry
Brooklyn	Primary Care O/P		Pulmonary Function Testing	Electro-cardiology	Bone Densitometry

Analysis
The primary service area for each of these five sites identified by the applicant is as follows:

Brooklyn: Zip Codes 11201, 11251, 11205, 11217, 11231, 11215
Hempstead: ZIP Codes 11550, 11510, 11552, 11553 and 11570.
Manhattan-Main Site: Zip Codes 10018, 10001, 10010, 10016, 10017, 10036;
Queens: Zip Codes 11374, 11368, 11373, 11375, 11379 and 11385;
Staten Island: Zip Codes 10306, 10304, 10305, 10308 and 10314.

An analysis of each site follows:

1. Brooklyn Analysis

Of the 214,696 service area residents, 47,562, 22 percent, are enrolled in Medicaid. Of these Medicaid enrollees, 57 percent are enrolled in HMOs and the remaining 43 percent are enrolled in the fee-for-service Medicaid plan.

Fee-for-service Medicaid patients had 8.56 primary care visits per person per year vs. the statewide average of 5.77 visits per year, totaling 175,926 visits.

The Brooklyn Site service area has a total of eight (8) D&TCs, 20 extension clinics, three (3) hospitals, 13 school-based D&TCs, four (4) specialty D&TC, and six (6) specialty clinics.

The service area also has a total of 131 physicians in private practice that serve the Medicaid population.

Brooklyn Site: Medicaid Enrollment and Ambulatory Services by Zip Code:

	Medicaid Enrollment			***Ambulatory Services***	
Mobile Health Services, LLC – Brooklyn Site	*Total Medicaid Recipients*	*HMO Enrollment*	*MA Fee for Service Recipients*	*Annual Primary Care Visits*	*Primary Care Use per Eligible Year*
11201	8,979	4,133	4,846	43,060	8.89
11205	13,037	8,338	4,699	37,952	8.08
11215	8,782	5,284	3,498	28,420	8.12
11217	8,882	4,533	4,349	41,216	9.48
11231	7,877	4,721	3,156	25,254	8
11251	5	4	1	24	48
Total	47,562	27,013	20,549	175,926	8.56
Statewide					*5.77*

Source: NYSDOH Medicaid Data

Count of Facilities in Service Area: Brooklyn Site	*Count*
CHHA	3
D&TC	8
Extension Clinic	20
Hospital	3
LTHHCP	1
RHCF	5
RHCF adult day care	2
School D&TC	13
Specialty D&TC	4
Specialty	6

Source: NYSDOH Medicaid Data

Prevention Quality Indicators (PQIs). PQIs are expressed as annual discharges per 100,000 persons, unless otherwise specified:

PQI	*Description*	*Unadjusted Rate*	*Adjusted Rate*	*Statewide Rate*	*% Difference between Adjusted and Statewide Rates*
1	Diabetes short-term complication	39.6	40.5	37.2	8.67%
2	Perforated appendix (Percentage of appendix discharges)*	25.67	27.91	27	3.36%
3	Diabetes long-term complication	134.14	165.31	105.85	56.17%
4	Pediatric asthma	87.1	109.38	72.59	50.68%
5	Chronic obstructive pulmonary disease	121.1	160.86	156.96	2.48%
6	Pediatric gastroenteritis	46.58	58.52	31.25	87.27%
7	Hypertension	62.41	73.03	40.21	81.62%
8	Congestive heart failure	364.7	477.1	334.36	42.69%
9	Low birth weight (Percentage of Births)*	5.77	5.77	5.75	0.34%
10	Dehydration	129.02	170.35	131.81	29.23%
11	Bacterial pneumonia	389.39	498.03	332.18	49.93%
12	Urinary tract infection	157.9	196	139.25	40.76%
13	Angina without procedure	36.33	43.17	49.25	-12.34%

14	Uncontrolled diabetes	81.98	94.49	29.95	215.51%
15	Adult asthma	221.71	237.95	126	88.85%
16	Lower-extremity amputation among patients with diabetes	34.47	44.34	30.14	47.14%

Source: NYSDOH Medicaid Data

2. Hempstead Analysis

Of the 165,956 service area residents, 26,376, 16 percent, are enrolled in Medicaid. Of these Medicaid enrollees, 49 percent are enrolled in HMOs and the remaining 51 percent are enrolled in the fee-for-service Medicaid plan.

The fee-for-service Medicaid patients had 3.95 primary care visits per person per year vs. the statewide average of 5.77 visits per year, totaling 53,438 visits.

The Hempstead Site service area has a total of three D&TCs, six extension clinics, two hospitals, one (1) school-based D&TCs, and two (2) specialty D&TC.

The service area also has a total of 22 physicians in private practice that serve the Medicaid population.

Hempstead Site: Medicaid Enrollment and Ambulatory Services by Zip Code:

	Medicaid Enrollment			***Ambulatory Services***	
Mobile Health Services, LLC – Hempstead Site	*Total Medicaid Recipients*	*HMO Enrollment*	*MA Fee for Service Recipients*	*Annual Primary Care Visits*	*Primary Care Use per Eligible Year*
11510	2,259	876	1,383	4,206	3.04
11550	15,431	8,036	7,395	27,184	3.68
11552	1,844	895	949	2,772	2.92
11553	5,060	2,319	2,741	13,206	4.82
11570	1,777	701	1,076	6,070	5.64
Total	26,372	12,827	13,545	53,438	3.95
Statewide					5.77

Source: NYSDOH Medicaid Data

Count of Facilities in Service Area: Hempstead Site	*Count*
CHHA	3
D&TC	3
Extension Clinic	6
Hospital	2
LTHHCP	1
RHCF	7
School D&TC	1
Specialty D&TC	2

Source: NYSDOH Medicaid Data

Prevention Quality Indicators (PQIs). PQIs are expressed as annual discharges per 100,000 persons, unless otherwise specified:

PQI	Description	Unadjusted Rate	Adjusted Rate	Statewide Rate	% Difference between Adjusted and Statewide Rates
1	Diabetes short-term complication	39.2	40.5	37.2	8.81%
2	Perforated appendix (Percentage of appendix discharges)*	22.11	21.43	27	-20.63%
3	Diabetes long-term complication	116.3	121.67	105.85	14.95%
4	Pediatric asthma	82.55	77.68	72.59	7.01%
5	Chronic obstructive pulmonary disease	130.15	137.79	156.96	-12.21%
6	Pediatric gastroenteritis	61.46	57.9	31.25	85.28%
7	Hypertension	62.67	65.05	40.21	61.78%
8	Congestive heart failure	336.84	353.86	334.36	5.83%
9	Low birth weight (Percentage of Births)*	5.99	5.95	5.75	3.54%
10	Dehydration	146.42	148.23	131.81	12.45%
11	Bacterial pneumonia	424.21	438.89	332.18	32.12%
12	Urinary tract infection	200.66	203.67	139.25	46.27%
13	Angina without procedure	59.65	62.44	49.25	26.77%
14	Uncontrolled diabetes	53.03	55.11	29.95	84.02%
15	Adult asthma	126.54	128.83	126	2.25%
16	Lower-extremity amputation among patients with diabetes	35.55	38.42	30.14	27.49%

Source: NYSDOH Medicaid Data

3. Manhattan Analysis

Of the 134,142 service area residents, 22,927, 17 percent, are enrolled in Medicaid. Of these Medicaid enrollees, 32 percent are enrolled in HMOs and the remaining 68 percent are enrolled in the fee-for-service Medicaid plan.

The fee-for-service Medicaid patients had 7.24 primary care visits per person per year vs. the statewide average of 5.77 visits per year, totaling 112,234 visits.

The Manhattan site service area has a total of five (5) D&TCs, 11 extension clinics, two (2) hospitals, two (2) school-based D&TCs, 16 specialty D&TCs, and two (2) specialty clinics. The service area also has a total of 31 physicians in private practice that serve the Medicaid population.

Manhattan Main Site: Medicaid Enrollment and Ambulatory Services by Zip Code:

	Medicaid Enrollment			Ambulatory Services	
Mobile Health Services, LLC – Manhattan (Main) Site	Total Medicaid Recipients	HMO Enrollment	MA Fee for Service Recipients	Annual Primary Care Visits	Primary Care Use per Eligible Year
10001	8,321	2,126	6,195	37,468	6.05
10010	2,049	729	1,320	7,028	5.32
10016	3,583	1,339	2,244	10,648	4.75
10017	596	186	410	2,502	6.1
10018	2,666	1,005	1,661	35,706	21.5
10036	5,712	2,046	3,666	18,882	5.15
Total	22,927	7,431	15,496	112,234	7.24
Statewide					5.77

Source: NYSDOH Medicaid Data

Count of Facilities in Service Area: Manhattan Site	Count
CHHA	5
D&TC	5
Extension Clinic	11
Hospice	1
Hospital	2
LTHHCP	1
School D&TC	2
Specialty D&TC	16
Specialty	2

Source: NYSDOH Medicaid Data

Prevention Quality Indicators (PQIs). PQIs are expressed as annual discharges per 100,000 persons, unless otherwise specified:

PQI	Description	Unadjusted Rate	Adjusted Rate	Statewide Rate	% Difference between Adjusted and Statewide Rates
1	Diabetes short-term complication	34.29	30.56	37.24	-17.93%
2	Perforated appendix (Percentage of appendix discharges)*	20.81	26.41	27.00	-2.19%
3	Diabetes long-term complication	84.98	82.86	105.85	-21.72%
4	Pediatric asthma	31.31	102.54	72.59	41.25%
5	Chronic obstructive pulmonary disease	135.68	140.90	156.96	-10.24%
6	Pediatric gastroenteritis	7.45	24.36	31.25	-22.04%
7	Hypertension	26.09	27.16	40.21	-32.45%
8	Congestive heart failure	237.06	248.38	334.36	-25.71%
9	Low birth weight (Percentage of Births)*	4.47	4.47	5.75	-22.12%
10	Dehydration	132.70	176.76	131.81	34.09%
11	Bacterial pneumonia	315.34	344.61	332.18	3.74%
12	Urinary tract infection	105.86	119.96	139.25	-13.85%
13	Angina without procedure	30.56	30.22	49.25	-38.64%

14	Uncontrolled diabetes	35.04	33.54	29.95	11.98%
15	Adult asthma	146.11	136.29	126.00	8.17%
16	Lower-extremity amputation among patients with diabetes	17.89	17.80	30.14	-40.92%

Source: NYSDOH Medicaid Data

4. Queens Analysis

Of the 445,465 service area residents, 119,419, 27 percent, are enrolled in Medicaid. Of these Medicaid enrollees, 61 percent are enrolled in HMOs and the remaining 39 percent are enrolled in the fee-for-service Medicaid plan.

The fee-for-service Medicaid patients had 4.95 primary care visits per person per year vs. the statewide average of 5.77 visits per year, totaling 230,366 visits.

The Queens Site service area has a total of three D&TCs, five extension clinics, four hospitals, three school-based D&TCs, one specialty D&TC, and one specialty clinic. The service area also has a total of 132 physicians in private practice that serve the Medicaid population.

Queens Site: Medicaid Enrollment and Ambulatory Services by Zip Code:

	Medicaid Enrollment			***Ambulatory Services***	
Mobile Health Services, LLC – Queens Site	*Total Medicaid Recipients*	*HMO Enrollment*	*MA Fee for Service Recipients*	*Annual Primary Care Visits*	*Primary Care Use per Eligible Year*
11368	37,800	25,585	12,215	65,238	5.34
11373	32,924	20286	12,638	45,820	3.63
11374	10,388	4,799	5,589	33,730	6.04
11375	9761	4332	5429	30,284	5.58
11379	3,460	1,580	1,880	9,664	5.14
11385	25,087	16,303	8,784	45,630	5.19
Total	119,419	72,885	46,534	230,366	4.95
Statewide					5.77

Source: NYSDOH Medicaid Data

Count of Facilities in Service Area: Queens Site	*Count*
CHHA	1
D&TC	3
Extension Clinic	5
Hospital	4
LTHHCP	1
RHCF	6
RHCF adult day care	2
School D&TC	3
Specialty D&TC	1
Specialty	1

Source: NYSDOH Medicaid Data

Prevention Quality Indicators (PQIs). PQIs are expressed as annual discharges per 100,000 persons, unless otherwise specified:

PQI	Description	Unadjusted Rate	Adjusted Rate	Statewide Rate	% Difference between Adjusted and Statewide Rates
1	Diabetes short-term complication	22.0	21.4	37.2	-42.43%
2	Perforated appendix (Percentage of appendix discharges)*	25.46	26.38	27	-2.30%
3	Diabetes long-term complication	101.47	105.71	105.85	-0.13%
4	Pediatric asthma	72.73	82.33	72.59	13.42%
5	Chronic obstructive pulmonary disease	136.94	142.4	156.96	-9.28%
6	Pediatric gastroenteritis	71.16	80.68	31.25	158.18%
7	Hypertension	43.33	44.6	40.21	10.92%
8	Congestive heart failure	285.99	295.36	334.36	-11.66%
9	Low birth weight (Percentage of Births)*	4.95	4.95	5.75	-13.90%
10	Dehydration	131.77	137.82	131.81	4.55%
11	Bacterial pneumonia	292.28	302.87	332.18	-8.82%
12	Urinary tract infection	156.47	161.67	139.25	16.10%
13	Angina without procedure	52.08	54.17	49.25	9.99%
14	Uncontrolled diabetes	33	33.73	29.95	12.63%
15	Adult asthma	116.51	116.98	126	-7.16%
16	Lower-extremity amputation among patients with diabetes	25.37	26.58	30.14	-11.79%

Source: NYSDOH Medicaid Data

5. Staten Island Analysis

Of the 244,392 service area residents, 38,732, 16 percent, are enrolled in Medicaid. Of these Medicaid enrollees, 57 percent are enrolled in HMOs and the remaining 43 percent are enrolled in the fee-for-service Medicaid plan.

The fee-for-service Medicaid patients had 5.08 primary care visits per person per year vs. the statewide average of 5.77 visits per year, totaling 84,198 visits.

The Staten Island site service area has a total of 12 extension clinics, four (4) hospitals, one (1) school-based D&TCs, and three (3) specialty D&TC. The service area also has a total of 46 physicians in private practice that serve the Medicaid population.

Staten Island Site: Medicaid Enrollment and Ambulatory Services by Zip Code:

	Medicaid Enrollment			**Ambulatory Services**	
Mobile Health Services, LLC – Staten Is. Site	*Total Medicaid Recipients*	*HMO Enrollment*	*MA Fee for Service Recipients*	*Annual Primary Care Visits*	*Primary Care Use per Eligible Year*
10304	12,310	7,569	4,741	25,272	5.33
10305	6,888	3,886	3,002	16,016	5.34
10306	6,348	3,445	2,903	15,706	5.41
10308	2,013	1,137	876	3,384	3.86
10314	11,174	6,108	5,066	23,820	4.7
Total	38,732	22,145	16,587	84,198	5.08
Statewide					5.77

Source: NYSDOH Medicaid Data

Count of Facilities in Service Area: Staten Island Site	*Count*
Extension Clinic	12
Hospice	1
Hospital	4
RHCF	8
RHCF adult day care	1
School D&TC	1
Specialty D&TC	3

Source: NYSDOH Medicaid Data

Prevention Quality Indicators (PQIs). PQIs are expressed as annual discharges per 100,000 persons, unless otherwise specified:

PQI	*Description*	*Unadjusted Rate*	*Adjusted Rate*	*Statewide Rate*	*% Difference between Adjusted and Statewide Rates*
1	Diabetes short-term complication	34.0	34.0	37.2	-8.59%
2	Perforated appendix (Percentage of appendix discharges)*	21.43	20.66	27	-23.47%
3	Diabetes long-term complication	135.44	131.68	105.85	24.40%
4	Pediatric asthma	54.01	54.68	72.59	-24.67%
5	Chronic obstructive pulmonary disease	246.73	241.71	156.96	53.99%
6	Pediatric gastroenteritis	44.6	45.2	31.25	44.64%
7	Hypertension	57.69	55.94	40.21	39.11%
8	Congestive heart failure	371.94	369.68	334.36	10.57%
9	Low birth weight (Percentage of Births)*	5.86	5.86	5.75	1.91%
10	Dehydration	126.85	126.21	131.81	-4.25%
11	Bacterial pneumonia	464.42	462.59	332.18	39.26%
12	Urinary tract infection	173.9	174.5	139.25	25.32%
13	Angina without procedure	56.06	54.56	49.25	10.77%
14	Uncontrolled diabetes	35.19	34.59	29.95	15.48%
15	Adult asthma	110.48	108.34	126	-14.01%
16	Lower-extremity amputation among patients with diabetes	33.55	32.8	30.14	8.84%

Source: NYSDOH Medicaid Data

Conclusion

Mobile Health Services will provide primary care, preventive and diagnostic services to patients that are currently being seen for pre-employment physicals and annual health screenings but who do not have access to primary care services. Mobile will expand upon their current relationship with these patients who are home health workers to ensure that health problems are treated appropriately and within a continuum of care. In addition, Mobile Health will be open to the public, in areas where, on the whole, PQI's and current health care service levels suggest that additional primary care services would be of benefit.

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Background

Establish a diagnostic and treatment center with four extension clinics.

Proposed Operator	Mobile Health Services	
Operator Type	LLC	
Site Addresses	(Main Site) 229 West 36th St New York	97-77 Queens Blvd Rego Park
	294 New Dorp Ln Staten Island	129 Jackson St Hempstead
	50 Court St Brooklyn	
Services	Primary Medical Care Diagnostic Radiology	
Shifts/Hours/Schedule	Monday through Friday, 7:30am to 6:00pm	
Staffing (1st Year / 3rd Year)	5.77 FTEs / 6.37 FTEs	
Medical Director	Daniel Schlusselberg	
Emergency, In-Patient and Backup Support Services Agreement	Being negotiated with several hospitals	

Compliance with Applicable Codes, Rules and Regulations

The medical staff will ensure that procedures performed at the Center conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The Center's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

A sliding fee scale will be in place for those without insurance, and provisions will be made for those who cannot afford services. The governing body intends on using a patient satisfaction measurement tool, and discussions with their patients, to reflect responsiveness to community need, as well as provide continuous, ongoing feedback to the organization for the total quality management improvement program.

Character and Competence

The sole managing member is Bert Brodsky. Mr. Brodsky has extensive business experience as well as experience serving on the boards of a residential health care facility and an assisted living facility.

Staff from the Division of Certification and Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant’s and relatives’ ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management (relative to Medicaid fraud and abuse), the Office of Professional Medical Conduct, and the Education Department databases.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action. Based on this information, staff concluded that the facilities have provided a substantially consistent high level of care as defined in New York State Public Health Law 2810(a)(3) and 10NYCRR 600.2 during the past 10 years.

Conclusion

The above reviews revealed nothing which would reflect adversely upon the applicant's character and competence or standing in the community.

Recommendation

From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Lease Rental Agreement

The applicant will occupy the main site and the five extension sites under the following executed leases, summarized below:

Main Site	
Date:	October 7, 2009
Premises:	10,083 square feet located at 229 West 36th Street, Manhattan, New York
Lessor:	229 W. 36th Street Partnership LP.
Lessee:	Mobile Health Management Services, Inc.
Term:	11 years
Rental:	Year 1- $302,490 annually ($30.00 per sq. ft.)
Provisions:	The lessee shall be responsible for real estate taxes and utilities. The lease rental payments will increase by 2.50% to 24% throughout the lease term.

Queens Site	
Date	December 3, 2009
Premises:	2,268 square feet located at 97-77 Queens Boulevard, Queens, New York
Lessor:	Boulevard Leasing Limited Partnership
Lessee:	Mobile Health Management Services, Inc.
Term:	The term is 10 years and 2 months, October 18, 2004 through December 17, 2017.
Rental:	Year 1- $67,858.00 annually ($29.91 per sq. ft.) with a 2.74% increase annually thereafter.

Brooklyn Site	
Date:	October 2010
Premises:	5,530 square feet located at 50 Court Street, Brooklyn, New York
Lessor:	Joseph P. Day Realty Corp.
Lessee:	Mobile Health Management Services, Inc.
Term:	10 years and six months
Rental:	Year 1 through 5- $160,370 annually ($29.00 per sq. ft.) Remainder of the term- $171,430 annually ($31.00 per sq. ft.)
Provisions:	The lessee shall be responsible for maintenance and repairs.

Staten Island Site	
Date:	December 19, 2008
Premises:	1,256 square feet located at 294 New Dorp Lane, 2nd Floor, Staten Island, New York
Lessor:	Joseph Puccio and Vita Puccio
Term:	5 years and 6 months expiring on June 18, 2014.
Rental:	Year One- $27,635 annually ($22.00 per sq. ft.) with a 3% increase each year thereafter.
Provisions:	The lessee shall be responsible for repairs, maintenance and utilities.

Hempstead Site	
Date:	August 1, 2008
Premises:	8,600 square feet located at 129 Jackson Street, Town of Hempstead, Nassau County, New York
Lessor:	BSI Jackson Street, LLC
Lessee:	Mobile Health Management Services, Inc.
Term:	12 years
Rental:	Year 1- $172,000 annually ($20.00 per sq. ft.) with a 3% annual increase thereafter.
Provisions:	The lessee shall be responsible for payment of real estate taxes.

The applicant has submitted an affidavit indicating that each of the lease arrangements will be an arms-length lease arrangement. The applicant has indicated that they are in negotiations with the landlords for the Queens and Staten Island site in order to attempt to meet the Department's 10-year lease term policy. As a contingency of approval, the applicant must submit amended leases for the Queens and the Staten Island sites.

Asset Purchase Agreement

The applicant has submitted a draft asset purchase agreement, which is summarized below:

Seller:	Mobile Health Medical Services, P.C.
Purchaser:	Mobile Health Services, LLC
Assets Transferred:	Business as a going concern; all furniture, fixtures, equipment, machinery and other tangible personal property used or held for use by Seller at the location at which the Business is conducted or otherwise owned or held by the Seller at the Closing; all inventories; all receivables; all books of account, general, financial, tax and personnel records, invoices, shipping records, supplies lists and records and files and any other rights thereto owned, associated with or employed by the Seller other than the organizational documents; the goodwill of the Seller; all of the Seller's right, title and interest in, to and under the Owned Intellectual Property; all claims, causes of action, chosen in action pertaining to, arising out of and inuring to the benefit of the Seller; all sales and promotional literature, customer lists and other sales-related materials owned, used, associated with or employed by the Seller as of the Closing; all rights of the Seller under all contracts, licenses, sublicenses, agreements, leases, commitments, and sales and purchase orders, and under all bids and offers; all municipal, state and federal franchises, permits, licenses, agreements held or used by the Seller; all cash of the Seller and all of the Seller's right, title and interest at the Closing.
Excluded Assets:	All rights of the Seller under this agreement and the Ancillary Agreements and the Company's seal, minute books, charter documents, stock or equity record books and such other books and records as pertain to the organization, existence or capitalization of the Seller.
Assumed Liabilities:	Upon the terms and subject to the conditions of this Agreement, at the Closing, the Purchaser shall assume all Liabilities of the Seller other than the Excluded Liabilities.
Excluded Liabilities:	All taxes of the Seller including Taxes arising out of the operation of the Business

	of the ownership of the Purchased Assets prior to the date of the Closing; all liabilities arising out of or relating to the Excluded Assets; all liabilities arising out of any violation of Law; and all liabilities to the Seller's present or former stockholders.
Purchase Price:	$1

Total Project Cost and Financing

Total project cost for renovations and consulting fees, which is for all the sites, is estimated at $195,621, broken down as follows:

Renovation and Demolition	$117,154
Design Contingency	11,715
Construction Contingency	11,715
Architect/Engineering Fees	14,059
Other Fees (Consultant)	37,919
CON Fees	2,000
Additional Processing Fee	1,059
Total Project Cost	$195,621

Project costs are based on a March 1, 2012 construction start date and a four month construction period. The applicant will provide equity to meet the total project cost from personal resources.

Operating Budget

The applicant has submitted an operating budget for the Article 28 component consisting of primary care services, in 2011 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues	$720,238	$827,561
Expenses:		
Operating	$692,126	$779,738
Capital	12,837	12,837
Total Expenses	$704,963	$792,575
Net Income	$15,275	$34,986
Utilization: (Visits)	8,998	10,649
Cost Per Visit	$78.34	$74.42

BFA Attachment E indicates the cost analysis of this project.

Utilization by payor source for the first and third years is as follows:

	Year One	Year Three
Medicaid-Fee-For-Service	5.74%	5.55%
Medicaid Managed Care	24.60%	23.74%
Medicare Fee-For-Service	2.45%	2.20%
Medicare Managed Care	1.44%	1.27%
Commercial Fee-For-Service	13.06%	12.48%
Commercial Managed Care	30.25%	29.08%
Private Pay	14.19%	16.47%
Charity Care	5.19%	5.89%
Other	3.08%	3.32%

Expense assumptions are based on the experience of the existing P.C., as well as the experience of other diagnostic and treatment centers in New York State, adjusted for facility specific volume estimates.

The applicant has indicated that currently they have 1,800 to 2,000 managed care enrollees via capitated plans who are served by the existing sites. The number alone would indicate annual volume of 6,300 to 7,000 visits, using the long time standard of 3.5 visits per year used by the federal government and the Department of Health.

The applicant is confident that the current physicians working at the sites will remain in place upon CON approval. The transformation to a diagnostic and treatment center will be relatively transparent in that they will continue to see patients within the scope of their practice expertise. To the extent that volume increases due to the development at the primary medical care service, Mobile Health Services will recruit additional physicians in relation to the growth, and as its extended history and success indicate, recruitment of high quality providers has not been an issue for this program.

Capability and Feasibility
Project costs of $195,621 will be met via equity from the proposed member's personal resources.

Working capital requirements are estimated at $132,095 which appears reasonable based on two months of third year expenses. The proposed member of Mobile Health Services, LLC, Bert Brodsky, will provide equity from his personal resources to meet the working capital requirements. Presented as BFA Attachment A is the personal net worth statement of the proposed member of Mobile Health Services, LLC, which indicates the availability of sufficient funds for the project cost and working capital equity requirements. Presented as BFA Attachment B, is the pro-forma balance sheet of Mobile Health Services, LLC, which includes combining Mobile Health Management Services, Inc. and Mobile Health Medical Services, P.C. As shown on Attachment B, the facility will initiate operations with $3,020,149 in members' equity.

The submitted budget indicates a net income of $1,5275 and $34,986 during the first and third years, respectively. Revenues are based on the Ambulatory Patient Group reimbursement methodology. The budget appears reasonable.

Presented as BFA Attachment C are the 2008 and 2009 financial statements of Mobile Health Management Services, Inc. and the 2009 financial statements of Mobile Health Medical Services, P.C. As shown on Attachment C, Mobile Health Management Services, Inc. had an average positive working capital position and an average positive net asset position during the period shown. Mobile Health Medical Services, P.C. had a negative working capital position and a negative net asset position. Also, the facility achieved a combined net income of $655,793 and $32,729 during 2008 and 2009, respectively.

Presented as BFA Attachment D are the December 31, 2010 internal financial statements of Mobile Health Management Services, Inc. and Mobile Health Medical Services, P.C. As shown, Mobile Health Management Services, Inc. has a negative working capital position and a positive net asset position through 2010, while Mobile Health Medical Services, P.C. has a negative working capital position and a negative net asset position through 2010. As shown on Attachment D, Mobile Health Medical Services, P.C. achieved a net income of $5,879 through 2010, and Mobile Health Management Services, Inc. incurred a net loss of $1,194,288 during 2010.

The applicant has indicated that the reason for the losses were the result of the following: the 2010 period covers the "ramp up" of operations at the Hempstead site, a new service site for Mobile Health and involved start-up expenses; added staff at all of its sites in anticipation of additional volumes associated with the current line of business. The Manhattan site was relocated in early 2010, and one-time relocation expenses appear in the income statement. Mr. Brodsky acquired the property that is the location of the new Hempstead site in late 2008, which resulted in unexpected property and school tax bills, mistakenly thought to be the responsibility of the prior owner, were expenses in the period.

The applicant implemented the following improvements: a new software application is expected to be in place in 2011, which will provide the opportunity to require staffing efficiencies and volume increases, unrelated to this application, will contribute to the bottom line.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner; and approval is recommended.

Recommendation
From a financial perspective, contingent approval is recommended.

Architectural Analysis

Review Summary
(24,411 SF of total renovation – 5 sites included)
The proposed project entails renovations at 5 separate sites to provide primary care, preventive and diagnostic treatment services. The main site is located in Manhattan and the 4 extension clinics are located in Brooklyn, Hempstead, Staten Island, and Queens.

- Manhattan (7,500 SF renovation)

The main primary care clinic is located in a 10,083 sf facility on the Tenth Floor of a 12 story, Type I construction office building. Two waiting areas are provided. One located at the facility entrance includes reception and provides 42 seats. The other provides seating for 47 and is located adjacent to the exam and phlebotomy areas and includes a reception/lab station. Eight (8) phlebotomy stations (one handicap accessible) with hand washing stations, eight (8) examination rooms (one handicap accessible), six (6) patient toilets, an X-ray room with control area, and soiled and clean storage. Also provided are four (4) offices, a conference room, employee's locker room, multi-fixture staff toilets for men and women, and a staff break room with kitchenette.

- Staten Island (925 SF renovation)

The proposed primary care clinic will occupy the 1205 gsf second floor of a 3-story office building. Facilities include a reception/work space and two waiting areas, one exam room, two phlebotomy stations, three toilets including one that is accessible, clean and soils storage closets, and a staff break room,

- Queens (1650 SF renovation)

This primary care clinic will occupy the ninth floor of a 13 story high-rise. Two waiting areas are provided, one adjacent to reception, the other near the two exam rooms, one of which is accessible. Three phlebotomy stations provided with one of those being accessible. Support spaces include three patient toilets with one being accessible, patient lockers, staff kitchenette, clean and soils storage closets, general storage, and a janitor's closet.

- Brooklyn (3615 SF renovation)

A 3615 sf portion of the tenth floor in a twelve story office building will be renovated to house this primary care clinic. 5 exam rooms and 4 phlebotomy stations are included with one of each to be handicap accessible. Two separate waiting and reception areas are provided at the facility entrance and within the clinical area. A total of six toilets are provided including one accessible room for patients and another for staff. Also proved are two offices, a triage room, medications room, storage room, a staff lounge with lockers, clean and soils closets, and a janitor's closet.

Environmental Review
The Department has deemed this project to be a TYPE II Action and will not have a significant effect on the environment. An Environmental Impact Statement is not required. However, any agency that has an interest in this project may make their own independent determination of significance and necessity for an EIS in accordance with the procedures specified within Part 97.8 of Title 10: Rules and Regulations.

Recommendation
From an architectural perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Personal Net Worth Statement- Proposed Member Of Mobile Health Services, LLC
BFA Attachment B	Pro-forma Balance Sheet of Mobile Health Services, LLC
BFA Attachment C	2009 internal financial statements of Mobile Health Management Services, Inc. and Mobile Health Medical Services, P.C.
BFA Attachment D	December 31, 2010 Internal Financial Statements of Mobile Health Management Services, Inc., and Mobile Health Medical Services, P.C.
BFA Attachment E	Summary of Detailed Budget
BFA Attachment F	Ambulatory Care Checklist
BHFP Attachment	Map

<u>RESOLUTION</u>

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish and construct an Article 28 diagnostic and treatment center that will consist of a main site at 229 West 36th Street, New York and four extension clinics located in Brooklyn, Hempstead, State Island and Queens, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER</u>:	<u>FACILITY/APPLICANT</u>:
101164-B	Mobile Health Services, LLC

APPROVAL CONTINGENT UPON:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of the marketing and advertising plan acceptable to the Department detailing information on the community outreach programs. [RNR]
3. Submission of a statement from the governing body of the Article 28, acceptable to the Department, that states the Organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations, such as racial and ethnic minorities, women and handicapped persons, and the commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of a written commitment that at least 5 percent of total visits to the approved extension clinics annually will be uninsured or under-insured patients by the second year of operation. [RNR]
5. Submission of a written agreement that the percentage of total visits annually by Medicaid managed care and fee-for-service beneficiaries, in the aggregate, to the approved extension clinics, will be at least 60 percent. [RNR]
6. Submission of a written commitment that at least 50 percent of total visits to the approved extension clinics will be for primary care. [RNR]
7. Written acknowledgement, executed by the governing body, that the third year of operation the approved extension clinics will achieve at least Level 1 practice certification under the NCQA Patient-Centered Medical Home standards and guidelines. [RNR]
8. Submit a comprehensive plan to achieve the “Prevention Agenda’s 2013 Objectives” in the identified service area. [RNR]
9. Submission of a letter of agreement to provide annual reports to the Department beginning in the second year of operation that track the applicant’s progress in achieving the “Prevention Agenda’s 2013 Objectives”. [RNR]
10. Submission of executed transfer and affiliation agreements, acceptable to the Department, with a local acute care hospital. [HSP]
11. Submission of an executed amended lease agreement for the Queens site with a 10 year term that is acceptable to the Department. [BFA]
12. Submission of an executed amended lease agreement for the State Island site with a 10 year term that is acceptable to the Department. [BFA]
13. Submission of an executed asset purchase agreement that is acceptable to the Department. [BFA]
14. Queens site: This clinic is provided with two exit stair enclosures that are accessible by a single corridor and are not adequately separated. Separation of the two exits in compliance with NFPA 101 will be required. [AER]
15. Brooklyn site: One of two waiting areas at this site must be reconfigured to ensure patient privacy in adjacent exam rooms. [AER]
16. All sites: Confirmation that the ventilation systems at all sites are in compliance with applicable regulation is to be provided. [AER]

17. Submission of a photocopy of the applicant's executed proposed articles of organization, which are acceptable to the Department. [CSL]
18. Submission of a photocopy of the applicant's executed proposed operating agreement, which is acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
2. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
3. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
4. The clinical space must be used exclusively for the approved purpose. [HSP]
5. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
6. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by March 1, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

Public Health and Health Planning Council

Project # 112142-E
Primary Health Care Plus, Inc.

County: **Nassau (Franklin Square)**
Purpose: **Establishment**
Program: **Diagnostic and Treatment Center**
Submitted: **September 7, 2011**

Executive Summary

Description
Primary Health Care Plus, Inc. (PHCP), an existing Article 28 diagnostic and treatment center (D&TC) located at 1209 Hemstead Turnpike, Franklin Square, is submitting this application requesting permanent life. Via CON #051049-E, PHCP received five-year limited life approval on March 2, 2006.

Currently, the PHCP provides primary care for conditions such as asthma, diabetes, and hypertension, as well as immunizations. Also, the primary care practice has established relationships with other specialty practices for referrals, and with Franklin Hospital and Mercy Medical Center, which routinely refers its discharge patients to the Center.

In 2009, PHCP received a Certificate of Recognition from the Nassau County Department of Health for its participation in Provider Based Immunization initiatives. The applicant proposes to add podiatry and radiology diagnostic services to its current complement of services, which include comprehensive primary care, certified physical and occupational therapy. No change in the physical plant is planned.

DOH Recommendation
Approval.

Need Summary
PHCP has implemented programs to target diseases with high Prevention Quality Indicator (PQI) rates in its primary service area and the surrounding communities. PHCP has instituted programs to diagnose, screen, and treat its patients for asthma, diabetes, and hypertension. PHCP also instituted programs to diagnose, screen, and treat its patients for breast, cervical, and colorectal cancer and lead poisoning.

PHCP received Level 3 Certificate of Recognition as a Patient-Centered Medical Home from the National Committee for Quality Assurance (NCQA) in 2010 for its systematic use of patient-centered, coordinated care management processes.

Payor data show that PHCP is serving the Medicaid population. Over the last 5 years, the facility has experienced significant growth in its primary care visits and in serving the residents in its service area.

Program Summary
Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

Financial Summary
There is no project cost associated with this application.

Budget:		
	Revenues:	*$ 1,282,960*
	Expenses:	*1,244,073*
	Gain/(Loss):	*$ 38,870*

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary
This project is for Establishment action only; therefore, no Architectural recommendation is required.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval conditional upon:

1. Submission of an explanation as to why few patients were seen from zip code 11565 (Malverne) and identify strategies to improve outreach within 90 days after receiving permanent status. [RNR]
2. Submission of Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) Recognition by NCQA as appropriate as appropriate at the end of the second year. [RNR]
3. Submission of a comprehensive plan to achieve the "Prevention Agenda's 2013 Objectives" in the identified service area after the first year of operation obtaining permanent status. [RNR]

Council Action Date
February 2, 2012.

Need Analysis

Background

Primary Health Care Plus, Inc. (PHCP) is an Article 28 diagnostic and treatment center located at 1209 Hempstead Turnpike, Franklin Square. PHCP is requesting that its limited life operating certificate, which was approved under CON #051049-E, be made permanent.

Analysis

PHCP has met the conditions of the 5-year limited life. It was established to provide services primarily to residents of Nassau County in the following zip codes:

Elmont	11003
Franklin Square	11010
West Hempstead	11552
Malverne	11565
Valley Stream	11580

PHCP also treats patients from surrounding areas of Nassau, Queens, Suffolk, and Kings Counties. The number of projected visits is as follows:

Current Year:	13,587
First Year:	13,971
Third Year:	13,971

PHCP has focused on primary medical care and physical therapy services during its limited life. It has not provided occupational therapy, although it intends to do so in the future. The applicant plans to add Podiatry O/P and Radiology-Diagnostic services.

The tables below provides information on the number and percentage of patient visits in PHCP's service area for 2007 to 2010. It shows that during these years, well over 90 percent of the visits were for primary care services.

Type of Visits	Number of Patient Visits in 2007-2010			
	2007	*2008*	*2009*	*2010*
Medical	11,558	12,645	12,736	12,861
Physical Therapy	201	823	514	726
Grand Total	*11,759*	*13,468*	*13,250*	*13,587*

Type of Visits	% of Patient Visits in 2007-2010			
	2007	*2008*	*2009*	*2010*
Medical	98.3%	93.9%	96.1%	94.7%
Physical Therapy	1.7%	6.1%	3.9%	5.3%
Grand Total	*100.0%*	*100.0%*	*100.0%*	*100.0%*

The table below provides information on the number and percentage of patient visits by the service area zip code for 2007 to 2010. These findings reveal the following:

- There was an increase of 15.5 percent in the number of visits from 11,759 in 2007 to 13,587 in 2010.
- During these years, approximately 71 percent of the patients came primarily from PHP's service area as follows:

- ➢ Elmont: An average of approximately 42 percent,
- ➢ Franklin Square: Approximately 13 percent,
- ➢ Valley Stream: Approximately 10 to 11 percent, and
- ➢ West Hempstead: Approximately 4 to 6 percent of the total visits.

- The remaining 29 percent of the visits came from about 15 different towns.

- There were no patients from Malverne, which was identified as being in the primary service area.

Towns	**Zip Codes**	**Patient Visits in 2007-2010**			
		2007	*2008*	*2009*	*2010*
Elmont	11003	4,846	5,376	5,642	5,781
Valley Stream	11580 to 11583	1,696	1,705	1,366	1,450
Franklin Square	11010	1,380	1,764	1,805	1,807
West Hempstead	11552	506	682	763	647
Malverne	11565	-	-	-	-
Total Above		8,428	9,527	9,576	9,685
All Other*		3,331	3,941	3,674	3,902
Grand Total		11,759	13,468	13,250	13,587

Towns	**Zip Codes**	**% of Patient Visits in 2007-2010**			
		2007	*2008*	*2009*	*2010*
Elmont	11003	41.2%	39.9%	42.6%	42.5%
Valley Stream	11580 to 11583	14.4%	12.7%	10.3%	10.7%
Franklin Square	11010	11.7%	13.1%	13.6%	13.3%
West Hempstead	11552	4.3%	5.1%	5.8%	4.8%
Malverne	11565	0.0%	0.0%	0.0%	0.0%
Total Above		71.7%	70.7%	72.3%	71.3%
All Other		28.3%	29.3%	27.7%	28.7%
Grand Total		100.0%	100.0%	100.0%	100.0%

In year 1 and year 3, the patient payer mix was nearly the same as follows:

PHP-Patient Payor Mix	*% of Patients in Year 1 (2007)*	*% of Patients in Year 3 (2009)*
Medicaid-FFS	4%	5%
Medicaid-M/C	54%	53%
Medicare-FFS	6%	7%
Commercial/Other	29%	29%
Private Pay	7%	6%

Source: CON #051049-E Report 4/2011

The table below provides information on the number of Medicaid recipients as well as the extent of HMO enrollment in the proposed service area. These data indicate the following:

- The Medicaid population in the service area is less than 10 percent.
- Eight (8) percent of the service area population is Medicaid population.
- The primary care utilization is significantly lower at 3.33 annual primary care visits per Medicaid client than that of the State at 5.77 annual primary care visits per Medicaid client. (The normative rate is 3.5 to 4 visits per year used as a standard for managed care planning and federally qualified health centers.)

Zip Code	Total Medicaid Recipients	HMO Enrollment	Ma Fee For Service Recipients	Annual Primary Care Visits	Primary Care Use Per Eligible Year
11003	4,641	2,078	2,563	7,488	2.92
11010	1,093	370	723	3,664	5.07
11552	1,844	895	949	2,772	2.92
11565	210	70	140	434	3.11
11580	3,017	1,236	1,781	6,146	3.45
Total	*10,805*	*4,649*	*6,156*	*20,504*	*3.33*
Statewide					*5.77*

Population of the Service Area	135,493
Medicaid (MA) Population as % of the Service Area Population	8.0%
HMO Enrollment as % of the Medicaid Recipients	43.0%
MA Fee-for-Service Recipients as % of the MA Recipients	57.0%

Source: Medicaid Data 2008

NYSDOH PQI data reveal that there are significant disparities in the PQI rates for many of the PQI conditions, including asthma, diabetes, and hypertension in PHP's service area. For example, hospital admissions as a percent expected by race and ethnicity for these three conditions are as follows:

Asthma:	Hispanic - 102%	African American - 100%	White 57%
All Diabetes:	Hispanic - 68%	African American - 146%	White 84%
Hypertension:	Hispanic - 111%	African American - 327%	White 77%

Source: NYSDOH-PQI Average 2008-09

In order to improve the health status of the residents of PHP's service area, the applicant needs to continue to address health disparities by developing and implementing a comprehensive plan for the general population, and with special reference to the special populations, with measurable goals and objectives that are consistent with the Prevention Agenda Toward the Healthiest State.

Conclusion

PHP seeks approval to extend its 5-year limited life. Payor data show that the Center is serving the Medicaid population. Over the last 5 years, the facility has experienced significant growth in its primary care visits and in serving the residents of its service area.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Primary Health Care Plus, Inc. seeks permanent life approval and requests approval to add outpatient podiatric and diagnostic radiology services. There will be no changes to staffing with the approval of this application.

Compliance with Applicable Codes, Rules and Regulations

The medical staff will continue to ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The

facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

Conclusion

Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an operating budget, in 2011 dollars, for the first and third years of operation. The budget, as compared to CON 051049 projected and actual performance, is summarized below:

	Projected Year Three*	Current Year (2010)	Years One and Three
Revenue	$1,192,396	$1,261,840	$1,282,960
Expenses:			
Operating	$1,020,850	$1,071,471	$1,088,641
Capital	89,969	155,432	155,432
Total Expenses	$1,110,819	$1,226,903	$1,244,073
Net Income (Loss)	$81,577	$34,937	$38,870
Utilization: (visits)	9,200	13,587	13,971
Cost Per Visit	$120.74	$90.30	$89.05

**From the applicant's projected Year Three Budget for CON #051049-E.*

Utilization by payor source during the first and third years is broken down as follows:

	Current Year (2010)	Years One and Three
Medicaid Fee-for-Service	5%	5%
Medicaid Managed Care	53%	53%
Medicare Fee-for-Service	7%	7%
Commercial Fee-for-Service	29%	29%
Private Pay	6%	6%

Expense and utilization assumptions are based on the experience of the center the geographic area and the impact of Medicaid Managed Care.

Capability and Feasibility

There is no project cost associated with this application.

The issue of feasibility is centered on the applicant's ability to offset ongoing expenses with revenues and maintain a viable operating entity. The submitted budget of the new operator indicates a net income in year one and three in the amount of $38,870. The budget appears reasonable.

Presented as BFA Attachment A is the financial summary of Primary Health Care Plus, Inc. 2009 and 2010 certified financial statements. The Center had an average positive working capital position of $124,003 and an average positive net asset position of $251,568 during the period shown. The surgery center achieved an operating excess of revenues over expenses of $34,937 during 2010 and incurred an excess of expenses over revenues of $152,296 during 2009. The reasons for the loss in 2009 were high salary and benefit costs and increased general administrative costs. The Center has cut salary expense, physician fees and benefits costs, which positively impacted the center in 2010.

Presented as BFA Attachment B are November 11, 2011 un-audited financial statements, which indicate a negative working capital position and positive net asset position. Also, the Center has an excess of revenues over expenses of $169,709 for the period shown.

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary (Certified) – Primary Health Care Plus, Inc. 2010/2009
BFA Attachment B	Financial Summary (un-audited) – Primary Health Care Plus, Inc. 11/30/2011

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby approves the following application to establish permanent life for the diagnostic and treatment center previously approved for a five year limited life through project # 051049, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
112142-E	Primary Health Care Plus, Inc.

APPROVAL CONDITIONAL UPON:

1. Submission of an explanation as to why few patients were seen from zip code 11565 (Malverne) and identify strategies to improve outreach within 90 days after receiving permanent status. [RNR]
2. Submission of Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) Recognition by NCQA as appropriate as appropriate at the end of the second year. [RNR]
3. Submission of a comprehensive plan to achieve the "Prevention Agenda's 2013 Objectives" in the identified service area after the first year of operation obtaining permanent status. [RNR]

Public Health and Health Planning Council

Project # 101068-E

Guilderland Center Rehabiliation and Extended Care Facility Operating Company, LLC d/b/a Guilderland Center Rehabiliation and Extended Care Facility

County: **Albany (Guilderland)**
Purpose: **Establishment**
Program: **Residential Health Care Facility**
Submitted: **March 16, 2010**

Executive Summary

Description

Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC d/b/a Guilderland Center Rehabilitation and Extended Care Facility, a limited liability company, is seeking approval for a change in ownership of Guilderland Center Nursing Home, an existing 127-bed, for-profit residential health care facility (RHCF) located at 428 Rte. 146, Guilderland Center. The current operator filed for Chapter 11 of the Bankruptcy Code. The facility filed voluntary petitions for reorganization under Chapter 11 of the Bankrupty Code.

Ownership of the operation before and after the requested change is as follows:

Current Owner		Proposed Owner	
Eugene Nachamkin	1%	MEMBERS:	
Dianna Koehler	49%	Aaron Seligson	33.34%
Howard Grant	25%	Martin Rothman	33.33%
Scott Bialick	25%	Patricia Bruder	33.33%

Watchhill Consultants, LLC will purchase the operation and then assign it to Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC (Guilderland Center). Watchhill Consultants, LLC is owned by ten members, of which Aaron Seligson and Martin Rothman are members.

DOH Recommendation

Contingent approval

Need Summary

Utilization at Guilderland Center Nursing Home decreased from 94.6% percent in 2008 to 89.4% in 2009, but rose to 94.1% in 2010, which was comparable to the 94.5% rate for Albany County as a whole.

County RHCF Bed Need	Albany
2016 Projected Need	1,844
Current Beds	1,889
Beds Under Construction	20
Total Resources	1,909
Unmet Need	- 65

Program Summary

No changes in physical environment are being proposed in this application. No negative information has been received concerning the character and competence of the applicants.

Financial Summary

The purchase price for the operations is $1,425,000, which will be satisfied as follows: $150,000 deposit and the remaining $1,275,000 will be paid as cash at closing from the proposed members.

Budget:		
	Revenues:	$ 9,161,907
	Expenses:	9,111,097
	Gain/(Loss):	$ 50,810

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

This project is for Establishment action only; therefore, no Architectural recommendation is required.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of an executed settlement agreement that is acceptable to the Department of Health. [BFA]
2. Submission of an executed assignment agreement that is acceptable to the Department. [BFA]
3. Submission of a photocopy of the executed Articles of Organization of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC, and any amendments or restatements thereof, acceptable to the Department. [CSL]
4. Submission of a photocopy of the executed Operating Agreement of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC, acceptable to the Department. [CSL]
5. Submission of evidence of site control, acceptable to the Department, which includes evidence, that back property taxes are paid. [CSL, BFA]
6. Submission of evidence of the transfer of the operational assets of the nursing home to the applicant, acceptable to the Department. [CSL]

Council Action Date
February 2, 2012.

Need Analysis

Background

Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC, seeks approval to be established as the new operator of Guilderland Center Nursing Home, a 127-bed residential health care facility (RHCF), located at 428 Rte. 146, Guilderland Center. Guilderland Center is certified for baseline RHCF services.

The facility, a proprietary LLC, is operated by Guilderland LTC Management, LLC.

Analysis

Utilization at Guilderland Center Nursing Home decreased from 94.6% percent in 2008 to 89.4% in 2009, but rose to 94.1% in 2010. Utilization for Albany County was consistent from 2008 to 2009, and decreased slightly in 2010.

Facility/County	*2008*	*2009*	*2010*
Guilderland Center	94.6%	89.4%	94.1%
Albany County	95.8%	95.5%	94.5%

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Facility Information

	Existing	*Proposed*
Facility Name	Guilderland Center Nursing Home, Inc.	Guilderland Center Rehabilitation and Extended Care Facility
Address	127 Main St.Guilderland Center	Same
RHCF Capacity	127	Same
ADHC Program Capacity	N/A	N/A
Type Of Operator	LLC	LLC
Class Of Operator	Proprietary	Proprietary
Operator	Guilderland LTC Management, LLC Members: Dianna Koehler 49% Howard Krant 25% Scott Bialick 25% Eugene Nachamkin 1%	Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC Members: Patricia Bruder 33.33 % (managing member) Aaron Seligson 33.34 % Martin Rothman 33.33 %

Character and Competence

- FACILITIES REVIEWED:

Nyack Manor Nursing Home 1/1/2002 to present

A review of Nyack Manor Nursing Home over the last ten years revealed that a substantially consistent high level of care has been provided.

- INDIVIDUAL BACKGROUND REVIEW:

Aaron Seligson has a NYS Nursing Home Administrator license in inactive status since 2001. Mr. Seligson is licensed as attorney-at-law in good standing employed as a partner in the law firm Seligson, Rothman, & Rothman, ESQ. from 1955 to present.

Mr. Seligson discloses the following ownership interest:

- Nyack Manor Nursing Home,1970 - present

Mr. Seligson also discloses former ownership interests, which were sold over ten years ago:

- Brookhaven Beach Nursing Home
- Brookhaven Beach Health Related Facility
- Rockville Residence Manor

Martin Rothman holds a NYS license as attorney-at-law in good standing. Mr. Rothman disclosed employment as partner in the law firm Seligson, Rothman, & Rothman, Esq., 1960 to present.

Mr. Rothman discloses the following ownership interest:

- Nyack Manor Nursing Home, 1970 - present

Mr. Rothman also discloses former ownership interests, which were sold over ten years ago:

- Brookhaven Beach Nursing Home
- Brookhaven Beach Health Related Facility
- Rockville Residence Manor

Ms. Patricia Bruder is a Registered Nurse (RN) and holds a NYS Nursing Home Administrator license in good standing. Ms. Bruder has been employed in the following positions:

Owner of Brown's Beach Properties, LLC, 2003-present,
Partner in Fee Owner of Long Term Care Properties, 2001-present,
Partner, Sterling Care Services, Inc. (nursing registry and staffing agency), 1999-2005,
Partner, Health Care Options (NYS LHCSA), 1998-2005,
Partner, Hudson Mgmt Consultants, Inc. (LTC Consulting and Staffing),1982-1999,
Licensed Nursing Home Administrator Nyack Manor Nursing Home,1972-1983,
Various positions including Director of Nursing, Licensed Nursing Home Administrator, and Consultant, at Brookhaven Beach Health Related Facility, 1983-1999,
Long Term Care Consultant at various facilities including, Nyack Manor Nursing Home, Guilderland Nursing Home, and Howd Nursing Home,1984-present,
Director of Nursing Services at Parkview Nursing Home,1969-1972,
Inservice Education Coordinator and Staff Nurse, Hudson View Nursing Home, 1969,
Public Health Nurse, Nassau County DOH,1968 – 1969.

Ms. Bruder also indicates she holds no ownership interest in health care facilities.

Character and Competence – Analysis:
No negative information has been received concerning the character and competence of the applicants.

A review of the operations of Nyack Manor Nursing Home revealed no enforcements for the period reviewed, resulting in the conclusion that a substantially consistent high level of care has been provided since there were no enforcements.

Project Review

No changes in program or physical environment are proposed in this application. No administrative services/consulting agreement is proposed in this application.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Asset Purchase Agreement

The change in operational ownership will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized as follows:

Date:	February 3, 2010
Seller:	Guilderland LTC Management, LLC
Purchaser:	Watchhill Consultants, LLC
Assets Transferred:	The business and operation of the facility; all licenses and permits held or owned; all leasehold improvements, furniture and equipment owned or leased by Seller; all unexpired, non-obsolete and undamaged inventory and supplies, to the extent authorized by the Court, all transferable contracts, agreements, leases and other arrangements; resident funds held in trust; the name "Guilderland Center Nursing Home"; all security deposits and prepayments; subject to the terms and conditions imposed by lessors and licensors; all telephone numbers and fax numbers used by the Facility; copies of all resident/patient records relating to the Facility; copies of all employee and payroll records; corporate goodwill; copies of all other books and records relating to the facility; Seller's Medicare and Medicaid provider numbers and provider agreements; the Accounts Receivable as of the date of the Closing; all cash, deposits and cash equivalents; all payments or cash equivalent credits relating to the Facility; all reserves and deposits held by landlord; all retroactive rate increases and/or lump sum payments and all other assets of Seller relating to the Facility.
Assumed Liabilities:	Seller shall retain and Buyer shall not assume nor in any manner be responsible for any of Seller's liabilities and obligations of any kind or nature.
Purchase Price:	$1,425,000
Payment of Purchase Price:	$150,000 deposit Cash at Closing The balance of the Purchase Price of $1,275,000 shall be distributed at the Closing as follows: $50,000 shall be paid to the Estate as a carve-out from GECC's first priority lien and security interest; $75,000 shall be paid to the State of New York in satisfaction of the Initial Payment and $1,150,000 shall be paid to GECC at the Closing in satisfaction of GECC's security interests and first priority liens in the Debtor's assets, including the Sale Proceeds. In addition, the APA Deposit shall be released to GECC at Closing.

Watchhill Consultants, LLC will assign the operation of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC. As a contingency of approval, the applicant must provide an executed assignment agreement for the operation.

The applicant submitted an affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. As of this date, the applicant currently has outstanding liabilities and assessments of $1,121,975.

Settlement Agreement

The applicant has submitted a draft settlement agreement in regards to the liabilities of the current operator, summarized below:

Parties:	Guilderland LTC Management. LLC (Debtor); New York State Department of Health (DOH); New York Office of Medicaid Inspector General (OMIG); Watchhill Consultants, LLC (Watchhill or Buyer) and General Electric Capital Corporation (GECC).
Treatment of DOH's Claim:	The DOH's unsecured priority claim against the Debtor's estate shall be reduced to and fixed at $406,000 and shall be deemed as a single allowed unsecured priority claim against the Debtor's estate.
Treatment of OMIG's Claim:	OMIG's general unsecured claim shall be reduced to and fixed at $1,000,000 and shall be deemed as a single allowed general unsecured non-priority claim against the Debtor's estate. The DOH and OMIG's respective claims against the Debtor's estates shall be referred to as the "State Claims".
Payment of State Claims:	Notwithstanding any provisions in the Asset Purchase Agreement (APA) or Sale Order to the contrary, the APA shall be deemed modified to provide that, as a condition for the sale of the Facility by the Debtor to Watchhill, Watchhill shall assume the Debtor's liability to pay the State Claims as follows: Initial Payment: Watchhill shall make a payment of $75,000 to the State of New York at the Closing of the Sale of the Facility. Monthly Payments: Watchhill shall make 284 regular monthly payments of $4,670.17 to the State of New York and then the last payment equal to $4,671.72 so that all payments to New York State total $1,406,000 in the aggregate.
Modification to the Asset Purchase Agreement:	This agreement shall be deemed to modify the APA as follows: The purchase price is reduced to $1,425,000 (inclusive of the $150,000 APA deposit). The balance of the Purchase Price of $1,275,000 shall be distributed at the Closing as follows: $50,000 shall be paid to the Estate as a carve-out from GECC's first priority lien and security interest; $75,000 shall be paid to the State of New York in satisfaction of the Initial Payment and $1,150,000 shall be paid to GECC at the Closing in satisfaction of GECC's security interests and first priority liens in the Debtor's assets, including the Sale Proceeds. In addition, the APA Deposit shall be released to GECC at Closing.

Lease Rental Agreement

The applicant has submitted an executed lease that the applicant will occupy, of which the terms are summarized below:

Dated:	July 31, 2009
Premises:	127 Main Street, Guilderland, New York
Lessor:	Guilderland Manor Group, LLC
Lessee:	Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC
Term:	20 years with a ten year renewal period
Rental:	$576,000 for year 1 through 20. The tenant is granted an option to renew this lease for a ten year period at the then market rent, but said market rent shall not be less than $662,400 per year.

Currently, capital reimbursement is based on the return of and return on equity reimbursement methodology. After the change in ownership, reimbursement will continue to be based on the return of and return on equity reimbursement methodology. The useful life of the facility has expired.

Operating Budget

The applicant has submitted an operating budget, in 2011 dollars, for the first year subsequent to the change in ownership:

	Per Diem	Total
Revenues:		
Medicaid	$145.97	$4,892,622
Medicare	304.35	1,768,577
Commercial	436.10	518,082
Private Pay	325.00	1,390,025
Ancillary Revenues		592,601
Total Revenues		$9,161,907
Expenses:		
Operating	$173.11	$7,898,092
Capital	26.58	1,213,005
Total Expenses	$199.69	$9,111,097
Net Income		$50,810
Utilization: (patient days)		45,625
Occupancy		98.42%

The following is noted with respect to the submitted RHCF operating budget:

- Expenses include lease rental
- Budgeted case mix of .9636 was utilized by the facility at the time of CON filing for change in ownership
- The capital component of the Medicaid rate is based on the return of and return and equity reimbursement methodology.
- Overall utilization for year one is projected at 98.42%. Utilization by payor source is expected as follows:

Medicaid	73.46%
Medicare	12.73%
Private Pay	9.37%
Commercial	4.44%

- Breakeven occupancy is projected at 97.88%.

Capability and Feasibility

The purchase price for the operations is $1,425,000 and will be met as follows: $150,000 deposit and the remaining $1,275,000 will be paid as Cash at Closing from the proposed members.

Working capital requirements are estimated at $1,518,516, based on two months of first year expenses. The proposed members will provide equity to be derived from the proposed member's personal net worth statement, which indicates the availability of sufficient funds to meet the equity requirement. Presented as BFA Attachment A, is the personal net worth statements of the proposed members of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, which indicates the availability of sufficient funds to meet the working capital requirement and the purchase price. BFA Attachment C presents the pro-forma balance sheet of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC. As shown, the facility will initiate operations with $1,261,724 in member's equity.

The submitted budget indicates a net income of $50,810. Following is a comparison of historical and projected revenues and expenses:

2010 Historical Revenue	$8,581,447
2010 Historical Expense	8,722,306
2010 Net Income	$(140,859)
Incremental Revenues	$580,460
Incremental Expenses	388,791
Incremental Net Income	$191,669
Projected Net Income	$50,810

Incremental income includes an increase in overall utilization of 4.36% from 2010 and an increase in Medicare (6.40%), Private Pay utilization (2.45%), and trended Medicare and Private Pay reimbursement rates.

The reason for the increase in overall utilization and the shift from Medicaid to Medicare and Private Pay is as follows: it is expected that once the facility is no longer in Bankruptcy and the negative effects of that 'stigma", occupancy will increase; the facility's previous admissions coordinator and social worker have been replaced; the new individuals assigned with the task of admissions is focusing more on higher case mix individuals with more therapy needs. In 2009, the facility began to utilize an outside service for physical, occupational and speech therapy, with more staff and more intense services, which has increased Medicare utilization and is expected to increase rehabilitation admissions and the new operator will provide additional services such as IV therapy; pain management; post hospital care; infectious disease care; hospice/palliative care and bedside private telephones/internet in each patient room. Incremental expenses include rent expense and the payments made to the State and the difference between the current year and average historical levels.

Presented as BFA Attachment B, is a financial summary of Guilderland Center Nursing Home. As shown on Attachment B, the facility had an average positive working capital position and an average positive net asset position. Also, the facility incurred an average net loss of $672,827. The loss in 2008 was attributed to an accrual in the amount of $1,427,261 for the Medicaid audit of prior years. The facility in late 2006 through 2008 was operated by another management group, and the facility during that period of time had significant reduction in census and major cost increases. In June 2008, the current management (ownership) regained operational control and census was immediately increased and a new four year union contract was negotiated and is favorable to the future operation of the facility. The losses in 2009 and 2010 were attributed to the following: prior period expenses; bad debt expenses; penalties and late fees; expenses related to the cost of bankruptcy that on-going operations of the new entity would not be incurring. The applicant has indicated that the facility has incurred an operating loss of $53,194 through July 31, 2011.

Presented as BFA Attachment D, is a financial summary of Nyack Manor Nursing Home. As shown on Attachment D, the facility had an average positive working capital position and an average positive net asset position from 2008 through 2010.

Also, the facility incurred an average operating net loss of $20,345 from 2008 through 2010. The losses were a result of Medicaid retro-active rate adjustments for prior years and some bad debts that were written off. Also, the costs for Union Benefits includes amounts that in future years will not be continued, as per the Union contract which allows the facility to waive payments to certain funds. These items excluded, will show the facility to be profitable.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation
From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Personal Net Worth Statement - Proposed Members
BFA Attachment B	Financial Summary - Guilderland Center Nursing Home
BFA Attachment C	Pro-forma Balance Sheet of Guilderland Center Rehabilitation and Extended Care Facility Operating Company
BFA Attachment D	Financial Summary - Nyack Manor Nursing Home
BFA Attachment E	Establishment Checklist

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC d/b/a Guilderland Center Rehabilitation and Extended Care Facility, as the new operator of Guilderland Center Nursing Home, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
101068-E	Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC d/b/a Guilderland Center Rehabilitation and Extended Care Facility

APPROVAL CONTINGENT UPON:

1. Submission of an executed settlement agreement that is acceptable to the Department of Health. [BFA]
2. Submission of an executed assignment agreement that is acceptable to the Department. [BFA]
3. Submission of a photocopy of the executed Articles of Organization of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC, and any amendments or restatements thereof, acceptable to the Department. [CSL]
4. Submission of a photocopy of the executed Operating Agreement of Guilderland Center Rehabilitation and Extended Care Facility Operating Company, LLC, acceptable to the Department. [CSL]
5. Submission of evidence of site control, acceptable to the Department, which includes evidence, that back property taxes are paid. [CSL, BFA]
6. Submission of evidence of the transfer of the operational assets of the nursing home to the applicant, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

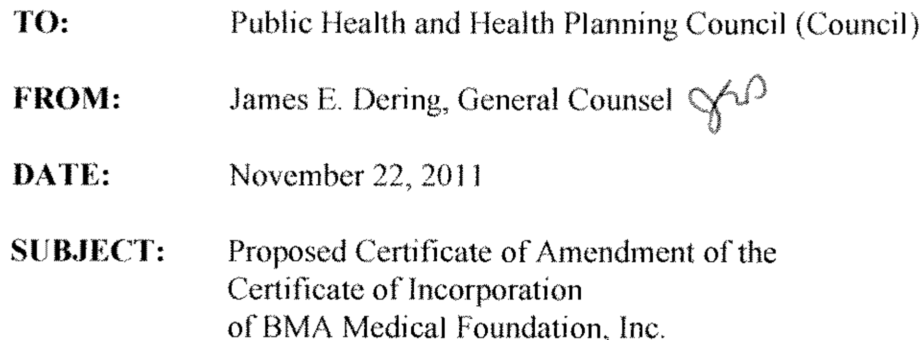
N/A

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

New York State Department of Health

Memorandum



TO: Public Health and Health Planning Council (Council)

FROM: James E. Dering, General Counsel

DATE: November 22, 2011

SUBJECT: Proposed Certificate of Amendment of the Certificate of Incorporation of BMA Medical Foundation, Inc.

Attached for the Council's review and approval is a photocopy of a Certificate of Amendment of the Certificate of Incorporation of BMA Medical Foundation, Inc. (Foundation). The Foundation seeks approval from the Council to (1) add to its powers and purposes the ability to raise funds for The New York Hospital Medical Center of Queens (NYH-Queens), which operates health care facilities pursuant to Article 28 of the Public Health Law (PHL); and (2) change its corporate name to "New York Hospital Queens Foundation, Inc.".

The Foundation was incorporated on February 25, 1987 to raise funds for clinical studies for the prevention and treatment of diseases. It now desires to raise funds specifically for the benefit of NYH-Queens. The change of name will connect the Foundation to its beneficiary, which is also its sole member. The Council's approval for both the addition of powers and purposes to raise funds for NYH-Queens and for the Foundation to change its name is required pursuant to Public Health Law § 2801-a(1) and (6). The proposed Certificate of Amendment is legally acceptable in form and the Department has no objection to its filing.

In addition to the proposed Certificate of Amendment, the following documents and information are attached in support of the Foundation's requests for approval:

1. A letter from the Foundation's attorney describing the reason for the changes and the types of fundraising activities in which the Foundation will engage;
2. A letter from the President/Chief Executive Officer of NYH-Queens acknowledging that the facility will accept fund raised on its behalf by the Foundation; and
3. Disclosure information regarding the Foundation's Board of Directors.

Attachments

CERTIFICATE OF AMENDMENT

OF THE

CERTIFICATE OF INCORPORATION

OF

BMA MEDICAL FOUNDATION, INC.

(Under Section 803 of the Not-for-Profit Corporation Law of the State of New York)

WE, THE UNDERSIGNED, being the President and a Director of BMA Medical Foundation, Inc. hereby certify that:

FIRST The name of the Corporation is BMA MEDICAL FOUNDATION, INC.

SECOND The Certificate of Incorporation of the Corporation was filed by the New York State Secretary of State on February 25, 1987 pursuant to the Not-For-Profit Corporation Law of the State of New York (the "NFPCL").

THIRD The Corporation is a corporation as defined in Section 102(a)(5) of the NFPCL. The Corporation is a Type B corporation under Section 201 of the NFPCL shall remain a Type B corporation after this amendment is effectuated.

FOURTH Paragraph First of the Certificate of Incorporation relating to Corporation's name is amended and restated, in its entirety, as follows:

"FIRST: The name of the Corporation is New York Hospital Queens Foundation, Inc."

FIFTH Paragraph Third of the Certificate of Incorporation relating to the purposes of the Corporation is amended and restated, in its entirety, as follows:

"THIRD: The purposes for which the Corporation is formed are charitable, educational and scientific in nature and more particularly:

A. Through the solicitation, receipt and disbursement of funds, income and real or tangible personal property obtained by bequests, gifts, donations, or otherwise, subject to any limitations imposed by the NFPCL or any other law of the State of New York, to render assistance and make grants to The New York Hospital Medical Center of Queens, a New York State not-for-profit corporation.

B. To solicit and receive grants, contracts and funds from federal, state and local government agencies, foundations or any other sources, to further the purposes of the Corporation.

C. To solicit, accept, receive and acquire by way of gift, devise, bequest, lease, purchase or otherwise, and to hold, invest and reinvest all property real or personal, including shares of stock, bonds and securities of other corporations and to dispose of property, real or personal, by gift, lease, sale or otherwise, all as may be necessary or desirable for the attainment of the purposes of the Corporation.

D. To borrow money, contract, incur debt, issue notes and secure payment of the performances of its obligations and to do all other acts necessary or expedient for the administration of the affairs and attainment of the purposes of the Corporation.

E. To further by clinical study, research, publication and teaching, the knowledge of disease and the application of such knowledge to prevention and treatment of disease.

F. To do anything and everything reasonably and lawfully necessary, proper, suitable or convenient for the achievement of the foregoing purposes or for the furtherance of said purposes."

SIXTH The third sentence of Paragraph Fifth of the Certificate of Incorporation relating unauthorized activities is amended and restated, in its entirety, as follows:

"Nothing in the Certificate of Incorporation shall authorize the Corporation to either: (i) establish, operate, or maintain a hospital, or to provide hospital services or health related services or to operate a home care services agency, a hospice, or a health maintenance organization, or to provide a comprehensive health services plan, as provided for by Articles 28, 36, 40 and 44 respectively, of the Public Health Law of the State of New York, as amended; or (ii) establish, operate, construct, lease or maintain an adult home, enriched housing program, or residence for adults, as provided by Article 7 of the Social Services Law of the State of New York, as amended, or otherwise raise or obtain any funds, contributions or grants from any source for any such purpose."

SEVENTH Paragraph Eighth of the Certificate of Incorporation relating to the dissolution of the Corporation is amended and restated, in its entirety, as follows:

"EIGHTH: In the event of dissolution of the Corporation or the winding up of its affairs, or other liquidation of its assets, the assets and property of the Corporation remaining after payment of expenses and the satisfaction of all liabilities shall be distributed to The New York Hospital Medical Center of Queens to be used for substantially similar purposes, subject to the approval of a court of competent jurisdiction upon application of the Corporation's Board of Directors, provided that no such distribution shall be made to The New York Hospital Medical Center of Queens unless The New York Hospital Medical Center of Queens shall at that time qualify as an organization described in Section 501(c)(3) of the Code. Any of such assets not so distributed shall be distributed to such other charitable and educational organizations as shall

qualify under Section 501(c)(3) of the Code, subject to the approval of a Justice of the Supreme Court of the State of New York or such other court having jurisdiction over the Corporation."

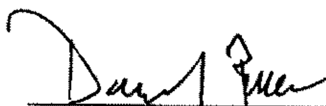
EIGHTH Paragraph Thirteenth of the Certification of Incorporation relating to service of process on the Corporation is amended and restated, in its entirety, as follows:

"THIRTEENTH: The Secretary of State of the State of New York is designated as the agent of the Corporation upon whom process against the Corporation may be served. The address to which the Secretary of State shall mail a copy of any process against the Corporation served upon him is c/o The New York Hospital Medical Center of Queens, 56-45 Main Street, Flushing, NY 11355."

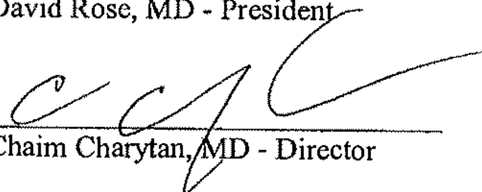
NINTH The amendment was authorized by the unanimous written consent of the members of the Board of Directors, as prior to the amendment, the Corporation had no members.

TENTH The Secretary of State of the State of New York is designated as the agent of the Corporation upon whom process against the Corporation may be served. The address to which the Secretary of State shall mail a copy of any process against the Corporation served upon him is c/o The New York Hospital Medical Center of Queens, 56-45 Main Street, Flushing, NY 11355.

IN WITNESS WHEREOF, we have signed this certificate on November 8, 2011, and do hereby affirm, under the penalties of perjury, that the statements contained herein have been examined by us and are true and correct.



David Rose, MD - President



Chaim Charytan, MD - Director

GARFUNKEL WILD, P.C.

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‡ LICENSED IN NEW JERSEY
# LICENSED IN CONNECTICUT
† RESPONSIBLE PARTNERS FOR NEW JERSEY OFFICE

FILE NO.: 5630.0001
REPLY TO: New York

WRITER'S EMAIL: lancona@garfunkelwild.com
WRITER'S DIRECT DIAL: (516) 393-2246

March 29, 2011

BY FEDERAL EXPRESS

Suzanne A. Sullivan
Senior Attorney
New York State Department of Health
Empire State Plaza
Corning Tower, 24th Floor
Albany, NY 12237-0029

Re: Proposed Certificate of Amendment of the Certificate of Incorporation of BMA Medical Foundation, Inc. (the "Foundation")

Dear Ms. Sullivan:

We are writing in response to your letter, dated October 8, 2010 (the "Letter"), regarding the proposed Certificate of Amendment of the Certificate of Incorporation of Foundation, a copy of which is attached. We have addressed each of the items raised in your Letter below in the order in which they are addressed in your Letter.

1. Attached as Attachment 1A is a copy of the Bylaws of the Foundation currently in effect. Attached as Attachment 1B is a copy of the proposed Amended and Restated Bylaws of the Foundation to be adopted after the approval of the Certificate of Amendment of the Certificate of Incorporation of the Foundation. Attached as Attachment 1C is a revised, executed copy of the Certificate of Amendment of the Certificate of Incorporation for the Foundation. The Certificate of Amendment of the Certificate of Incorporation for the Foundation has been revised to incorporate the required language set forth in Item 1 of your Letter.

2. Attached as Attachment 2A is a list of the current directors of the Foundation along with their home addresses, their present employment and their past and present affiliations with other nonprofit organization. Attached as Attachment 2B are Curriculum Vitae for each such director which lists their employment history and any other health care experience and community involvement of each such director.

3. New York Hospital Medical Center of Queens is the only entity which controls the Foundation, as is listed in its Certificate of Amendment of the Certificate of Incorporation for the Foundation and the proposed Amended and Restated Bylaws of the Foundation. Please note that in 1994 New York Hospital Medical Center Queens changed its name from Booth Memorial Hospital, as is listed in the current Bylaws of the Foundation. There are no other entities controlled by or controlling of the Foundation.

4. The Foundation intends to continue its current fundraising activities in support the operation of the New York Hospital Medical Center of Queens. The types of fund raising/development programs that the Foundation would undertake are as follows:

a. Major Gifts Program (including direct solicitation, stewardship and cultivation)
b. Direct Mail Campaign
c. Planned Giving& Endowment Program
d. Special Events including, but not limited to Annual Gala, Golf Outing, Pediatric Miniature Golf outing, Lang Dinner, Donor Recognition events
e. Foundation, Corporate and Public Grant writing
f. Capital Campaign (Major Modernization)
g. Restricted Campaigns (i.e. Save a Life)
h. Women's Auxiliary
i. Employee Giving Campaign
j. Physicians Annual Giving Campaign

5. Attached as Attachment 5 is a letter from New York Hospital Medical Center of Queens, which states that it is aware that the Foundation will solicit funds on its behalf and that it will accept those funds.

6. The Foundation has not previously received Public Health Counsel approval for activity.

Please contact me at 516-393-2245 should you have any questions or concerns regarding the responses above or the documents attached.

Very truly yours,

Lara Jean Ancona

GARFUNKEL WILD, P.C.

1673712v.1

56-45 MAIN STREET
FLUSHING, NY 11355-5095

Stephen S. Mills, FACHE
President & Chief Executive Officer

Tel: 718-670-1025
Fax: 718-661-7937
ssmills@nyp.org

December 6, 2010

Susanne A. Sullivan
Senior Attorney
Bureau of House Counsel
State of New York, Department of Health
Empire State Plaza
Corning Tower, 24th Floor
Albany, NY 12237-0029

Re: BMA Medical Foundation, Inc. (the "Corporation")

Dear Ms. Sullivan:

This will confirm that New York Hospital Medical Center of Queens (the "Hospital") is aware that the Corporation intends to change its name to New York Hospital Queens Foundation, Inc. and solicit funds on behalf of the Hospital. The Hospital intends on accepting such funds.

The Hospital will be pleased to provide any further information or authorization required by any agencies of New York State in connection with the approval of the Certificate of Amendment to the Certificate of Incorporation of the Corporation.

Very truly yours,

Stephen S. Mills

1634464v.1

Position	Name	NYHQ Date of Hire	Home Address	Present Employment	Title	Employment History	Healthcare Experience	Community Involvement	Affiliation Nonprofit Entities
Chairman	Stephen Rimar	3/8/2007	300 Joyce Road Hamden, CT 06518	MD-NYHQ	Senior VP & Chief Medical Officer	See CV	See CV	See CV	Weill College of Medicine
Secretary	Chaim Charytan	9/6/1972	85 Verdon Avenue New Rochelle, NY 10804	MD-NYHQ & Nephrology Assoc, PC	Director, Nephrology	See CV	See CV	See CV	Albert Einstein College of Medicine Jacobi Montefiore
Treasurer	James J. Rahal	12/15/1987	314 W. 77th Street, #8B, NY, NY 10024	MD-ID-NYHQ	Director, Infectious Diseases	See CV	See CV	See CV	None
Board Member	Bruce S. Spinowitz	8/28/1979	95 Overlook Road New Rochelle, NY 10804	MD-NYHQ & Nephrology Assoc, PC	Associate Chairman, Assistant Director, Nephrology	See CV	See CV	See CV	Albert Einstein College of Medicine
Board Member	Moshe Rubin	1/22/2008	1020 Park Avenue, Fl. 1 NY, NY 10028	MD-NYHQ	Director, Division of Gastroenterology	See CV	See CV	See CV	Weill College of Medicine

September 2008

Curriculum Vitae

Stephen Rimar, M.D., M.B.A.

Birthdate: March 28, 1955
Birthplace: Trenton, New Jersey

Citizenship: USA
Family: Wife: Joan Meighan Rimar
Children: Elizabeth and Christine

Office: 56-45 Main Street
Flushing, NY 11355
Tel: 718-670-1549
Cell: 347-924-2185
Email: srimar@nyp.org

Home: 300 Joyce Road
Hamden, CT 06518
Tel: 203-288-0624

Email: srimar@hotmail.com

Education

Yale University, New Haven, CT	B.S.	1977
George Washington University, Washington, DC	M.D.	1982
University of New Haven, New Haven, CT	M.B.A.	1997

Post-Graduate Training

Intern in Pediatrics, Yale-New Haven Hospital, New Haven, CT	1982-83
Resident in Pediatrics, Yale-New Haven Hospital	1983-85
Resident in Anesthesiology, Yale-New Haven Hospital	1985-87
Clinical Fellow in Pediatric Anesthesiology, Yale University School of Medicine Program Director: Tae Oh, M.D.	1987
Post-Doctoral Fellow in Lung Pharmacology & Pathophysiology, Yale University School of Medicine, Program Director: C.N. Gillis, Ph.D.	1988-89

Appointments and Positions

Instructor in Anesthesiology, Yale University School of Medicine	1988-89
Assistant Professor of Anesthesiology & Pediatrics, Yale Univ Sch Med	1989-94
Associate Professor of Anesthesiology & Pediatrics, Yale Univ Sch Med	1994-01
Associate Professor (Joint Appointment), Yale School of Management	1998-01
Associate Clinical Professor of Pediatrics, Weill College of Medicine, Cornell Univ 03/2006-09	2001-
Professor of Anesthesiology, Robert Wood Johnson Medical School, UMDNJ	2005-07

Chief, Section of Pediatric Anesthesia, Yale University School of Medicine	1991-96
Vice-Chairman for Administration and Finance, Department of Anesthesiology, Yale University School of Medicine	1996-00
Executive Director, Yale Center for Pain Management	1996-97
Acting Administrator, Department of Anesthesiology, Yale Univ Sch Med	1997-98
Director, Yale Management Program for Physicians, Yale School of Management	1998-01
Medical Director, Yale Medical Group, Yale Univ Sch of Medicine	1999-01
Executive Director, Yale Corporate Medical Program	1999-01
Fellow, Silliman College, Yale University	1999-01

Appointments and Positions cont'd

Executive Vice President & Chief Medical Officer, The Brooklyn Hospital Center	2001-03
Executive Vice President & Chief Medical Officer, The Cooper Health System	2003-07
Chief Operating Officer, Cooper University Physicians	2003-07
Senior Vice President and Chief Medical Officer, New York Hospital Queens	2007-

Associate Attending in Anesthesiology, Yale-New Haven Hospital	1988-89
Attending in Anesthesiology, Yale-New Haven Hospital	1989-01
Medical Director, Pediatric Surgery Center, Children's Hospital at Yale	1993-96
Associate Director of Operating Rooms (Pediatrics), Yale-New Haven Hospital	1993-96
Attending in Anesthesiology, The Brooklyn Hospital Center	2001-03
Attending in Anesthesiology & Pediatrics, Cooper University Hospital	2003-07
Attending in Anesthesiology & Pediatrics, New York Hospital Queens	2007-
Senior Vice President & Chief Medical Officer, New York Hospital Queens	2007-

Honors and Awards

"Best Doctors in America"	1997
"Best Doctors in America"	1998
"Best Doctors in America"	1999
"Best Doctors in America"	2000
"Who's Who in Medicine and Health Care"	1999
"Who's Who in America"	2001
"Who's Who in the World"	2001
"Friend of Nursing Award", The Brooklyn Hospital Center	2002

Directorships, Boards and Advisory Panels

Children's Clinical Research Center, Yale University School of Medicine	
Advisory Board	1992-95
Yale University	
Health Professions Advisory Board	1995-01
Center for Outcomes Research and Evaluation, Yale-New Haven Hospital	
Clinical Advisory Board	1997-99
Impact Physician Management Services, Ltd	
Board of Directors	1999-01
Yale Dermatology Associates, PC	
Board of Directors, Secretary	1999-01
Association of American Medical Colleges, Group on Information Resources	
Leadership Advisory Board	1999-01
Yale-New Haven Physicians Independent Practice Association	
Board of Directors	2000-01
ComTrust, LLC, Healthcare Internet Security	
Medical Advisory Board	2001
Weill Medical College, Cornell University	
Council of Affiliated Deans	2001-03
LCME Advisory Panel	2002
Cancer Institute of New Jersey	
Board of Directors	2003-07
University of Medicine and Dentistry of New Jersey	
Camden Medical School Task Force	2004
RWJMS Dean's Executive Faculty Committee	2003-07

Certification and License

National Board of Medical Examiners	1983
American Board of Pediatrics	1987
American Board of Anesthesiology	1988
State of Connecticut #027805	1988-01
State of New York #222872	2001-
State of New Jersey #25MA07696800	2003-

Committees / Task Forces / Advisory Groups

Yale Department of Anesthesiology

Curriculum Committee	1990-94
Resident Selection Committee	1990-99
Executive Committee	1991-00
Finance Committee, Chairman	1996-99

Yale Medical Group (Faculty Practice Plan)

Ambulatory Care Information Systems Committee	1997-01
Credentialing Committee, Chairman	1996-01
Clinical Chiefs Committee, Chairman	1996-01
Contracting Committee	1999-01
Finance Committee	1996-01
HCFA Compliance Oversight Committee	1997-01
Marketing and Strategic Development Advisory Group	1998-01
IDX Implementation Steering Committee	1997-99
Infection Control Committee, Chairman	1999-01
Research and Education Committee	1999-01

Yale-New Haven Hospital / Yale-New Haven Health System

Children's Hospital Task Force	1991-93
Operating Room Committee	1994-98
Conscious Sedation Task Force	1996-97
Conscious Sedation Committee, Chairman	1997-00
HIPAA Implementation Committee	2000-01
Information Services Steering Committee	2000-01
Medical Management Task Force	1999-01
Performance Improvement Leadership Group	2000-01
Yale-New Haven Heart Center, Cabinet Member	1999-01

Yale-New Haven Physicians Independent Practice Association

Credentialing Committee	1999-01
Contracting Committee	1999-01
Utilization Management Committee	1999-01

Committees / Task Forces / Advisory Groups cont'd

Yale University / Yale School of Medicine	
Academic Mentorship Program in the Sciences, Yale College	1992-96
Clinical Information Task Force	1996-97
Clinical Information Confidentiality Committee (HIPAA), Chairman	1999-01
Telemedicine Clinical Subcommittee, Chairman	1998-99
MCIC Vermont, Claims and Risk Management Committee	1999-01
Y2K Steering Committee	1999-00
Yale New-Haven Health System Affiliation Agreement	
Managed Care/Corporate Services Group	1998

Professional Societies

American Academy of Pediatrics, Section on Anesthesiology	1988-97
American Board of Pediatrics, Program for Renewal of Certification	1992
American College of Healthcare Executives	2003-
American College of Physician Executives	1996-
American Heart Association, Council on Cardiopulmonary & Critical Care	1988-96
American Physiological Society	1995-98
American Society of Anesthesiologists	1985-01
Subcommittee on Pediatric Anesthesia	1996-97
Subcommittee on Experimental Circulation	1996-98
Association of American Medical Colleges	1996-
Group on Faculty Practice	1999-
Group on Information Resources – Program Committee	1999-01
Program Chair, 2001 Annual Meeting	2000
Association of University Anesthesiologists	1995-01
Connecticut State Society of Anesthesiologists	1992-01
National Legislative Conference Representative	1997-99
Medicare Carrier Advisory Representative	1998-00
International Anesthesia Research Society	1985-97
Medical Group Management Association	1998-01
Medical Society of the State of New York	2001-
Society of Cardiovascular Anesthesiologists	1990-95
Society for Pediatric Anesthesia	1988-01
Assistant Editor, Newsletter	1994-96
Program Committee	1996-00

Editorial Activities

Academic Medicine, Reviewer	2000-
American Journal of Physiology, Reviewer	1992-96
Anesthesia & Analgesia, Reviewer	1992-98
Anesthesiology, Reviewer	1991-98
Critical Care Medicine, Reviewer	2003-
Journal of Applied Physiology, Reviewer	1992-98
Journal of Clinical Anesthesia, Reviewer	1996-98
Pediatric Research, Reviewer	1995-98
Journal of Clinical Monitoring, Reviewer	1997

Journal of Evidence Based Healthcare, Reviewer 1999-01

Research Grant Review

Thesis Review Committee, Yale University School of Medicine, Ad Hoc Reviewer, 1993
The Soros Foundation General Scholarship Competition, Ad Hoc Reviewer, 1994
NIH Special Emphasis Panel: Clinical Centers and Clinical Coordinating Center for a Clinical Network for the Treatment of Adult Respiratory Distress Syndrome (ARDS). NHLBI, 1994
NIH Special Emphasis Panel: Clinical Investigator Development Award. NHLBI, 1994
NIH Special Emphasis Panel: Clinical Scientist Development Award. NHLBI, 1995
NIH Special Emphasis Panel: Comprehensive Sickle Cell Centers, nitric oxide projects. NHLBI, 1997
Connecticut Hospital Association, Committee on Quality Assessment, 2000-02

Research Grants and Awards

National Research Service Award, NHLBI HL-07410, Research Training in Lung Pharmacology and Pathophysiology. Stephen Rimar, Post-Doctoral Fellow. C.N. Gillis, Preceptor. 1988-89

NIH BRSG RR 05358, Uptake of Angiotensin Converting Enzyme Inhibitors by the Coronary Circulation. Principal Investigator. 1989-90

Foundation for Anesthesia Education and Research Starter Grant, Effects of General Anesthesia on Endothelin Induced Coronary Vasoconstriction. Principal Investigator. 1990-91

Society of Cardiovascular Anesthesiologists Research Grant, Role of Circulating Endothelin in Post-Coronary Bypass Hypertension. Principal Investigator. 1991-92

Sanofi-Winthrop Pharmaceuticals Research Award, Mechanisms of Pulmonary Vasodilation by the PDE Inhibitors Amrinone and Milronone. Co-Investigator. 1992-93

Astra Pharmaceuticals Research Award, EMLA Cream for Skin Anesthesia in Children Undergoing Invasive Procedures. Center Principal Investigator. 1992-93

Edward A. Bouchet Science Fellowship, Yale College. The Role of Cyclic Guanosine Monophosphate in Phosphodiesterase Inhibitor Induced Vasodilation. Abhijit Patel, Recipient. Stephen Rimar, Preceptor. 1992

Glaxo Research Institute Grant, A Randomized, Double-Blinded, Placebo-Controlled, Multicenter Study of Intravenous Ondansetron for the Prevention of Postoperative Emesis in Pediatric Patients Undergoing Outpatient Surgery. Center Principal Investigator. 1993-94

Howard Hughes Medical Institute Postdocoral Research Fellowship, Effect of Free Radical Exposure on Pulmonary Endothelial Production of Nitric Oxide. Maxine Lee-Mengel, Postdoctoral Fellow. Stephen Rimar, Preceptor. 1992-95

NIH M01 RR 06022, General Clinical Research Center. Principal Investigator on Subproject: Inhaled Nitric Oxide in Neonatal Pulmonary Hypertension. 1993-98

Pharmaton Research Grant, Action of G115 on Free Radical-Induced Injury to the Vascular Endothelium and Relationship to Nitric Oxide Synthesis. Principal Investigator. 1994-95

MCIC Quality of Care and Risk Management Grant, The Use of a Conscious Sedation Policy to Improve Documentation and Outcomes, Principal Investigator. 1998-99

Partnerships for Quality Education, Managed Care Curriculum for Pediatric Residents, Robert Wood Johnson Foundation, Co-Investigator. 1999-2002

Bibliography

Laboratory Publications

Rimar S. and Gillis C.N. Pulmonary vasodilation by inhaled nitric oxide following endothelial injury. J Appl Physiol 73(5): 2179-2183, 1992.

Rimar S. and Gillis C.N. Differential uptake of endothelin-1 from the coronary and pulmonary circulations. J Appl Physiol 73(2): 557-562, 1992.

Rimar S. and Gillis C.N. Rapid reversal of angiotensin converting enzyme inhibition by lisinopril in the perfused rabbit lung. Pulm Pharm 5: 103-109, 1992.

Rimar S. and Gillis C.N. Selective pulmonary vasodilation by inhaled nitric oxide is due to hemoglobin inactivation. Circulation 88(5): 2884-2887, 1993.

Zapol W.M., Rimar S., Gillis C.N., Marletta M., and Bosken C. NIH Workshop: Nitric oxide and the lung. Am Journ Resp Crit Care Med 149: 1375-1380, 1994.

Rimar S. and Gillis C.N. Site of pulmonary vasodilation by inhaled nitric oxide in the perfused lung. J Appl Physiol 78(5): 1745-1749, 1995.

Rimar S., Lee-Mengel M., and Gillis C.N. Pulmonary protective and vasodilator effects of a standardized Panax ginseng preparation following artificial gastric digestion. Pulm Pharm 9(4): 205-9, 1996.

Rimar S. The pharmacology of inhaled nitric oxide. Anaesthetic Pharmacol Physiol Rev 4:88-95, 1996.

Rimar S. and Gillis C.N. Effect of oxygen radicals on pulmonary endothelial function. In: Nitric Oxide and Radicals in the Pulmonary Vasculature, edited by Weir E.K, Archer AL, and Reeves, JT.. Futura, New York, 1996, pp 87-104.

Rimar S. and Gillis C.N. Nitric oxide and experimental lung injury. In: Nitric Oxide and the Lung. Edited by Zapol W.M. and Bloch K.D. Marcel Dekker, New York, 1997, pp165-83.

Bruckheimer E,, Rimar S., Dubois A.B. and Douglas J.S. Measurement of endogenous nitric oxide production. J Clin Monitoring 16: 21-23, 2000.

Clinical Publications

Schachter E.N., Rimar S., Littner M., Beck G.J., and Bouhuys A. Airway reactivity and exercise in health subjects. Chest 81: 461-465, 1982.

Rimar S., Shaywitz S.E., Shaywitz B.A., Lister G., Anderson G.M., Leckman J.F., and Cohen D.J. Autonomic dysfunction, peripheral neuropathy and depression. Ped Neurol 1(2): 120-3, 1985.

Rimar S., Westry J.A., and Rodriquez R.L. Compartment syndrome in an infant following emergency intraosseous infusion. Clin Ped 27: 259-260, 1988.

Bell C., Rimar S., and Barash P.G. Intraoperative ST-segment changes consistent with myocardial ischemia in the neonate: A report of three cases. Anesthesiology 71: 601-604, 1989.

Rimar S., and Urban M.K. Newborn physiology and development. In: The Pediatric Anesthesia Handbook. edited by Bell C., Hughes C., and Oh T.H. Mosby, St. Louis, 1991, pp 1-17.

Rimar S. Valvular and congenital heart disease. Curr Opin Anesth 4: 59-61, 1991.

Kain Z.N., Rimar S., and Barash, P.G. Cocaine abuse in the parturient and effects on the fetus and neonate. Anesth Analg 77: 835-845, 1993.

Kain Z.N., Gaal D.J., Kain T., Jaeger D.D., and Rimar S. A first-pass cost analysis of propofol versus barbiturates for children undergoing magnetic resonance imaging. Anesth Analg 79: 1102-1106, 1994.

Kain Z.N. and Rimar S. Management of Chronic Pain in Children. Pediatrics in Review 16: 218-222, 1995.

Kain Z.N., Mayes L.C. Cicchetti D.V., Caramico L.A., Spieker M., Nygren M.M., and Rimar S. A measurement tool for pre-operative anxiety in children: the Yale Preoperative Anxiety Scale (YPAS). Child Neuropsychology 1(3): 203-210, 1995.

Kain Z.N., Mayes L.C., Caramico L.A., Silver D., Spieker M., Nygren M.M., Anderson G. and Rimar S. Parental presence during induction of anesthesia. A randomized controlled trial. Anesthesiology 84(5): 1060-7, 1996.

Kain Z.N., Ferris C.A., Mayes L.C., and Rimar S. Parental presence during induction of anesthesia: practice differences between the United States and Great Britain. Paediatric Anaesthesia 6(3): 187-93, 1996.

Kain Z.N., Mayes L.C., Bell C., Weisman S., Hofstadter M.B., and Rimar S. Premedication in the United States: a status report. Anesth Analg 84(2): 427-32, 1997.

Patel R.I., Davis P.J., Orr R.J., Ferrari L.R., Rimar S., Hannallah R.S., Cohen I.T., Colingo K., Donlon J.V., Haberkern C.M., McGowan F.X., Prillaman B.A., Parasuraman T.V., and Creed M.R. Single-dose ondansetron prevents postoperative vomiting in pediatric outpatients. Anesth Analg 85(3): 538-45, 1997.

Roberts J.D., Fineman J.R., Morin F.C., Shaul P.W., Rimar S., Schreiber M.D., Polin R.A., Zwass M.S., Zayek M.M., Gross I., Heymann M.A., and Zapol WM. Inhaled nitric oxide and persistent pulmonary hypertension of the newborn. The Inhaled Nitric Oxide Study Group. N Engl J Med 336(9): 605-10, 1997.

Management Publications

Rimar S., and Garstka S.J. The Balanced Scorecard: Development and implementation in an academic clinical department. Academic Medicine. 74(2):114-22, 1999.

Kain Z., Fasulo A., and Rimar S. Establishment of a pediatric surgery center: Increasing anesthetic efficiency. J Clin Anesth 11: 540-44, 1999.

Rimar S. Medical group practice organizations have less influence on physicians' practice styles than expected. J Evidence-Based Healthcare 4(2): 32, 2000.

Rimar S. Teaching physicians to be leaders. Academic Medicine 75(10): 958, 2000.

Rimar S. Strategic planning and the balanced scorecard for faculty practice plans. Academic Medicine 75(12): 1186-1188, 2000.

Rimar S. The Balanced Scorecard: Strategy and performance for academic health centers. Proceedings of the 2000 Forum on Emerging Issues, Executive Leadership in Academic Medicine Program for Women, Philadelphia, PA, 2001.

Rimar S. Contributing author. Guidelines for academic medical centers' implementation of security and privacy regulations (HIPAA). Association of American Medical Colleges, Washington, DC, 2001.

Rimar S. Selling an idea. Academic Physician and Scientist, 2001.

Rimar S. The Yale Management Guide for Physicians. Wiley and Sons, New York, 2001.

Laboratory, Clinical and Management Presentations

Rimar S., and Gillis C.N. Rapid reversal of angiotensin converting enzyme (ACE) inhibition by lisinopril in the perfused rabbit lung. Circulation 78(4): II-205, 1988.

Rimar S., and Gillis C.N. Differential uptake of endothelin by the rabbit coronary and pulmonary circulation. Circulation 80(4): II-213, 1989.

Rimar S., and Gillis C.N. Discrepancy between lisinopril binding and [^{3}H]benzoyl-phe-ala-pro (BPAP) hydrolysis in the perfused rabbit lung. Amer Rev Resp Dis 239(4): 619, 1989.

Rimar S., and Gillis C.N. Prolonged duration of inhaled nitric oxide-induced vasodilation in perfused rabbit lungs. Circulation 84(4): II-91, 1991.

Rimar S., and Gillis C.N. Methylene blue does not prevent the pulmonary vasodilator response to inhaled nitric oxide in the perfused rabbit lung. Amer Rev Resp Dis 143(4): A774, 1991.

Rimar S., and Gillis C.N. Pulmonary vasodilatation by inhaled nitric oxide is unaffected by free radical injury in the intact lung. FASEB J 5(6): A1722, 1991.

Rosenkranz P.G., Rimar S., and Gillis C.N. Potentiation of endothelin-1-induced pulmonary vasoconstriction by acidosis. Vascular Endothelium (NATO ASI) 208: 286, 1991.

Lee M., Rimar S., and Gillis C.N. Methylene blue does not inhibit guanylate cyclase activity during inhaled nitric oxide exposure in the perfused lung. Circulation 86(4): I-603, 1992.

Lee M., Rimar S., and Gillis C.N. Amrinone-induced vasodilation is associated with elevated cGMP levels in the perfused rabbit lung. Anesthesiology 77(3A): A632, 1992.

Rimar S., and Gillis C.N. Elevation of arterial endothelin-1 following cardiopulmonary bypass. Amer Rev Resp Dis 145(4): A641, 1992.

Rimar S., and Gillis C.N. Selective pulmonary vasodilation by inhaled nitric oxide is due to hemoglobin inactivation. FASEB J 6(4): A947, 1992.

Rimar S. and Gillis C.N. Site of pulmonary vasodilation by inhaled nitric oxide in the intact lung. Circulation 88(4): I-477, 1993.

Kain Z.N., Gaal D.J., Jaeger D.D., Rimar S. Sedation for MRI in children: propofol vs barbiturates. Anesthesiology 79(3A): A1158, 1993.

Kain Z.N., Mayes L., Cicchetti D.V., Caramico L., Speiker M., Nygren M., and Rimar S. A tool for measurement of pre-operative anxiety in children: the Yale Preoperative Anxiety Scale (YPAS). Anesthesiology 81: 1361, 1994.

Rimar S., Chaisson K.M., Gillis, C.N. Oxygen free radical injury inhibits nitric oxide synthase (NOS) activity in the intact lung. FASEB J 8(5): A665, 1994.

Urban M.K., Rimar S., McDonald M., Urquhart B. The increase in PVR associated with cemented total knee arthroplasty may be related to endothelin release. Anesth Analg 78: S446, 1994.

Kain Z.N., Mayes L., Nygren M., Speiker M., Brandriff C., and Rimar S. Does a preparation program decrease preoperative anxiety in children and parents? Anesthesiology 81: A1362, 1994.

Laboratory, Clinical and Management Presentations cont'd

Kain Z.N., Mayes L., Nygren M., and Rimar S. Behavioral disturbances in children following surgery. Anesthesiology 81: A1382, 1994.

Hannallah R, Davis PJ, Orr R, Ferrari L, and Rimar S. Prophylactic administration of ondansetron effectively decreases postoperative emesis in children. Anesthesiology 83: A1177, 1995.

Rimar S., Lee-Mengel M, and Gillis CN. Impaired acetylcholine induced cGMP and effluent nitric oxide release following free radical injury in the intact lung. FASEB J 9(3): A276, 1995.

Kain Z.N., Mayes L., Nygren M., Caramico L., Brandriff C., and Rimar S. How do parents react to surgery performed on their children? Anesth Analg 80: S222, 1995.

Roberts J.D., Fineman J., Morin F.C., Shaul P.W., Rimar S., Shreiber M.D., Polin R.A., Thusu K.G., Zayek M., Zwass M.S., Zellers T.M., Wylam M.E., Gross I., Zapol W.M., and Heyman M.A. Inhaled nitric oxide gas improves oxygenation in PPHN. Ped Res 39: 241A, 1996.

Rimar S., Lee-Mengel M, and Gillis CN. Pulmonary protective and vasodilator effects of ginseng (G115) following artificial digestion. FASEB J 10(3): A106, 1996.

Rimar S., and Garstka S.J. The Balanced Scorecard: a strategic management system for an academic anesthesiology department. Anesthesiology 87: A1016, 1997.

Swamidoss C., Crede W., and Rimar S. Documentation and Compliance in the Practice of Conscious Sedation. Anesthesiology 89: A1339, 1998.

Kain Z., Fasulo A., and Rimar S. Establishment of a pediatric anesthesia section: Does it make a difference? Anesthesiology 89: A1342, 1998.

Recent Invited Lectures and Panels

"The Balanced Scorecard: Strategy and Performance for Academic Health Centers", ELAM Program, 2000 Forum on Emerging Issues, Bryn Mawr, PA, April 2000.

"HIPAA Compliance and Physicians", Modern Healthcare Seminar, *Successful Business Strategies for HIPAA Compliance*, New York, NY, May 2000.

"Physicians and Medical Record Privacy", Superior CEO Summit, Chicago, IL, September 2000.

"The Healthcare Supply Chain", Electron Economy Healthcare Advisory Board, Cupertino, CA, October 2000.

"HIPAA: Are you ready?", Association of American Medical Colleges Annual Meeting, Chicago, IL, November 2000.

"Conscious Sedation Policy Implementation in an Academic Medical Center", MCIC Vermont Risk Management, New York, NY, February 2001.

"Academic Medical Centers and HIPAA: Impact on Core Missions", University HealthSystem Consortium Annual Meeting, Washington, DC, March 2001.

"HIPAA: It's Here to Stay, Everything You've Been Afraid to Ask...", Association of American Medical Colleges Summer Symposium, Toronto, Canada, July 2001.

"Developing Leadership Skills for Physicians", Association of Academic Dermatologic Surgeons Annual Meeting, Chicago, Ill, September 2001.

"2001 Management Practice Seminar", Yale University School of Public Health, New Haven, CT, October 2001.

"How to Develop an Idea and Make It a Reality", New York City Health & Hospitals Corporation Annual Physician Leadership Training Conference, November 2001.

"Teaching Physicians to Behave Like Managers", Balanced Scorecard Collaborative Best Practices Conference, Cambridge, MA, April 2002.

Program Developer and Moderator, *2002 Physician Leadership Institute*, National Association of Public Hospitals and Health Systems, Chicago, Il, May, 2002.

"Performance Measurement and the Turnaround Hospital", Balanced Scorecard Collaborative Health Care Summit, Hilton Head, SC, April 2003.

"Developing a Business Plan", Executive Management Program, Yale School of Management, New Haven, CT, July 2004.

"Core Competencies and Corporate Planning in Healthcare", Cooper-Wharton Leadership Development Program, Camden, NJ, October 2004.

"Business Planning and Medical Practice", Executive Management Program, Yale School of Management, New Haven, CT, July 2005.

"Developing and Using Business Plans", Executive Management Program, Yale School of Management, New Haven, CT, July 2006.

CURRICULUM VITAE
CHAIM CHARYTAN, M.D.

Address — N.Y. Hospital Queens, Renal Division/Nephrology Associates, P.C.
56-45 Main Street, Flushing, N.Y., 11355

07/1970-Present — 1874 Pelham Parkway South, Bronx, New York, 10461

BIOGRAPHICAL DATA:

Education — Yeshiva University, B.A., Magna Cum Laude, 05/1960
Albert Einstein College of Medicine, M.D., 06/1964
Junior AOA

PROFESSIONAL TRAINING:

07/64-06/65 — Medical Internship, Bronx Municipal Hospital (of the Albert Einstein College of Medicine)

07/65-06/67 — Medical Residency, as above, Medicine

07/67-06/68 — Renal Fellowship, Boston University and Boston City Hospitals with Drs. Relman and Levinsky

MILITARY SERVICE:

07/1968-07/1970 — Captain, USAF
Renal Division at the 1000 bed Wilford Wall, USAF Medical Center including Renal Hypertension Ward and Service, Active Dialysis and Transplant Program, San Antonio, Texas

Chief, Renal Section Renin and Aldosterone Laboratory

Research Associate with the Aerospace Research Unit (Clinical), San Antonio, Texas

CERTIFICATION:

11/1969 — Diplomat, American Board of Internal Medicine
10/1974 — Diplomat, American Board of Nephrology

SOCIETIES, FELLOWSHIPS:

Alpha Omega Alpha
American Medical Association
American Society of Artificial Internal Organs
Bronx County Medical Society
Fellow, American College of Physicians
International Society of Artificial Internal Organs
International Society of Nephrology
International Society of Peritoneal Dialysis
New York Society of Nephrology
Renal Physicians Association

ACADEMIC/TEACHING APPOINTMENTS

Clinical Professor of Medicine
Cornell University Medical College

Adjunct Clinical Professor of Medicine
Albert Einstein College of Medicine

07/1970-Present — Chief, Renal Division
Director, Dialysis Units
New York Hospital Queens

LICENSURE: New York, License No. 94700; California

HOSPITAL APPOINTMENTS:

07/1983-Present — Consultant/Director, Bayside Dialysis Center, Inc.
07/1970-Present — Attending, Albert Einstein College of Medicine
07/1970-Present — Attending, New York Hospital Queens
07/1970-Present — Attending, Montefiore Medical Center

OTHER PROFESSIONAL ACTIVITIES

Editorial Board: Peritoneal Dialysis Bulletin, Clinical Nephrology, Nephron
Chairman, Council of New York Nephrologists
Nephrology Representative to the Carrier Advisory Committee
Consultant, Governor's Advisory Council on Nephrology (N.Y.S.)
Consultant in CAPD to Baxter Laboratories
Medical Advisory Board NY/NJ National Kidney Foundation
Queens NAPHT Advisory Council

07/1990-Present	Executive Committee, ESRD Network of N.Y.,
07/1992-07/1996	President, ESRD Network of New York,
07/1997-07/1999	President, Renal Physicians Association,
07/1989-07/2003	Board of Directors, RPA,
	Consultant, Oxford HealthCare, Capitation Initiative

COMMITTEES:

Albert Einstein College of Medicine

Promotions – Einstein
Clinical Faculty Steering Committee
Alumni Council

COMMITTEES CONT'D

New York Hospital Queens

House Staff
Evaluations
Recruitment
Curriculum
Executive Board, Faculty Practice Plan
Executive Board, BMA Foundation (Research/Education)
Computer Planning
Institutional Planning and Development
Public Affairs Committee
Department of Medicine Search Committee (for new Chairman)

OTHER

ESRD

Waste Disposal
Dialysis Technicians Certification
Computer Committee
Patient Referral and Transfer Policy (Involuntary Discharge)

Renal Physicians Association

Past Chairman, Carrier Relations
Member, Executive Board
Chair, Government Affairs Council
Chair, Nephrology Coverage Advisory Board, 2003-Present

Governmental Advisory Committees

Congresswoman Nita Lowy, Westchester County,
01/1990-Present
Chair, Government Affairs Council (RPA)
Nephrology Representative to Carrier Advisory Committee

CURRICULUM VITAE

NAME: James J. Rahal, Jr.

BORN: Boston, Massachusetts; October 14, 1933

EDUCATION: Harvard College, A.B. cum laude, 1955

Tufts University School of Medicine, M.D. cum laude. Alpha Omega Alpha, 1959

POSTGRADUATE TRAINING:

Intern and Assistant Resident in Medicine
Second (Cornell) Medical Division
Bellevue Hospital, New York, N.Y. - 1959-1961.

Senior Resident in Medicine
New England Medical Center Hospitals - 1961-1962.

Chief Resident In Infectious Diseases
New England Medical Center Hospitals - 1963-1964

U.S.P.H.S Trainee in Infectious Diseases - New England Medical Center Hospitals - 1962-1963; 1964-1965.

FULL TIME APPOINTMENTS:

Assistant Physician, Department of Medicine and Infectious Disease Service, New England Medical Center Hospitals 1965-1969.

Instructor in Medicine, Tufts University School of Medicine 1965-1966.

Senior Instructor in Medicine, Tufts University School of Medicine - 1966-1968.

Assistant Professor of Medicine, Tufts University School of Medicine - 1968-1969

Assistant Professor of Medicine, New York University School of Medicine - 1969-1974.

Chief, Division of Infectious Disease, Manhattan Veterans Administration Medical Center - 1969-1986.

Chief, Infectious Disease Section, New York Infirmary Beekman Downtown Hospital 1986-1988.

Associate Professor of Medicine, New York University School of Medicine - 1974-1989.

Director, Infectious Disease Section, The New York Hospital Medical Center of Queens, formerly Booth Memorial Medical Center - 1988-present.

Associate Professor of Medicine, Albert Einstein College of Medicine - 1988-1991.

Visiting Professor of Medicine, Albert Einstein College of Medicine - 1994-present.

Professor of Medicine, Albert Einstein College of Medicine - 1991-1992.

Clinical Professor of Medicine, Weill College of Medicine, Cornell University - 1992-2000.

Professor of Medicine, Weill College of Medicine, Cornell University - 2001-present.

Assistant Dean, Weill College of Medicine, Cornell University - 2004-Present

Director, Certified Infectious Disease Training Programs:

New York (Manhattan) V.A. Medical Center 1970-1986
New York Hospital Medical Center of Queens 1988-present

SPECIALTY BOARDS:

American Board of Internal Medicine - 1967
American Board of Infectious Diseases - 1972

RESEARCH AWARDS:

Research Fellowship - Medical Foundation of Boston - 1966-1968
Principal Investigator - USPHS Research Grant #AI-07066
"Mechanism of Action of Bacterial Exotoxins" 1966-1969

Principal Investigator - Veterans Administration Research Grant - "Biochemical Mechanisms in Septic Shock: The Role of Bacterial Toxins" 1971-1978

Chairman - V.A. Cooperative Study #89 - "Nafcillin Therapy of Staphylococcal Bacteremia: Four week versus six week therapy for staphylococcal endocarditis and two week versus four week therapy for bacteremia without evidence of endocarditis" - 1978-1981

Albion O. Bernstein, MD Award - April 17, 2004 - Presented by the Medical Society of the State of New York in recognition of identification, treatment and prevention of nosocomial infection with multi-drug resistant gram negative organisms.

TEACHING AWARDS:

Teacher of the year Award-Booth Memorial Medical Center Medical Housestaff - 1988-1989

First Annual Infectious Disease Fellows Award-Albert Einstein College of Medicine - 1991-1992

RESEARCH APPOINTMENT:

Visiting Investigator, Department of Biochemistry, Public Health Research Institute of the City of New York, 1969-1970

SCIENTIFIC SOCIETIES:

Fellow-Infectious Diseases Society of America

President, New York Society of Infectious Diseases 1996-97.

Fellow-American College of Physicians

American Federation for Clinical Research

American Society for Microbiology

American Association for the Advancement of Science

PROFESSIONAL COMMITTEES - REGIONAL AND NATIONAL:

Advisory Expert Committee on Infectious Disease Control - New York City Department of Health, Member, 1974-1985

Veterans Administration Advisory Committee on Infectious Disease, V.A. Central Office, Washington, D.C., Member, 1976-1981

New York State AIDS Institute - Subcommittee on Access to Therapeutic Trials - Member, 1987-1988

New York State Chapter, American College of Physicians - AIDS Subcommittee of the Health and Public Policy Committee - Member, 1988.

National Institute of Health - Data and Safety Monitoring Board for AIDS Treatment Evaluation Units - Member, 1988-1996

New York State Department of Health AIDS Institute: AIDS Drug Assistance Program - Chairman, Medical Advisory Council 1991-1993.

New York State Department of Health AIDS Institute: HIV Uninsured Care Programs-Member, Steering Committee and Chairman, Clinical Subcommittee - 1993-2001.

EDITORIAL BOARD MEMBER

Microbial Drug Resistance
Current Treatment Options in Infectious Diseases
Infectious Disease News

EDITORIAL REVIEWER

New England Journal of Medicine
Journal American Medical Association
Annals of Internal Medicine
Archives of Internal Medicine
Journal of Infectious Diseases
Clinical Infectious Diseases
The Medical Letter

INVITED LECTURES - NATIONAL OR INTERNATIONAL MEETINGS:

Rahal, J.J. - Treatment of Fungal Endocarditis Conference on Treatment of Bacterial Endocarditis. American Heart Association National Center, Dallas, Texas - April 28-30, 1980.

Rahal, J.J. - Staphylococcal Bacteremia and Endocarditis. Symposium on Current Problems in Staphylococcal Infections. 20th Interscience Conference on Antimicrobial Agents and Chemotherapy, New Orleans Louisiana - September 22-24, 1980.

Rahal, J.J. - Meningitis in Adults. Symposium on Bacterial Meningitis. 21st Interscience Conference on Antimicrobial Agents and Chemotherapy, Chicago, Illinois - November, 1981.

Rahal, J.J. - Teaching Staff. International Course on the Evaluation of Antibiotic Resistance Mechanisms: The Methicillin Resistant *Staphylococcus aureus*. Gulbenkian Institute of Science and Rockefeller University, Oeiras, Portugal, July 22, - August 2, 1991.

Rahal, J.J. - Antimicrobial resistance in Gram-Negative Pathogens: a Global View: Table Ronde Roussel UCLAF, No. 75, Microbial Antibiotic Resistance: Challenge to Science and Chemotherapy. Versailles, France. July 5-6, 1993.

Rahal, J.J. - Teaching Staff. Salzburg Cornell Seminar in Infectious Diseases. Soros Foundation, Salzburg, Austria. July 13-20, 1996.

Rahal J.J. - *Acinetobacter*: Fertile soil for the Emergence of Antibiotic Resistance. Infectious Diseases Society of America, Denver, Colorado. November 12, 1998.

Rahal J.J. Squeezing the antibiotic resistance balloon: Is it inevitable? 41st Interscience Conference Conference Antimicrobial Agents and Chemotherapy, Chicago, Illinois -September, 2001.

Rahal J.J. Prevention of antibiotic resistance in hospitals. Meet the Experts Session. 41st Interscience Conference on Antimicrobial Agents and Chemotherapy, Chicago, Illinois - September, 2001.

Rahal J.J. Effects of Interferon Alpha-2b on St. Louis Virus Meningoencephalitis. National Institute of Allergy and Infectious Diseases Symposium on West Nile infection. Bethesda, Md. 11/21/02.

Rahal, J.J. Emerging Resistance in Nosocomial Pathogens - Multidrug-resistant *Acinetobacter* and *Pseudomonas*. International Conference on Emerging Infectious Diseases. Centers for Disease Control and Prevention, Atlanta, GA. 3/1/04.

Rahal J.J. Combination Therapy for Multiply Resistant *Acinetobacter*
and *Pseudomonas*. Update on Serious Gram Negative Bacterial Infections in the I.C.U. University of Pittsburgh, Pittsburgh, PA. 5/8/04.

Rahal, J.J. Epidemiology and Control of Carbapenem Resistance. Interscience Conference on Antimicrobial Agents and Chemotherapy, American Society for Microbiology. Washington, D.C. 10/31/04.

Rahal, J.J. Multi-resistant *Acinetobacter*: A Worldwide Pandemic. Treatment Options. 45th Interscience Conference on Antimicrobial Agents and Chemotherapy. Washington, D.C. 12/18/05.

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3. Rahal JJ Jr, MacMahon HE, Weinstein L. Thrombocytopenia and Symmetrical Peripheral Gangrene in Staphylococcal and Streptococcal Bacteremia. Ann Int Med 69:35, 1968.

4. Rahal JJ Jr, Meyers B, Weinstein L. Treatment of Bacterial Endocarditis with Cephalothin. N Eng J Med 279:1305, 1968.

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7. Rahal JJ Jr, Henle G. Infectious Mononucleosis and Reye's Syndrome: A Fatal Case with Studies for Epstein-Barr Virus. Pediatrics 46:776, 1970.

8. Rahal JJ Jr, Meade RH III, Bump C, Reinauer A. Upper Respiratory Carriage of Gram-Negative Enteric Bacilli by Hospital Personnel. JAMA 214:754, 1970.

9. Smithivas T, Hyams PJ, Rahal JJ Jr. Gentamicin and Ampicillin in Human Bile. J Infect Dis 124:S106, 1971.

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11. Hyams PJ, Smithivas T, Matalon R, Katz L, Simberkoff MS, Rahal JJ Jr. The Use of Gentamicin in Peritoneal Dialysis. II Microbiologic and Clinical Results. J Infect Dis 124:S84, 1971.

12. Rahal JJ Jr. Rat Bite Fever. Current Therapy 1972.

13. Rahal JJ Jr. Comparative Effects of Purified Staphylococcal Alpha and Delta Toxin on Mitochondrial Metabolism. J Inf Dis 126:96, 1972.

14. Rahal JJ Jr. Treatment of Gram Negative Bacillary Meningitis in Adults. Ann Intern Med 77:295, 1972.

15. Hyams PJ, Simberkoff MS, Rahal JJ Jr. *In vitro* Bactericidal Effectiveness of Four Aminoglycoside Antibiotics. Antimicrob Agents and Chemotherapy 3:87-94, 1973.

16. Rahal JJ Jr. *In vitro* Effects of Staphylococcal Alpha and Delta Toxins on Liver Mitochondria. Staphylococcal Infections. Recent Progress. Edit. by Jeljaszewicz. Polish Medical Publishers 1973 pp.345-51.

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128. Yoon J, Urban C, Terzian C, Mariano N, Rahal JJ. *In vitro* double and triple synergistic activities of polymyxin B, imipenem, and rifampin against multi-drug resistant *Acinetobacter baumannii*. Antimicrob Agents Chemother Mar. 2004,753-7.

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137. Li X, Mariano N, Rahal JJ, Urban CM, Drlica K. Quinolone-resistant Haemophilus influenzae in a long-term care facility: nucleotide sequence characterization of alterations in t he genes encoding DNA gyrase and topoisomerase IV. Antimicrob Agents Chemother 2004; 48:3570-3572.

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CURRICULUM VITAE

BRUCE S. SPINOWITZ, M.D., FACP

Address: 1874 Pelham Parkway South, Bronx, N.Y., 10461
Renal Division, N.Y. Hospital Medical Center of Queens
56-45 Main Street, Flushing, N.Y. 11355

BIOGRAPHICAL DATA:

Date of Birth: February 4, 1948

Education:

1965-1969	Yeshiva University, B.A.
1969-1973	New York University School of Medicine, M.D.

POSTGRADUATE TRAINING:

1972-1973	Internship, Internal Medicine, Bellevue Hospital
1973-1974	Resident, Internal Medicine, Bellevue Hospital
1975-1976	Sr. Assist. Resident, Internal Medicine, Bellevue Hospital

FELLOWSHIPS:

1974-1975	NIH Postdoctoral Fellowship, New York University School of Medicine, Department of Physiology
1976-1978	Postdoctoral Fellow in Nephrology, New York University, Bellevue Hospital Center

EMPLOYMENT:

1978-1979	Associate Director, Dialysis Services, Bellevue Hospital Attending Physician, New York University Hospital
1979-Present	Associate, Nephrology Associates, PC, (Offices in the Bronx and Queens)

CERTIFICATION:

1976	American Board of Internal Medicine
1978	American Board of Nephrology

LICENSURE: New York, 1974

SOCIETIES:

1974	American Society of Internal Medicine
1978	American Society of Nephrology
1978	International Society of Nephrology
1981	American Society of Artificial Internal Organs
1987	Fellow, American College of Physicians

FACULTY APPOINTMENTS:

1980-1987	Albert Einstein College of Medicine, Instructor in Medicine
1987-1992	Albert Einstein College of Medicine, Assistant Clinical Professor of Medicine
1992-1996	Albert Einstein College of Medicine, Associate Clinical Professor of Medicine
1996-Present	Cornell University Medical College, Assoicate Clinical Professor of Medicine

HOSPITAL APPOINTMENTS:

1978-1979	Attending Physician, University Hospital, New York, NY Associate Director, Dialysis Unit, Bellevue Hospital Center, New York, NY
1979-Present	Attending Physician, Associate Director Division of Nephrology, New York Hospital Medical Center of Queens
1980-Present	Attending, Hospital of the Albert Einstein College of Medicine
1980-Present	Attending, Montefiore Hospital Medical Center
1995-Present	*Assistant Chairman*, Department of Medicine New York Hospital Medical Center of Queens, Flushing, NY

CONSULTANT:

1982-Present	Bronx Lebanon Hospital Center
1982-Present	St. Barnabas Hospital
1982-Present	Parkway Hospital
1982-Present	Western Queens Community Hospital (formerly Astoria General)

COMMITTEES:

New York Hospital Medical Center of Queens

- Department of Medicine
  - Curriculum Committee
  - Residency Review Committee
  - Investigational Review Board
  - Pharmaceutical & Therapeutics Committee
- President, New York Hospital Medical Center of Queens IPA (Independent Physicians Association)

Curriculum Vitae

February 2011

Name:	Moshe Rubin
Email:	rubinmo@nyp.org mrubinmd@mac.com
Address:	New York Hospital Queens 56-45 Main Street Flushing, NY 11355 1020 Park Avenue Floor 1 New York, NY 10028
Telephone:	(718) 670-2559 (212) 772-1012
Fax:	(212) 772-2877
Birthdate:	October 28, 1957
Birthplace:	New York, N.Y.
Citizenship:	USA
College:	Queens College (CUNY) B.A. Psychology 1979
Medical School:	Yale University M.D. 1983
License:	New York 158806
Internship:	Internal Medicine New York Hospital - Cornell Medical Center

1983 -1984

Residency: Internal Medicine
New York Hospital - Cornell Medical Center
1984 - 1986

Fellowship: Gastroenterology
Columbia - Presbyterian Medical Center
1986 - 1988

Board Certification: Internal Medicine - 1987
Gastroenterology - 1989

Society Membership: American College of Gastroenterology (Fellow)
American Gastroenterological Association
American Society of Gastrointestinal Endoscopy
New York Society of Gastrointestinal Endoscopy
American Medical Association
New York Clinical Society
Crohn's & Colitis Foundation

Academic Appointment: Associate Professor of Clinical Medicine, Weill-Cornell Medical College, 2008-2010
Associate Clinical Professor of Medicine, Columbia University, 1986- 2007

Hospital Appointments: Attending Physician New York Hospital Queens 2008-Present
Attending Physician Lenox Hill Hospital 2007 – 2008
Attending Physician New York Presbyterian Hospital, 1988 – 2007

Administration: Director, Division of Gastroenterology, New York Hospital Queens, 2008 – Present

Program Director, Gastroenterology Fellowship Training Program, New York Hospital Queens, 2008-Present

Member, Information Technology Committee, New York Hospital Queens, 2008 – Present

Member, GME Committee, New York Hospital Queens 2008 – Present

Member, Comprehensive Cancer Center Committee, New York Hospital Queens 2010

Member, New York Presbyterian Board of Trustees Special Committee on the Environment, 2002 - 2005

Director, GI Endoscopy Unit, Allen Pavilion, New York Presbyterian Hospital, 1988 – 1994

Director, GI Quality Care Committee, Allen Pavilion, New York Presbyterian Hospital, 1988-1994

Medical Staff Position: President, Society of Practitioners of The Presbyterian Hospital, 1998-2001

Vice President, Society of Practitioners of The Presbyterian Hospital, 1996 - 1998

Executive Board, Columbia Presbyterian Physician Network, 1997 – 2001

Board Member, Columbia-Cornell Care, 1998 -2001

Honors: Alpha Omega Alpha
Phi Beta Kappa
Alfred Markowitz, M.D. Service Award, New York Presbyterian Hospital, 2005

Teaching: Physical Diagnosis Course, Weill-Cornell Medical College, 2008-Present

Undergraduate Medical Education - Gastrointestinal Pathophysiology, Lecturer and Teacher of GI syllabus, Columbia University, classes of 25-30 2nd year medical students, reviewing lecture materials, case studies and grading papers.
1988- 2005

Undergraduate Medical Education – Columbia University, Physical Diagnosis Course, basic physical exam techniques, bedside evaluation of patients, 20 week course. 1988-2000

Graduate Medical Education - Internal Medicine Teaching/Supervising Medical Attending,
General Medical Service, for Residents, Interns and Students, 4 weeks/year, 1988-2007

Gastroenterology Fellowship Training Program, Direct supervision of Fellows, in the evaluation and management of outpatients and inpatients including all routine and emergency endoscopic procedures, advanced endoscopic procedures including ERCP, polypectomy, percutaneous gastrostomy, stent insertion, dilation, control of hemorrhage, control of variceal bleeding, Double Balloon Enteroscopy, Capsule Endoscopy. 1988- 2007

Fellowship Research Mentor – Direct supervision of Fellows in clinical research including protocol development, funding, IRB submission, conduct of trials, collection of data, writing and submitting research papers. 1994 - 2007

Postgraduate – Gastroenterology, Lecturer in Board review courses and Endoscopy Society Meetings, 1990-2007

Subspecialty Areas:

Celiac Disease
Inflammatory Bowel Disease
Wireless Capsule Endoscopy
Double Balloon Enteroscopy

BIBLIOGRAPHY

Articles in Peer-Reviewed Journals

1. Schacter, E. N. **Rubin, M.** The effect of an aerosolized antihistamine, chlorpheniramine maleate on exercise induced bronchospasm. Ann Allergy. 1985. Jan. 54(1). 14-18.

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4. McFarland, L.V. Surawicz, C.M. **Rubin, M.** et al Recurrent Clostridium difficile disease: Epidemology and clinical characteristics Infect Control Hosp Epidemiol 1999:20:43-50

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6. Larghi, A., Leffler, D., Frucht, H., **Rubin, M.,** et al, Hepatitis B Virus Reactivation After Kidney Transplantation and Lymphoma J. Clin Gastroenterol, 2003:36(3)

7. Culliford AN, Daly, J, Diamond, B, **Rubin, M,** Green, PH. The value of wireless capsule endoscopy in patients with complicated celiac disease. Gastrointest Endosc. 2005 Jul;62(1): 55-61

8. Green, P. and **Rubin, M.,** Capsule Endoscopy and Celiac Disease, Gastrointest Endosc. 2005, 62 (5), 797

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10. Green, P.H. and **Rubin, M.** Capsule endoscopy in celiac disease: diagnosis and management. Gastrointest Endosc Clin N Am. 2006 Apr;16(2):307-16.

11. Hussain, S and **Rubin, M.** Identification of small bowel diverticula with double balloon endoscopy following non-diagnostic capsule endoscopy

Dis Sci. 2009 Oct;54(10):2296-7. Epub 2008 Dec 3. PubMed PMID: 19051015.

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Dig Dis Sci. 2009 Dec 24

13. **Rubin, M**, Hussain, S, Shalomov, A, Cortes, R,. Smith, M, Kim, S., Risk Stratification of Upper GI Bleeding Patients in the Emergency Room with LiveView Video Capsule Endoscopy – A Pilot study. Dig Dis Sci. 2010 Jul 15. [Epub ahead of print]

14. Puri V, Alagappan A, **Rubin M**, Merola S. Management of bleeding from gastric remnant after Roux-en-Y gastric bypass. Surg Obes Relat Dis. 2010 Sep 16. [Epub ahead of print] PubMed PMID: 21130706

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Books, book chapters and reviews

Sweeting, J. and **Rubin, M.** Inflammatory Bowel Disease. The Electronic Textbook, 1991. Columbia-Presbyterian Medical Center

Green, P.H. and **Rubin, M.** Malabsorption; Capsule Endoscopy Text and DVD, Ch. 17, St. Louis, MO: Elsevier; 2008

Abstracts

1. Stevens, P.D., Finegold J., Garcia, J., Greene, PHR., Meyer,F., Rosenberg, R., and **Rubin, M.** Effectiveness of a protocol based team approach to gastrointestinal hemorrhage Gastrointestinal Endosc 1997;45:AB51

2. Culliford, AN, **Rubin, M,** and Green, PH. High yield of capsule endoscopy in patients with celiac disease and recurrent abdominal pain. Am J Gastroenterol. 2003 Oct;98(10):AB P149

3. Culliford, AN, **Rubin, M,** Daly, J, Green PH. Interobserver variability in wireless capsule endoscopy: 40 cases of celiac disease Gastrointest Endosc. 2004 Apr;59(5)AB 1818

4. Daly, J, Culliford AN, **Rubin, M,** Green, PH. High yield of wireless capsule endoscopy in complicated celiac disease Gastrointest Endosc. 2004 Apr;59(5)AB 1806

5. Schnoll-Sussman, F, Bergwerk, A, Eliakim, R, Legnani, P, Lewis, B, **Rubin, M**, Schmelkin I. New Capsule Endoscopy Viewing Mode May Improve Reading Efficiency Without Effect On Pathology Detection Rate *Gastrointestinal Endoscopy* April 2006 (Vol. 63, Issue 5, Page AB227)

6. Arramraju, S; John, Bijo K.; Shalomov, A; Huang, Z; **Rubin, M**. High Mortality Rate in Hospitalized Patients Who Develop Clostridium Difficile Associated Diarrhea. Gastroenterology, May 2009, Vol. 136, Issue 5, Pages A-708

7. John, B; Arramraju, S; Shalomov, A; **Rubin, M.** The use of antiplatelet agents does not impact the hospital course of patients admitted with GI bleed. Gastroenterology, May 2009, Vol. 136, Issue 5, Pages A-634

8. Shalomov, A, Hussain, S, Cortes' R. Kim[1], Somnay' K,, Brodsky' N, Smith, M.S., **Rubin' M**. Risk Stratification Of Upper GI Bleeding Patients In The Emergency Room With "Real Time" Capsule Endoscopy Am Journal of Gastroenterology 104(3) ABS 1091, 2009

9. Shalomov, A, Hussain, S, Cortes' R. Kim[1], Somnay' K,, Brodsky N, Smith, M.S., **Rubin' M.** Rapid Evaluation of the Upper GI Tract Using Real-Time Pillcam™ ESO in Emergency Room Patients with Acute UGI Bleeding. Am Journal of Gastroenterology, 104(3) ABS 1344, 2009

10. Arramraju, S, Shalomov, A, John, B, **Rubin, M.**
Higher Resolution Rate of Clostridia Difficile Enteritis in Hospitalized Patients With Normal Vitamin D Levels Gastroenterology May 2010 (Vol. 138, Issue 5, Supplement 1, Page S-580)

12. Mukherjee, R, Sheikh, M, **Rubin, M**, Lebwohl, B, Green, P.
Evaluation of Gastric and Small Bowel Transit Time by Video Capsule Endoscopy *Gastrointestinal Endoscopy* April 2010 (Vol. 71, Issue 5, AB373)

13. Gutkin, E, Gray, S, Judeh, H, Shalomov, A, Hussain, S, Cortes, Kim, S, **Rubin, M** PillCam ESO® Is More Accurate Than Clinical Scoring Systems in Risk Stratifying Emergency Room Patients With Acute Upper Gastrointestinal Bleeding Gastrointestinal Endoscopy April 2010 (Vol. 71, Issue 5, Pages AB157-AB158)

14. Gutkin, E, Hussain, S, Shalamov, A, Kim, S, Mehta, P, Du, L, and **Rubin, M**, Diagnosis of Multifocal Small bowel Carcinoid with Double Balloon Enteroscopy Am J Gastro, Vol.105, Supp 1, Oct 2010

Current Research:

Wireless Capsule Endoscopy in Acute Gastrointestinal Bleeding

Wireless Capsule Endoscopy in Celiac Disease

Double Balloon Endoscopy in small bowel disease

Clostridium difficile enteritis, epidemiology and association with Vitamin D levels

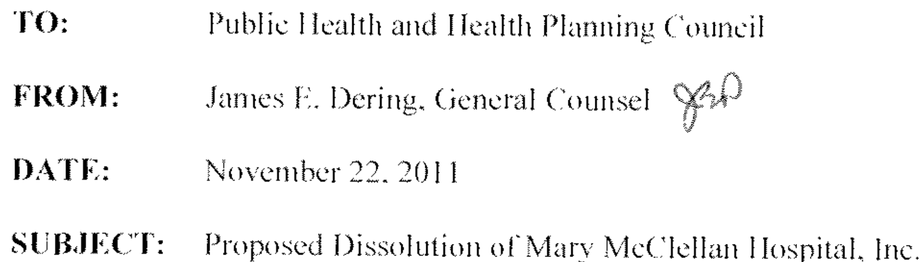
Antiplatelet agents and gastrointestinal bleeding

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 2nd day of February, 2012, approves the filing of the Certificate of Amendment of Certificate of Incorporation of BMA Medical Foundation, Inc., dated November 8, 2011.

New York State Department Of Health

Memorandum



TO: Public Health and Health Planning Council

FROM: James E. Dering, General Counsel

DATE: November 22, 2011

SUBJECT: Proposed Dissolution of Mary McClellan Hospital, Inc.

Mary McClellan Hospital, Inc. ("Mary McClellan") requests Public Health and Health Planning Council approval of its proposed Dissolution in accordance with the requirements of Not-For-Profit Corporation Law §1002(c) and §1003, as well as 10 NYCRR Part 650.

Mary McClellan was formed in 1916 under the Membership Corporations Law and operated a general hospital and residential health care center in Washington County until 2003, when Mary McClellan ceased operations and surrendered its operating certificates to the Department. Therefore, there is no longer a reason for Mary McClellan to exist. Pursuant to Mary McClellan's Plan of Dissolution, if approved by the Attorney General, Mary McClellan's remaining liabilities will be paid from a reserve fund it has maintained.

Attached are a copy of the duly executed proposed Certificate of Dissolution, a letter from Mary McClellan's attorney explaining the need for the proposed Dissolution, a proposed Plan of Dissolution, and a proposed Verified Petition seeking the Attorney General's approval of Mary McClellan's Certificate of Dissolution.

The Certificate of Dissolution is in legally acceptable form.

Attachments

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER LLP
677 Broadway - 9th Floor, Albany, New York 12207-2996 Tel: (518) 449-8893 Fax: (518) 449-8927

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Miami • New Jersey • New York • Orlando • Philadelphia • San Diego • San Francisco • Stamford • Washington, DC • West Palm Beach • White Plains
Affiliates: Berlin • Cologne • Frankfurt • Mexico City • Munich • Paris*

www.wilsonelser.com

June 2, 2011

Jean Quarrier, Esq.
Acting Director, Bureau of House Counsel
Division of Legal Affairs
New York State Department of Health
Corning Tower, 24th floor
Albany, New York 12237

Re: Public Health and Health Planning Council Approval – Dissolution of Mary McClellan Hospital, Inc.

Dear Ms. Quarrier:

Pursuant to section 1002(c) of the Not-for-Profit Corporation Law, Mary McClellan Hospital, Inc. (Mary McClellan) is seeking approval of the Public Health and Health Planning Council to dissolve.

Mary McClellan was originally formed on April 12, 1916 under the Membership Corporations Law of the State of New York. Until 2003, Mary McClellan was a not-for-profit community health care provider with its primary location in Cambridge, New York. Financial difficulties caused Mary McClellan to cease operations, which at the time consisted of an inpatient hospital, an attached skilled nursing facility and four outpatient health centers. The hospital and nursing home were closed and the operations of the four health centers were transferred to Glens Falls Hospital. Mary McClellan subsequently filed for bankruptcy. Mary McClellan has emerged from bankruptcy, complied with its Bankruptcy Plan, sold all of its real property, and is now seeking a voluntary dissolution pursuant to Article 10 of the Not-for-Profit Corporation Law.

In conjunction with the Public Health and Health Planning Council's approval, enclosed are the following documents:

1. The proposed Certificate of Dissolution;

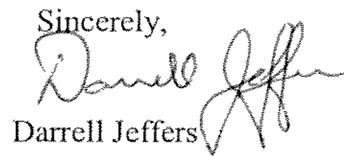
2. A copy of the Plan of Dissolution approved by the Board of Directors of Mary McClellan; and

3. Certificate of Incorporation of Mary McClellan and amendments.

Please let me know if you have any questions or require any additional information.

Thank you for your prompt consideration of this matter.

Sincerely,



Darrell Jeffers

Enclosures

Certificate of Dissolution

of

Mary McClellan Hospital, Inc.

Pursuant to § 1003 of the Not-for-Profit Corporation Law

I, Michael Catalfimo, the Chairman of Mary McClellan Hospital, Inc. certify:

1. The name of this corporation is Mary McClellan Hospital, Inc

2. The Certificate of Incorporation of Mary McClellan Hospital was filed by the Department of State of the State of New York on the 12th day of April, 1916.

3. The names and addresses of each of the officers and directors of the corporation and the title of each are as follows:

Name	Title	Address
James E. Briglin	Director	1120 County Route 64 Shushan, New York 12873
Michael. J. Catalfimo	Director and Chairman	20 Corporate Woods Blvd. Albany, NY 12211-2362
Arthur E. Center, Jr.	Director and Vice Chairperson	27 Washington Street Cambridge, New York 12816
Mal Lambert	Director	20 Jackson Avenue Greenwich, New York 12834
Dale MacNeil	Director and Secretary	244 Rexleigh Road Salem, New York 12865
Paul Tomlinson	Director and Treasurer	5025 State Route 22 Salem, New York 12865

4. Dissolution of the corporation was authorized by a unanimous vote of the Board of Directors.

5. The corporation elects to dissolve.

6. At the time of dissolution, the corporation is a Type B corporation.

7. The corporation filed with the Attorney General a certified copy of its Plan of Dissolution.

8. The Plan of Dissolution filed with the Attorney General included a statement that at the time of dissolution the corporation had no assets other than a reserve fund in the amount of $24, 906.90 to be used to pay both (i) the costs of winding up the organizations affairs such as attorneys and accountants' fees and (ii) any liabilities, which may not exceed a total of $10,000.

9. The corporation has carried out its Plan of Dissolution, paid all of its liabilities and submitted a final report to the Attorney General.

10. At the time of the authorization of its Plan of Dissolution, the corporation did not hold any assets that are legally required to be used for a particular purpose pursuant to the Not-for-Profit Corporation Law.

11. Prior to the filing of this Certificate with the Department of State, the endorsement of the Attorney General and the approval of the Public Health and Health Planning Council will be attached.

IN WITNESS WHEREOF, the undersigned has signed this Certificate of Dissolution of Mary McClellan Hospital, Inc. this 25th day of October, 2011.

Signature

Michael J. Catalfimo, Chairman, Board of Directors
Name of Officer and Title

Certification

I, Michael J. Catalfimo, Chairman of the Mary McClellan Hospital, Inc. hereby certify under penalties for perjury that the within Plan of Dissolution was duly submitted and approved by unanimous written consent of the Board of Directors of the Corporation.

Michael J. Catalfimo, Chairman

Dated the 18th day of May, 2011.

PLAN OF DISSOLUTION

of

Mary McClellan Hospital, Inc.

The Board of Directors of Mary McClellan Hospital, Inc. by unanimous written consent, having considered the advisability of voluntarily dissolving the corporation, and it being the unanimous opinion of the Board that dissolution is advisable and it is in the best interests of the corporation to effect such a dissolution, and the Board of Directors having adopted, by unanimous vote, a Plan for a voluntary dissolution of the corporation, does hereby resolve that the corporation be dissolved in accordance with the following Plan:

1. There being no members of the corporation, no vote of membership is required to approve this dissolution, and action of the Board of Directors is sufficient.

2. Approval of the dissolution of the corporation is required to be obtained from the New York State Public Health and Health Planning Council, whose approval will be attached hereto.

3. (A) The corporation has a reserve fund in the amount of $24, 906.90 to be used to pay both (i) the costs of winding up the organization's affairs, such as attorneys and accountants' fees, and (ii) liabilities, which may not exceed a total of $10,000; and has no other assets to distribute. The amount of such fees are $ 15,652.57.

(B) The corporation has liabilities of no more than $10,000 and a description of those liabilities is as follows:

The Department of Health and Human Services	- $ 131.83
DeTec	- $ 11.18
The Mary McClellan Foundation	- $8041.52
New York State Medicaid	- $1069.80

4. Within ten (10) days after the authorization of the Plan of Dissolution by a vote of the board, a certified copy of the Plan shall be filed with the Attorney General of the State of New York pursuant to N-PCL § 1002 (d).

5. Within two hundred seventy days of filing of the Plan with the Attorney General, the corporation shall carry out the Plan and pay its liabilities.

6. A Certificate of Dissolution shall be executed and all approvals required under Section 1003 of the Not-for-Profit Corporation Law shall be attached thereto.

This consent in writing may be signed in one or more counterparts, each of which shall be deemed an original and constitute one and the same instrument.

Michael J. Catalfimo — Date: 5/9/11

Arthur E. Center, Jr. — Date

Dale MacNeil — Date

Paul Tomlinson — Date

James E. Briglin — Date

Mal Lambert — Date

279397.1

4. Within ten (10) days after the authorization of the Plan of Dissolution by a vote of the board, a certified copy of the Plan shall be filed with the Attorney General of the State of New York pursuant to N-PCL § 1002 (d).

5. Within two hundred seventy days of filing of the Plan with the Attorney General, the corporation shall carry out the Plan and pay its liabilities.

6. A Certificate of Dissolution shall be executed and all approvals required under Section 1003 of the Not-for-Profit Corporation Law shall be attached thereto.

This consent in writing may be signed in one or more counterparts, each of which shall be deemed an original and constitute one and the same instrument.

Michael J. Catalfimo	Date
Arthur E. Center, Jr.	May 5, 2011 Date
Dale MacNeil	Date
Paul Tomlinson	Date
James E. Briglin	Date
Mal Lambert	Date

4. Within ten (10) days after the authorization of the Plan of Dissolution by a vote of the board, a certified copy of the Plan shall be filed with the Attorney General of the State of New York pursuant to N-PCL § 1002 (d).

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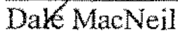
Michael J. Catalfimo	Date
Arthur E. Center, Jr.	Date
 Dale MacNeil	5/5/11 Date
Paul Tomlinson	Date
James E. Briglin	Date
Mal Lambert	Date

279397.1

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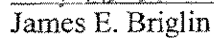
Michael J. Catalfimo	Date
Arthur E. Center, Jr.	Date
Dale MacNeil	Date
Paul Tomlinson	Date
	5-5-11
James E. Briglin	Date
Mal Lambert	Date

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5. Within two hundred seventy days of filing of the Plan with the Attorney General, the corporation shall carry out the Plan and pay its liabilities.

6. A Certificate of Dissolution shall be executed and all approvals required under Section 1003 of the Not-for-Profit Corporation Law shall be attached thereto.

This consent in writing may be signed in one or more counterparts, each of which shall be deemed an original and constitute one and the same instrument.

Michael J. Catalfimo	Date
Arthur E. Center, Jr.	Date
Dale MacNeil	Date
Paul Tomlinson	Date
James E. Briglin (signed)	5/5/11 Date
Mal Lambert	Date

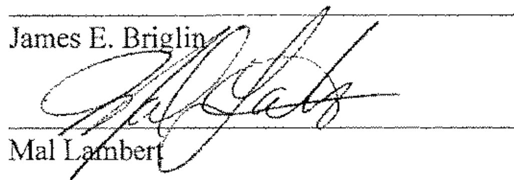
4. Within ten (10) days after the authorization of the Plan of Dissolution by a vote of the board, a certified copy of the Plan shall be filed with the Attorney General of the State of New York pursuant to N-PCL § 1002 (d).

5. Within two hundred seventy days of filing of the Plan with the Attorney General, the corporation shall carry out the Plan and pay its liabilities.

6. A Certificate of Dissolution shall be executed and all approvals required under Section 1003 of the Not-for-Profit Corporation Law shall be attached thereto.

This consent in writing may be signed in one or more counterparts, each of which shall be deemed an original and constitute one and the same instrument.

Michael J. Catalfimo	Date
Arthur E. Center, Jr.	Date
Dale MacNeil	Date
Paul Tomlinson	Date
James E. Briglin	Date
Mal Lambert	5-4-11 Date



In the Matter of the Application of:

MARY McCLELLAN HOSPITAL, INC.,

For Approval of Certificate of Dissolution pursuant to Section 1002 of the Not-for-Profit Corporation Law.

VERIFIED PETITION FOR APPROVAL OF CERTIFICATE OF DISSOLUTION

TO: THE ATTORNEY GENERAL OF THE STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL
Charities Bureau - The Capitol
Albany, New York 12224-0341

Petitioner, Mary McClellan Hospital, Inc., by Michael Catalfimo, Chairman of the corporation for its Verified Petition alleges:

1. Mary McClellan Hospital, Inc., whose principal address is P.O. Box 542, Cambridge, New York 12816, was incorporated pursuant to New York's Membership Corporation Law on April 11, 1916. A copy of the Certificate of Incorporation is attached.

2. The names, addresses and titles of the corporation's officers and directors are as follows:

Name	Title	Address
James E. Briglin	Director	1120 County Route 64 Shushan, New York 12873
Michael. J. Catalfimo	Director and Chairman	20 Corporate Woods Blvd. Albany, NY 12211-2362
Arthur E. Center, Jr.	Director and Vice Chairperson	27 Washington Street Cambridge, New York 12816
Mal Lambert	Director	20 Jackson Avenue Greenwich, New York 12834

Dale MacNeil	Director and Secretary	244 Rexleigh Road Salem, New York 12865
Paul Tomlinson	Director and Treasurer	5025 State Route 22 Salem, New York 12865

3. The purpose for which the corporation was organized is as follows:

Establish hospital for persons suffering from injury or disease, and persons requiring medical or surgical attention, and for general hospital purposes.

4. The corporation is a Type B corporation.

5. Written consent was signed on May 18, 2011 by all of the directors of the corporation adopting a Plan and authorizing the filing of a Certificate of Dissolution in accordance with Section 1003 of the Not-for-Profit Corporation Law. A copy of the Plan, approved by unanimous written consent of the directors is attached as an exhibit.

6. The corporation has no members.

7. A certified copy of the corporation's Plan of Dissolution was filed with the Office of the Attorney General.

8. The corporation carried out the plan of Dissolution, and a copy of its final report showing zero assets has been filed with the Attorney General.

9. Approval of the dissolution of the corporation is required to be obtained from the Public Health and Health Planning Council, and a copy of such approval is attached.

10. With this Petition, the original Certificate of Dissolution is being submitted to the Attorney General for approval pursuant to Not-for-Profit Corporation Law Section 1003.

WHEREFORE, Petitioner requests that the Attorney General approve the Certificate of Dissolution of Mary McClellan Hospital, Inc., a not-for-profit corporation, pursuant to Not-For-Profit Corporation Law Section 1003.

IN WITNESS WHEREOF, the corporation has caused this Petition to be executed the ____day of ___________, 2011.

By:_____________________________________
Michael Catalfimo, Chairman

VERIFICATION

STATE OF NEW YORK)
COUNTY OF _________________) SS:

MICHAEL CATALFIMO, being duly sworn, deposes and says:

I am the Chairman of Mary McClellan Hospital, Inc., the corporation named in the above Petition and make this verification at the direction of its Board of Directors. I have read the foregoing Petition and know the contents thereof to be true of my own knowledge, except those matters that are stated on information and belief and as to those matters I believe them to be true.

____
MICHAEL CATALFIMO

Sworn to before me this
______day of _________, 2011.

____
Notary Public - State of New York

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 2nd day of February, 2012, approves the filing of the Certificate of Dissolution of Mary McClellan Hospital, Inc., dated October 25, 2011.

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Stat Staff Professionals, Inc.
Address:	Clifton Park
County:	Saratoga
Structure:	For-Profit Corporation
Application Number:	1959-L

Description of Project:

Stat Staff Professionals, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law. Stat Staff Professionals, Inc. is an existing medical staffing company providing professional services to acute care hospitals in the Capital District. Stat Staff Professionals, Inc. wishes to expand its services to include services in the home. Stat Staff Professionals, Inc. uses the name "Stat Staff Professionals, Inc." as its business name. However, it uses the d/b/a Adirondack Health & Wellness to indicate its educational division.

The applicant has authorized 200 shares of stock which are owned solely by David Theobald.

The Board of Directors of Stat Staff Professionals, Inc. comprises the following individual:

David M. Theobald, R.N.
CEO, Stat Staff Professionals, Inc.

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 258 Ushers Road, Suite 103, Clifton Park, New York 12065:

Saratoga	Franklin	Clinton	Essex	Hamilton
Warren	Washington	Fulton	Montgomery	Schenectady
Albany	Rensselaer	Otsego	Schoharie	Delaware
Greene	Columbia	Ulster		

The applicant proposes to provide the following health care services:

Nursing	Physical Therapy	Occupational Therapy	Respiratory Therapy
Nutrition			

Review of the Disclosure Information indicates that the applicant has no affiliations with other health care facilities.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the staff of the New York State Department of Health and the Establishment and Project Review Committee of the Council, and after due deliberation, hereby approves the following applications for licensure, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY:
1640 L	Acute Care Experts, Inc. (Bronx, Queens, Kings, Richmond, Nassau, and New York Counties)
1956 L	Advantage Management Associates, Inc. d/b/a Advantage Homecare Agency (New York, Westchester, Kings, Queens, Bronx, and Richmond Counties)
1678 L	Amazing Grace Home Care Services, LLC (New York, Bronx, Kings, Richmond, and Queens Counties)
1696 L	Diana's Angels, Inc. (Putnum, Bronx, Westchester and Dutchess Counties)

1957 L	Evergreen Choice, LLC (New York, Bronx, Kings, Richmond and Queens Counties)
1668 L	Five Borough Home Care, Inc. (Bronx, Kings, New York, Richmond, and Queens Counties)
1733 L	Heritage Homecare Services, Inc. (New York, Kings, Queens, Bronx, Nassau, Suffolk and Richmond Counties)
1994 L	Independent Living for Seniors, Inc. (Monroe and Wayne Counties)
1835 L	Longevity Care, LLC (Westchester County)
1959 L	Stat Staff Professionals, Inc. (Saratoga, Warren, Albany, Greene, Franklin, Washington, Rensselaer, Columbia, Clinton, Fulton, Otsego, Ulster, Essex, Montgomery, Schoharie, Hamilton, Schenectady, and Delaware Counties)
2004 L	Long Island Living Center, LLC d/b/a Long Island Living Center (Bronx, Kings, and Queens Counties)
2079 L	Metrostar Home Care, LLC (Kings, Bronx, Queens, Richmond, New York and Nassau Counties)
1875 L	ALJUD Licensed Home Care Services, LLC (Nassau and Suffolk Counties)

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 2: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Without Dissent by HSA
- Without Dissent by Establishment and Project Review Committee

CON Applications

Acute Care Services – Establish **Exhibit #16**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112185 E	Inter-Lakes Health, Inc. (Essex County) Mr. Booth –Interest Dr. Rugge- Interest	Contingent Approval

Ambulatory Surgery Centers – Establish/Construct **Exhibit #17**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112244 E	Unity Linden Oaks Surgery Center, LLC (Monroe County) Mr. Booth – Interest Mr. Robinson – Recusal	Contingent Approval

Certified Home Health Agencies – Establish **Exhibit #18**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	102239 E	North Shore University Hospital, Inc., d/b/a North Shore Home Care (Nassau County) Mr. Kraut - Recusal	Approval

Residential Health Care Facility – Establish **Exhibit #19**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112218 E	***DEFERRED AT THE DEPARTMENT'S REQUEST** Waterfront Operations Associates, LLC d/b/a Waterfront Center for Rehabilitation and Health Care (Erie County) Mr. Booth - Interest Mr. Fassler – Recusal	Contingent Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #20**

Number	Applicant/Facility	E.P.R.C. Recommendation
1994 L	Independent Living for Seniors, Inc. (Monroe and Wayne Counties) Mr. Booth – Interest Mr. Robinson – Recusal	Contingent Approval

Public Health and Health Planning Council

Project # 112185-E

Inter-Lakes Health, Inc.

County: **Essex (Ticonderoga)**
Purpose: **Establishment**
Program: **Acute Care Services**
Submitted: **October 14, 2011**

Executive Summary

Description

Inter-Lakes Health, Inc. (ILH), a New York not-for-profit membership corporation, seeks approval to be established as the co-operator of Moses Ludington Hospital and Moses Ludington Nursing Home, Inc. (MLNH), d/b/a Heritage Commons Residential Health Care. Moses Ludington Hospital (MLH) is a 15-bed Critical Access Hospital located at 1019 Wicker Street Ticonderoga, and Moses Ludington Nursing Home (MLNH) is an 84-bed residential health care facility also located at the aforementioned address.

In January 2003, ILH became the sole corporate member of MLH and MLNH, and this application seeks to formalize that relationship as active parent and co-operator. Approval of the proposed establishment would grant ILH direct powers over MLH and MLNH corporations. ILH will work with MLH and MLNH in the management of the day-to-day direct operations.

There are no costs associated with this application. MLH and MLNH will be subsidiaries in ILH, Inc. ILH, MLH, and MLHN will remain separate not-for-profit Article 28 corporations and maintain separate operating certificates. There will be no change in authorized services or number or type of bed complements at MLH or MLNH as a result of the proposed establishment.

DOH Recommendation

Contingent approval.

Need Summary

The integration of MLH and MLNH into ILH will result in continued coordination of care, increased efficiencies, and elimination of duplicative administration functions. There will be no change in patient beds or services and no construction is involved in this application.

Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Summary

There are no significant issues of capability or feasibility associated with the subject application.

Architectural Summary

This project is for Establishment action only; therefore, no Architectural recommendation is required.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of a photocopy of the applicant's executed proposed certificate of amendment of its certificate of incorporation, which is acceptable to the Department. [CSL]
2. Submission of a photocopy of the applicant=s executed proposed amended bylaws, which are acceptable to the Department. [CSL]
3. Submission of a photocopy an executed proposed certificate of amendment of the certificate of incorporation of Moses Ludington Nursing Home Co., Inc., which is acceptable to the Department. [CSL]
4. Submission of a photocopy of proposed amended bylaws of Moses Ludington Nursing Home Co., Inc., which is acceptable to the Department. [CSL]
5. Obtaining Department of Health approval of a CON application under the NYS Social Services Law authorizing the applicant to manage the operation of Moses Ludington Adult Care Facility. [CSL]

Council Action Date
February 2, 2012.

Need Analysis

Background
Inter-Lakes Health, Inc. (ILH) seeks approval to be established as the co-operator of Moses Ludington Hospital (MLH) and Moses Ludington Nursing Home, Inc. (MLNH), d/b/a Heritage Commons Residential Health Care. Moses Ludington Hospital is a 15-bed Critical Access Hospital located at 1019 Wicker Street, Ticonderoga, and Moses Ludington Nursing Home is an 84 bed-residential health care facility located at the same aforementioned address.

Moses Ludington Hospital and Moses Ludington Nursing Home have the following certified beds and services:

Table 1:
Distribution of Beds: Moses Ludington Hospital and Moses Ludington Nursing Home

Bed Category	*Moses Ludington Hospital*	*Moses Ludington Nursing Home*
Special Use Beds	15	
RHCF Beds		84
Total	15	84

Table 2:
Distribution of Services: Moses Ludington Hospital and Moses Ludington Nursing Home

Service Category	*Moses Ludington Hospital*	*Moses Ludington Nursing Home*
Ambulatory Surgery - Multi Specialty	✓	
Audiology		✓
Baseline Services - Nursing Home		✓
Clinical Laboratory Service		✓
Dental		✓
CT Scanner	✓	
Dental O/P	✓	
Emergency Department	✓	
Medical Social Services	✓	✓
Nursing		✓
Nutritional		✓
Optometry		✓
Outpatient Surgery	✓	
Pharmaceutical Service		✓
Physical Medicine and Rehabilitation O/P	✓	
Physician Services		✓
Primary Medical Care O/P	✓	
Psychology		✓
Radiology - Diagnostic		✓
Swing Bed Program	✓	
Therapy - Occupational		✓
Therapy - Occupational O/P	✓	
Therapy - Physical		✓
Therapy - Physical O/P	✓	
Therapy - Speech Language Pathology	✓	✓

Analysis
Moses Ludington Hospital is a 15-bed Critical Access Hospital and sole community provider located in Southern Essex County. Between 2008 and 2010, the hospital discharged an average of 247 patients a year. In 2008, the hospital recorded an average length of stay (ALOS) of 3.7 days. By 2009, the ALOS declined to 3.4 days and continued the downward trend to 3.3 days in 2010. The associated occupancy rates generated by these patients ranged from 14.7 percent to 17.3 percent. In addition, MLH operates an 84-bed Residential Health Care Facility (RHCF). During the

same period, the occupancy rates for the RHCF were 96.7 percent, 95.5 percent and 95.2 percent, respectively (Table 3).

The facility also provides emergency services in the community. During the years under review, the hospital saw an average of 7,597 total Emergency Department visits. Of these, approximately 3.0 percent were admitted as an inpatient.

Table 3:
Distribution of Utilization Statistics: Moses Ludington Hospital and Moses Ludington Nursing Home

Category	2008	2009	2010
Moses Ludington Hospital			
Discharges	253	235	254
Average Length of Stay	3.7	3.4	3.3
Occupancy	17.3%	14.7%	15.3%
Moses Ludington Nursing Home			
RHCF Occupancy	96.7 %	95.5 %	95.2 %

Source: Inpatient SPARCS 2008-2010; Nursing Home, RHCF Cost Reports 2008-2010

Conclusion
Inter-Lakes Health seeks approval to be established as the co-operator of Moses-Ludington Hospital, Inc. and Moses-Ludington Nursing Home Company, Inc. The integration of MLH and MLNH into ILH, will result in improved coordination of care, increased overall efficiencies and elimination of duplicative administrative functions. There will be no changes in services or beds under this transaction

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Character and Competence
The board members of the Inter-Lakes Health, Inc. are:

Name	Position
Sandra R. Bolton	Chair
Roland Allen	Vice-Chair
Dawn Stoddard	Secretary
Chattie Van Wert	Treasurer
Ross Kelley	
Anna Carney	
Deborah Endsley	
Bud Bresett	
Robert Dedrickl	
Glen Chapman, MD	
Charles Miceli	Interim CEO, Moses-Ludington Hospital

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's and relatives' ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management (relative to Medicaid fraud and abuse), the Office of Professional Medical Conduct, and the Education Department databases.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections.

Heritage Commons Residential Health Care was enforced four times in the last ten years based on surveys in 2007, 2008, 2009 and 2010. However, none of the deficiencies rise to the level of repeat deficiencies that would taint the operator.

The review found that any citations were properly corrected with appropriate remedial action. Based on this information, staff concluded that the applicant have provided a substantially consistent high level of care as defined in New York State Public Health Law 2810(a)(3) and 10NYCRR 600.2 during the past 10 years.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Background

The application from ILH seeks to formalize its relationship as active parent and co-operator of MLNH and MLH. ILH requests permission to accept the amended certificates of incorporation of MLNH and MLH. Approval of the proposed establishment would grant ILH direct powers over MLH and MLNH corporations. ILH will work with MLH and MLNH in the management of the day-to-day direct operations.

MLH and MLNH will enable ILH the ability exercise active parent powers as stated below. The active powers will be exercised once approval has been granted. MLH, MLNH and ILH currently have mirror boards. The terms and conditions of the agreement are summarized as follows:

a) to elect and remove Directors;
b) to dismiss the Chief Executive Officer;
c) to approve operation and capital budgets and financial and strategic/business plans;
d) to approve the purchase, acquisition, sale or mortgage or receipt of gift of real property;
e) to approve any borrowing or indebtedness in claims; litigation; guaranteed payments of judgments;
f) to approve contracts for the management of the corporation, reorganization, and the establishment of, investment in or purchase of, corporations,
g) limited liability companies, partnerships, joint ventures, and other entities or affiliations;
h) to approve any amendments to the Certificate of Incorporation or Bylaws of the Corporation;
i) amend the articles of incorporation or take action to dissolve or liquidate any facility;
j) to approve, fix the number of, and remove, with or without cause, the directors of the Hospital or Nursing Home;
k) to approve any application to the NYS Dept. of Health submitted by the Hospital or Nursing Home;
l) to approve any final settlement by the Hospital or Nursing Home related to Medicaid or any other payor audits;
m) to approve any rate appeals to be initiated by the Hospital or Nursing Home.

There are no costs associated with the subject application. MLH and MLNH will be subsidiaries in ILH, Inc. ILH, MLH, and MLHN will remain separate not-for-profit Article 28 corporations and maintain separate operating certificates. There will be no change in authorized services or number or type of bed complements at MLH or MLNH as a result of the proposed establishment.

Capability and Feasibility

There are no significant issues of capability or feasibility associated with the subject application.

Presented as BFA Attachment A, is the financial summary for Inter-Lakes Health, Inc. and Subsidiaries. As shown on Attachment A, the facility has maintained an average positive working capital position of $1,576,075 and an average negative net asset position of $5,784,953 during the period shown. Also, ILH achieved an average operating excess of expenses over revenues totaling $317,152 for the period shown. The loss was due to medical malpractice costs rising more than budgeted and employee benefits increasing more than estimated. A regular review of budgeted items and the consolidation of benefits and administration under the proposed active parent arrangement will cut costs and help offset losses.

The applicant's proposal to become active parent and co-established with MLH and MLNH is consistent with its governance restructuring effort to streamline and strengthen the MLH and MLNH System. The applicant is committed to restructuring for efficiencies and streamlining management to further enhance revenue from its Hospital and Nursing Home service.

It appears the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary – Inter-lakes Health, Inc.
BFA Attachment B	Organizational Chart – Inter-lakes Health, Inc.

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to be established as the co-operator of Moses Ludington Hospital and Moses Ludington Nursing Home, Inc. d/b/a Heritage Commons Residential Health Care, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
112185-E	Inter-Lakes Health, Inc.

APPROVAL CONTINGENT UPON:

1. Submission of a photocopy of the applicant's executed proposed certificate of amendment of its certificate of incorporation, which is acceptable to the Department. [CSL]
2. Submission of a photocopy of the applicant's executed proposed amended bylaws, which are acceptable to the Department. [CSL]
3. Submission of a photocopy an executed proposed certificate of amendment of the certificate of incorporation of Moses Ludington Nursing Home Co., Inc., which is acceptable to the Department. [CSL]
4. Submission of a photocopy of proposed amended bylaws of Moses Ludington Nursing Home Co., Inc., which is acceptable to the Department. [CSL]
5. Obtaining Department of Health approval of a CON application under the NYS Social Services Law authorizing the applicant to manage the operation of Moses Ludington Adult Care Facility. [CSL]

APPROVAL CONDITIONAL UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

Public Health and Health Planning Council

Project # 112244-E
Unity Linden Oaks Surgery Center, LLC

County: **Monroe (Rochester)**
Purpose: **Establishment**
Program: **Ambulatory Surgery Center**
Submitted: **October 24, 2011**

Executive Summary

Description

Unity Linden Oaks Surgery Center, a limited liability company, requests approval to become the operator of Linden Oaks Surgery Center, and existing Article 28 freestanding Ambulatory Surgery Center. The sole member of Unity Linden Oaks will be Unity Ambulatory Surgery Center, Inc., a not-for-profit corporation whose sole member is Unity Health System. Unity Health System is an existing not-for-profit health system in Western New York.

Once all the necessary approvals have been received, Unity Health System Inc. will assign all of its rights and obligations under the Asset Purchase Agreement to its affiliate, Unity Linden Oaks Surgery Center, LLC, a not-for-profit limited liability company which will be a wholly-owned subsidiary of Unity Ambulatory Surgery Center, Inc., a not-for-profit corporation.

Unity Linden Oaks Surgery Center, LLC will continue the multi-specialty certification accorded to the current operator. And through an assignment of lease, the FASC will continue to lease 17,089 square feet on the ground floor of a 60,000 square foot building located at 10 Hagen Drive, Rochester. The FASC will have four operating rooms, four procedure rooms, preoperative and post-anesthesia care areas, and various other non-clinical areas.

The following summary shows the current and proposed ownership.

Current	Proposed
Linden Oaks Surgery Center, Inc. Sole Owner -- Vito C. Quatela, M.D.	Unity Linden Oaks Surgery Center, LLC Wholly Owned Subsidiary & Sole Member -- Unity Ambulatory Surgery Center, Inc Sole Member Not-for-Profit Passive Parent -- Unity Health System, Inc.

DOH Recommendation

Contingent approval.

Need Summary

Linden Oaks Surgery Center performed 6,835 procedures in 2010.

Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Summary

The $8,500,000 asset purchase price for Linden Oaks Surgery Center, Inc. will be provided through a $7,500,000 loan from JPMorgan Chase Bank, N.A. with repayment terms of 7 years at 5.25%, or at closing, they may pick a variable rate option of LIBOR plus 375 basis points, whichever is the lowest rate. The additional $1,000,000 will be provided from the facility's transfer of account receivables. There are no project costs associated with this proposal.

Budget:		
	Revenues:	*$ 13,279,000*
	Expenses:	*11,657,000*
	Gain/(Loss):	*$ 1,622,000*

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

This project is for Establishment action only; therefore, no Architectural recommendation is required.

Recommendations

Health Systems Agency

The Finger Lakes HSA has recommended approval of this project.

Office of Health Systems Management

Approval contingent upon:

1. Submission of an executed transfer and affiliation agreement, acceptable to the Department of Health, with a local acute care hospital. [HSP]
2. Submission of an executed lease agreement that is acceptable to the Department. [BFA]
3. Submission of an executed administrative services agreement that is acceptable to the Department. [BFA]
4. Submission of a photocopy of the executed Articles of Organization of Unity Linden Oaks Surgery Center, LLC, acceptable to the Department. [CSL]
5. Submission of a photocopy of the executed Operating Agreement of Unity Linden Oaks Surgery Center, LLC, acceptable to the Department. [CSL]
6. Submission of a photocopy of the executed assumption agreement between Unity Health System and Linden Oaks Surgery Center, Inc., as referenced in the asset purchase agreement between those parties, acceptable to the Department. [CSL]
7. Submission of a photocopy of the executed asset purchase agreement by and among Linden Oaks Surgery Center, Inc., Unity Health System and Vito C. Quatela, M.D., acceptable to the Department. [CSL]
8. Submission of evidence of the assignment to, and assumption by, the applicant of rights and obligations of Unity Health System under the October 1, 2011 asset purchase agreement by and among Linden Oaks Surgery Center, Inc., Unity Health System and Vito C. Quatela, M.D., acceptable to the Department. [CSL]
9. Submission of an executed amendment to the administrative services agreement between Linden Oaks Surgery Center, Inc., and LOSC Management, LLC, acceptable to the Department. [CSL]

Council Action Date

February 2, 2012.

Need Analysis

Background
The Unity Health System requests approval to acquire and operate Linden Oaks Surgery Center, located at 10 Hagen Drive, Rochester, Monroe County, to be co-licensed by Linden Oaks Surgery Center, LLC and Unity Ambulatory Surgery Center, Inc.

Analysis
Unity Health System Inc., an existing not-for-profit passive parent corporation of a health system in Monroe County requests approval to co-establish and co-license two new affiliates: "Unity Ambulatory Surgery Center, Inc." and "Unity Linden Oaks Surgery Center, LLC" for the purpose of acquiring Linden Oaks Surgery Center, Inc., an existing Article 28 freestanding ambulatory surgery center (FASC). Unity Linden Oaks Surgery Center, LLC will continue the multi-specialty certification accorded the current operator. The FASC will have four operating rooms, four procedure rooms, preoperative and post-anesthesia care areas as well as various non-clinical areas.

The applicant expects that for the current year they will perform 6,800 procedures and for the third year they will perform 9,185 procedures. For the third year, Medicaid and Medicaid Managed Care will comprise 9.4% and charity care will be 2.8% of total utilization.

The acquisition of the FASC will improve timely access to care, shift outpatient cases from Unity Hospital, and ensure that surgical procedures are performed in the most appropriate setting.

Existing Freestanding Ambulatory Surgery Centers – Monroe County	
Facility	*2010 Utilization*
Brighton Surgery Center	6,261
Greater Rochester Digestive	406
Lattimore Community Surgicenter	2,948
Linden Oaks Surgery Center	6,835
Lindsay House Surgery Center	549
Lindsay House Surgery Center	13,766

Source: SPARCS

Conclusion
Unity Health System requests approval to acquire an existing Article 28 freestanding ambulatory surgery center. Linden Oaks Surgery Center performed 6,835 surgical procedures in 2010. The acquisition of the Linden Oaks Surgery Center will allow Unity Health System to perform procedures in the most appropriate setting and improve access to outpatient services for their patients.

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Background
Change in ownership of an existing ambulatory surgery center.

Proposed Operator	Unity Linden Oaks Surgery Center
Operator Type	LLC
Site Address	10 Hagen Drive, Rochester
Services	Multi-specialty
Emergency, In-Patient and Backup Support Services Agreement	Expected to be provided by Unity Hospital
Distance	12.8 miles and 19 minutes

Integration with Community Resources

As part of the registration process the facility will ask patients if they have a primary care physician. If the patient does not have a primary care physician the facility will provide the resources needed to assist the patient.

The facility will be affiliated with the Unity Health System (System). As such, the System, in order to reach underserved communities, will advertise throughout the community. Additionally they use brochures and frequent media announcements regarding the range of services, including this free-standing facility.

The facility will use an Electronic Medical Record system and will become a part of the Regional Health Information Organization in the Rochester area. While the facility will not be pursuing membership in an Accountable Care Organization, it will be associated with the System and as such will actively participate in various pilot and demonstration projects, within the community, in which the System is a participant.

Compliance with Applicable Codes, Rules and Regulations

The medical staff will ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

Character and Competence

The sole member of the proposed operator is a proposed not-for-profit corporation, Unity Ambulatory Surgery Center, Inc., whose sole member is Unity Health System, an existing not-for-profit health system which is the passive parent over numerous health care facilities including a hospital, three nursing homes, two home care agencies and an enriched housing program. The managers of the proposed operator are also the board members of the sole member and are board members of the Unity Health System.

Managers
Warren Hern
Faheem A.R. Masood
Jeffrey C. Mapstone
Michael R. Nuccitelli

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's and relatives' ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management (relative to Medicaid fraud and abuse), the Office of Professional Medical Conduct, and the Education Department databases.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections.

- Unity Living Center was fined $1,000 for a February 2003 Resident Rights finding.
- Park Ridge Nursing Home was fined $1,000 for an October 2002 Quality of Care finding; $1,000 for a May 2007 Quality of Care finding; $1,000 for a November 2008 Quality of Care finding; and $2,000 for a February 2010 Quality of Care finding.
- Edna Tina Wilson Living Center was fined $2,000 for an August 2002 Quality of Care finding.

The review found that any citations were properly corrected with appropriate remedial action. Based on this information, staff concluded that the applicants have provided a substantially consistent high level of care as defined in New York State Public Health Law 2810(a)(3) and 10NYCRR 600.2 during the past 10 years.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Recommendation

From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Background

Unity Health System, Inc. is comprised of Unity Health Care Group, Unity Housing Group, PRH, Inc. and Subsidiaries, Park Ridge Child Care Center, Inc., and Unity Health System Foundation. Included in Unity Health Care Group is Unity Hospital of Rochester, which is accredited by The Joint Commission and has received the New York State Department of Health's designation as a Stroke Center and Level 1 Perinatal Center.

Asset Purchase Agreement

The subject transaction will be completed under the terms of the executed asset purchase agreement, as summarized below:

Date:	October 1, 2011
Seller:	Linden Oaks Surgery Center, Inc.
Purchaser:	Unity Health System, Inc. Once all approvals have been obtained, Unity Health System will assign all of its rights and obligations to its to-be established affiliate "Unity Linden Oaks Surgery Center, LLC."
Purchased Assets :	All assets including: equipment and other tangible personal property, goodwill, copies of patient lists and medical records, operating manuals, marketing materials, transferable correspondence and agreements, intangible assets, assignable equipment leases, contracts, licenses and permits, real property lease, inventory, transferable intellectual property, prepaid costs and deposits, telephone and facsimile numbers, mailing addresses, accounts receivables and refunds.
Excluded Assets:	Financial and tax records, insurance policies and prepaid premiums, Federal Identification, Medicaid and Medicare Agreements and Numbers, cash and equivalents, and tax refunds.
Assumed Liabilities:	All liabilities of the seller including note payable to Vito C. Quatela M.D., PLLC, equipment leases and a Real Estate Lease.
Excluded Liabilities:	Liabilities from breach of agreements, taxes, environmental, legal, insurance, over billing claims, and obligations associated with seller's employees.
Purchase Price	$8,500,000 $ 300,000 escrowed upon signing this agreement $5,131,832 at closing $1,577,287 estimated liabilities paid off at closing $1,490,881 estimated other obligations paid as they become due.

**Note: Unity Linden Oaks Surgery Center, LLC will directly operate the FASC and will be a wholly owned subsidiary of Unity Ambulatory Surgery Center, Inc. whose sole member is Unity Health Systems, Inc.*

The applicant's plan for financing the acquisition appears as follows:

Using a portion of the facilities account receivables	$ 1,000,000
Bank Loan (7 year term @ 5.25% or LIBOR plus 375 basis points)	7,500,000
Total	$ 8,500,000

JPMorgan Chase Bank, N.A. has committed to the above bank loan.

The applicant has provided an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility.

Administrative Services Agreement

The applicant has submitted a draft administrative services agreement, the terms are summarized below:

Facility:	Unity Linden Oaks Surgery Center, LLC
Contractor:	LOSC Management, LLC
Services Provided:	General Administrative Services: Provide or cause to be provided all administrative business functions. Billing and Collection Services: Collect, deposit, administer and reconcile lock box, and enforce the rights of Surgery Center as a creditor under any contract. Human Resources Management: Assist in the recruitment, compensation, evaluation and benefit advice. Strategic Planning and Budgeting: Assist in creating and evaluating a business plan and budgets. Information Services: Provide or arrange for information systems, hardware, software necessary to operate the Surgery Center and make recommendations for upgrades. Contract Negotiation and Marketing: In accordance with Surgery Center's parameters and final approval-solicit and negotiate agreements with payors and/or providers.
Term:	10 year – automatically renews for three additional five (5) year terms
Fee:	Total Annual Fee $1,020,000 (1/12 to be paid monthly = $85,000) Fee will increase by Consumer Price Index-All Services-Urban

The administrative services provider, LOSC Management, LLC, is a related party to Vito C. Quatela, M.D., sole member of the selling entity, Linden Oaks Surgery Center, Inc.

Lease Rental Agreement

The applicant will occupy the existing leased property under the terms, as summarized below:

Date:	April 30, 2003; amended 5/1/03, 4/1/05, 2/1/06, and 11/15/06
Premises:	17,089 gross sq. ft. located at 10 Hagen Drive, Rochester, New York.
Landlord:	Linden Oaks North A, LLC
Lessee/Current:	Linden Oaks Surgery Center, Inc. f/k/a Lindsey House Surgery Center, Inc.
Lessee/Successor:	Unity Linden Oaks Surgery Center, LLC
Term:	From May 1, 2003 to July 31, 2019
Rental	$589,119 per year ($34.47 per sq. ft.) Yearly rate will increase by 2% per year.
Provisions:	Utilities and increase in taxes over base year.

The Consent to Lease Assignment was signed on October 23, 2011, and documentation for rent reasonableness has been submitted.

Operating Budget

The applicant has submitted first and third years operating budgets, in 2011 dollars, as summarized below:

	Year One	Year Three
Revenues	$8,342,000	$13,279,000
Expenses:		
Operating	$7,490,000	$10,523,000
Capital	1,161,000	1,134,000
Total Expenses	$8,651,000	$11,657,000
Net Income or (Loss)	($309,000)	$1,622,000
Utilization: (procedures)	6,800	9.185
Cost Per Procedure	$1,272.21	$1,269.13

Utilization by payor source for the third year is anticipated as follows:

	Third Year
Medicaid Fee-For-Service	1.3%
Medicaid Managed Care	8.1%
Medicare Fee-For-Service	8.8%
Medicare Manage Care	22.6%
Commercial Fee-For-Service	24.7%
Commercial Manage Care	26.0%
All Other	5.7%
Charity	2.8%

The utilization projection for the first year is 6,800 procedures, which is slightly less than the 7,000 currently being performed. The facility expects to increase the current volume by 1%, and transfer a total of 3,475 cases from Unity's Hospital by the end of the fourth year. It is estimated 1,158 cases or a third will transfer each year starting in the 2nd year, bringing the third year total estimated procedures to 9,185. Expenses are based on projected volume, along with increases associated with yearly inflationary adjustments ranging from 2% to 3%.

It appears all third year costs will be covered at approximately 88% of projected volume, or 8,080 procedures.

Capability and Feasibility

The $8,500,000 purchase price for Linden Oaks Surgery Center, Inc. is being met through a $7,500,000 loan commitment from JPMorgan Chase Bank, N.B. at the above stated terms, and $1,000,000 from the facility's re-assigned account receivables.

Working capital requirements are estimated at $1,441,833, which is based on the first years budgeted expenses. It is expected working capital will be met through the collection of existing accounts receivables, and any potential shortfall will be cured via Unity Health System's centralized cash management system at a ratio of 50% equity and 50% inter-company loan. Presented as Attachment A and B is Unity Health System, Inc. and Subsidiaries' 2009 and 2010 certified financial summary, and their September 30, 2011 internal financial statement, which indicates sufficient resources for this purpose. Presented as Attachment C & D is Linden Oaks Surgery Center, Inc. 2009 and 2010 certified financial summary and their June 30, 2011 internal financial statement.

The FASCs first year budget show's a $309,000 operating loss and by the third year, they are forecasting a $1,622,000 operating surplus. Revenues reflect current and projected Federal and State government reimbursement rates, while other third-payors are expected to increase by a trend factor of 2% per year. The budget appears reasonable.

Review of Attachment A and B, Unity Health System, Inc. and Subsidiaries' 2009 and 2010 certified financial summary and their internal financial statement ending September 30, 2011, shows the organization had an average positive working capital of $38,892,000, net assets of $101,954,000 as of September 30, 2011, and an average excess of revenues over expenses of $15,705,091.

Recommendation
From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary for 2009 and 2010, Unity Health System, Inc. and Subsidiaries
BFA Attachment B	Internal Financial Statement as of September 30, 2011, Unity Health System, Inc. and Subsidiaries
BFA Attachment C	Financial Summary for 2009 and 2010, Linden Oaks Surgery Center, Inc.
BFA Attachment D	Internal Financial Statement as of June 30, 2011, Linden Oaks Surgery Center, Inc.
BFA Attachment E	Organizational Chart
BFA Attachment F	Establishment Checklist for Ambulatory Care Sites

<u>RESOLUTION</u>

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application for Unity Linden Oaks Surgery Center, a limited liability company, to become the operator of Linden Oaks Surgery Center, and existing Article 28 freestanding Ambulatory Surgery Center, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
112244-E	Unity Linden Oaks Surgery Center, LLC

APPROVAL CONTINGENT UPON:

1. Submission of an executed transfer and affiliation agreement, acceptable to the Department of Health, with a local acute care hospital. [HSP]
2. Submission of an executed lease agreement that is acceptable to the Department. [BFA]
3. Submission of an executed administrative services agreement that is acceptable to the Department. [BFA]
4. Submission of a photocopy of the executed Articles of Organization of Unity Linden Oaks Surgery Center, LLC, acceptable to the Department. [CSL]
5. Submission of a photocopy of the executed Operating Agreement of Unity Linden Oaks Surgery Center, LLC, acceptable to the Department. [CSL]
6. Submission of a photocopy of the executed assumption agreement between Unity Health System and Linden Oaks Surgery Center, Inc., as referenced in the asset purchase agreement between those parties, acceptable to the Department. [CSL]
7. Submission of a photocopy of the executed asset purchase agreement by and among Linden Oaks Surgery Center, Inc., Unity Health System and Vito C. Quatela, M.D., acceptable to the Department. [CSL]
8. Submission of evidence of the assignment to, and assumption by, the applicant of rights and obligations of Unity Health System under the October 1, 2011 asset purchase agreement by and among Linden Oaks Surgery Center, Inc., Unity Health System and Vito C. Quatela, M.D., acceptable to the Department. [CSL]
9. Submission of an executed amendment to the administrative services agreement between Linden Oaks Surgery Center, Inc., and LOSC Management, LLC, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

Public Health and Health Planning Council

Project # 102239-E

North Shore University Hospital, Inc.
d/b/a North Shore Home Care

County: **Nassau (Westbury)**
Purpose: **Establishment**
Program: **Certified Home Health Agency**
Submitted: **September 17, 2010**

Executive Summary

Description

North Shore University Hospital, Inc., d/b/a North Shore Home Care, a not-for-profit certified home health agency (CHHA) serving Nassau, Queens and Suffolk Counties, is seeking permanent approval to assume St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency operations in the counties of New York, Richmond, Bronx, Westchester and Kings.

Pursuant to U.S. Bankruptcy Court Case # 10-11963 (CGM), this proposed acquisition and merger by North Shore Home Care CHHA, and closure of SVCMC Home Health Agency CHHA, actually occurred on September 20, 2010, following an emergency approval for this transaction issued by the Department of Health's Metropolitan Area Regional Office on August 19, 2010. The emergency approval required subsequent submission of this CON application for Public Health and Health Planning Council approval

The North Shore-LIJ Home Care Network, within the North Shore-LIJ Health System, has provided management agreement services to their three member CHHAs, which include; Franklin CHHA, North Shore University Hospital CHHA, and Long Island Jewish CHHA since 2000. Those services include central intake, coordination of performance improvement, education, orientation, finance, information services, marketing and vendor management.

DOH Recommendation

Approval, with an effective date of September 20, 2010, the date of the actual court-ordered sale and transfer of assets from SVCMC Home Health Agency CHHA to North Shore University Hospital, Inc., d/b/a North Shore Home Care CHHA.

Need Summary

As this project involves the change in ownership of an existing CHHA, no Need review will be provided.

Program Summary

Rather than operate two separate CHHA agencies upon transfer of ownership, North Shore Home Care will instead merge all the operations of, and approvals for, SVCMC Home Health Agency CHHA into its existing North Shore Home Care CHHA operations, resulting in the ultimate closure of the former SVCMC Home Health Agency. The acquisition of the assets of St. Vincent's CHHA, via this CON, ensures continuity of care for these patients.

Financial Summary

The asset purchase price is $17,000,000 for the CHHA, and there will be no interruption of services or accounts receivables and accounts payables. There are no project costs associated with this proposal.

Budget:	Revenues:	$ 15,575,613
	Expenses:	13,871,819
	Gain/(Loss):	$ 1,703,794

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

This project is for Establishment action only; therefore, no Architectural review is required.

Recommendations

Health Systems Agency
There will be HSA recommendation for this application.

Office of Health Systems Management
Approval is recommended, with an effective date of September 20, 2010, the date of the actual court-ordered sale and transfer of assets from St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA to North Shore University Hospital, Inc., d/b/a North Shore Home Care CHHA.

Council Action Date
February 2, 2012.

Programmatic Analysis

Background

St. Vincent's Catholic Medical Centers of New York, d/b/a St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency, was a not-for-profit Article 36 CHHA approved to serve Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester Counties, and a not-for profit Article 36 LTHHCP approved to serve Bronx, Kings, New York, Queens, and Nassau Counties. St. Vincent's Catholic Medical Centers of New York declared bankruptcy and proceeded to divest itself of its health care facilities and agencies, requiring the closure of St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency. Pursuant to U.S. Bankruptcy Court Case # 10-11963 (CGM), North Shore University Hospital, Inc., d/b/a North Shore Home Care, a not-for-profit Article 36 CHHA approved to serve Nassau, Suffolk, and Queens Counties, was the successful bidder to purchase, acquire, and merge the St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA only, into the existing North Shore Home Care CHHA. (Visiting Nurse Service of New York Home Care LTHHCP was the successful bidder to purchase, acquire, and merge the St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency LTHHCP only, which was resolved under a separate CON project #102124-C, receiving final State Hospital Review and Planning Council approval on October 4, 2010, and becoming effective on November 15, 2010, the date of sale.) Accordingly, since North Shore Home Care CHHA already had approval to serve Nassau, Suffolk, and Queens Counties, North Shore Home Care CHHA would acquire from the closed St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA, approval to add Bronx, Kings, New York, Richmond, and Westchester Counties as additional approved geographic service areas. In addition, North Shore Home Care CHHA will operate two new branch offices at locations that had served as branch office locations for the former St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA. These two new additional North Shore Home Care CHHA branch office practice locations being assumed from St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA are located in New York County and Richmond County. The actual court-ordered sale and legal transfer of assets of the CHHA occurred on September 20, 2010.

North Shore-Long Island Jewish Health System, Inc., a not-for-profit corporation, is the member corporation of Hospice Care Network, d/b/a Hospice Care of Long Island, Queens, South Shore, a not-for-profit Article 40 hospice, and of North Shore-Long Island Jewish Health Care, Inc., also a not-for-profit corporation. North Shore-Long Island Jewish Health Care, Inc., is in turn the member corporation of North Shore-Long Island Jewish Health System Laboratories, Inc., a clinical laboratory licensed pursuant to Article 5 of the Public Health Law, RegionCare, Inc., a not-for-profit Article 36 LHCSA, and the following not-for-profit corporations: the applicant North Shore University Hospital, Inc. (d/b/a North Shore Home Care), an Article 28 hospital which also operates Syosset Hospital, another Article 28 hospital, and North Shore Home Care, an Article 36 CHHA which in turn operates North Shore Home Care LTHHCP, an Article 36 LTHHCP; North Shore University Hospital Stern Family Center for Extended Care and Rehabilitation, an Article 28 RHCF; Staten Island University Hospital, an Article 28 hospital (including Staten Island University Hospital-North, and Staten Island University Hospital-South), which also operates Staten Island University Hospital University Hospice, an Article 40 Hospice; Glen Cove Hospital, Forest Hills Hospital, Plainview Hospital, Lenox Hill Hospital, Southside Hospital, and Huntington Hospital, all Article 28 hospitals; Long Island Jewish Medical Center, an Article 28 hospital (including Long Island Jewish Hospital, Cohen Children's Medical Center, and The Zucker Hillside Hospital), which also operates Long Island Jewish Medical Center Home Care Department, an Article 36 CHHA; and Franklin Hospital, an Article 28 hospital which also operates Orzac Center for Extended Care and Rehabilitation, an Article 28 RHCF, and Franklin Hospital Medical Center Home Health Agency, an Article 36 CHHA. An organizational chart is included.

The governing bodies of North Shore University Hospital, Inc. (d/b/a North Shore Home Care), its member North Shore-Long Island Jewish Health Care, Inc., and its member North Shore-Long Island Jewish Health System, Inc., all have the identical Board of Trustees members, as follows:

Richard S. Abramson – Trustee
SVP and Senior National Managing Director,
Bernstein Global Wealth Management
(Investments)

William Achenbaum – Trustee
Chairman, Gansevoort Hotel Group

John W. Alexander, CPA – Trustee
Chairman and Chief Executive Officer, Northfield Bank

Ira I. Altfeder – Trustee
President, Imperial/Harvard Label Company

Philip S. Altheim – Trustee
Executive Vice President, Five Star Electric Corp.

Stanley A. Applebaum, Esq. – Trustee
Self-Employed - Law Practice

Michael L Ashner, Esq. – Trustee
Chairman and Chief Executive Officer, Winthrop Realty Trust

Beverly V.P. Banker – Trustee
Retired

Ralph M. Baruch – Trustee
Retired

Morton M. Bass – Trustee
Owner, Morton M. Bass, P.C. (Attorney at Law)

Frank J. Besignano – Trustee
Manager, Signature Bank

Affiliations:
- Board Director, Visiting Nurse Association of Staten Island

Elise M. Bloom, Esq. – Trustee
Partner, Co-Chair Labor and Employment Law Department, Proskauer Rose, LLP (Law Firm)

Eric S. Blumencranz, Esq. – Trustee
Executive Vice President/Partner, BWD Group, LLC (Insurance Broker)

Roger A. Blumencranz – Trustee
President, BWD Group, LLC (Insurance Broker)

David Blumenfeld – Trustee
Vice President, Self (Real Estate Developer)

Edward Blumenfeld – Trustee
President, Self (Real Estate Developer)

E. Steve Braun – Trustee
Brokerage, Cassidy and Turley (Real Estate Advisory)

Dayton T. Brown, Jr. – Trustee
Chairman, Dayton T. Brown, Inc. (Independent Engineering and Testing Laboratory)

Allen E. Busching – Trustee
Consultant and Private Investments, B&B Capital

Jonathan S. Canno – Trustee
Retired

Michael Caridi – Trustee
Vice President, Kozy Shack (Food Manufacturer)

Rudolph C. Carryl – Trustee
Chief Executive Officer and Chief Investment Officer, Carryl Capital Management
Founder and Chief Executive Officer, CRT Asset Management

Robert W. Chasanoff – Trustee
Chief Operating Officer, Chasanoff Properties (Commercial Real Estate Investment)

Alan Chopp, NHA (NY, NJ, NH) – Trustee
Compliance/HIPAA/Risk Management Officer, SentosaCare, LLC (Health Care Consulting)

Affiliations:
- Member, Avalon Gardens Rehab & HCC (5/2003 – Present)
- Member, Bayview Nursing and Rehab Center (4/2003 – Present)

Mark Claster, Esq. – Trustee
Former Attorney (Retired)
President, Carl Marks & Company, Inc
(Investment Banking)

Barry H. Cohen, M.D. – Trustee
Physician/Partner, Northshore Internal Medicine Association, P.C.

Diana F. Colgate – Trustee
Retired

Daniel M. Crown – Trustee
President and Chief Executive Officer, Foray Entertainment (Movie Production)

Philippe P. Dauman, Esq. – Trustee
President and Chief Executive Officer Viacom, Inc. (Media Company)

Daniel C. de Roulet – Trustee
President, Patrina Corporation (Computer Services)

Lorinda de Roulet – Trustee
Private Investor

Affiliations:

- Board Member, New York Presbyterian Hospital
- Board Member, Gracie Square Hospital

Thomas E. Dewey, Jr. – Trustee
Managing Member, Dewey Devlin & King, LLC (Investment Banking)

Thomas E. Dooley – Trustee
SVP and Chief Operating Officer, Viacom, Inc. (Media)

Michael J Dowling – Trustee
President and Chief Executive Officer, North Shore-LIJ Health System

Affiliations:

- Trustee, Huntington Hospital

Robert N. Downey – Trustee
Retired

Melvin Dubin – Trustee
President, Chairman/Owner, Slant/Fin Corporation (Electrical Engineer)
Chairman, Redox Pharmaceutical

Affiliations:

- Trustee, Gurwin Jewish Nursing and Rehabilitation Center

Patrick R. Edwards, Esq. – Trustee
Retired

Toni J. Elliott – Trustee
Managing Director, CitiGroup / Citi Private Bank

Michael A. Epstein, Esq. – Trustee
Partner, Weil, Gotshal & Manges, LLP (Law Firm)

Leonard Feinstein – Trustee
Co-Chairman, Bed, Bath, and Beyond (Retail)

Michael E. Feldman, Esq. – Trustee
Retired

Anthony C. Ferreri – Trustee
President and Chief Executive Officer, Staten Island University Hospital

Arlene Lane Fisher – Trustee
Retired

Catherine C. Foster – Trustee
Retired

Eugene B. Friedman, M.D. – Trustee
Pediatrician, Park Pediatrics, LLP

Sy Garfinkel – Trustee
Chief Executive Officer and Chief Financial Officer, Fabrique DBA Sykel (Importer)

Richard Guarasci, Ph.D. – Trustee
President, Wagner College

Lloyd M. Goldman – Trustee
President, BLDG Management Company, Inc. (Building Management)

Richard D. Goldstein, Esq. – Trustee
Chairman and Chief Executive Officer, AEP Capital, LLC (Investment Banking)

J. Joaquin Gonzalez – Trustee
Senior Program Manager, The Port Authority of NY and NJ

Michael Gould – Trustee
Chairman and Chief Executive Officer, Bloomingdale's

Albert F. Granger, D.D.S. – Trustee
Dentist, Owner/Manager, Albert Granger DDS, PLLC

Alan I. Greene – Trustee
Managing Director, Neuberger Berman, LLC (Investment Management)

Affiliations:

- Director and Trustee, Eisenhower Medical Center, California

James R. Greene – Trustee
Retired

Stanley Grey, CPA – Trustee
Retired

Paul B. Guenther – Trustee
Retired

Henry L. Hackmann – Trustee
Retired

Amy M. Hagedorn – Trustee
Retired

Stephen L. Hammerman, Esq. – Trustee
Retired

Ira Hazan – Trustee
Retired

Linda W. Heaney, CPA – Trustee
Partner, Friedman, LLP (Accountants and Advisors)

Marlene Hess – Trustee
Retired

William O. Hiltz – Trustee
Senior Managing Director, Evercore Partners (Investment Bank)

Michael Hoffman – Trustee
Managing Director, Riverstone Holdings, LLC (Investment)

Gedale B. Horowitz, Esq. – Trustee
Senior Managing Director, Citigroup (Banking)

Richard A. Horowitz – Trustee
Chairman, P & F Industries, Inc. (Manufacturer)

M. Allan Hyman, Esq. – Trustee
Senior Partner, Certilman, Balin, Adler, and Hyman, LLP (Law Firm)

Mark Jacobson – Trustee
President, Grocery Haulers, Inc.

Jeffrey S. Jurick – Trustee
Chief Executive Officer and President, The Jurick Group, Inc. (Privacy Breach Notification and Risk Management Services)

Lyn Jurick – Trustee
Retired

Arthur Kalish, Esq. – Trustee
Retired

Steven L. Kantor, Esq. – Trustee
Executive Managing Director and Global Head of Investment Bank, Cantor Fitzgerald (Investment Banking)

David M. Katz – Trustee
Partner, Sterling Equities (Investments)

Michael Katz, CPA – Trustee
Executive Vice President, Senior Partner, Sterling Equities (Investments)

Saul B. Katz – Trustee
President, Sterling Equities (Investments)

Lisa A. Kaufman – Trustee
Unemployed

Robert Kaufman – Trustee
President, William Kaufman Organization, LTD (Real Estate)
President, Sage Realty Corporation

Cary Kravet, Esq. – Trustee
President, Kravet, Inc (Wholesaler)

Affiliations:

- Trustee, Huntington Hospital

Stanley Kreitman – Trustee
Chief Executive Officer, Manhattan Assoc. (Consulting and Investing)

Seth H. Kupferberg – Trustee
Principle, Kepco, Inc. (Power Electronics)

Jeffrey B. Lane – Trustee
Chief Executive, Modern Bank

Curt N. Launer – Trustee
Managing Director, Natural Resources Group, Deutsche Bank Securities, Inc. (Investment Banking)

Kevin F. Lawlor – Trustee
President and Chief Executive Officer, Huntington Hospital

Michael S. Leeds – Trustee
President, Flight Star, Inc. (Aviation Management)
Business Development Consultant, Pilot, Executive Fliteways, Inc.

David W. Lehr – Trustee
Retired

Jonathan W. Leigh – Trustee
President, Long Island Hearing & Speech Society (Charity)

Sylvia Lester – Trustee
Chairman, North Shore University Hospital

Arthur S. Levine – Trustee
Chief Executive Officer, Tahari Levine, LLC (Apparel)

Stuart R. Levine – Trustee
Chairman and Chief Executive Officer, Stuart Levine & Associates (Management Consulting)

Seth Lipsay, Esq. – Trustee
Managing Director, New World Realty Management, LLC (Real Estate)

David S. Mack – Trustee
Senior Partner, The Mack Company (Real Estate Development and Management)

Affiliations:

- Board Member, Joseph L. Morse Geriatric Center, Florida

William L. Mack – Trustee
Chairman and Founder, Area Property Partners (Real Estate)

Howard S. Maier – Trustee
President, Maier Ventures, Inc. (Marketing and Sales Consulting)

Linda Manfredi – Trustee
Assistant Principal, PS 29

James S. Marcus – Trustee
Retired

Bradley J. Marsh, D.P.M. – Trustee
Managing Member, Jemcap, LLC (Real Estate)
Chief Executive Officer, Tripod Labs, Inc. (Health and Beauty)

Jeffrey S. Maurer, Esq. – Trustee
Partner, Chief Executive Officer, Evercore Wealth Management, LLC (Investment Advisors)

Ronald J. Mazzucco, Esq. – Trustee
Attorney, Ronald J. Mazzucco, Esq.

F.J. McCarthy – Trustee
President, Site Selection Advisory Group, Inc. (Real Estate)

Patrick F. McDermott – Trustee
Partner, McDermott & Thomas Associations (Financial Planning/Employee Benefits)

Katherine T. McEnroe, RN – Trustee
Retired

James McMullen – Trustee
Retired

Charles Merinoff – Trustee
Vice Chairman and Chief Executive Officer, The Charmer Sunbelt Group (Wine and Spirits Distribution)

Aimée M. Merszei – Trustee
Retired

Marilyn B. Monter, Esq. – Trustee
Executive Vice President, Holiday Organization, Inc (Real Estate Development)

Richard D. Monti – Trustee
Vice President, Crest Hallow County Club

Richard Murcott – Trustee
President and Chief Executive Officer, Murcott Merchandising (Supermarket Equipment)

Affiliations:
- Trustee, Huntington Hospital

Ralph A. Nappi, Esq. – Trustee
President, North Shore-Long Island Jewish Health Systems Foundation

Richard B. Nye – Trustee
President, Baker Nye Advisers (Investment Management)

Clyde I. Payne, Ed.D. – Trustee
Dean, Dowling College

Arnold S. Penner – Trustee
Owner, Arnold S. Penner, Real Estate Investments

John J. Raggio – Trustee
Vice President, Sealift, Inc. (U.S. Flag Ship Owner)

Lewis S. Ranieri – Trustee
Partner, Chairman, President and Managing Director, Ranieri Partners Management, LLC, and Ranieri & Co., Inc. (Private Investment Advisors and Management)

Affiliations:
- Board Director, Peninsula Hospital Center (1989 – 4/15/2005)

Jay R. Raubvogel – Trustee
Retired

William H. Frazier – Trustee
Managing Director, Gates Capital Corporation (Securities Brokerage Firm)

Corey Ribotsky – Trustee
Managing Member, The N.I.R. Group, LLC (Financial Management)

Dennis L. Riese – Trustee
Chairman and Chief Executive Officer, The Riese Organization (Restaurants)

Terry P. Rikin, M.D. – Trustee
President, Great Neck OB/GYN P.C.

Robert A. Rosen – Trustee
Chairman and Chief Executive Officer, Rosen Associates Management Corp. (Real Estate Management and Consulting)

Laura Lauria, RN – Trustee
Corporate Secretary/Treasurer, Mark Lauria Associates, Inc. (Insurance Agency)

Marcie Rosenberg – Trustee
Director of Development, Tilles Center for the Performing Arts, C.W. Post Campus of Long Island University

Robert D. Rosenthal, Esq. – Trustee
Chairman and Chief Executive Officer, First Long Island Investors

Bernard M. Rosof, M.D. – Trustee
Chief Executive Officer, Quality in Health Care Advisory Group, LLC (Consultants)

Affiliations:
- Trustee, Huntington Hospital

Jack J. Ross – Trustee
Principle, Waterfall Asset Management, LLC

Barry Rubenstein – Trustee
Managing Partner, Wheatley Partners (Venture Capital)

Herbert Rubin, Esq. – Trustee
President, Herzfeld & Rubin, P.C. (Law Firm)

Scott Rudolph – Trustee
Chairman and Chief Executive Officer, NBTY, Inc. (Manufacturer/Distributor Vitamins and Food Supplements)

Michael H. Sahn, Esq. – Trustee
Senior Partner, Sahn Ward Coschignano & Baker, PLLC (Law Firm)

Frank W. Scarangello, Sr. – Trustee
Manager, Owner, President, Scaran Oil Service Heat and Air Conditioning

Norman Schlanger – Trustee
Retired

Lois C. Schlissel, Esq. – Trustee
Managing Attorney/Member, Meyer, Suozzi, English & Klein (Law Firm)

John M. Shall, CPA – Trustee
Partner, DeSantis, Kiefer & Shall, LLP (CPA)

Robert F. Shapiro – Trustee
Vice Chairman, Klingenstein, Fields & Co., LLC (Investment Advisor)

Marc V. Shaw – Trustee
Senior Vice Chancellor for Budget, Finance, & Financial Policy, CUNY

Sean G. Simon – Trustee
President, Black Capital, LLC (Asset Management)

Richard Sims – Trustee
Vice President, Invogel DBA Scarlett (Apparel Mfg)

Michael C. Slade – Trustee
Retired

Phyllis Hill Slater – Trustee
President, Hill Slater Group (Electrical/Architectural)

Howard D. Stave, Esq. – Trustee
Attorney, Howard D. Stave

Russell Stern – Trustee
President, Norsa Corporation (Importer/Distributer)

Maganlal Sutaria, M.D. – Trustee
Chairman, Interpharm Holding, Inc (Generic Pharmaceutical Company)

John B. Thomson, Jr. – Trustee
President, Ventura Marina Management Corp. (Retail)

Peter Tilles – Trustee
Managing Partner, Tilles Companies (Real Estate Investment Management)

Sandra Tytel, Esq. – Trustee
Retired

Tomas D. Morales, Ph.D. – Trustee
President, College of Staten Island

Nancy Waldbaum Nimkoff – Trustee
Director/Administrator, I. Waldbaum Family Foundation

Gary Walter – Trustee
President, Theo Walter Co, Inc. (Jewelry)

Howard Weingrow – Trustee
President & Founder, Stanoff Corporation (Investments)

Lewis M. Weston – Trustee
Retired

Jon A. Wurtzburger – Trustee
Retired

Barbara Hrbek Zucker – Trustee
Consultant, Manhattan Skyline Management (Real Estate)

Donald Zucker – Trustee
Chairman of the Board, The Donald and Barbara Zucker Family Foundation
Chairman of the Board, Donald Zucker Company (Real Estate Management)

Roy J. Zuckerberg – Trustee
Private Investor, Roy J. Zuckerberg
Owner, Samson Investments

Rev. Demetrius S. Carolina, Ed.D. – Trustee
Professor, Strayer University
Director, First Central Baptist Church
CEO, Central Family Life Center (Community Center)

All of the above listed Trustees also serve on the Board of Trustees of: North Shore University Hospital Stern Family Center for Extended Care and Rehabilitation, Staten Island University Hospital, Glen Cove Hospital, Forest Hills Hospital, Plainview Hospital, Lenox Hill Hospital, Southside Hospital, Long Island Jewish Medical Center, and Franklin Hospital.

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A search of all of the above named board members, employers, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the Office of the Inspector General's Provider Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile, and the Office of Professional Medical Conduct, where appropriate, indicate no issues with the licensure of the health professionals associated with this application. In addition, the attorneys have all submitted current Certificates of Good Standing.

The Clinical Laboratory Evaluation Program in the Wadsworth Center reviewed the compliance history of the affiliated Article 5 clinical laboratory for the time period 2001 to present. It has been determined that the clinical laboratory has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The Division of Certification and Surveillance reviewed the compliance history of all affiliated Article 28 hospitals for the time period 2001 to present, or for the time periods specified as the affiliations, whichever applied.

An enforcement action was taken against North Shore University Hospital, Inc., in 2002 based on violations citing the performance of a brain procedure on the wrong side of the brain. This enforcement action was resolved with a $10,000 civil penalty. An additional enforcement action was taken against North Shore University Hospital, Inc., in 2008 based on violations citing inadequate post-operative care leading to decubitus ulcers, falls, and renal failure. This enforcement action was resolved with an $18,000 civil penalty.

An enforcement action was taken against Syosset Hospital in 2010 based on violations citing improper surgical clearance for a tonsillectomy that resulted in the patient's death. This enforcement was resolved with a $42,000 civil penalty.

An enforcement action was taken against Staten Island University Hospital in 2007 based on violations citing wrong-sided chest tube insertion. This enforcement was resolved with an $8000 civil penalty. An additional enforcement action was taken against Staten Island University Hospital, also in 2007, based on violations citing medication overdose, and continued medication with a drug that had been discontinued, resulting in the patient's death. This enforcement was resolved with a $12,000 civil penalty.

An enforcement action was taken against Forest Hills Hospital in 2006 based on violations citing wrong-sided hernia repair. This enforcement was resolved with a $12,000 civil penalty.

An enforcement action was taken against Southside Hospital in 2006 based on violations citing wrong-sided ovarian cyst surgery. This enforcement was resolved with a $14,000 civil penalty.

An enforcement action was taken against Huntington Hospital in 2002 based on violations citing wrong-sided stent replacement, and performing surgery without proper consent. This enforcement was resolved with a $16,000 civil penalty.

An enforcement action was taken against Long Island Jewish Medical Center Hospital in 2003 based on violations of regulations governing medical resident working hours. This enforcement was resolved with a $6,000 civil penalty.

An enforcement action was taken against New York Presbyterian Hospital - Columbia in 2003 based on violations of regulations governing medical resident working hours. This enforcement was resolved with an $18,000 civil penalty. An additional enforcement action was taken against New York Presbyterian Hospital – Columbia, again in 2003, based on violations of regulations governing medical resident working hours. This enforcement was resolved with a $12,000 civil penalty. An additional enforcement action was taken against New York Presbyterian Hospital – Columbia in 2005 based on violations of regulations governing medical resident working hours. This enforcement was resolved with a $6,000 civil penalty.

An enforcement action was taken against New York Presbyterian Hospital - Cornell in 2003 based on violations of regulations governing medical resident working hours. This enforcement was resolved with a $6,000 civil penalty. An additional enforcement action was taken against New York Presbyterian Hospital – Cornell, again in 2003, based on violations of regulations governing medical resident working hours. This enforcement was resolved with a $25,000 civil penalty. An additional enforcement action was taken against New York Presbyterian Hospital – Cornell in 2004 based on violations of regulations governing medical resident working hours. This enforcement was resolved with a $50,000 civil penalty.

The Division of Certification and Surveillance also reports that there is currently a pending enforcement action against Glen Cove Hospital, which has been officially referred to the Division of Legal Affairs and of which the hospital has been officially notified. Executive Staff has recommended that this CON application proceed while the negotiations continue toward settlement of this pending hospital enforcement.

The Division of Residential Services reviewed the compliance history of all affiliated Article 28 nursing homes for the time period 2001 to present, or for the time periods specified as the affiliations, whichever applied.

An enforcement action was taken against Bayview Nursing and Rehabilitation Center in 2005 based on a November, 2004 survey citing violations in Quality of Life: Environment; Quality of Care; Quality of Care: Pressure Sores; and Quality of Care: Accidents. This enforcement was resolved with a $7000 civil penalty. In addition, a federal civil monetary penalty of $74,658.64 was imposed by CMS on Bayview Nursing and Rehabilitation Center based on this same survey. An additional enforcement action was taken against Bayview Nursing and Rehabilitation Center in 2007 based on a December, 2005 survey citing a violation in Comprehensive Care Plans. This enforcement action was resolved with a $2000 civil penalty.   An additional enforcement action was taken against Bayview Nursing and Rehabilitation Center in 2011 based on a December, 2010 survey citing a violation in Quality of Care: Pressure Sores. This enforcement action was resolved with a $10,000 civil penalty.

An enforcement action was taken against Avalon Gardens Rehabilitation and Health Care Center in 2009 based on a May, 2008 survey citing a violation in Quality of Care: Accidents. This enforcement was resolved with a $2000 civil penalty.

An enforcement action was taken against Gurwin Jewish Nursing and Rehabilitation Center in 2007 based on a February, 2005 survey citing a violation in Quality of Care, and a January, 2006 survey citing a violation in Quality of Care: Pressure Sores. This enforcement was resolved with a $2000 civil penalty.

An enforcement action was taken against Franklin Hospital's Orzac Center for Extended Care and Rehabilitation in 2004 based on a January, 2002 survey citing a violation in Quality of Care: Nutrition. This enforcement was resolved with a $1000 civil penalty.

The Division of Home and Community Based Services reviewed the compliance history of all affiliated Article 36 long term home health care programs, certified home health agencies, licensed home care service agencies, and Article 40 hospices, for the time period 2001 to present, or for the time periods specified as the affiliations, whichever applied. It has been determined that the long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices have all exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations, and all have been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

Requests for compliance statements have been made to the States of California and Florida to provide the compliance status and histories of the out-of-state health care facilities listed above as affiliations. The Florida Agency for Health Care Administration reports that the health care facilities affiliated with the Joseph L. Morse Geriatric Center, Inc., are in compliance with all applicable codes, rules, and regulations, with no enforcement histories. As of this time, the State of California has not responded with the requested information regarding the health care facilities affiliated with Eisenhower Medical Center.

A review of all personal qualifying information indicates there is nothing in the background of the board members of North Shore University Hospital, Inc. (d/b/a North Shore Home Care), its member North Shore-Long Island Jewish Health Care, Inc., and its member North Shore-Long Island Jewish Health System, Inc., to adversely effect their positions on the board. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

From a programmatic perspective, approval is recommended, with an effective date of September 20, 2010, the date of the actual court-ordered sale and transfer of assets from St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA to North Shore University Hospital, Inc., d/b/a North Shore Home Care CHHA.

Financial Analysis

Asset Purchase Agreement

The change in operational ownership of the CHHA will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized below:

Date:	August 10, 2010
Seller:	St. Vincent's Catholic Medical Centers of New York
Buyer:	North Shore University Hospital
Included Assets:	All assets used in operation of the business; tangible property, equipment; inventory and supplies; assignable contracts, licenses and permits, prepayments, phone numbers, financial books and records; cash, trade secrets, goodwill and intellectual property of Seller's Business; and any amounts payable under any insurance policies.
Excluded Assets:	Cash in bank on Effective Date, accounts receivable for services provided prior to effective date, excluded contracts, refunds, settlements and retroactive adjustments.
Assumed Liabilities:	All liabilities accruing from and after the closing with respect to assigned contracts and the purchase of real property leases, severance obligations and contingent Medicaid Liabilities up to $1,500,000.

Excluded Liabilities:	All liabilities arising from the operations prior to the closing.
Price:	$17,000,000 with a $850,000 down payment and the remaining $16,150,000 payable at closing.

The applicant has provided an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility.

Operating Budget

The applicant has submitted an incremental operating budget, in 2011 dollars, for the first and third years of operation of the CHHA, summarized as follows:

	Year One	Year Three
Revenues	$6,873,149	15,575,613
Expenses	9,651,198	13,871,819
Net Income(Loss)	$(2,778,049)	$1,703,794

Expenses are allocated as follows:

Year One

Service	Total Expenses	Visits/Hours	Cost/Visit/Hour
Nursing	$6,230,422	23,921	$260.46
Physical Therapy	1,321,333	8,726	$151.42
Speech Therapy	60,518	324	$186.78
Occupational Therapy	76,920	630	$122.10
Home Health Aide *	1,825,363	70,433	$25.92
Medical Social Services	136,642	975	$140.15
Total	$9,651,198		

** Data reported in hours*

Year Three

Service	Total Expenses	Visits/Hours	Cost/Visit/Hour
Nursing	$7,791,886	54,194	$143.78
Physical Therapy	2,236,032	19,746	$113.24
Speech Therapy	98,946	728	$135.91
Occupational Therapy	136,350	1,426	$95.62
Home Health Aide *	3,375,608	162,006	$20.84
Medical Social Services	232,997	2,193	$106.25
Total	$13,871,819		

** Data reported in hours*

Utilization by payor source for years one and three is anticipated as follows:

	Year One	Year Three
Medicaid Fee-for-Service	4.0	4.0
Medicare Fee-for-Service	66.0	65.0
Commercial Fee-For-Service	28.0	29.0
Charity Care	2.0	2.0

Utilization and expenses are based on the historical experience of the existing CHHA.

Capability and Feasibility

There are no project costs associated with this application**.**

The submitted incremental budget projects net loss of $(2,778,049) and a net gain of $1,703,794 during the first and third years, respectively.

NSUH has submitted a letter stating that the Hospital will absorb the loss of the CHHA. Review of BFA-Attachment B, 2010 financial summary of North Shore University Hospital, indicates the facility has maintained positive working capital, net asset position and net income. Revenues reflect prevailing reimbursement methodologies for CHHA services. Monthly expenses per registrant are not within the initial 2011 applicable geographic expenditure cap for year one but are below the geographic expenditure caps for year three.

Based on the preceding, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Organizational Chart, North Shore-Long Island Jewish Health System, Inc.
BFA Attachment B	2010-September 30, 2011 Financial Summary, North Shore University Hospital

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council, and after due deliberation, hereby approves the following application to assume operations of the St. Vincent's Catholic Medical Center certified home health agency in Westchester, New York, Richmond, Bronx and Kings counties, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER	APPLICANT/FACILITY
102239-E	North Shore University Hospital, Inc. d/b/a North Shore Home Care

APPROVAL CONTINGENT UPON:

N/A

APPROVAL CONDITIONED UPON:

N/A

OFFICE OF HEALTH SYSTEMS MANAGEMENT

Approval is recommended, with an effective date of September 20, 2010, the date of the actual court-ordered sale and transfer of assets from St. Vincent's Catholic Medical Centers (SVCMC) Home Health Agency CHHA to North Shore University Hospital, Inc., d/b/a North Shore Home Care CHHA.

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

112218 E
Waterfront Operations Associates, LLC d/b/a
Waterfront Center for Rehabilitation and Health Care
(Erie County)

DEFERRED AT THE REQUEST OF THE DEPARTMENT

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency: Independent Living for Seniors, Inc.
Address: Rochester
County: Monroe
Structure: Not-For-Profit Corporation
Application Number: 1994-L

Description of Project:

Independent Living for Seniors, Inc., a not-for-profit business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The board members of Independent Living for Seniors, Inc. comprise the following individuals:

Linda S. Becker – Chair
Chief Executive Officer, Healthcare Benefits Network

Affiliations:
- Chair, Behavioral Health Network, Inc. (2008 – Present)
- Chair, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2008 – Present)
- Chair, Rochester General Hudson Housing (2008 – Present)
- Member, Rochester General Health System (fka ViaHealth) (2002 – Present)
- Member, Rochester General Hospital (2008 – Present)

Jeanne E. Grove, DO – Secretary/Treasurer
Partner, Panorama Valley OB/GYN

Affiliations:
- Member, Behavioral Health Network, Inc. (2008-Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2008-Present)
- Member, Rochester General Hospital (2008-Present)
- Member, Rochester General Hudson Housing (2008-Present)

Mark C. Clement – Member
President/Chief Executive Officer, Rochester General Health System

Affiliations:
- Member, Behavioral Health Network, Inc. (2006 – Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2006 – Present)
- Member, Rochester General Hudson Housing (2006 – Present)
- Member, Rochester General Health System (fka ViaHealth) (2006 – Present)
- Member, Rochester General Hospital(2008 – Present)

Robert A. Dobies – Member
Retired

Affiliations:
- Chair, Rochester General Health System (fka ViaHealth) (2004 – Present)

Daniel M. Meyers – Member
President, Al Sigl Community of Ages

Affiliations
- Member, Rochester General Hospital (1990-2010 and July 2011 – Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (1999 – Present)
- Member, Newark Wayne Community Hospital (2000 – Present)

Robert R. Mayo, MD – Member
Sr. leader, Physician Patient Safety Officer, Rochester General Health System

Affiliations:
- Member, Behavioral Health Network, Inc. (2010-Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2010 – Present)
- Member, Rochester General Hudson Housing (2010 – Present)
- Member, Rochester General Hospital (2010 – Present)

Thomas E. Penn, MD – Member
Physician, Private Practice

Affiliations:
- Member, Behavioral Health Network, Inc. (2009-Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2009 – Present)
- Member, Rochester General Hudson Housing (2009 – Present)
- Member, Rochester General Hospital (2009 – Present)

John R. Riedman, Member
Member of the Board of Directors, Brown and Brown Insurance Company

Affiliations:
- Member, Behavioral Health Network, Inc. (2010-Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2010 – Present)
- Member, Rochester General Hudson Housing (2010 – Present)
- Member, Rochester General Hospital (2010 – Present)

Margaret A. Sanchez – Member
Principal, Sanchez & Associates

Affiliations:
- Member, Behavioral Health Network, Inc. (2009-Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2009 – Present)
- Member, Rochester General Hudson Housing (2009 – Present)
- Member, Rochester General Hospital (2009 – Present)

Robert S. Sands – Member
President and Chief Executive Officer, Constellation Brands

Affiliations:
- Member, Behavioral Health Network, Inc.
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home
- Member, Rochester General Hudson Housing
- Member, Rochester General Hospital
- Member, Rochester General Health System Board

The board members of Rochester General Health System comprise the following individuals:

Robert A. Dobies – Chair
Retired

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2004 – Present)

Joyce D. Haag, Esq. – Vice Chair
Retired

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2008 – Present)

Robert F. Havrilla – Treasurer
Retired

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2005 – Present)
- Member, Newark Wayne Community Hospital (2005 – Present)

Anna E. Lynch, Esq. – Secretary
Managing Partner, Underberg & Kessier, LLP

Affiliations:
- Secretary, Rochester General Health System (fka ViaHealth) (2006 – Present)

Linda S. Becker – Member
(Previously Disclosed)

Charles Brown, Jr. – Member
Retired

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2010 – Present)
- Member, Unity Hospital (2006-2009)

Mark C. Clement – Member
(Previously Disclosed)

William W. Destler, Ph.D. – Member
President, Rochester Institute of Technology

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2009 – Present)

John L. Genier, MD – Member
Physician, Private Practice

Affiliations:
- Member, Behavioral Health Network, Inc. (2002-Present)
- Member, Rochester General Long Term Care d/b/a Hill Haven Nursing Home (2002 – Present)
- Member, Rochester General Hudson Housing (2002 – Present)
- Member, Rochester General Hospital (2002 – Present)

Daniel M. Meyers – Member
(Previously Disclosed)

Mary Sue Napoleon, MD – Member
Ophthalmologist, Wayne Regional Eye Care

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2002 – Present)
- Member, Newark Wayne Community Hospital (2005 – Present)

Pastor George Nicholas – Member
Pastor, Grace United Methodist Church

Affiliations:
- Member, Rochester General Health System (fka ViaHealth) (2008 – Present)

John R. Riedman, Member
(Previously Disclosed)

Robert S. Sands – Member
(Previously Disclosed)

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile and the Office of Professional Medical Conduct, where appropriate, indicate no issues with the licensure of the health professionals associated with this application.

A Certificate of Good Standing has been received for all attorneys.

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A 10 year review of the operations of the following facilities was performed as part of this review (unless otherwise noted):

Rochester General Long Term Care, Inc. d/b/a Hill Haven Nursing Home
Rochester General Housing, Inc.
Rochester General Hospital
Unity Hospital (2006-2009)
Newark Wayne Community Hospital (2005 – Present)
Independent Living for Seniors, Inc. (LTHHCP)

Rochester General Hospital was fined six thousand dollars ($6,000.00) pursuant to a stipulation and order dated June 11, 2002 for performing a wrong sided thoracentesis.

The information provided by the Division of Certification and Surveillance has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations

Rochester General Long Term Care, Inc. d/b/a Hill Haven Nursing Home was fined two thousand dollars ($2,000.00) pursuant to a stipulation and order dated October 21, 2002 for inspection findings of May 10, 2002 for violations 10 NYCRR Sections 415.12(c) – Quality of Care: Pressure Sores.

Rochester General Long Term Care, Inc. d/b/a Hill Haven Nursing Home was fined two thousand dollars ($2,000.00) pursuant to a stipulation and order dated November 3, 2004 for inspection findings of March 19, 2004 for violations 10 NYCRR Sections 415.12(h)(2) – Quality of Care: Accidents.

The Information provided by the Bureau of Quality Assurance for Nursing Homes has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Independent Living For Seniors, Inc. was fined nine thousand dollars ($9,000.00) pursuant to a stipulation and order dated January 8, 2008 for inspection findings of January 31, 2007 for violations of 10 NYCRR Sections 763.4(a) & (h): Policies and Procedures of Service Delivery; 763.5(a): Patient Referral, Admission and Discharge; 763.6(b), (c) & (e): Patient Assessment and Plan of Care; 763.7(a): Clinical Records; and 763.11(a) & (b): Governing Authority.

Independent Living For Seniors, Inc. was fined six thousand five hundred dollars ($6,500.00) pursuant to a stipulation and order dated November 2, 2011 for inspection findings of September 29, 2009 for violations of 10 NYCRR Sections 763.4(h): Policies and Procedures of Service Delivery; 763.6(a): Patient Assessment and Plan of Care; 763.6(b): Patient Assessment and Plan of Care; 763.6(e): Patient Assessment and Plan of Care; 763.11(a): Governing Authority; and 763.11(b): Governing Authority.

The information provided by the Division of Home and Community Based Services has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The applicant proposes to serve the residents of the following counties from an office located at 2066 Hudson Avenue, Rochester, New York 14467:

Monroe	Wayne

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care	Medical Social Services
Occupational Therapy	Physical Therapy	Housekeeper	Speech-Language Pathology
Respiratory Therapy	Audiology	Nutrition	Homemaker

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 10, 2012

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the staff of the New York State Department of Health and the Establishment and Project Review Committee of the Council, and after due deliberation, hereby approves the following applications for licensure, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY:
1640 L	Acute Care Experts, Inc. (Bronx, Queens, Kings, Richmond, Nassau, and New York Counties)
1956 L	Advantage Management Associates, Inc. d/b/a Advantage Homecare Agency (New York, Westchester, Kings, Queens, Bronx, and Richmond Counties)
1678 L	Amazing Grace Home Care Services, LLC (New York, Bronx, Kings, Richmond, and Queens Counties)
1696 L	Diana's Angels, Inc. (Putnum, Bronx, Westchester and Dutchess Counties)

1957 L	Evergreen Choice, LLC (New York, Bronx, Kings, Richmond and Queens Counties)
1668 L	Five Borough Home Care, Inc. (Bronx, Kings, New York, Richmond, and Queens Counties)
1733 L	Heritage Homecare Services, Inc. (New York, Kings, Queens, Bronx, Nassau, Suffolk and Richmond Counties)
1994 L	Independent Living for Seniors, Inc. (Monroe and Wayne Counties)
1835 L	Longevity Care, LLC (Westchester County)
1959 L	Stat Staff Professionals, Inc. (Saratoga, Warren, Albany, Greene, Franklin, Washington, Rensselaer, Columbia, Clinton, Fulton, Otsego, Ulster, Essex, Montgomery, Schoharie, Hamilton, Schenectady, and Delaware Counties)
2004 L	Long Island Living Center, LLC d/b/a Long Island Living Center (Bronx, Kings, and Queens Counties)
2079 L	Metrostar Home Care, LLC (Kings, Bronx, Queens, Richmond, New York and Nassau Counties)
1875 L	ALJUD Licensed Home Care Services, LLC (Nassau and Suffolk Counties)

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 3: Applications Recommended for Approval with the Following:

- No PHHPC Member Recusals
- Establishment and Project Review Committee Dissent, or
- Contrary Recommendations by or HSA

Ambulatory Surgery Centers – Establish/Construct **Exhibit #21**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	111552 B	The Surgery Center of Bayside, LLC (Queens County)	Contingent Approval
2.	112032 B	PBGS, LLC d/b/a Downtown Brooklyn Gynecology Center (Kings County)	Contingent Approval

Public Health and Health Planning Council

Project # 111552-B
The Surgery Center of Bayside, LLC

County: **Queens (Bayside)**
Purpose: **Establishment and Construction**
Program: **Ambulatory Surgery Center**
Submitted: **June 28, 2011**

Executive Summary

Description

The Surgery Center of Bayside, LLC, an existing limited liability company, requests approval to establish and construct a multi-specialty freestanding ambulatory surgery center (FASC) to perform procedures relating to otolaryngology, orthopedics and ophthalmology. The FASC will be located in leased space on the second floor of a to-be-constructed building at 45-64 Frances Lewis Boulevard, Bayside. The proposed members of The Surgery Center of Bayside, LLC consist of three Classes:

Class A	50%
Class B	20%
Class C	30%

The proposed members in Class A of the LLC are 23 local board certified physicians who must meet the eligibility requirements per the Operating Agreement.

Class B proposed members include one non-physician and three board-certified physicians who are also members of other ASCs and have been previously approved by the Public Health Council.

The Class C proposed member is NYEE Holding Corp., a not-for-profit corporation formed by New York Eye and Ear Infirmary specifically to participate in this joint venture. New York Eye and Ear Infirmary, who is a member of Continuum Health Partners, has guaranteed to fund NYEE Holding Corps proportionate share of equity required for project costs and working capital.

The facility will enter into an administrative services agreement with Ambulatory Surgery Centers of America (ASCOA) to provide services including, but not limited to, budgeting, credentialing and billing.

In response to the Department's inquiry, objection was received by one of the three hospitals in the area of the proposed ASC – Flushing Hospital and Medical Center. The information submitted by the hospital provides an insufficient basis for reversal or modification of the Department's recommendation for five-year limited life approval based on public need, financial feasibility and operator character and competence.

Total project costs are estimated at $7,388,104.

DOH Recommendation

Contingent approval for a 5-year limited life.

Need Summary

The number of projected procedures is as follows:

Current Year:	0
First Year:	7,000
Third Year:	7,426

Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Summary

Project costs will be met with $738,810 in equity and a $6,649,294 bank loan.

Budget:	*Revenues:*	*$ 6,885,625*
	Revenues:	*5,363,061*
	Gain/(Loss):	*$ 1,522,564*

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

The proposed FASC will occupy approximately 13,460 SF on the second floor of a new, fully-sprinklered, 2-story commercial building. The program will have 4 Class 'C' operating rooms, a pre-op area with 7 bays, a recovery area with 12 bays, and the appropriate support facilities.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval for limited life of five years from the date of the issuance of an operating certificate is recommended contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the Department of Health beginning in the second year of operation. Said reports shall include:
   - Data showing actual utilization including procedures;
   - Data showing breakdown of visits by payor source;
   - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
   - Data showing number of emergency transfers to a hospital;
   - Data showing percentage of charity care provided, and
   - Number of nosocomial infections recorded during the year in question. [RNR]
3. Submission by the governing body of the ambulatory surgery center of an organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of the statement from the applicant, acceptable to the Department, that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with consultation of the legal counsel, and if it is concluded that proceeding with the proposal is acceptable. [RNR]
5. Submission of an assumed name, if applicable, acceptable to the Department. [HSP]
6. Submission of an executed administrative services agreement that is acceptable to the Department. [BFA, CSL]
7. Submission of an executed loan commitment that is acceptable to the Department. [BFA]
8. Submission of an executed sublease and a lease, that is acceptable to the Department. [CSL]
9. Submission of an executed Amendment to the Articles of Organization, that is acceptable to the Department. [CSL]
10. Submission of an executed Operating Agreement, that is acceptable to the Department. [CSL]
11. Submission of an executed Certificate of Incorporation of NYEE Holding Corp., that is acceptable to the Department. [CSL]

Approval conditional upon:

1. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
2. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
3. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
4. The clinical space must be used exclusively for the approved purpose. [HSP]
5. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to start of construction. [AER]
6. The applicant shall complete construction by August 31, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date
February 2, 2012.

Need Analysis

Background
The Surgery Center of Bayside, LLC seeks approval to establish and construct a diagnostic and treatment center (D&TC) that will be certified as a multi-specialty freestanding ambulatory surgery center (FASC), to be located at 45-64 Francis Lewis Blvd, Bayside.

Analysis
The primary service area is Queens County. More specifically, the primary service area will include 14 zip codes in the Northeastern section of Queens County: zip code 11361 where the proposed Center would be located; zip codes 11362-364, zip codes 11354-360, zip codes 11365-367.

The proposed Center will serve the following communities:

Bayside	Douglaston	Little Neck	Oakland Gardens
Aburndale	Bay Terrace	Clearview	College Park
Flushing	Whitestone	Fresh Meadows	Hillcrest
Kew Garden Hills			

The proposed Center is not in a HPSA area (HRSA).

The table below presents data on the number of patients at the four multi-specialty ASCs in Queens County. From 2008 to 2009, this number increased nearly nine (9) percent.

Multi-Specialty ASCs – Queens County	*2008*	*2009*	*Change*
Choices Women's Medical Center	9,056	9,641	6.5%
Hillside D&TC	649	1,309	101.7%
Physicians' Choice Surgicenter	1,057	1,164	10.1%
Queens Surgi-Center	5,442	5,525	1.5%
Total	*16,204*	*17,639*	*8.9%*

Source: SPARCS 2008-09

The number of total ambulatory surgery patients in Queens County was 94,437 in 2008 and 99,460 in 2009; an increase of 5.3 percent.

The proposed Center will have a transfer and affiliation agreement for backup and emergency services with Queens Hospital center that is about 5.8 miles and 10 minutes travel from the proposed Center.

The applicant commits to providing charity care for persons without the ability to pay, and to utilize a sliding fee scale for persons who are unable to pay the full charge for services or are uninsured.

The number of D&TCs and hospital-based ASCs in Queens County is as follows:

Type of Facility-Queens County	*Single Specialty*	*Multi-Specialty*
D&TC	1-Gastroenterology	---
D&TC	1-Ophthalmology	---
D&TC	---	4
Hospitals	---	10

Source: HFIS

None of the four multi-specialty D&TCs and ten hospitals are located in the proposed Center's zip code 11361. Of the ten hospitals listed above, only two hospitals are located in zip code 11355, one of the 14 zip codes in the primary service area of the proposed Center. These two hospitals are Flushing Hospital Medical Center, which does not have an extension clinic, and New York Hospital Medical Center of Queens, which does have an extension clinic. The

Center for Developmental Disability and Neuroscience Center is located in zip code 11365 and the Family Health Center is located in zip code 11355. These are two of the 14 zip codes in the primary service area of the proposed Center.

The remaining two single specialty D&TCs are also not located in zip code 11361 or in any of the 14 zip codes in the primary service area of the proposed Center.

Recommendation
From a need perspective, contingent approval is recommended.

Programmatic Analysis

Program Proposal
Establish a diagnostic and treatment center that will also be federally certified as an ambulatory surgery center.

Proposed Operator	The Surgery Center of Bayside
Operator Type	LLC
Site Address	45-64 Francis Lewis Boulevard, Bayside
Surgical Specialties	Multispecialty, including: Otolaryngology Orthopedics Ophthalmology
Operating Rooms	4
Procedure Rooms	0
Hours of Operation	Monday through Friday from 7:00 am to 6:00 pm (Extended as necessary to accommodate patient needs).
Staffing (1st Year / 3rd Year)	24.74 FTEs / 26.09 FTEs
Medical Director(s)	Gary S. Hirshfield, MD
Emergency, In-Patient and Backup Support Services Agreement	Will be provided by Queens Hospital Center
Distance	5.8 miles and 10 minutes travel time
On-call service	Access to the facility's on-call physician during hours when the facility is closed.

Integration with Community Resources
The center has had discussions with Queens Hospital Center to provide medical clearances for surgery and to provide primary care follow-up for all patients referred who require such access. Additionally, the center will conduct community outreach, including working with community based agencies and groups to discuss the services available at the center and to provide information about other health services in the area.

The center intends to affiliate with all developing Accountable Care Organizations and/or Medical Homes for both its benefit and the benefit of the community. They will utilize an Electronic Medical Record system and plan to join the Queens Consortium for Healthcare Information Exchange, an operational Regional Health Information Organization. The intention is to have full participation in place at the time of opening.

Compliance with Applicable Codes, Rules and Regulations
The medical staff will ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

A sliding fee scale will be in place for those without insurance, and provisions will be made for those who cannot afford services.

Character and Competence

The members of the LLC are:

A. Class A (50%)		
Andrew Blank, MD	2.450%	Manager
Edwin Chan, MD	2.450%	Manager
Aspasia Draga, MD	1.225%	Manager
Irene Draga, MD	1.225%	Manager
David Edelstein, MD	1.225%	Manager
Donald Fox, MD	2.450%	Manager
Mark Friedman, MD	2.450%	Manager
Gregg Gordon, MD	2.450%	Manager
Gary Hirshfield, MD	2.450%	Manager
Cheryl Kaufmann, MD	2.450%	Manager
Yong Kim, MD	2.450%	Manager
Daniel Laroche, MD	2.450%	Manager
Eric Lichtenstein, MD	3.450%	Manager
Greg Mashkevich, MD	1.225%	Manager
Peter Menger, MD	2.450%	Manager
Gurston Nyquist, MD	2.450%	Manager
Nilesh Patel, MD	2.450%	Manager
Stephen Perrone, MD	2.450%	Manager
Deborah Silberman, MD	1.225%	Manager
Gerald Suh, MD	2.450%	Manager
Gennady Ukrainsky, MD	2.450%	Manager
Ken Wald, MD	1.225%	Manager
Zhenquing Brett Wu, MD	2.450%	Manager
Class B (20%)		
Thomas J. Bombardier, MD	6.000%	Manager
Brent Lambert, MD	6.000%	
George Violin, MD	6.000%	
Luke Lambert	2.000%	
Class C (30%)		
NYEEI Holding Corp.	30.000%	
Allen H. Fine		Manager
Charles Figliozzi		Manager
Ralph Lambiasi		

The Class A members are individual physicians who currently have medical practices within the proposed service area.

The Class B members are employees of, and have ownership interests in, Ambulatory Surgery Centers of America (ASCOA). ASCOA provides administrative and consulting services to ambulatory surgery centers nationwide. The center will enter into an administrative services agreement with ASCOA. Additionally, all four Class B members have ownership interests in at least one approved and operating Article 28 ambulatory surgery center in New York State.

The Class C member, NYEEI Holding Corp., is a proposed not-for-profit subsidiary of New York Eye and Ear Infirmary, a 69-bed hospital located in Manhattan. The proposed directors of NYEEI Holding Corp. are employees of the hospital. The hospital is a member of Continuum Health Partners. Neither NYEEI nor Continuum will take an active role in the operation of the center.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's and relatives' ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management (relative to Medicaid fraud and abuse), the Office of Professional Medical Conduct, and the Education Department databases.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action. Based on this information, staff concluded that the applicants have provided a substantially consistent high level of care as defined in New York State Public Health Law 2810(a)(3) and 10NYCRR 600.2 during the past 10 years.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicants' character and competence or standing in the community.

Recommendation

From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Administrative Services Agreement

The Surgery Center of Bayside, LLC, LLC will enter into an administrative services agreement with ASCOA, whose members are Thomas Bombardier, M.D., Brent Lambert, M.D., Luke Lambert, and George Violin, M.D. The consultant will provide certain non-professional business and administrative services to the ambulatory surgery center relating to the operation of the facility.

The applicant has submitted a proposed agreement, which is summarized below:

Facility:	NYEEQASC, LLC
Contractor:	Cataract and Laser Center Partners, LLC d/b/a Ambulatory Surgical Centers of America
Administrative Term:	10 years with the option to renew for successive three year terms.
Compensation:	$450,000 per year ($37,500/month)
Duties of the Contractor:	Financial management services, strategic planning and development, policies and procedures, contracting services, personnel, billing and collection services, supply acquisition, utilities and waste management, operating licenses and banking.

Sublease Rental Agreement

The applicant will lease approximately 13,459 square feet of space on the second floor of a to-be-constructed building located at 45-64 Frances Lewis Boulevard, Bayside under the terms of the proposed sublease agreement summarized below:

Sublessor:	New York Eye & Ear Infirmary
Sublessee:	NYEEQASC, LLC
Term:	20 years with the option to renew for two additional five year terms.
Rental:	$471,065 ($35.00 per sq. ft.) for the first four years with an 11% increase every five years.
Provisions:	The sublessee will be responsible for taxes, utilities, insurance and maintenance.

The applicant has indicated that the lease will be a non-arm's length lease agreement, and letters of opinion from Licensed Commercial Real Estate Brokers have been submitted indicating rent reasonableness.

Total Project Costs and Financing

Total project costs are estimated at $7,388,104, broken down as follows:

Renovation & Demolition	$3,364,750
Design Contingency	336,475
Construction Contingency	336,475
Architect/Engineering fees	484,524
Consultant fees	100,000
Movable Equipment	2,524,000
Financing Costs	66,493
Interim Interest Expense	132,986
Application Fee	2,000
Additional Processing Fee	40,401
Total Project Cost	$7,388,104

Project costs are based on a March 1, 2012 construction start date and a six month construction period.

The applicant's financing plan appears as follows:

Cash	$738,810
Loan (6.52%, 7 years)	$6,649,294

A letter of interest from TD Bank has been submitted by applicant.

Operating Budget

The applicant has submitted an operating budget in 2011 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues:	$6,490,362	$6,885,625
Expenses:		
Operating	$3,715,173	$3,882,405
Capital	1,583,376	1,480,656
Total Expenses;	$5,298,549	$5,363,061
Net Income:	$1,191,813	$1,522,564
Utilization: (procedures)	7,000	7,426
Cost per procedure:	$756.94	$722.20

Utilization by payor source for the first and third years is as follows:

	Years One and Three
Commercial Fee for Service	15%
Commercial Managed Care	50%
Medicare Fee for Service	25%
Medicare Managed Care	2%
Medicaid Fee for Service	2%
Medicaid Managed Care	3%
Private Pay	1%
Charity Care	2%

Expense and utilization assumptions are based on the historical experience of the participating physicians with similar centers within New York State. The applicant has submitted physician referral letters in support of utilization projections.

Capability and Feasibility

The applicant will finance the project costs through a loan from TD Bank for $6,649,294 at stated terms, with the remaining $738,810 from proposed member's equity.

Presented as BFA Attachment C, is the net worth statements of the proposed members, which indicates the availability of sufficient funds.

Working capital needs are estimated at $893,843, based on two months of third year expenses and will be provided as member's equity. Presented as BFA Attachment D, is the pro-forma balance sheet of NYEEQASC, LLC as of the first day of operation, which indicates positive member's equity of $1,632,653.

The submitted budget indicates a net income of $1,191,813 and $1,522,564 during the first and third years of operation, respectively. Reimbursement will be determined on an average rate by ambulatory surgery center and region enhanced by the applicable service intensity weight (SIW). The budget appears reasonable.

Presented as BFA Attachments E and F are the financial summaries of the facilities currently operated by proposed members. As shown, Specialty Surgery Center of Central New York and Melville Surgery Center, LLC, maintained positive working capital and equity and generated positive net income for 2009 and 2010.

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Architectural Analysis

Review Summary

The second floor will consist of approximately 13,460 SF of new construction and will consist of a patient waiting area, interview area, offices, exam room, pre-op area with seven bays, PACU 1 with seven bays, PACU 2 with five bays, a nurse station, four Class 'C' operating rooms, an anesthesia work room, clean and soiled work rooms, sterile storage room, other storage rooms, patient and staff toilets, staff lounge, and men's and women's staff locker rooms with showers.

Environmental Review

The Department has deemed this project to be a TYPE I Action and the lead agency shall be the county of Queens or the authority having jurisdiction.

Recommendation

From an architectural perspective, approval is recommended.

Attachments

BFA Attachment A	Organizational Chart of NYEEQASC, LLC with percentage of membership interest of proposed members.

BFA Attachment B	Financial Summary, New York Eye & Ear Infirmary
BFA Attachment C	Net Worth of proposed members
BFA Attachment D	Pro-forma Balance Sheet
BFA Attachment E	Financial Summary, Specialty Surgery Center of Central New York
BFA Attachment F	Financial Summary, Melville Surgery Center
BFA Attachment G	Establishment Checklist
BHFP Attachment	Map

Supplemental Information

Outreach

Below are presented summaries of responses by hospitals to letters from the Department asking for information on the impact of the proposed ambulatory surgery center (ASC) in their service areas. There follows a summary of the applicant's response to DOH's request for information on the proposed facility's volume of surgical cases, the sources of those cases, and on how staff will be recruited and retained by the ASC.

Facility: Queens Hospital Center
82-68 164th Street
Jamaica, NY 11432

No response.

Facility: New York Hospital Medical Center of Queens
56-45 Main Street
Flushing, NY 11355

No response.

Facility: Flushing Hospital and Medical Center
45th Avenue and Parsons Boulevard
Flushing, NY 11355

Current OR Use	Surgery Cases		Amb. Surg. Cases by Applicant Physicians	Reserved OR Time for Applicant Physicians
	Ambulatory	**Inpatient**		
80%	7,200	2,800	Not specified[1]	Yes[2]

[1] Flushing states that five of the 23 physicians proposed to practice at the ASC have privileges at the hospital.
[2] Two of the five physicians have block time reserved in the OR.

Flushing Hospital opposes the application. The hospital estimates that it will lose 1,000 cases to the proposed facility, entailing a gross revenue loss of $2 million. The hospital states that on total costs of its OR of $22.8 million, this loss would be devastating. The hospital also states that its ophthalmology and general surgery residency training programs would be adversely affected by the loss of ophthalmology and ENT cases to the proposed ASC. The hospital does not describe any specific effect of the projected loss of revenues on its community-oriented services.

In 2009, Flushing Hospital received revenue, gains and other support of $293.1 million over expenses of $279.0 million, for an excess of $14.1 million. In 2010, the hospital received revenue, gains and other support of $282.2 million against expenses of $274.5 million, for an excess of $7.4 million. In 2009, the hospital had a working capital ratio of 0.97. In 2010, the ratio was 0.94. The hospital's total bad debt and charity care in 2009 was $29.6 million, and in 2010, the total came to $27.6 million.

Supplemental Information from Applicant

- Need and Sources of Cases

The applicant states that 20 percent of the projected procedures for the proposed facility are now performed at New York Eye and Ear Infirmary, on patients that travel from the proposed facility's service area. An additional 60 percent of the proposed cases are now performed in freestanding surgery centers or in office-based practices. The applicant also states that the proposed ASC will address the needs of patients by reducing current scheduling backlogs, improving access to the broader community and providing state-of-the-art facilities and equipment to the region's residents.

- Staff Recruitment and Retention

Some staff will be recruited from the existing private practices of the applicant physicians. Additional staff recruitment will be directed at the general marketplace. Measures to recruit and retain skilled staff and counter staff turnover will include attractive compensation and benefits packages, continuing education opportunities, recognition and appreciation programs to reward high performers, and an open work atmosphere that encourages staff involvement and continuous improvement.

- Office-Based Cases

The applicant states that 60 percent of the procedures projected for the facility are currently performed in both office-based settings and in non-hospital affiliated ambulatory surgery settings.

OHSM Comment

The Department notes that only one of three hospitals in the area of the proposed ASC chose to comment on this application.

The objecting hospital projects a loss of 1,000 cases, or 10 percent of its total surgical volume (inpatient and outpatient) to the proposed ASC. The hospital states that five physicians affiliated with the proposed ASC currently practice at its facility, two of whom have reserved OR block time. This compares to 37 other physicians who have OR block time at the hospital and an unspecified number who perform surgery at the facility without reserved block time. The hospital does not make clear how many of the cases projected to be lost would be attributable to the five ASC physicians (their current caseloads at the hospital are not specified) and how many may be based on the hospital's stated speculation that other physicians currently performing surgery at the hospital might at some point join the proposed ASC. These uncertainties, and the fact of only one hospital commenting in opposition to the application, do not provide a sufficient basis for reversal or modification of the recommendation for five-year, limited life approval of the proposed ASC based on financial feasibility, public need and operator character and competence.

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish and construct a multi-specialty freestanding ambulatory surgery center to perform procedures relating to otolaryngology, orthopedics and ophthalmology, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
111552-B	The Surgery Center of Bayside, LLC

APPROVAL CONTINGENT UPON:

Approval for limited life of five years from the date of the issuance of an operating certificate is recommended contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the Department of Health beginning in the second year of operation. Said reports shall include:

    - Data showing actual utilization including procedures;
    - Data showing breakdown of visits by payor source;
    - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
    - Data showing number of emergency transfers to a hospital;
    - Data showing percentage of charity care provided, and
    - Number of nosocomial infections recorded during the year in question. [RNR]

3. Submission by the governing body of the ambulatory surgery center of an organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of the statement from the applicant, acceptable to the Department, that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with consultation of the legal counsel, and if it is concluded that proceeding with the proposal is acceptable. [RNR]
5. Submission of an assumed name, if applicable, acceptable to the Department. [HSP]
6. Submission of an executed administrative services agreement that is acceptable to the Department. [BFA, CSL]
7. Submission of an executed loan commitment that is acceptable to the Department. [BFA]
8. Submission of an executed sublease and a lease, that is acceptable to the Department. [CSL]
9. Submission of an executed Amendment to the Articles of Organization, that is acceptable to the Department. [CSL]
10. Submission of an executed Operating Agreement, that is acceptable to the Department. [CSL]
11. Submission of an executed Certificate of Incorporation of NYEE Holding Corp., that is acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
2. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
3. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
4. The clinical space must be used exclusively for the approved purpose. [HSP]
5. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to start of construction. [AER]
6. The applicant shall complete construction by August 31, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

Public Health and Health Planning Council

Project # 112032-B

PBGS, LLC
d/b/a Downtown Brooklyn Gynecology Center

County: **Kings (Brooklyn)**
Purpose: **Establishment and Construction**
Program: **Ambulatory Surgery Center**
Submitted: **July 18, 2011**

Executive Summary

Description

PBGS, LLC d/b/a Downtown Brooklyn Gynecology Center, requests approval to establish and construct an Article 28 single-specialty, freestanding ambulatory surgery (FASC) center to perform abortion and other gynecology procedures, at 81 Willoughby St., Brooklyn. The proposed membership interest in PBGS, LLC is as shown below:

Proposed members	*Percent*
Dmitry Bronfman, M.D.	92%
Frontier Healthcare Associates, LLC	8%
-- Oleg Gutnik, M.D. (50%)	
-- Jordan Fowler (50%)	

Dmitry Bronfman, M.D. specializes in obstetrics and gynecology, and is converting the surgical aspect of his existing private, office-based practice to an Article 28 FASC through this application. Oleg Gutnik, M.D. will not practice at the Center.

As investors or through an equal ownership in Frontier Healthcare Associates, LLC, Jordan Fowler and Dr. Gutnik have an ownership interest or an indirect ownership interest in the following FASCs:

- *Digestive Diseases and Diagnostic & Treatment Center, LLC* (Kings County)
- *QEASC, LLC* (Queens County).
- *Queens Boulevard GI, LLC* (Queens County)
- *Putnam GI, LLC* (Putnam County)
- *Yorkville Endoscopy, LLC* (New York County)

The facility will enter into an administrative services agreement with Frontier Healthcare Management, LLC. Members include Mr. Fowler (47.7%), Dr. Gutnik (47.5%), and Mr. Roy Bejarano (5.0%).

No responses were received to the Department's inquiry to local hospitals regarding the impact of the proposed ASC in the service area.

Total project costs are estimated at $3,168,798.

DOH Recommendation

Contingent approval for a 5-year limited life.

Need Summary

The Center will have 1 operating room, 2 procedure rooms, 3 pre-operative holding stations, and 7 post-anesthesia recovery bays. The projected number of visits to be performed is as follows:

Current Year:	0
First Year:	4,560
Third Tear:	4,838

All the projected procedures are presently being performed in the member physician's private practice.

Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Summary

Project costs will be met with $296,899 in cash and a $2,871,899 bank loan.

Budget:		
	Revenues:	*$ 3,485,835*
	Expenses:	*2,591,431*
	Gain/(Loss):	*$ 894,404*

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

The proposed space is located on the second floor of an existing eight-story commercial building in Brooklyn. The floor area to be renovated is approximately 8,000 SF.

Recommendations

Health Systems Agency

There will be no HSA recommendation for this application.

Office of Health Systems Management

Approval for a limited life of 5 years from the date of issuance of an operating certificate is recommended contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the Department of Health beginning in the second year of operation. Said reports shall include:
   - Data showing actual utilization including procedures;
   - Data showing breakdown of visits by payor source;
   - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
   - Data showing number of emergency transfers to a hospital;
   - Data showing percentage of charity care provided, and
   - Number of nosocomial infections recorded during the year in question. [RNR]
3. Submission by the governing body of the ambulatory surgery center of an organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of the statement from the applicant, acceptable to the Department, that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with consultation of the legal counsel, and if it is concluded that proceeding with the proposal is acceptable. [RNR]
5. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
6. Submission of an executed building lease that is acceptable to the Department of Health. [BFA, CSL]
7. Submission of a loan commitment for project costs acceptable to the Department of Health. [BFA]
8. Submission of a working capital loan commitment that is acceptable to the Department of Health. [BFA]
9. Submission of a Restated Article of Organization of PBGS, LLC which is acceptable to the Department. [CSL]
10. Submission of the Operating Agreement which is acceptable to the Department. [CSL]
11. Submission of a Joinder to the Operating Agreement for PBGS, LLC which is acceptable to the Department. [CSL]
12. Submission of an Amended and Restated Articles of Organization of Frontier Healthcare Associates, LLC. which is acceptable to the Department. [CSL]
13. Submission of the Operating Agreement of the LLC member which is acceptable to the Department. [CSL]

Approval conditional upon:

1. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
2. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
3. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
4. The clinical space must be used exclusively for the approved purpose. [HSP]
5. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
6. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the start of construction. [AER]
7. The applicant shall complete construction by October 1, 2013. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

February 2, 2012.

Need Analysis

Background

PBGS, LLC seeks approval to establish and construct an Article 28 diagnostic and treatment center (D&TC) that will be certified as a single-specialty freestanding ambulatory surgical center (FASC) specializing in gynecological services. PBGS, LLC will do business as Downtown Brooklyn Gynecology Center, and be located at 81 Willoughby Street, Brooklyn.

Analysis

The service area for this project is Kings County. The proposed Center is located in a health professional shortage area for primary care and mental health services. It is also located in a Medically Underserved Area/Population (HRSA).

Dr. Bronfman has projected that the facility will perform 4,560 surgical procedures in the first year. This is the level of procedures currently being performed in his private practice. Dr. Bronfman reported that none of the projected procedures will migrate to the Center from any hospital.

The following table provides information on the number and percent of procedures by type:

Breakdown of Procedures by Type

CPT Code	*Description*	*Percent.*	*Cases Year 1*	*Cases Year 3*
59812	Treatment of incomplete abortion	1%	46	49
58120	Dilation and Curettage	5%	228	242
58558, 58653	Hysteroscopy	2%	92	98
56515*	Level I Female Reproductive Procedures	15%	682	724
572, 259, 820	Level II Female Reproductive Procedures	4%	183	194
59840, 59841	Level III Female Reproductive Procedures	73%	3,329	3,532
	Total	***100%***	***4,560***	***4,838***

** Also includes the following CPT-4 Codes: 57454, 57511 and 59200.*

Detailed breakdown of the percentage of these procedures is as follows:

CPT-4 Code	*% of Procedures under Each Code*
56515 (Destruction of lesion; extensive)	2%
57454 (Colposcopy with biopsy of cervix)	8%
57511 (Cryocautery of cervix, initial or repeat)	3%
57522 (Conization of cervix, loop electrode excision)	1%
58120 (Dilation and curettage, diagnostic and/or therapeutic)	5%
58558 (Hysteroscopy, surgical, with biopsy of endometrium)	1%
58563 (Hysteroscopy, surgical, with endometrial ablation)	1%
59200 (Insertion of cervical dilator)	2%
59812 (Treatment of incomplete abortion, completed surgically)	1%
59820 (Treatment of missed abortion, completed surgically)	3%
59840 (Induced abortion, by dilation or curettage)	68%
59841 (Induced abortion, by dilation and evacuation)	5%

All patients will be treated on the basis of need for the procedure, regardless of their ability to pay. The applicant commits to providing two (2) percent charity care. Brooklyn Hospital Center has entered into a transfer and affiliation agreement to provide backup and emergency services to the Center.

The proposed Center will be open Monday-Saturday, 8:00 am to 5:00 pm.

There is one D&TC Extension Clinic in Kings County that provides abortion O/P and other services as follows; this clinic is in the same zip code 11201 where the proposed Center will be located.

Abortion O/P	Family Planning O/P	Medical Social Services O/P
Outpatient Surgery	Pediatric O/P	Prenatal O/P
Primary Medical Care O/P		

Conclusion

Downtown Brooklyn Gynecology Center has the opportunity to improve access to care for the communities in Kings County. The Center's viability is not based upon patient migration from neighboring hospitals. Dr. Bronfman has entered into an affiliation agreement with Brooklyn Hospital Center for backup and emergency services.

Recommendation

From a need perspective, approval is recommended for a limited life of five years from the date of issuance of an operating certificate.

Programmatic Analysis

Program Proposal

Establish a diagnostic and treatment center that will also be federally certified as an ambulatory surgery center.

Proposed Operator	**PBGS, LLC**
Operator Type	LLC
Doing Business As	Downtown Brooklyn Gynecology Center
Site Address	81 Willoughby Street, Brooklyn
Surgical Specialties	Gynecology including abortion
Operating Rooms	1
Procedure Rooms	2
Hours of Operation	Monday through Saturday from 8:00 am to 5:00 pm (Extended as necessary to accommodate patient needs).
Staffing (1st Year / 3rd Year)	14.90 FTEs / 15.60 FTEs
Medical Director(s)	
Emergency, In-Patient and Backup Support Services Agreement	Will be provided by the Brooklyn Hospital Center
Distance	1.5 miles and 6 minutes travel time
On-call service	Access to the facility's on-call physician during hours when the facility is closed.

Integration with Community Resources

The applicant plans to work with its patients to educate them regarding availability of, and services offered by, local primary care physicians. Additionally, prior to leaving the center each patient will be provided information concerning the local availability of post-abortion counseling, family planning and contraception options.

The center intends to promote the accessibility of their services for all persons in need of such services with particular emphasis on traditionally underserved populations. Additionally, the applicant is aware that four provider-led Medicaid Health Homes in Brooklyn have been conditionally approved and at the appropriate time will consider the potential of joining or affiliating with them. The center will implement an Electronic Medical Record system and will investigate the potential of affiliating with the Brooklyn Hospital Center's Regional Health Information Organization.

Compliance with Applicable Codes, Rules and Regulations

The medical staff will ensure that procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

A sliding fee scale will be in place for those without insurance, and provisions will be made for those who cannot afford services.

Character and Competence

The members of the LLC are:

Name	
Dmitry Bronfman, MD	92% Member / Manager
Frontier Healthcare Associates, LLC	8% Member
Oleg Gutnick, MD – 50%	
Jordan Fowler – 50%	Manager

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's and relatives' ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management (relative to Medicaid fraud and abuse), the Office of Professional Medical Conduct, and the Education Department databases.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action. Based on this information, staff concluded that the applicant have provided a substantially consistent high level of care as defined in New York State Public Health Law 2810(a)(3) and 10NYCRR 600.2 during the past 10 years.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Administrative Services Agreement

Frontier Healthcare Management, LLC will be providing all of the following services, however the Facility retains ultimate control in all of the final decisions associated with the services.

The applicant has submitted an executed agreement, which is summarized below:

Facility:	PBGS, LLC d/b/a Downtown Brooklyn Gynecology Center
Contractor:	Frontier Healthcare Management, LLC
Dated:	July 1, 2011

Services Provided:	Provide executive oversight including: Staffing, scheduling, accounting, compliance, medical staff credentialing, accreditation, physical plant and material management. Provide management of revenue cycle services (billing and collections), including assessing business office policies, initiate third party payor contracts negotiations; prepare quarterly financial reports and analysis. Provide marketing and networking services including: marketing plan, strategic planning, and annual budgeting. Provide quality improvement management including: familiarize staff with clinical policies, monitor and report clinical benchmarks. Provide strategic planning. Facilitate acquisition and implementation of electronic health records.
Term:	3 years. May be renewed on annual basis upon mutual agreement.
Fee:	$150,000 per annum.

Lease Rental Agreement

The applicant has submitted a letter of interest for the site under the terms of the proposed lease agreement summarized below:

Lessor:	Kecheck Realty Corp.
Lessee:	PBGS, LLC
Site:	81 Willoughby Street, Brooklyn, NY 11201
Term:	15 Years
Rental:	First year $144,000 ($18.00 per sq. ft) per annum / $12,000 per month. Increases 2% annually.
Provisions:	Included: hot and cold water, security, real estate taxes, and elevator. Not included: heat, sprinkler and fire alarm services.

The applicant has indicated that the lease will be an arm's-length lease arrangement, and has submitted letters from real estate brokers attesting to the reasonableness of the per square foot rental.

Total Project Cost and Financing

Total project costs for renovations and the acquisition of movable equipment is estimated at $2,871,899 itemized as follows:

Renovation & Demolition	$ 1,824,000
Design Contingency	182,400
Construction Contingency	182,400
Architect/Engineering Fees	145,920
Other Fees (Consulting)	60,800
Movable Equipment	403,962
Financing costs	25,750
Interim Interest Expense	28,969
Application Fee	2,000
Additional Processing Fee	15,698
Total Project Cost	$2,871,899

Project costs are based on a June 1, 2012 construction start date and a four month construction period. The applicant's financing plan appears as follows:

Equity	$ 296,899
Bank Loan @4.5%, five years	2,575,000

Operating Budget

The applicant has submitted an operating budget in 2011 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues:	$3,291,934	$3,485,835
Expenses:		
Operating	$2,112,775	$2,189,544
Interest	123,973	72,560
Depreciation and Rent	323,510	329,328
Total Expenses	$2,560,258	$2,591,431
Net Income	$731,676	$894,404
Utilization: (procedures)	4,560	4,838
Cost Per Procedure:		
Operating:	$463.33	$452.57
Capital:	98.13	83.07
Total:	$561.46	$535.64

Utilization by payor source for the first and third years is as follows:

	First Year	Third Year
Commercial Insurance-Fee-For-Service	12.1%	11.7%
Commercial Insurance-Managed Care	22.5%	22.5%
Medicare Fee-For-Service	0.3%	0.3%
Medicaid Fee-For-Service	9.6%	9.6%
Medicaid Managed Care	45.5%	45.9%
Self Pay	8.0%	8.0%
Charity Care	2.0%	2.0%

Expense and utilization assumptions are based on the experience of the proposed physician member's private practice.

Capability and Feasibility

Project cost will be satisfied by a loan of $2,575,000 from TD Bank at stated terms, for which a letter of interest has been provided, with the remaining $296,899 from proposed member's equity.

Working capital requirements, estimated at $431,906, appear reasonable based on two months of third year expenses. The applicant will finance $215,953 via a revolving line of credit at an interest rate of 3.75% for a one year term, for which a letter of interest has been provided by TD Bank. Presented as BFA Attachment B is a summary of net worth statement of the proposed members of Downtown Brooklyn Gynecology Center, which indicates the availability of sufficient funds for the stated levels of equity and project cost. Presented as BFA Attachment C, is the pro-forma balance sheet of Downtown Brooklyn Gynecology Center as of the first day of operation, which indicates positive member's equity position of $512,853.

The submitted budget indicates a net income of $731,676 and $894,404 during the first and third years of operation, respectively. Reimbursement is determined on an average rate by free-standing ambulatory surgery centers and region enhanced by the applicable service intensity weight (SIW). The budget appears reasonable.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Architectural Analysis

Review Summary

The second floor will consist of approximately 8,000 SF of renovation and will include a patient waiting area, reception and filing area, pre-op and recovery area with (10) recovery bays, a centrally located nurse station for visual observance of patients and traffic to the procedure rooms, (2) Class 'B' gynecological procedure rooms, (1) Class 'C' operating room, a decontamination room, anesthesia work room, scope processing room, scope storage room, clean and soiled work rooms, other storage rooms, offices, conference room, patient and staff toilets, and a staff lounge with lockers. The building is fully handicapped accessible and is provided with a 24 hour central station fire alarm system. A Type 1 Essential Electrical System (EES) will also be provided for emergency power.

Environmental Review

The Department has deemed this project to be a TYPE II Action and will not have a significant effect on the environment. An Environmental Impact Statement is not required. However, any agency that has an interest in this project may make their own independent determination of significance and necessity for an EIS in accordance with the procedures specified within Part 97.8 of Title 10: Rules and Regulations.

Recommendation

From an architectural perspective, approval is recommended.

Attachments

BFA Attachment A	Organizational Chart of Downtown Brooklyn Gynecology Center LLC
BFA Attachment B	Summary Net Worth Statement of Proposed Members of Downtown Brooklyn Gynecology Center
BFA Attachment C	Pro-forma Balance Sheet
BFA Attachment D	Establishment Checklist
BHFP Attachment	Map

Supplemental Information

Outreach

Below are presented summaries of responses by hospitals to letters from the Department asking for information on the impact of the proposed ambulatory surgery center (ASC) in their service areas. There follows a summary of the applicant's response to DOH's request for information on the proposed facility's volume of surgical cases, the sources of those cases, and on how staff will be recruited and retained by the ASC.

Facility: The Brooklyn Hospital Center
Downtown Campus
121 DeKalb Avenue
Brooklyn, New York 11201

No response.

Facility: Woodhull Medical & Mental Health Center
760 Broadway
Brooklyn, New York 11206

No response.

Facility: Long Island College Hospital
339 Hicks Street Street
Brooklyn, New York 11201

No response.

Facility: New York Methodist Hospital
506 6th Street
Brooklyn, New York 11215

No response.

Supplemental Information from Applicant

- Need and Sources of Cases

The first-year caseload of 4,560 procedures for the proposed ASC will be drawn from the applicant physician's current office-based practice. The projected procedures for the ASC's third year (4,838) reflect a modest allowance for growth of three percent per year from the existing practice. The applicant also states that the ASC will serve a Brooklyn population that contains a large percentage of traditionally medically underserved individuals, including racial minorities and persons living below the Federal poverty level. The applicant also believes that performing cases in a facility that is under the control of the member physician who has a practice in the local community will result in greater convenience and efficiency for patients, which will encourage utilization of the proposed ASC.

- Staff Recruitment and Retnetion

The applicant states that initial recruitment will be of selected staff currently employed by the applicant physician in his private practice, particularly the nursing and technical staff. Staff will also be recruited through accredited schools, newspaper advertisements, training programs, local recruiters and, if needed, job fairs. Competitive salaries and benefits are expected to aid in the recruitment and retention of skilled employees, as are a positive work environment and flexible working hours. The applicant also expects that nurses and technicians currently employed by hospitals who choose to augment their income will be able to find supplemental employment at the proposed ASC because of the flexible work schedule, without cutting back on or abandoning their hospital employment.

- Office-Based Cases

As noted the projected utilization for the proposed ASC is based upon the applicant physician's current caseload. All of the projected procedures are currently performed in his office-based practice.

OHSM Comment

The absence of comments from hospitals in the proposed service area provides no basis for reversal or modification of the recommendation for five-year limited life approval of the proposed ASC based on public need, financial feasibility and operator character and competence.

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish and construct an Article 28 single-specialty, freestanding ambulatory surgery, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
112032-B	PBGS, LLC d/b/a Downtown Brooklyn Gynecology Center

APPROVAL CONTINGENT UPON:

Approval for a limited life of 5 years from the date of issuance of an operating certificate is recommended contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the Department of Health beginning in the second year of operation. Said reports shall include:

   - Data showing actual utilization including procedures;
   - Data showing breakdown of visits by payor source;
   - Data showing number of patients who need follow-up care in a hospital within seven days after
     ambulatory surgery;
   - Data showing number of emergency transfers to a hospital;
   - Data showing percentage of charity care provided, and
   - Number of nosocomial infections recorded during the year in question. [RNR]

3. Submission by the governing body of the ambulatory surgery center of an organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of the statement from the applicant, acceptable to the Department, that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with consultation of the legal counsel, and if it is concluded that proceeding with the proposal is acceptable. [RNR]
5. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
6. Submission of an executed building lease that is acceptable to the Department of Health. [BFA, CSL]
7. Submission of a loan commitment for project costs acceptable to the Department of Health. [BFA]
8. Submission of a working capital loan commitment that is acceptable to the Department of Health. [BFA]
9. Submission of a Restated Article of Organization of PBGS, LLC which is acceptable to the Department. [CSL]
10. Submission of the Operating Agreement which is acceptable to the Department. [CSL]

11. Submission of a Joinder to the Operating Agreement for PBGS, LLC which is acceptable to the Department. [CSL]
12. Submission of an Amended and Restated Articles of Organization of Frontier Healthcare Associates, LLC. which is acceptable to the Department. [CSL]
13. Submission of the Operating Agreement of the LLC member which is acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
2. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
3. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
4. The clinical space must be used exclusively for the approved purpose. [HSP]
5. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
6. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the start of construction. [AER]
7. The applicant shall complete construction by October 1, 2013. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

B. <u>APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES</u>

<u>CATEGORY 4</u>: Applications Recommended for Approval with the Following:

- PHHPC Member Recusals
- Establishment an Project Review Committee Dissent, or
- Contrary Recommendation by HSA

<u>HOME HEALTH AGENCY LICENSURES</u> **Exhibit #22**

Number	Applicant/Facility	E.P.R.C. Recommendation
1640 L	Acute Care Experts, Inc. (Bronx, Queens, Kings, Richmond, Nassau, and New York Counties) Ms. Regan – Interest	Contingent Approval
1956 L	Advantage Management Associates, Inc. d/b/a Advantage Homecare Agency (New York, Westchester, Kings, Queens, Bronx, and Richmond Counties) Ms. Regan – Interest	Contingent Approval
1678 L	Amazing Grace Home Care Services, LLC (New York, Bronx, Kings, Richmond, and Queens Counties) Ms. Regan – Interest	Contingent Approval
1696 L	Diana's Angels, Inc. (Putnum, Bronx, Westchester and Dutchess Counties) Ms. Regan – Interest	Contingent Approval

1957 L	Evergreen Choice, LLC (New York, Bronx, Kings, Richmond and Queens Counties) Ms. Regan – Interest	Contingent Approval
1668 L	Five Borough Home Care, Inc. (Bronx, Kings, New York, Richmond, and Queens Counties) Ms. Regan – Interest	Contingent Approval
1733 L	Heritage Homecare Services, Inc. (New York, Kings, Queens, Bronx, Nassau, Suffolk and Richmond Counties) Ms. Regan – Interest	Contingent Approval
1835 L	Longevity Care, LLC (Westchester County) Ms. Regan – Interest	Contingent Approval
2004 L	Long Island Living Center, LLC d/b/a Long Island Living Center (Bronx, Kings, and Queens Counties) Ms. Regan – Interest	Contingent Approval
2079 L	Metrostar Home Care, LLC (Kings, Bronx, Queens, Richmond, New York and Nassau Counties) Ms. Regan – Interest	Contingent Approval
1875 L	ALJUD Licensed Home Care Services, LLC (Nassau and Suffolk Counties) Ms. Regan – Interest	Contingent Approval

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Acute Care Experts, Inc.
Address:	Staten Island
County:	Richmond
Structure:	For-Profit Corporation
Application Number:	1640-L

Description of Project:

Acute Care Experts, Inc., a New Jersey business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has submitted a Certificate of Authority to do Business in New York State.

The applicant has authorized 200 shares of stock, which are owned as follows:

Frederick Lucich – 200 Shares

The Board of Directors of Acute Care Experts, Inc. comprises the following individuals:

Frederick Lucich, RN – President/Secretary
Owner/President Acute Care Experts, Inc (NJ)
Registered Nurse, Accerdo AHG of New York

Jennifer Lucich-Gralitzer – Treasurer
Director of Operations, Acute Care Experts (NJ)

The Office of the Professions of the State Education Department indicates no issues with the licensure of the health professional associated with this application.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located Staten Island, New York:

Bronx	Kings	Nassau	New York
Queens	Richmond		

The applicant proposes to provide the following health care services:

Nursing

A 10 year review of the operations of Acute Care Experts, Inc., New Jersey was performed as part of this review.

The information provided by the New Jersey regulatory agency indicated that Acute Care Experts, Inc. has provided sufficient supervision to prevent harm to the health, safety and welfare of patients and to prevent recurrent code violations

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 10, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Advantage Management Associates, Inc. d/b/a Advantage Homecare Agency
Address:	Fresh Meadows
County:	Queens
Structure:	For-Profit Corporation
Application Number:	1956-L

Description of Project:

Advantage Management Associates, Inc., d/b/a Advantage Homecare Agency, a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned solely by Phillip Krivoruk.

The Board of Directors of Advantage Management Associates, Inc., d/b/a Advantage Homecare Agency comprises the following individual:

Phillip Krivoruk, sole director
Administrator, Focus Home Healthcare (Florida)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 61-43 186th Street, Fresh Meadows, New York 11365:

New York Kings Queens Bronx Richmond
Westchester

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Respiratory Therapy
Speech Language Pathology	Audiology	Medical Social Services
Nutrition	Homemaker	Housekeeper

Review of the Disclosure Information indicates that the applicant has no affiliations with other health care facilities.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Amazing Grace Home Care Services, LLC
Address:	Brooklyn
County:	Kings
Structure:	Limited Liability Company
Application Number:	1678-L

Description of Project:

Amazing Grace Home Care Services, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

Amazing Grace Home Care Services, LLC is composed of the following members:

Grace Abakpa, R.N., 50%
Staff Nurse, NYC Health & Hospitals Corporation

Charles Abakpa, 50%
Case Manager, New York City HRA

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 1215 East 83rd Street, Brooklyn, New York 11236:

New York	Kings	Queens
Bronx	Richmond	

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Speech-Language Pathology
Homemaker	Housekeeper	

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Diana's Angels, Inc.
Address:	Carmel
County:	Putnam
Structure:	For-Profit Corporation
Application Number:	1696-L

Description of Project:

Diana's Angels, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned solely by Drita Djeljevic.

The Board of Directors of Diana's Angels, Inc. comprises the following individual:

Drita Djeljevic, President
Self-employed home health aide

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 34 Avery Road, Carmel, New York 10512:

Putnam	Westchester	Dutchess
Bronx		

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Homemaker	Housekeeper	

Review of the Disclosure Information indicates that the applicant has no affiliations with other health care facilities.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency: Evergreen Choice, LLC
Address: New York
County: New York
Structure: Limited Liability Company
Application Number: 1957L

Description of Project:

Evergreen Choice, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law. Evergreen Choice, LLC is currently operational as a companion care agency.

Evergreen Choice, LLC is composed of the following members:

Kelly A. Blundy, D.C., 50%
Chiropractor, The Spine & Health Center of Montvale

Ann D. Stoller, 50%
Manager, American Orthopedic and Sports Medicine

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 1375 Broadway, 6th Floor, New York, New York 10018:

New York	Kings	Queens
Bronx	Richmond	

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Homemaker	Housekeeper	

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Five Borough Home Care, Inc.
Address:	Brooklyn
County:	Kings
Structure:	For-Profit Corporation
Application Number:	1668L

Description of Project:

Five Borough Home Care, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock, which are owned as follows:

Yuri Rozenblyum, 160 shares
President, B I Analytics, Inc.
(business intelligence & performance management company)

Emiliya Kozlenko, 40 shares
Personal Specialist, Home Attendant Vendor Agency, Inc. (home care agency)

The members of the Board of Directors of Five Borough Home Care, Inc. are as follows:

Yuri Rozenblyum, President
(disclosed above)

Diana Zhelkover, HHA, PCA Vice President
Case Coordinator, I and Y Senior Care, Inc.
(home health care agency)

Emiliya Kozlenko, Secretary/Treasurer
(disclosed above)

Anna Viderman, R.N., Director
Assistant Director of Patient Services, I and Y Senior Care, Inc.
Service Visiting Nurse, Excellent Home Care Services
All Units Float RN, Staten Island University Hospital

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 1374 East 70th Street, Brooklyn, New York, 11234:

Bronx Kings New York Richmond Queens

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Review of the Disclosure Information indicates that the applicant has no operational interest in other health care facilities.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Heritage Homecare Services, Inc.
Address:	Brooklyn
County:	Kings
Structure:	For-Profit Corporation
Application Number:	1733-L

Description of Project:

Heritage Homecare Services, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 20,000 shares of stock which are owned as follows:
35 shares owned by Gabriel S. Bomide, 35 shares owned by Margaret A. Bomide and 30 shares owned by Oluwafunmilayo B. Bomide. 19,900 shares remain unissued.

The Board of Directors of Heritage Homecare Services, Inc. comprises the following individuals:

Gabriel S. Bomide, Chairperson
CEO, Heritage Homecare Services, Inc.
Case Manager, Institute for Community Living, Inc.

Oluwafunmilayo B. Bomide, R.N.,Vice Chairperson, Secretary
Medical School Student, Windsor University School of Medicine

Margaret A. Bomide, Treasurer
Fraud Investigator, City of New York HRA

Mary O. Ajibade, R.N.
R.N., Richmond University Teaching Hospital, Behavioral Health Department

Tajudeen O. Dabiri, M.D.
Clinical Assistant Professor, SUNY Downstate

Adebola A. Osewa, R.N.
Staff Nurse, Harlem Hospital Center
Clinical Nurse Manager, Wartburg Lutheran Home

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department, the New York Physician Profile and the Office of Professional Medical Conduct, where appropriate, indicates no issues with the licenses of the healthcare professionals associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 1295 Herkimer Street, Brooklyn, New York 11233:

New York Kings Queens Bronx Richmond

The applicant proposes to serve the residents of the following counties from an office located in Nassau County:

Nassau Suffolk

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Speech Language Pathology
Medical Social Services	Homemaker	Housekeeper

Review of the Disclosure Information indicates that the applicant has no affiliations with other health care facilities.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

<u>Contingency</u>
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Longevity Care, LLC
Address:	Rye
County:	Westchester
Structure:	Limited Liability Company
Application Number:	1835-L

Description of Project:

Longevity Care, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The members of Longevity Care, LLC are as follows:

Edvard Joseph, 50%
Director of Operations, Jefferson Plumbing

Sandra Joseph, R.N., 50%
Home Care Nurse, Precise Care, LLC
(Connecticut)

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of Westchester County from an office located at 411 Theodore Fremd Road, Suite 206, Rye, New York 10580.

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Medical Social Services
Speech Language Pathology	Homemaker	Housekeeper
Audiology	Respiratory Therapy	Nutrition

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Long Island Living Center, LLC d/b/a Long Island Living Center
Address:	Far Rockaway
County:	Queens
Structure:	Limited Liability Company
Application Number:	2004-L

Description of Project:

Long Island Living Center, LLC, d/b/a Long Island Living Center, a limited liability company, requests approval of a change in ownership of Long Island Living Center Assisted Living Program under Article 36 of the Public Health Law. Long Island Living Center Assisted Living Program is a currently operational ALP and LHCSA operated as a sole proprietorship by Amram Shetrit. This proposal seeks to transfer 70% ownership interest to Jeffrey J. Edelman and convert the entity to a LLC to be called Long Island Living Center, LLC d/b/a Long Island Living Center.

Long Island Living Center, LLC d/b/a Long Island Living Center (LHCSA) was previously approved as a licensed home care services agency by the Public Health Council at its May 20, 1994 meeting and subsequently licensed as 9452L001.

The members of Long Island Living Center, LLC d/b/a Long Island Living Center are as follows:

Jeffrey J. Edelman, 70%
Operator, Wavecrest Home for Adults
Operator, Parkview Home for Adults
Affiliations: Wavecrest HFA
Parkview HFA

Amram Shetrit, 30%
Operator/Administrator, Long Island Living Center

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to continue to serve the residents of the following counties from an office located at 431 Beach 20th Street, Far Rockaway, New York 11691:

Bronx	Kings	Queens

The applicant proposes to continue to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Medical Social Services
Speech Language Pathology	Respiratory Therapy	Nutrition

A ten year review of the operations of the following facilities was performed as part of this review:

Parkview Home for Adults
Wavecrest Home for Adults
Long Island Living Center (ALP)
Long Island Living Center (LHCSA)

The information provided by the Division of Assisted Living has indicated that the adult care facilities reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Division of Home and Community Based Services has indicated that the licensed home care services agency (LHCSA) reviewed has provided sufficient supervision to prevent harm to the health, safety and welfare of patients and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

<u>Contingeny</u>
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2012

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Metrostar Home Care, LLC
Address:	Far Rockaway
County:	Queens
Structure:	Limited Liability Company
Application Number:	2079-L

Description of Project:

Metrostar Home Care, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law. Metrostar Home Care, LLC is the proposed LHCSA affiliated with Central Assisted Living, LLC, an existing 186 bed adult home/ALP and a proposed 14 bed enriched housing program/assisted living program (EHP/ALP).

The members of Metrostar Home Care, LLC are as follows:

Boris Mendel, 85%

Affiliations:
Central Assisted Living LLC dba Central Home Care
Central Assisted Living (ACF/ALP)
New Central Manor (ACF/ALP)
Prime Home Health Services, LLC
NCM Home Care LLHCSA

Eric Mendel, 15%

Affiliations:
Central Assisted Living LLC dba Central Home Care
Central Assisted Living, LLC (ACF/ALP)
New Central Manor (ACF/ALP)
Prime Home Health Services, LLC
NCM Home Care LLHCSA

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 11-38 Foam Place, Far Rockaway, New York 11691:

Kings	Queens	New York
Bronx	Richmond	Nassau

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Respiratory Therapy
Speech Language Pathology	Audiology	Medical Social Services
Nutrition	Homemaker	Housekeeper

A review of the following facilities and agencies was performed as part of this review:

Central Assisted Living, LLC (2008- present)
Central Assisted Living, LLC d/b/a Central Home Care (2008- present)
New Central Manor ALP (2002 - 2008)
NCM Home Care LLHCSA
Prime Home Health Services, LLC (9/07 – present)

The information provided by the Division of Assisted Living indicated that the assisted living facilities reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Division of Home and Community Based Services indicated that the home care agencies reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of patients and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingeny
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: December 30, 2011

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	ALJUD Licensed Home Care Services Agency, LLC
Address:	Brooklyn
County:	Kings
Structure:	Limited Liability Company
Application Number:	1875-L

Description of Project:

ALJUD Licensed Home Care Services Agency, a Limited Liability Company, requests approval to change the structure of the licensed home care services agencies and limited home care services agency under Article 36 of the Public Health Law.

ALJUD Licensed Home Care Services Agency, a business partnership, was approved as a home care services agency by the Public Health Council at its November 18, 1994 meeting and subsequently licensed as 9438L001, 9438L002, 9438L003, 0915A001 and 0915A002. At that time the partnership was as follows: Alfred Schonberger – 50%, Judith Schonberger – 50%.

The members comprise the following individuals:

Alfred Schonberger – Executive Director, 50%
Executive Director, Aljud Management
President – Sales and Consulting, Jet Hardware Management Corporation

Judith Schonberger – President, 50%
Consultant, Aljud Management

A search of the individuals and entities named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 391 North Country Road, Smithtown, New York 11787:

Nassau   Suffolk

The applicant proposes to provide the following health care services:

Nursing	Nutrition	Housekeeper	Medical Social Work
Physical Therapy	Audiology	Personal Care	Durable Medical Equipment
Respiratory Therapy	Homemaker	Home Health Aide	Speech-Language Pathology
Occupational Therapy			

A 10 year review of the operations of the following facilities was performed as part of this review (unless otherwise noted):

- Maimonides Medical Center – Hospital (1990 – present)
- Keser Nursing and Rehab. Ctr f/k/a Avraham Residential Health Facility – RHCF (2002 – 2005)
- Amber Court of Pelham Gardens – Adult Care Facility
- Amber Court of Brooklyn – Adult Care Facility
- Amber Court of Westbury – Adult Care Faculty
- Amber Court of Suffolk – Adult Care Facility (2008 – present)
- Alfred Schonberger and Judith Schonberger d/b/a ALJUD Home Care Services-Brooklyn 9438L001 Licensed Home Care Services Agency
- Alfred Schonberger and Judith Schonberger d/b/a Judith Lynn Assisted Living for Seniors 9438A001 Licensed Home Care Services Agency
- Alfred Schonberger and Judith Schonberger d/b/a ALJUD Home Care Services-Westbury 9438L002 Licensed Home Care Services Agency

- Alfred Schonberger and Judith Schonberger d/b/a Thomas Jefferson Assisted Living Seniors LHCSA – Brooklyn
  9438A002 Licensed Home Care Services Agency
- Alfred Schonberger and Judith Schonberger d/b/a Thomas Jefferson Assisted Living Seniors LLHCSA – Brooklyn
  9438L003 Licensed Home Care Services Agency

The Bureau of Quality Assurance and Surveillance for Nursing Homes has indicated the following:

Aishel Avraham Nursing Home Corporations was fined four thousand dollars ($4,000.00) pursuant to a stipulation and order dated May 20, 2003 for surveillance findings of October 3, 2001 and January 23, 2002. Deficiencies were found under 10 NYCRR 415.12(h) Quality of Care: Accidents.

The information provided by the Bureau of Hospital & Diagnostic and Treatment Center, Certification and Surveillance has indicated that the hospital has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Division of Home and Community Based Services has indicated that the Licensed Home Care Services Agency has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Division of Assisted Living has indicated that the Adult Care Facility has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The Bureau of Professional Credentialing has indicated that Alfred A Schonberger, holds a NHA license #00983 issued 6/17/1971 in good standing. His license is currently voluntarily inactive and he may not practice nursing home administration in NYS. In order to qualify for reactivation of his license, he will need to document 48 hours of acceptable continuing education credits. The Board of Examiners of Nursing Home Administrators has never taken disciplinary action against Mr. Schonberger nor is such action pending.

The Bureau of Professional Credentialing has indicated that Judith Schonberger, holds a NHA license #01810 issued 6/16/1972 in good standing. Her license is currently voluntarily inactive with a $40.00 penalty fee and she may not practice nursing home administration in NYS. In order to qualify for reactivation of her license, she will need to pay the penalty fee and document 48 hours of acceptable continuing education credits. The Board of Examiners of Nursing Home Administrators has never taken disciplinary action against Ms. Schonberger nor is such action pending.

A review of the above listed facilities has determined that all of the facilities have exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency
Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval
Date: January 9, 2011

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the staff of the New York State Department of Health and the Establishment and Project Review Committee of the Council, and after due deliberation, hereby approves the following applications for licensure, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY:
1640 L	Acute Care Experts, Inc. (Bronx, Queens, Kings, Richmond, Nassau, and New York Counties)
1956 L	Advantage Management Associates, Inc. d/b/a Advantage Homecare Agency (New York, Westchester, Kings, Queens, Bronx, and Richmond Counties)
1678 L	Amazing Grace Home Care Services, LLC (New York, Bronx, Kings, Richmond, and Queens Counties)
1696 L	Diana's Angels, Inc. (Putnum, Bronx, Westchester and Dutchess Counties)

1957 L	Evergreen Choice, LLC (New York, Bronx, Kings, Richmond and Queens Counties)
1668 L	Five Borough Home Care, Inc. (Bronx, Kings, New York, Richmond, and Queens Counties)
1733 L	Heritage Homecare Services, Inc. (New York, Kings, Queens, Bronx, Nassau, Suffolk and Richmond Counties)
1994 L	Independent Living for Seniors, Inc. (Monroe and Wayne Counties)
1835 L	Longevity Care, LLC (Westchester County)
1959 L	Stat Staff Professionals, Inc. (Saratoga, Warren, Albany, Greene, Franklin, Washington, Rensselaer, Columbia, Clinton, Fulton, Otsego, Ulster, Essex, Montgomery, Schoharie, Hamilton, Schenectady, and Delaware Counties)
2004 L	Long Island Living Center, LLC d/b/a Long Island Living Center (Bronx, Kings, and Queens Counties)
2079 L	Metrostar Home Care, LLC (Kings, Bronx, Queens, Richmond, New York and Nassau Counties)
1875 L	ALJUD Licensed Home Care Services, LLC (Nassau and Suffolk Counties)

New York State Department of Health
Public Health and Health Planning Council

February 2, 2012

B. <u>APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES</u>

<u>CATEGORY 6</u>: Applications for Individual Consideration/Discussion

Certified Home Health Agencies – Establish **Exhibit # 23**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	111096 E	L. Woerner, Inc., d/b/a HCR (Schoharie County)	To be presented at the Special Establishment/Project Review Committee on 2/2/12 No Recommendation
2.	121027 E	L. Woerner, Inc. d/b/a HCR (Delaware County)	To be presented at the Special Establishment/Project Review Committee on 2/2/12 No Recommendation

Residential Health Care Facility – Establish **Exhibit #24**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112031 E	Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center (Kings County)	To be presented at the Special Establishment/Project Review Committee on 2/2/12 Contingent Approval 11/17/11 EPRC-Contingent Approval

111096 E
L. Woerner, Inc., d/b/a HCR
(Schoharie County)

To Be Distributed Under Separate Cover

121027 E
L. Woerner, Inc., d/b/a HCR
(Delawar County)

To Be Distributed Under Separate Cover

Public Health and Health Planning Council

Project # 112031-E
Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center

County: **Kings (Brooklyn)**
Purpose: **Establishment**
Program: **Residential Health Care Facility**
Submitted: **July 18, 2011**

Executive Summary

Description
Alliance Health Associates, Inc., d/b/a Linden Gardens Rehabilitation and Nursing Center, an existing proprietary corporation, requests approval to be established as the operator of Ruby Weston Manor, a 240-bed not-for-profit residential health care facility (RHCF) located at 2237 Linden Boulevard, Brooklyn. Ownership of the operation before and after the requested change is as follows:

Current	
Ruby Weston Manor	100%
Proposed Owner	
Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center	
MEMBERS:	
-- Joel Landau	40%
-- Jack Basch	30%
-- Marvin Rubin	15%
-- Soloman Rubin	15%

The operator of Ruby Weston Manor received final CON approval in 1995 to construct a 280-bed RHCF. The facility opened in 1998, but was never constructed to the full 280-bed authorization and the applicant never modified its CON approval. With this current CON proposal, the Department finalizes its certification for this RHCF at the current 240-bed capacity.

In recent years, Ruby Weston Manor experienced significant financial losses, low utilization and operator instability. These factors led to quality of care concerns that caused the Department to approve Alliance Health Associates, Inc. as receiver in 2011 to stabilize operations and ensure quality oversight.

Alliance Health Associates, Inc. will enter into a lease agreement with Alliance Health Property, LLC for the property. The applicant has submitted an executed real property purchase agreement between Alliance Health Property, LLC and Ruby Weston Manor dated June 2, 2011.

Jack Basch has ownership interests in Elmhurst Care Center, Inc, a 240-bed RHCF in East Elmhurst, and Bezalel Rehabilitation and Nursing Center, a 120-bed RHCF in Far Rockaway, while Soloman Rubin has ownership interests in Hamilton Park Nursing and Rehabilitation Center, a 150-bed RHCF in Brooklyn.

DOH Recommendation
Contingent approval.

Need Summary
Occupancy rates for the facility showed an increase from 74.3% in 2007 to 87.8%% in 2010. The applicant has submitted documentation that occupancy as of September 30, 2011 is 93.7%

Program Summary
The review of operations of Elmhurst Care Center, Inc., Bezalel Rehabilitation and Nursing Center and Hamilton Park Nursing and Rehabilitation Center results in a conclusion of substantially consistent high level of care since there were no enforcements for the time periods indicated.

Financial Summary
Total purchase price of $9,500,000 will be met with a bank loan of $7,125,000, with the remaining $2,375,000 coming from members' equity.

Budget:		
	Revenues:	*$ 18,216,413*
	Expenses:	*18,045,787*
	Gain/(Loss):	*$ 170,626*

Subject to noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary
This project is for Establishment action only; therefore, no Architectural review is required.

Recommendations

Health Systems Agency
There will be no HSA recommendation for this application.

Office of Health Systems Management
Approval contingent upon:

1. Submission of an executed loan commitment for the purchase price acceptable to the Department of Health. [BFA]
2. Submission of a working capital loan commitment acceptable to the Department. [BFA]
3. Submission of an executed lease agreement acceptable to the Department. [BFA. CSL]
4. Submission of a photocopy of the applicant's executed Certificate of Amendment of its Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's adopted Amended and Restated Bylaws, acceptable to the Department. [CSL]

Council Action Date
February 2, 2012.

Need Analysis

Background
Alliance Health Associates, Inc., d/b/a Linden Gardens Rehabilitation and Nursing Center, proposes to be established as the operator of Ruby Weston Manor, a 240-bed residential health care facility (RHCF) located at 2237 Linden Boulevard, Brooklyn, Kings County. The sole shareholder of Alliance Health Associates, Inc. is Jack Basch. Mr. Basch will be transfer a total of 70% of interest to Marvin Rubin who will have 15%, Solomon Rubin who will have 15%, and Joel Landau who will have 40%.

RHCF Bed Need	*New York City*
2016 Projected Need	51,071
Current Beds	43,454
Beds Under Construction	635
Total Resources	44,089
2016 Projected Unmet Need	6,982

RHCF Occupancy	*2007*	*2008*	*2009*	*2010*
Ruby Weston Manor	74.3%	64.8%	78.5%	87.8%*
Kings County	91.8%	92.2%	92.3%	92.8%

** 2010 occupancy is unaudited.*

The Ruby Weston reported occupancy rates were 74.3%, 64.8%, 78.5%, and 87.8% in 2007, 2008, 2009, and 2010 respectively. Additionally, the applicant has submitted documentation that occupancy as of September 30, 2011 is 93.7%. Those rates are well below the planning optimum of 97% and the occupancy percentage in Kings County.

In 2010 Ruby Weston had 20 physical A's and 7 physical B's with a CMI of .905.

Conclusion
Since this is a request for a change in ownership and occupancy has increased to acceptable levels, there will be no changes in beds or services following the completion of this project.

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Facility Information

	Existing	*Proposed*
Facility Name	Ruby Weston Manor	Linden Gardens Rehabilitation and Nursing Center
Address	2237 Linden Boulevard Brooklyn, NY 11207	Same
RHCF Capacity	240	Same
ADHC Program Capacity	NA	Same
Type OF Operator	Not-for-Profit	Proprietary
Class of Operator	Business Corporation	Same

Operator	Ruby Weston Manor	Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center <u>Shareholders</u> Jack Basch 30% Marvin Rubin 15% Joel Landau 40% Solomon Rubin 15%

Character and Competence

- FACILITIES REVIEWED

<u>Residential Health Care Facilities</u>

Elmhurst Care Center, Inc.	11/01 to present (10 years)
Bezalel Rehabilitation and Nursing Center	11/01 to present (10 years)
Hamilton Park Nursing and Rehabilitation Center	11/01 to present (10 years)

<u>Other Health Related Facilities</u>

Shiel Medical Laboratory, Inc.	11/01 to present (10 years)

- INDIVIDUAL BACKGROUND REVIEW

Jack Basch is employed as the Director of Alliance Health Associates. Mr. Basch discloses the following ownership interests.

Shiel Medical Laboratory, Inc.	1994 to present
Elmhurst Care Center, Inc.	1/1999 to present
Bezalel Rehabilitation and Nursing Center	1989 to present

Mr. Basch has disclosed an indirect ownership interest in Genesis Healthcare, Inc. Genesis HealthCare, Inc. is headquartered in Kennett Square, Pennsylvania and operates over 200 nursing homes and long term care facilities in 13 Eastern states. Jack and Miriam Basch hold a 4.3478% membership interest in MCP Genesis, LLC, which is a 9.2% member of FC Investors XI. FC Investors XI is an entity formed by Formation Capital, which, along with JER Partners, is a co-owner of Genesis HealthCare, Inc. Mr. Basch has indicated his ownership interest is made solely for investment purposes, and he does not possess any controlling powers over the company or any of its health care operations. In recognition of DOH concern regarding the nature of his ownership interest, Mr. Basch has submitted an affidavit whereby he attests that he has no director, officer, or operating role or interest in Genesis HealthCare.

Marvin Rubin is employed in management at Hamilton Park Nursing and Rehabilitation Center in Brooklyn, NY. Mr. Rubin indicates he holds no ownership interests in health care facilities.

Joel Landau is the Director of Care to Care IPA, LLC, a radiology benefit management company. In addition Mr. Landau is also the owner of The Intelimed Group, a medical contracting and credentialing group and EZ-Bill, a medical billing company. Mr. Landau indicates he holds no ownership interests in health facilities.

Solomon Rubin is employed by Grandell Rehabilitation and Nursing Center as controller, since November, 1997. Mr. Rubin also is employed by Beach Terrace Care Center as controller, since February, 1998.

Mr. Rubin discloses the following ownership interests:

Hamilton Park Nursing and Rehabilitation Center	August 2009 to present

Character and Competence – Analysis:
Joel Landau was named as a defendant on February 8, 2011 in a civil action in New York County Civil Supreme Court. On June 21, 2011, the action was dismissed.

No adverse information regarding the other three proposed members has been received.

The review of operations of Elmhurst Care Center, Inc., Bezalel Rehabilitation and Nursing Center and Hamilton Park Nursing and Rehabilitation Center results in a conclusion of substantially consistent high level of care since there were no enforcements for the time periods indicated.

The review of Shiel Medical Laboratory, Inc. indicates there are no issues with its license.

There are no proposed changes in either the program or physical environment of the facility.

Recommendation
From a programmatic perspective, approval is recommended.

Financial Analysis

Asset Purchase Agreement
The applicant has submitted an executed asset purchase agreement, the terms of which are summarized below:

Date:	June 2, 2011
Seller:	Ruby Weston Manor
Buyer:	Alliance Health Associates, Inc d/b/a Linden Gardens Rehabilitation and Nursing Center
Assets Transferred:	All of Seller's right and title to and interest in all of the assets of every kind, nature and description owned or leased by the Seller and used by, for and in connection with the business.
Excluded Assets:	Any collective bargaining agreement between the Seller and any labor organization which represents the Seller's employees, claims against third parties, Seller's non-transferable licenses, organizational documents, corporate seal, tax returns, and other tax records of Seller, all equity interests in Seller and the real property.
Assumed Liabilities:	None
Purchase Price:	$9,500,000
Payment:	$475,000 down payment upon execution of this agreement with the balance due at closing.

The applicant has provided an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law, with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. Currently, there are no outstanding Medicaid audit liabilities and approximately $1,231,195 in Health Facility Cash Assessment Program liabilities and $2,074,584 in retro Medicaid rate liabilities.

Lease Rental Agreement
The applicant has submitted a draft lease agreement, the terms of which are summarized below:

Landlord:	Alliance Health Property, LLC
Leesee:	Alliance Health Associates, Inc.
Premises:	All buildings, structures, fixtures and equipment located at 2237 Linden Boulevard, Brooklyn

Rental:	2,500,000 per year, increasing 5% every three years.
Term:	25 years with the option to renew for an additional ten years.
Provisions:	The lessee shall be responsible for taxes, utilities, insurance and maintenance.

The lease agreement is between related entities with common ownership and is, therefore, a non-arm's length agreement. The applicant has submitted an executed real property purchase agreement between Alliance Health Property, LLC and Ruby Weston Manor.

Operating Budget

The applicant has submitted an operating budget, in 2011 dollars, for the first year subsequent to change in ownership:

Revenues:	$18,216,413
Expenses:	
Operating	$14,830,607
Capital	3,215,180
Total Expenses:	$18,045,787
Net Income:	$170,626
Utilization: (patient days)	78,942
Occupancy:	90.1%

The following is noted with respect to the submitted RHCF operating budget:

- Expenses include lease rental.
- Medicare and private pay assume current rates of payment.
- Medicaid rate is based on the facility's 2011 Medicaid rate published by DOH, adjusted to reflect change in capital reimbursement due to conversion from not-for-profit to proprietary.
- Utilization by payor source for year one is expected as follows:

Medicare Fee for Service	5.6%
Medicaid Fee for Service	75.9%
Private Pay	18.5%

- Breakeven occupancy is projected at 89.3%.

Capability and Feasibility

The purchase price of $9,500,000 will be provided through a $7,125,000 bank loan from First Meridian at a 6% interest rate for 20 years and $2,375,000 in equity from the proposed members. Presented as BFA Attachment A is the net worth statements of the proposed members showing sufficient funds. The applicant has submitted an affidavit from each member which states that he is willing to contribute resources disproportionate to ownership percentages.

Working capital contributions are estimated at $3,007,631, based on two months of first year expenses, and will be satisfied by a working capital loan in the amount of $1,503,815 at an interest rate of 6.25% for a 5 year term, for which a letter of interest has been provided by First Meridian. The remainder, $1,503,816, will be provided as equity from the proposed members. Presented as BFA Attachment B, is the pro-forma balance sheet of Alliance Health Associates, Inc. as of the first day of operation, which indicates positive member's equity position of $3,878,816.

Review of Attachment C, financial summary of Ruby Weston Manor, indicates that the facility has maintained average positive equity and experienced average negative working capital and an average net loss of $2,776,379 for the period shown. The applicant has indicated the reasons for the losses were low occupancy levels, inadequate controls on operating expenses and a retroactive Medicaid rate adjustment which resulted in a reduction in revenue of $1,456,183 for 2009. In 2010, the facility developed and implemented a plan for increasing occupancy and a change in management led to tighter fiscal controls. Occupancy increased from 78.5% in 2009, to 87.8% in 2010, and expenses have decreased by $325,696 from 2009. As of September 30, 2011, occupancy has increased to 93.7%.

The submitted budget indicates a net income of $170,626 for the first year subsequent to change in ownership. The budget appears reasonable.

Review of BFA Attachments D and E, financial summaries for Elmhurst Care Center and Bezalel Rehabilitation and Nursing Center, indicates that the facilities have maintained positive working capital and positive equity, and experienced an average net income of $431,275 and $115,381, respectively, for the period shown.

Review of BFA Attachment F, financial summary for Hamilton Park Nursing and Rehabilitation Center, indicates that the facility has experienced average negative working capital, average negative equity, and experienced an average net loss of $458,281 for the period shown. The applicant has stated the reason for the losses was a result of two and a half years of retroactive rate adjustments due to the reduction and elimination of the facility's trend factors, and other State Budget reductions that the new operator could not have anticipated during 2010. The facility has since adjusted its operating expenses for 2011, and has generated a net income of $1,009,757 as of July 31.

Based on the preceding, and subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Personal Net Worth Statement
BFA Attachment B	Pro-forma Balance Sheet
BFA Attachment C	Financial Summary, Ruby Weston Manor
BFA Attachment D	Financial Summary, Elmhurst Care Center
BFA Attachment E	Financial Summary, Bezalel Rehabilitation and Nursing Center
BFA Attachment F	Financial Summary, Hamilton Park Nursing and Rehabilitation Center
BFA Attachment G	Establishment Checklist

ALLIANCE HEALTH ASSOCIATES, INC.
Doing Business As
LINDEN GARDENS REHABILITATION AND NURSING CENTER

PRO FORMA BALANCE SHEET

ASSETS

Working Capital	$3,007,631
Prepaid Expenses	$115,176
Inventory (Supplies)	$59,428
Nursing Home - Goodwill	$9,325,396
TOTAL ASSETS	**$12,507,631**

LIABILITIES AND EQUITY

LIABILITIES

Mortgage	$7,125,000
Working Capital Loan	$1,503,815
TOTAL LIABILITIES	$8,628,815
MEMBER EQUITY	$3,878,816
TOTAL LIABILITIES AND MEMBER EQUITY	**$12,507,631**

Financial Summary

Ruby Weston Manor

	FISCAL PERIOD ENDED		
	12/31/10	12/31/09	12/31/08
ASSETS - CURRENT	$5,504,940	$3,159,216	$4,535,813
ASSETS - FIXED AND OTHER	23,598,257	26,371,318	27,934,875
LIABILITIES - CURRENT	7,809,096	$3,394,859	2,609,727
LIABILITIES - LONG-TERM	21,584,943	22,471,067	23,967,655
EQUITY	(290,842)	3,664,608	5,893,306
INCOME	$16,539,075	$16,830,253	$17,077,201
EXPENSE	20,670,011	19,154,688	18,950,967
NET INCOME	(4,130,936)	(2,324,435)	(1,873,766)
OPERATOR/RELATIVE SALARIES	$140,000	$350,000	$153,600
NUMBER OF BEDS	240	240	280
PERCENT OF OCCUPANCY (DAYS)	87.8%	78.5%	64.6%
PERCENT OCCUPANCY (DAYS):			
MEDICAID	75.4%	81.6%	82.1%
MEDICARE	5.1%	4.0%	4.3%
PRIVATE/OTHER	19.5%	14.4%	13.6%
MEDICAID RATE BREAKDOWN:	2011	2010	2009
OPERATING	$164.18	$162.59	161.37
CAPITAL	33.71	33.71	31.71
TOTAL	$197.89	$196.30	193.08

Financial Summary

Elmhurst Care Center

	FISCAL PERIOD ENDED		
	12/31/10	12/31/09	12/31/08
ASSETS - CURRENT	$7,936,097	$7,820,562	$8,199,124
ASSETS - FIXED AND OTHER	989,115	1,287,049	2,431,671
LIABILITIES - CURRENT	5,692,638	$6,464,618	7,949,713
LIABILITIES - LONG-TERM	272,220	237,309	205,559
EQUITY	2,960,354	2,405,684	2,475,523
INCOME	$29,878,490	$28,758,037	$29,385,934
EXPENSE	30,300,545	28,301,341	28,126,751
NET INCOME	(422,055)	456,696	1,259,183
OPERATOR/RELATIVE SALARIES	$234,000	$270,832	$261,979
NUMBER OF BEDS	240	240	278
PERCENT OF OCCUPANCY (DAYS)	92.3%	94.2%	85.7%
PERCENT OCCUPANCY (DAYS):			
MEDICAID	77.0%	74.9%	84.9%
MEDICARE	12.7%	18.3%	7.2%
PRIVATE/OTHER	10.3%	6.8%	7.9%
MEDICAID RATE BREAKDOWN:	2011	2010	2009
OPERATING	$202.60	$200.52	190.4
CAPITAL	52.13	52.13	50.39
TOTAL	$254.73	$252.65	$240.79

Financial Summary

Bezalel Rehabilitation and Nursing Center

	FISCAL PERIOD ENDED		
	12/31/10	12/31/09	12/31/08
ASSETS - CURRENT	$4,811,856	$5,134,966	$5,217,126
ASSETS - FIXED AND OTHER	1,577,687	1,647,104	1,625,824
LIABILITIES - CURRENT	2,019,961	$2,299,359	2,475,669
LIABILITIES - LONG-TERM	804,891	958,452	1,143,994
EQUITY	3,564,691	3,524,259	3,223,287
INCOME	$11,592,536	$11,552,862	$11,533,205
EXPENSE	11,556,069	11,224,730	11,551,661
NET INCOME	36,467	328,132	(18,456)
OPERATOR/RELATIVE SALARIES	$0	$0	$0
NUMBER OF BEDS	120	120	120
PERCENT OF OCCUPANCY (DAYS)	98.3%	95.7%	96.6%
PERCENT OCCUPANCY (DAYS):			
MEDICAID	89.7%	88.0%	84.8%
MEDICARE	7.0%	7.9%	9.6%
PRIVATE/OTHER	3.3%	4.1%	5.6%
MEDICAID RATE BREAKDOWN:	2011	2010	2009
OPERATING	$194.94	$193.02	191.39
CAPITAL	10.48	10.48	11.22
TOTAL	$205.42	$203.50	202.61

Financial Summary

Hamilton Park Nursing and Rehabilitation Center

	FISCAL PERIOD ENDED		
	12/31/10	12/31/09	
ASSETS - CURRENT	$5,114,681	$4,307,163	
ASSETS - FIXED AND OTHER	1,665,338	2,149,872	
LIABILITIES - CURRENT	6,673,904	$6,858,051	
LIABILITIES - LONG-TERM	22,676	22,367	
EQUITY	83,439	(423,383)	
INCOME	$32,177,951	$9,824,905	
EXPENSE	32,671,129	10,248,288	
NET INCOME	(493,178)	(423,383)	
OPERATOR/RELATIVE SALARIES	$104,615	$31,385	
NUMBER OF BEDS	150	150	
PERCENT OF OCCUPANCY (DAYS)	97.0%	99.5%	
PERCENT OCCUPANCY (DAYS):			
MEDICAID	75.8%	76.7%	
MEDICARE	14.2%	11.0%	
PRIVATE/OTHER	9.9%	12.3%	
MEDICAID RATE BREAKDOWN:	2011	2010	2009
OPERATING	$252.26	$250.03	$234.55
CAPITAL	$35.19	35.19	35.19
TOTAL	$287.45	$285.22	269.74

ESTABLISHMENT CHECKLIST FOR NURSING HOMES

APPLICATION: 111031-E Alliance Health Associates, Inc d/b/a Linden Gardens Rehabilitation & Nursing Center

NATURE OF PROPOSAL: Change in operational ownership

EFFECT ON OPERATIONAL OWNERSHIP: Change from a not-for-profit corporation to a corporation with 100% new members.

EFFECT ON REAL ESTATE OWNERSHIP: N/A

FIXED ASSET PURCHASE PRICE: N/A

FIXED ASSET MEDICAID VALUE: N/A

CAPITAL REIMBURSEMENT:

______ Arms Length Lease
__X__ Historic Cost Method
______ Shortfall; Average Annual Amount

BUSINESS PURCHASE PRICE: $9,500,000

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 2nd day of February, 2012, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center as the new operator of Ruby Weston Manor Residential Health Care Facility, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:	FACILITY/APPLICANT:
112031 E	Alliance Health Associates, Inc. d/b/a Linden Gardens Rehabilitation and Nursing Center

APPROVAL CONTINGENT UPON:

1. Submission of an executed loan commitment for the purchase price acceptable to the Department of Health. [BFA]
2. Submission of a working capital loan commitment acceptable to the Department. [BFA]
3. Submission of an executed lease agreement acceptable to the Department. [BFA. CSL]
4. Submission of a photocopy of the applicant's executed Certificate of Amendment of its Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's adopted Amended and Restated Bylaws, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Mr. Keith McCarthy
Acting Director
Bureau of Project Management
NYS Department of Health
Hedley Building - 6th Floor
433 River Street
Troy, New York 12180-2299